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Educators' Perceptions of Implementation and Outcomes of Trauma-Informed Care Training in Three Appalachian Elementary Schools

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by

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ABSTRACT

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The purpose of this study is to gain insight into the perceptions of the impact of trauma-informed care training in three Appalachian elementary schools. Childhood adversity can negatively affect a student's experience in the classroom (van der Kolk, 2014; Ogata, 2019) with findings showing an estimate of one half to two-thirds of children experiencing at least one traumatic event before the age of 18 (CDC, 2016; Finkelhor, 2015; McInerney & McKlindon, 2021). Trauma, an event or occurrence that causes great distress by exposure to physical or psychological abuse, violence, crime, has been linked to academic failure, various illnesses, both physical and mental, substance abuse, and criminal behavior, and may impact concentration, memory, language skills and organization, which are considered necessary traits to achieve academic success (Center for Treatment of Anxiety and Mood Disorder, n.d.; Liberman et al., 2011; Ogata, 2012). Trauma can also affect social, self-regulation, and relational skills as well as cognitive abilities (National Child Traumatic Stress Network, 2016). As reported by O'Neill et al. (2010), these situations should be addressed through proper trauma education and training which include intervention strategies. The trauma-informed care (TIC) approach is a strengths-based framework based on the awareness of the impact of trauma that takes a universal precaution approach, emphasizing safety and reestablish control (Huckshor & LeBel, 2013).

DEDICATION

"Anything that's human is mentionable, and anything that is mentionable can be more manageable. When we can talk about our feeling, they become less overwhelming, less upsetting, and less scary. The people we trust with that important talk can help us know that we are not alone." – Fred Rogers

This work is dedicated to those who have experienced trauma and to those who have helped mitigate that trauma.

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Chapter 1. Introduction

Trauma, an event or occurrence that causes great distress by exposure to physical or psychological abuse, violence, or crime, has been linked to academic failure, various illnesses, both physical and mental, substance abuse, and criminal behavior (Center for Treatment of Anxiety and Mood Disorder, n.d.; Liberman et al., 2011). Findings show an estimate of one half to two-thirds of children experience at least one traumatic event before the age of 18 (CDC, 2016; Finkelhor, 2015; McInerney & McKlindon, 2021), potentially resulting in a student's inability to regulate emotional, social, and behavioral functions (Perry, 2009). Bayless and Craig-Olden (2003) contended the impacts of trauma usually manifest through social strains, disruptive behaviors, and educational delays. As reported by O'Neill et al. (2010), these situations should be addressed through proper trauma education and training which include intervention strategies. The trauma-informed care (TIC) approach is a strengths-based framework based on the awareness of the impact of trauma that takes a universal precaution approach, emphasizing safety and reestablish control (Huckshor & LeBel, 2013).

Research indicates populations may be at a higher risk of experiencing adversity (CDC, 2009; Center for Youth Wellness, 2014). Kim and Drake (2018) maintained that child abuse and neglect disproportionately effect children living in poverty across ethnic and racial groups, while Slopen et al. (2016) found that black and Hispanic children seem to be exposed to childhood trauma more than Caucasian children. With approximately 25% of the children living in poverty in the United States (Hughes & Tucker, 2018), Sacks and Murphey (2018) reported 45% of those children encounter at least one traumatic adversity. McCormick et al. (2018) noted that youth who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ) are at a much higher risk for trauma exposure. Furthermore, Sogomonyan and Cooper (2010) added that children in

military families are also a risk for adversity. Also, homeless youth usually have experienced previous trauma while dealing with present traumatic experience (NCTSN, n.d.). Children with intellectual and developmental disabilities are at a higher risk for physical, psychological, and sexual abuse. Furthermore, NCTSN noted the connection between substance abuse and childhood trauma. Poverty-stricken communities which lack access to optimum educational opportunities, employment, nourishing food, and adequate housing seem to have higher rates of adverse childhood experiences and suffer from the numerous effects of trauma exposure (Center for Youth Wellness, 2014; CDC, 2009).

Protective factors, those characteristics, mentors, or conditions that mitigate the risk of a child experiencing an event, must be in place to promote healthy development and resiliency (Smart, 2017). Protective factors assist in negating risk factors, which are any characteristics, conditions, circumstances, events, or individual traits of a person, community, or culture that may increase the chances a person will experience adversity (Smart, 2017; WHO, n.d.) Effects from trauma may emerge from insufficient social supports, living in poverty, and prior history of trauma (Child Welfare Information Gateway, 2004; Smart, 2017). The National Center for Mental Health Promotion and Youth Violence Prevention (2004) noted that while a child may be associated with a risk factor, that child may not experience trauma or the effects if protective factors are in place. The National Scientific Council on the Developing Child (2014) reported that the reliability of a nurturing and responsive adult is the most effective protective factor connected to building resilience as this presence can establish senses of predictability, control, and safety as well as provide ways to process traumatic events and re-traumatization (Bartlett et al., 2017; Blaustein & Kinniburgh, 2010; Lieberman, 2004; NSCDC, 2014). Support from friends and family, as well as school and community members, may provide protective factors

for a traumatized child (NCTSN, 2010). Self-efficacy, self-esteem, and a positive sense of self-worth are all considered valuable protective factors. Life-application skills and talents are also deemed imperative in mitigating the effects of trauma. Feelings of safety inside the home, at school, and in the community add to the protective factor component. Furthermore, cultural and spiritual beliefs play a role in providing a sense of value and well-being to the child's life.

Schools are considered community-based supports that can offer protective factors that may build resiliency, trust, and coping mechanisms in students exposed to trauma (Kirk et al., 2013). Kirk et al. posited community-based supports, such as educational settings, are the most effective in providing support, developing and reinforcing appropriate social and emotional behaviors, and improving the overall well-being of a student. Since educators can be considered an influential part of a student's community, TIC training in the school setting could prove beneficial. As a community-based support, schools can create a safe system for student choices that empower the individuals through strength-based approach to services and support systems (Hopper, 2010). Because trauma socially (Becker-Weidman & Hughes, 2008) and educationally (van der Kolk et al., 2005) affects students, O'Neill et al. (2010) maintained an educational system should implement TIC training.

Even though dealing with traumatized students is not new in the arena of education, research suggests educators who are trained in TIC develop a greater ability to recognize and understand trauma-related behaviors and are prepared with strategies and techniques needed to mitigate the effects of trauma (Chak, 2010; Siegel, 2009). This knowledge of trauma allows the educator to provide environments that foster a feeling of personal and emotional safety while increasing opportunities for students to develop self-regulation, confidence, and positive relationships. Studies indicate a faculty trained in TIC can help reduce the number of student

disruptions, possibly due to improved interactions between teacher and student (Azeem et al., 2011; Brown et al., 2011; Gonshak, 2011). TIC training emphasizes the importance of understanding the effects of trauma and the educator's display of empathy toward the student. O'Neill et al. (2010) emphasized the TIC approach enables an educator to establish a safe and supportive environment by understanding certain student behaviors.

Statement of the Problem

The trauma-informed care approach (TIC), a method of care that recognizes the benefits of acknowledging and encompassing manners of dealing with trauma, is becoming part of the educational conversations as the school systems can be viewed as critical systems of support (The National Child Traumatic Stress Network, n.d.). As more research reveals the short-and long-term effects of childhood trauma, schools have begun to acknowledge the need to address trauma-induced issues that arise in the classroom. To help deal with these concerns, TIC approach training has become part of the resources provided to educators. The scope of training in this area ranges from overviews to intensive instruction. For training to be beneficial, the training should be perceived as effective and applicable to educators (Knowles, 1975).

Purpose

The purpose of this qualitative phenomenological study was to examine the implications and outcomes of trauma-informed care approach training as perceived by educators.

Significance of the Study

Childhood trauma has risen in recent years according to research, with estimates of one half to two-thirds of children experiencing trauma (McInerney & McKlindon, 2021; Sauers & Hall, 2016;). An educational or school-related setting has opportunities for adults to become valuable points of contact for students. Since trauma exposure has been shown to be prevalent in

children, it may be advantageous for all administrators, educators, and other personnel to use and understand identical verbiage when speaking of trauma matters as well as the recognizing the significance of resilience. Stakeholders may use the information from the study to re-evaluate the topics and training items of this particular training as well as gauge the culture of the school.

Research Questions

An overarching research question steered this qualitative phenomenological study: What are the educators' perceptions of the quality of the implementation and subsequent outcomes of the trauma-informed care approach training in three Appalachian elementary schools? Additionally, the following supporting sub-questions guided the study:

1. What was the perception of the level of knowledge about trauma-informed care prior to the trauma informed care training of:
    a. Teachers
    b. Counselors
    c. Administrators
2. What was the perception of the factors in the trauma informed care training that assist in identifying a student's possible exposure to trauma of:
    a. Teachers
    b. Counselors
    c. Administrators
3. What was the perception of the factors in the trauma informed care training that assist in identifying and assisting students who have been exposed to trauma of:
    a. Teachers
    b. Counselors

c. Administrators

4. What was the perception of the supports needed for the elements of the trauma-informed care training to be implemented of:
    a. Teachers
    b. Counselors
    c. Administrators
5. What was the perception of the level of knowledge about trauma-informed care after implementation by:
    a. Teachers
    b. Counselors
    c. Administrators

Definitions of Terms

The following terms are defined for the purpose of this study:

- Acute trauma: trauma that results from a single stressful or dangerous event (Leonard, 2020).
- Adverse Childhood Experiences (ACEs): abuse, neglect, dysfunctions in the home, exposure to other traumatic stressors such as witnessing violence, experience bullying or racism, or being separated from family, before the age of 18 (Center for Disease Control and Prevention [CDC], 2018)
- Childhood Trauma: an event that is emotionally painful or distressing to someone under 18 which often results in lasting (delayed or immediate) psychological and physical effect (National Child Traumatic Stress Network, 2018)
- Chronic trauma: trauma that results from repeated and prolonged exposure to highly stressful events. Examples include cases of child abuse, bullying, or domestic violence (Leonard, 2020).

- Complex trauma: chronic, usually early, exposure to multiple traumatizing experiences, often at the hands of caregivers (National Child Traumatic Stress, Network, 2018).

- Positive stress: stress, which is considered both helpful and healthy, while briefly increasing heart rate with only mild hormonal elevations (Center on the Developing Child at Harvard University, n.d.) Shonkoff et al., (2012) added that this physiologic state is brief and mild to moderate in degree, while Franke (2014) maintained that this normal stress response is vital for a child's growth and development.

- Tolerable stress: stressful events that are tragic and unavoidable but can be buffered if a supportive caregiver is in place (Shonkoff et al., 2012).

- Toxic stress: prolonged activation of the stress response in the absence of protective relationships: the result of chronic adversity without adult support (Shonkoff et al., 2012).

- Trauma: an event or occurrence that causes great distress by exposure to physical or psychological abuse, violence, crime, has been linked to academic failure, various illnesses, both physical and mental, substance abuse, and criminal behavior (Center for Treatment of Anxiety and Mood Disorder, n.d.; Liberman et al., 2011).

- Trauma-informed care (TIC): a strengths-based framework based on the awareness of the impact of trauma that takes a universal precaution approach, emphasizing safety and reestablish control (Huckshor & LeBel, 2013).

Limitations

Limitations with a phenomenology study generally include time limitations, small samples, and participation bias (Peoples, 2021). Given the time limitations, the educators' perceptions of the implementation and outcomes of the trauma-informed care approach training was limited to what was revealed through the interviewing process. The specific sampling was chosen to gain deeper understanding of a lived experience of a phenomenon. Because of the small sample size, generalizations from a phenomenological study cannot be applied to a population; however, the results can add to research. Although the participants were given directions to answer the open-ended interview questions honestly, there is a chance of participant

bias. Participant bias occurs when answers are given based on a preconceived idea of that the interviewer wants to hear.

Delimitations

Purposeful sampling was utilized to limit participants to those who received the "Building Strong Brains Tennessee" training while being employed by three Appalachian elementary schools in Northeast Tennessee. Open-ended questions were asked to give participants opportunities to reveal the essence of the phenomenon. The Zoom Video Communications system was chosen for the interview platform since educators were familiar with and likely were comfortable with this format.

Overview of the Study

This study includes five chapters. Chapter 1 establishes the foundation for this study by including an introduction to the study, a statement of the purpose of the study, the research questions, definitions of related terms, and the limitations and delimitations of the study. Chapter 2 is a review of the literature related to trauma and trauma-informed care. This review includes an overview of the prevalence of trauma, the effects of trauma, trauma-informed care approach, and the implementation of trauma-informed care approach in educational settings. Chapter 3 describes the research methodology, the research questions, population, instrumentation, data collection, and data analysis. Chapter 4 presents the data interpretation, the coding of illuminating data, and the research findings. Chapter 5 is a summary of the findings and the conclusions, as well as implications for practice and recommendations for further research.

Chapter Summary

This qualitative study explores educators' perceptions of the impact of trauma-informed care approach training in three Appalachian elementary schools. Chapter 1 includes the

introduction, statement of the problem, limitations and delimitations, definition of terms, research questions, significance of the study, and overview of the study.

Chapter 2. Literature Review

Introduction

Trauma, according to the Center for Treatment of Anxiety and Mood Disorders (n.d.), is an event or experience that causes great distress to a person either by exposure to physical or psychological abuse, violence, or crime. The National Child Traumatic Stress Network (n.d). defines trauma as sudden, unexpected events that cause a rational or an irrational sense of fear. The American Psychiatric Association (2000) identifies trauma as witnessing or experiencing an event that involves threatened or actual harm, including death. Furthermore, McInerney and McKlindon (2014) posited that trauma is a naturally occurring response to one or more external influences that impact a person beyond one's typical coping skills. Lieberman et al. (2011) added that trauma is quite frequently the cause of various illnesses, both physical and mental, academic failure, substance abuse and even criminal behavior. Interestingly, the Greek meaning of the word "trauma" is simply *wound* or *injury* (Boyd, 2007; Cerney, 1995).

Traumatic events are not defined solely on the event itself, but how an individual interprets that particular event (SAMHA, 2014). It is a person's inability to cope with the ramifications of an event that determines the level of trauma (Rice & Groves, 2005). Trauma, however, does not affect everyone in the same manner (Wilson et al., 2013; Wolpow et al., 2016). Some people experience an event that may be considered traumatic but exhibit no long-standing adverse emotional or physical effects; however, another person may experience the same incident and develop disparaging issues. Wilson et al. (2013) noted that traumatic response is highly individualized and shaped by a wide range of factors, including genetics, cultural and environmental factors, previous experiences, and available support systems. Receiving help from professionals delivered in a trauma-informed environment helps mitigate the effects. On the

other hand, assistance delivered in a trauma-insensitive approach can also have a negative impact on the person exposed to trauma.

Experts in the educational field report that trauma does indeed affect a student's performance, academically, socially, and physically, with research continuing in the minimizing and mitigation of the impact of trauma in the classroom (Souers & Hall, 2016; Thomas et al., 2019). According to Souers and Hall (2016), the effect of trauma on students permeates the culture of the schools, thus sometimes leaving teachers unprepared to deal with the ramifications felt in the classroom. Cook (2015) reported that trauma affects around 46 million children a year, with one in 10 children experiencing five or more incidents that involve violence. Cook noted that the Department of Justice's Defending Childhood Initiative reports that a child's risks of physical and mental issues rise with exposure to trauma, often affecting physical, emotional, cognitive, and social development. In the realm of academics, childhood trauma could manifest through truancy, academic failure, and behavior issues in the classroom.

Between 1995 and 1997, Kaiser Permanente Health Appraisal Clinic conducted a longitudinal study with over 17,000 participants (Felitti et al., 1998). This study revealed that numerous negative social behaviors and health conditions were indicative of a participant having experienced trauma as a child (Felitti et al., 1998; Plumb et al., 2016). Felitti's et al. (1998) initial findings were based on the answers from a questionnaire known as the Adverse Childhood Experiences, or ACEs, that included areas such as abuse (mental, physical, and sexual abuse) as well as neglect (environmental, physical, emotional) and significant household dysfunction (familial substance and domestic abuse, familial mental illness, and incarceration) during the developmental years before 18 years of age (Plumb et al., 2016; Santoro et al., 2016). The full ACEs measure range is from zero to 10. The higher the ACE score, the more likely the person

will develop negative emotional and physical effects. ACEs has since become the descriptive umbrella term that encompasses abuse, neglect, and traumatic experiences occurring under the age of 18 years (Goddard, 2021). According to Soleimanpour et al. (2017), multiple studies since the initial ACEs study have revealed that at least 55% of the population have experienced at least one traumatic experience. The original ACEs study (Felitti et al., 1998) catapulted the Trauma Informed Care (TIC) Approach to help recognize and better deal with trauma victims.

Historical Background of Trauma-Informed Care

The trauma-informed care approach began as an effort to better serve the lives of those who had been exposed to trauma, even though professional caretakers had long been providing attention intuitively in a trauma-informed manner (Wilson et al., 2013). What began as deep investigation into the post-traumatic stress syndrome following the Vietnam War, the dearth of research and inquiry that ensued led to significant studies into the causes of short- and long-term effects of trauma. The women's movement in the 1970s aided female victims to speak of their own trauma and feelings and behaviors associated with spousal abuse, rape, and other victimization. In the 1980s, child abuse and neglect were examined and brought to light with child-advocacy centers and other multidisciplinary teams were forged. The mental health community began advocating for further research and ways to assess and combat the detrimental effects of trauma. In 1985, the International Society for Traumatic Stress was formed in the United States, serving as a central point for professionals seeking answers to support greatly traumatized populations. By 1989, the United States Department of Veterans Affairs had created the National Center for Post-Traumatic Stress Disorder. Consequently, the Substance Abuse and Mental Health Services Administration (SAMHSA), within the U.S. Department of Health and Human Services, recognized and acknowledged the role of trauma in a vast number of women's

issues and gender-specific treatments in the 1990s. Over the next 20 years, an enormous expansion of knowledge concerning trauma and traumatic stress occurred (Blodgett & Dorado, 2016; Wilson et al., 2013). This included not only improved diagnostic measures but also the development and expansion of empirically tested treatments for PTSD and other related trauma symptoms.

However, the initial ACEs study brought awareness to the frequent occurrences of adverse childhood experiences and the possible detrimental effects, which in turn, typically connects TIC to ACEs as a method to mitigate those effects (SAMHSA, 2014). SAMHSA (2014b) defines TIC as recognizing the symptoms of trauma and the role it has played in the person who has experienced trauma's life. The conceptional framework of TIC focuses on realizing the prevalence of trauma while attempting to reduce its occurrence. Also, TIC acknowledges and implements practices that are sensitive to the person's history with traumatic events so appropriate treatment can be observed. Crucial elements of a TIC approach consist of practices and principles that include creating an environment that is both physically and psychologically safe, recognizing the signs of trauma, focusing on the strengths of the person who has experienced trauma, and careful consideration as not to retraumatize the person. Furthermore, it is necessary for those exposed to trauma to be treated with a sense of compassion and respect while providing recovery resources.

Prevalence of Trauma

Childhood trauma has risen in recent years with estimates of one half to two-thirds of children experiencing trauma (CDC, 2016; Finkelhor, 2015; McInerney & McKlindon, 2021; Sauers & Hall, 2016). Egger and Angold (2006) indicated that 52% of children between the ages of 2 and 5 had experienced severe trauma. Furthermore, the National Survey of Children's

Health (2011) found that almost 35 million children in the United States had been exposed to trauma. Cook (2015) found that trauma affects around 46 million children a year, with one in 10 children experiencing five or more incidents that involve violence. According to Childhelp (2013), every 10 seconds a report is made concerning some form of child abuse. The U.S. Department of Health and Human Services Administration for Children and Families (2019) reported that child neglect and abuse are common among children under the age of three. In 2017, the Department reported 75% of children were victims of neglect, with 18% suffering from physical abuse and 9% were victims of sexual abuse. Furthermore, McLaughlin et al. (2013) reported than nearly half of all children in the United States are exposed to at least one type of trauma before their eighth birthday. Community-based surveys indicate that 55% to 90% of the United States' population have experienced at least one traumatic adversity, with some individuals averaging experiencing five traumatic events (Briere, 2012; Harris & Fallot, 2001; Plumb et al., 2016). While trauma transpires throughout the lifespan, for many people seeking the assistance of social workers and other helping professionals, the trauma began in childhood (Wilson et al., 2013). Trauma has occurred in all populations, including socioeconomic, cultural, religious, ethnic, and levels of education.

Populations at Risk

Even though trauma has occurred in all realms, research indicates certain populations are at a higher risk of experiencing adversity (CDC, 2009; Center for Youth Wellness, 2014; Hughes & Tucker, 2018; Kim & Drake, 2018; McCormick et al., 2018; NCTSN.org, n.d.; Sacks & Murphey, 2018; Soopen et al., 2016; Sogomonyan & Cooper, 2010). Kim and Drake (2018) reported that child abuse and neglect disproportionately effects children living in poverty across ethnic and racial groups. Slopen et al. (2016) found that exposure to childhood trauma is more

prevalent among black and Hispanic children than Caucasian children. With approximately 25% of the nation's children living in poverty (Hughes & Tucker, 2018), Sacks and Murphey (2018) noted 45% of those children experience at least one traumatic adversity. McCormick et al. (2018) reported that children who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ) are at a higher risk for trauma exposure. Sogomonyan and Cooper (2010) added that children in military families also are a risk for adversity. Furthermore, homeless youth usually have experience previous trauma while also dealing with traumatic experiences in the present (NCTSN, n.d.). NCTSN also reported that children with intellectual and developmental disabilities are at a higher risk for physical, psychological, and sexual abuse. Also, NCTSN acknowledged the connection between substance abuse and childhood trauma, as well as economic stress. Poverty-stricken communities which lack access to optimum educational opportunities, employment, nourishing food, and adequate housing seem to have higher rates of adverse childhood experiences (Center for Youth Wellness, 2014; CDC, 2009).

Levels of Trauma

A child's inability to appropriately handle or manage an adverse experience is described as trauma (Brunzell et al., 2015; Cavanaugh, 2016; Crosby, 2015). The ability to deal with the various types of trauma is dependent upon factors such as the child's age, support system, personal coping skills, and other resources. Trauma can be further categorized into acute, chronic, or complex types.

Acute Trauma

Acute trauma is defined as experiencing a short-term severe instant of stress that renders a child unable to cope appropriately (Marsac & Kassam-Adams, 2016; Plumb et al., 2016; Wolpow et al., 2016). Acute trauma, although a brief and often a single event such as a car

accident or a natural disaster, can have profound effects on a student's ability to cope appropriately (Wolpow et al., 2016; Marsac & Kassam-Adams, 2016). Even though acute trauma refers to a one-time occurrence, research indicates the victim is 85% more likely to have additional comorbid adverse childhood experiences (Felitti et al., 1998; Plumb et al., 2016).

Chronic Trauma

Chronic trauma is different than acute as chronic stress is continuous for a great amount of time and can also be reoccurring (Wolpow et al., 2016). The autonomic nervous system cannot activate the relaxation response because of the intensity or frequency of the traumatic event. Students who are exposed to chronic trauma often live within a household of domestic violence. Ongoing neglect, continuous physical and/or sexual abuse are also classified as chronic trauma. Wolpow et al. also suggested that living in a dangerous neighborhood with a gang presence can be considered a chronic traumatic experience.

Complex Trauma

Complex trauma is chronic trauma that begins in early childhood and most often spans a lifetime (Souers & Hall, 2016). In 2003, the NCTSN Complex Trauma Task Force delved into the idea of complex trauma, recognizing that a person could experience numerous difficulties for long periods of time. Sequential and simultaneous exposure to trauma is the differentiating factor for this type of trauma as well as the impact (Cook et al., 2003). Complex trauma involves both the long and short-term results of ongoing exposure to traumatic events such as physical, emotional and sexual abuse, violence, and maltreatment (Cook et al., 2005; van der Kolk, 2014). Because complex trauma usually occurs with a caregiver, the victim has difficulty forming secure attachments.

Modes of Trauma

Physical Abuse

Goodman et al. (1997) defined physical abuse as the act of causing or attempting to cause physical pain or injury to an individual. Examples of physical abuse may include hitting, slapping, punching, kicking, biting, or burning or causing injury to another person through physical manners. Hodas (2016) reported that children who are physically abused are at a higher risk for anxiety and depression. Also, behavior may become aggressive.

Psychological Abuse

Psychological abuse, also known as emotional abuse, verbal abuse, or mental cruelty, generally occurs when a difference in control and power is present with the abuser using a systematic method of destroying the victim's sense of safety or self-esteem (Follingstand & Dehart, 2000). Humiliation, ridiculing, isolation, contact deprivation, and threats of abandonment are all forms of psychological abuse. Psychological abuse can consist of incidents that are isolated or ongoing situations due to the failure of one's support system to furnish an appropriate environment (Norman et al., 2012). Furthermore, psychological abuse is considered a form of interpersonal violence with detrimental short- and long-term effects (Dutton et al., 2001). Interpersonal trauma, which includes various types of emotional, physical, or sexual abuse, occurs with people who know each other, such as children, parents, or spouses (SAMHSA, 2014). Several researchers maintain this form of abuse produces greater trauma in the victims than infrequent physical abuse (Davis & Frieze, 2002; Guthrie, 2001; Hildyard & Wolf, 2002). According to Shi (2013), psychological abuse experienced in childhood is one of the clearest predictors of displaying symptoms of trauma in adulthood.

Child Abuse

Identifying sets of acts or behaviors that determine child abuse and neglect is provided by federal legislation. The Federal Child Abuse Prevention and Treatment Act (CAPTA), as amended by the CAPTA Reauthorization Act of 2010, defines child abuse and neglect as an act or failure to act on the part of a caretaker or parent that presents a risk of serious harm or an act that results in sexual, physical, or emotional abuse (Child Welfare Information Gateway, n.d.). Approximately twenty-five percent of children experience abuse (Dvir et al., 2013). SAMHSA (2014) added that these traumas are referred to as developmental traumas if occurring during the various developmental stages and have the potential to hinder later adjustment, development, and mental and physical health.

Sexual Abuse

Child sexual abuse, according to the World Health Organization (n.d.), is the coercion of a child to engage in any unlawful sexual activities or practices. The National Center for Victims of Crime (n.d.) reported that not all sexual abuse includes physical contact, but child pornography, exposure, and voyeurism are considered sexual abuse as well (Watford, 2020). The U.S. Department of Health and Human Services Children Bureau reported that 9.2% of abused children were sexually assaulted. According to the Crimes against Children Research Center (n.d.), 1 in 5 girls is the victim of child sexual abuse while 1 in 20 boys has been victimized. The research center also reported that 16% of adolescents ages 14 to 17 had been sexually abused during a one-year period in the United States, with 28% of that age group had been victimized over a lifespan. The National Institute of Justice (2003) reported that three out of four victims who were sexually abused were victimized by someone who was familiar to them, such as a trusted caregiver. Children of sexual abuse traumatization often become withdrawn, mistrustful

of adults, develop low self-esteem, or even have thoughts of suicide. Hodas (2006) reported that sexual abuse often produces internalized reactions with external reactions occurring among older children and adolescents.

Trauma's Relationship to Stress

Stress is the physiological and cognitive responses to situations that are identified as challenges or threats (Watford, 2020). Stress is generally defined as a means of describing the response to the challenges confronted daily throughout one's lifetime (Franke 2014). Stress can be a positive or a negative experience. However, not all negative stress proves detrimental as support can be found in a caring adult, often referred to as "buffers." Stress is categorized into three types: positive, tolerable, and toxic.

Positive Stress

According to the Center on the Developing Child at Harvard University (n.d.), positive stress is considered both helpful and healthy, while briefly increasing heart rate with only mild hormonal elevations. Shonkoff et al. (2012) added that this physiologic state is brief and mild to moderate in degree, while Franke (2014) maintained that this normal stress response is vital for a child's growth and development. A parent or other responsive adult may act as a protective social and emotional support, allowing the stress response to return in a normal fashion (Franke, 2014). Supporting a child's ability to return to a healthy baseline of coping is an integral part in TIC. Traumatic events that may trigger positive responses are dealing with frustration, being in new situations, or learning a new task.

Tolerable Stress

Tolerable stress is serious as it involves a greater enormity of threat or adversity, but like positive stress, the stress responses can be alleviated through supportive relationships with adults

(Shonkoff et al., 2012). Franke (2104) posited that because the body responds to the stress with greater intensity, the biochemical responses may negatively affect brain architecture. However, brain and other affected organs may fully recover once the adversity is removed. Not unlike positive stress, a victim of tolerable stress can reap the benefits of a strong support system. Examples of tolerable stress is experiencing the death of a loved one, a parental divorce, a natural disaster, or a serious illness or injury.

Toxic Stress

When stress responses are activated for a prolonged amount of time, this stress becomes known as toxic stress (Franke, 2014). Garner and Shonkoff (2012) defined a degree of stress known as "toxic stress" as being the excessive activation of the physiologic stress response systems that can occur when a stable relationship is not secured. Toxic stress is manifested through traumatic experiences and lacks a support system of protective relationships and is considered the most damaging of stress. Toxic stress is the most detrimental as it can have a profound effect on the development of the brain. Toxic stress occurs when the body's stress response system is powerful, repeated, and long-lasting without the protective buffer of a supportive and compassionate adult relationship (Shonkoff et al., 2012). According to the American Academy of Pediatrics (n.d.), the amygdala, hippocampus, and prefrontal cortex, areas of the brain that involve learning and behavior, can be functionally changed if in prolonged states of stress. The body believes it is in a state of emergency and will act accordingly. This type of stress may put the child at a higher risk for brain development abnormalities or mental health issues. Furthermore, toxic stress can impair a child's ability to learn or build healthy relationships. Examples of toxic stress include neglect, abuse, violence, household dysfunction, extreme poverty and food scarcity (Franke, 2014).

Stressors

Stressors, or triggers, are instruments or catalysts that produce stress (Franke, 2014). Stressors refer to situations or events that cause the release of stress hormones and are categorized into two broad categories: physiological and psychological (Watford, 2020). Physiological stressors place strain on the body such as with illness or pain. The effects of physiological stressors are an increase in heart rate, respirations, oxygen consumption, and blood pressure (Dusek & Benson, 2009). An individual may even "shut down" entirely, unable to react to the stressful situation (Kolk, 2014; NCTSN, n.d.). The physiological response is triggered due to the biochemical structure responding as if the trauma were reoccurring (Wilson et al., 2013). Typically, once the stressor is removed, the physiological changes return to the baseline state. Psychological stressors are events, individuals, or threats. Stressors may be physical, emotional, theoretical, and environmental. As with the interpretation of trauma, stressors can also be considered individualized. Stressors such as subtle changes in the tone of voice or facial expression can cause a child to enter a volatile state (Call et al., 2014; Cole et al., 2005). Also, movements or gestures that are viewed as threatening can also trigger impulsive responses. Sensory stressors such as an odor, touch, sound, taste, or a particular scene may be a subconscious reminder of trauma (Wilson et al., 2013).

States of Alert

The neurobiology of trauma is the body's natural response to protect oneself; therefore, healthy responses to stress can provide a sense of safety, control, motivation, and perseverance (stacarecenter.org, 2016). However, in cases of extreme stress or danger or the perception of danger, the brain prepares the body to respond by releasing stress hormones such as cortisol to promote survival (Cook et al., 2005). When cortisol is activated, one of three states of alert

occur: flight, fight, or freeze (Sauers & Hall, 2016). Biologically, the flight response is the first response to peril as to avoid. If this is not possible, the fight state of alert is generated. The freeze state of alert occurs when the biological connection cannot be made to flee or fight. These heightened states of alert are meant to last for a short amount of time. When the body releases the chemical in large doses, they can become toxic causing the flight, fight, or freeze responses to linger longer than necessary. This extreme response to trauma may cause children to develop exaggerated and heightened sense of stress response.

Trauma's Neuroscience Connection

Research shows that properly building the architecture of the brain is critical to establish the foundation for cognitive, social, and emotional skills (Knudsen et al., 2006). However, toxic stress in a child's environment can weaken or damage the development of the brain and nervous system (NCTSN, n.d.). According to Phillips and Shonkoff (2000), research also has shown brain anatomy and chemical activity can be altered significantly due to trauma. Furthermore, the brain, due to its functional and structural plasticity, can develop both adaptive and maladaptive consequences (McEwen, 2007; Sheline, 2003). The American Academy of Pediatrics (n.d.) also posited that children who experience ACEs endure the effects of this toxic stress. Garner and Shonkoff (2012) acknowledged that physical as well as chemical changes occur in the neural networks and metabolic processes.

Emerging neuroscience research reveals the effects of trauma on the brain, which may give insight into the ever-growing implementation of TIC in schools (Cozolino, 2013; Van der Kolk, 2014). The connection between trauma and illness and behaviors seems to be increasingly validated by studies of the brain. According to the Center on the Developing Child at Harvard University (2019), scientists explain that brain architecture is built as billions of neurons make

connections across various areas of the brain. According to the Tennessee Commission on Children and Youth (2018), more than one million new neural connections in the brain form every second in the first few years of life. A process called pruning, which reduces connection, allows the brain's circuits to become more efficient. The architecture of the brain is built through interactions, both environmental conditions and personal experiences (Hensch, 2005; Horn 2004). According to Walford (2020), the brain is built over time from the bottom up, beginning in the womb and continuing into adulthood. Kraybill (2018) added that the lower parts of the brain are in control of ensuring survival and responding to stress, while the upper parts are responsible for evaluating experiences and moral judgement. The architecture is shaped by genes, experiences, and relationships (Boyce et al., 2020; Zhang & Meaney, 2010). Not only do infants quickly develop cognitive, language, and motor control skills, but they also develop the capacity to deal with a variety of emotions (Thompson, 2001; Thompson & Lagattuta, 2006). This emotional development becomes part of the brain's foundation which can later affect the ability to develop relationships, emotional regulation, and social-emotional functioning (Collins & Laursen, 1999). Researchers contend that it is imperative for infants and young children to receive positive emotional experiences since emotion is wired in the central nervous system (LeDoux et al., 2000; Gunnar et al., 2003). This emotional reciprocation has been termed "serve and return."

According to the Tennessee Commission on Children and Youth (n.d.), the "serve and return" interaction is between a caregiver and a child that provides communication among neurons that focus in various categories of brain functions important for early brain development. It is this connection that marries genes to provide a strong foundation in the construction of the brain's architecture. The National Scientific Council on the Developing Child (n.d.) reinforced

this theory by stating children do indeed develop in an environment of relationships. Several researchers posit that scientific proof of this belief exists through brain imaging and other medical technical methods (Kok et al., 2015; Romeo et al., 2018). Romeo et al. (2018) reported that neuroimaging shows an increased activation in the left inferior frontal regions of the brain during "serve and return." The language-related brain function may positively impact the development of the brain. Kok et al. (2015) contended that brain development at eight years of age may be due to caregivers' appropriate response to needs. These findings, according to Kok et al., may mean a traumatized child may have future ability to develop secure relationships and cognitive competency with fewer psychological issues. Sethna and Wang (2017) reported that smaller volumes of subcortical grey matter are associated with lower maternal sensitivity. In other words, the quality of the "serve and return" seems to correlate with brain development. Rifkin-Graboi et al. (2015) reported that analyses show a link between maternal connection with the volume of the hippocampus, an area responsible for emotional function. Levy et al. (2019) noted that biological synchrony, which is a mechanism that affords the parent's physiological systems to influence the child's environment-dependent systems, allows the parent and child to harmonize heart rhythms, neural responses, and oxytocin release, helping to shape the area of the brain that regulates empathy.

Differential Reactions to Trauma

Research suggests a child's reaction to traumatic exposure correlates with the age of the child at the time of the trauma as well as the degree in which the child is affected (Perry, 2004). The earlier the child is exposed to trauma, the greater the potential impact on the growth, function, and structure of the brain (Schwartz & Perry, 2004). Hodas (2006) noted children five years and younger tend to regress to thumb-sucking and bedwetting as well as having an

apprehension toward darkness. Also, a child may have severe anxiety separation with bouts of crying, screaming, and trembling. Aimless movement or immobility may also occur. The NCSTN (n.d.) reported children up to the age of two may have poor appetites and low weight along with digestive problems. Also noted is children three to six years of age may have difficulty learning in school and show poor skill development. Children also tend to blame themselves for the trauma and develop low self-esteem. Children may also act out the trauma they have experienced and become verbally abusive. Making and maintain friendships often are difficult. Hodas (2016) acknowledged that children ages six to 11 may demonstrate both internal symptoms and external behaviors. A child may withdraw, exhibit depression and anxiety, or become emotionally numb. Maintaining attention becomes problematic, while some children may develop irrational fears and sleepwalking tendencies. Children of this age group often have outburst of anger combined with fighting. Truancy can also become an issue. Hodas also reported adolescents 12 to 17 years show responses mirroring those of an adult. Adolescents often exhibit signs of depression, anxiety, withdrawal, and isolation. Victims may also have flashbacks, nightmares, and sleep disturbances. Suicidal thoughts and suicides also occur. Victims may also suffer from low self-esteem and develop anti-social behaviors. Furthermore, those exposed to trauma may tend to abuse substances and avoid school.

Risk Factors

A risk factor is any characteristic, condition, circumstance, event, or individual traits of a person, community, or culture that may increase the chances a person will experience adversity (Smart, 2017; WHO, n.d.). The adversities may include childhood trauma, re-traumatization, or negative consequences connected to trauma. Specific types of trauma may include insufficient social supports, living in poverty, and prior history of trauma (Child Welfare Information

Gateway, 2004; Smart, 2017). The National Center for Mental Health Promotion and Youth Violence Prevention (2004) noted that while a child may be associated with a risk factor, that child may not experience trauma or the effects if protective factors are in place.

Protective Factors

For children to build resilience to trauma, protective factors, those characteristics, mentors, or conditions that mitigate the risk of a child experiencing an event, must be in place to promote healthy development (Smart, 2017). The National Scientific Council on the Developing Child (2014) reported that the reliability of a nurturing and responsive adult is the most effective protective factor connected to building resilience. Researchers assert the presence of a caring adult can establish senses of predictability, control, and safety as well as providing ways to process traumatic events and re-traumatization (Bartlett et al., 2017; Blaustein & Kinniburgh, 2010; Lieberman, 2004; NSCDC, 2014). According to the NCTSN (2010), support from friends and family, as well as school and community members, provide protective factors for a traumatized child. Also, protective factors such as self-efficacy, self-esteem, and a positive sense of self-worth will battle potentially harmful effects. The NCTSN also reported feelings of safety inside the home, at school, and in the community lends to the protective component. Furthermore, cultural and spiritual beliefs play a role in providing a sense of well-being to the child's life. Other protective factors are life-application skills and talents.

Trauma's Effect on Physical Health

Research suggests the effects of trauma can manifest negatively in both present and future health of students, with approximately two-thirds of the population experiencing effects of trauma within a lifetime (Feletti et al., 1998; Plumb et al., 2016). The "dose effect," or the direct correlation between an ACE score and the likelihood of suffering with mental or physical health

concerns later in life, can produce issues such as sexually transmitted diseases, obstructive pulmonary disease, obesity, depression, intravenous drug use, attempted suicide, or death (Felitti et al., 1998). Further research attempts to solidify the link between a high ACE score and health issues in children such as asthma, obesity, speech problems, and frequent illness (Blodgett, 2012). Ramifications of trauma can also manifest through children participating in activities or behaviors that position them in danger of mortality or morbidity (Eaton et al., 2010).

Trauma's Effect on Mental Health

Not only can trauma affect physical health, but mental health can also succumb to the effects of trauma exposure as well (Anda et al., 2006, Felitti et al.,1998; NCTSN, n.d.). Because of trauma exposure, students may experience social anxiety and a decreased level of resiliency. Researchers Roozendaal et al. (2009) pointed out that that exposure to trauma can result in developing mood disorders, high levels of anxiety, as well as post-traumatic stress disorder (PTSD). Aggression, irritability, and low concentration are signs that students may have experienced trauma. Feelings of shame and guilt are more prominent during the middle and high school years, while aggressive behaviors and rebellion against authority figures are often pronounced. Furthermore, students are often faced with bouts of depression, suicidal thoughts, and suicide. Anxiousness and depression are prevalent in students of all ages. Feelings of shame and guilt can plague trauma victims as well as grief and sadness. Childhood trauma victims often feel helpless, sad, and often angry. Post-traumatic stress disorder (PTSD) has also been linked to trauma. The long-lasting effects of trauma can include interruption in a sense of safety and self, lessen the ability to self-regulate emotions, and the inability to form positive interpersonal relationships (Hopper et al., 2010).

Trauma's Impact on Academic Performance

Students who have endured trauma or in the thresholds of trauma may not have the ability to achieve their highest academic potential due to trauma being toxic to the brain, which may interfere with development and learning (Souers & Hall, 2016). Shock and Ciccehtti (2001) reported that proper engagement in academia includes self-regulation, initiative, and paying attention in order to complete challenging tasks, undertakings that may be difficult for the traumatized child. According to Cicchetti et al. (1989), children who have a solid foundation in positive relationships at home are more likely to be successful in the classroom, both academically and socially. This positive worldview acts as the building block of achievement. On the other hand, students who have experienced trauma often have a different view of the world which can consequentially have a negative impact on classroom experience. Their sense of hyperarousal can cloud their judgement and evaluative processes. When a victim becomes astutely attune to their abuser's mood, it is difficult to have a positive outlook and cannot view the classroom as a nonthreatening environment (Herman, 1997).

Experiencing trauma can cause a low concentration, lack of memory skill adaptations, and ineffective organizational skills (Cole et al., 2005). As Shonk and Cicchetti (2001) reported, children who have been exposed to trauma are more likely to receive special education services, have lower achievement test scores, demonstrate less than stellar work habits, and are 2.5 times more likely to be retained. Processing new thoughts and maintaining attentiveness are areas of concern as well (Anda et al., 2006). Acquiring literacy skills and learning new verbal information with the ability to retrieve it is also difficult task for those who have experience trauma. Raunch (1996) found that trauma can affect the way in which the brain processes language, which causes issues in verbal communication. Furthermore, traumatized students may

see communication through the lens of the controlling abuser. Communication is not viewed as a way to express feelings or thoughts which may prohibit the ability to grasp abstract thoughts, which is an imperative first step in achieving literacy skills (Donaldson, 1978). The ability to problem-solve, according to Coster and Cicchetti (1993), can also be hindered due to improper language development. Another impediment is the struggle to develop sequential memory or a coherent narrative of memories. Verbal communication, as well as difficulty in reading and writing, can stem from a lack of sequential memory (Osofsky, 1993).

Trauma's Impact on Student Behavior

Like the inability to reach full academic achievement, trauma can also affect student behavior. School underachievement, and even failure, can be the effects of childhood trauma, which can affect a student's behavior in the classroom (Cole et al., 2005). Students may lack the ability to self-regulate and form empathetic relationships with peers and adults in authority. Trust issues can arise and cause a student to isolate or act inappropriately in the classroom. Harris (2010) acknowledged that students also may exhibit emotions from hyperarousal to the other end of the spectrum of emotional withdrawal. Garrett (2006) contended that traumatized students often are suspended due to inappropriate outburst and aggression because of inability to self-regulate emotions. On the other hand, students may also exhibit a strong desire for perfectionism, which can lead to high levels of anxiety and even depression (Garret, 2006). Another area that can cause unwanted student behavior is the lack of self-confidence and low personal expectations for achievement (O' Donnel, 2002). O'Donnel asserted that participating in school misconduct begins at an early age and will often continue throughout the student's education. Van der Kolk (2005) noted that a child's inability to plan is related to the fact that he or she may have an inner misrepresentation of the world, therefore acting unreasonably instead of

appropriately. Students exposed to trauma historically have higher rates of absenteeism. According to Blad (2016), TIC could be used as a tool to combat absenteeism to some degrees. Responding to trauma may manifest itself in disruptive or unwanted classroom behaviors. Wolpow et al. (2016) contended that the student displaying these behaviors often are labeled as difficult, uninterested, or misdiagnosed as having a learning disability. McIntyre et al. (2019) reported that academic and behavior challenges that stem from trauma mistakenly place a student in special education services at higher rates.

Trauma's Impact on the Economy

Beyond the losses of academic achievement, health, and mental stability is trauma's impact on the economy. Van der Kolk (2014) noted child abuse can be considered the grimmest and most costly public health issue in the United States, exceeding overall costs associated with cancer or heart disease. According to NCTSN (n.d.), the average cost of maltreatment of children is around $284.3 million per day or $103.8 billion annually. This cost includes mental health care, child welfare systems, hospitalizations, and law enforcement. Included are also the costs associated with secondary or long-term effects of neglect such as juvenile delinquency, adult criminal justice systems, healthcare, and lost productivity.

Trauma-Informed Care Strategies in Schools

In 2005, SAMHSA established the National Center for Trauma-Informed Care (NCTIC, n.d.). The NCTIC suggested that organizations and management systems follow a specific framework for creating a trauma-informed establishment. The conceptual framework for providing a TIC approach in an educational setting as suggested by the SAMHSA (2014) consists of six key areas: safety, trustworthiness and transparency, empowerment, personnel

support, collaboration, and cultural responsiveness. Numerous researchers agree that these areas are ideal for entrenching TIC strategies for the school.

Table 1

Trauma Informed Care Key Areas

Key Areas	***Strategies***
Safety	The physical individuals' strengths and experiences are setting is safe and interpersonal interactions recognized and built upon. The organization promote a sense of safety.
Trustworthiness and Transparency	Decisions are conducted with transparency with the goal of building and maintain trust with all involved in the organization.
Peer Support	Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing stories and experiences to promote recovery and healing.
Empowerment, Voice, and Choice	Individuals' strengths and are recognized and built upon. Clients are supported in shared decision-making, choice, and goal setting. Staff are facilitators of recovery rather than controllers.
Collaboration and Mutuality	Importance is placed on partnering and the leveling of power differences. Everyone has a role to play in a trauma-informed approach.
Cultural, Historical, and Gender Issues	Incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.

Note: Strategies are modified from definitions with SAMHSA, 2014.

Safety

Carello and Butler (2015) posited that being physically and emotionally safe in a school is a priority and establishing the TIC approach could be instrumental in establishing this goal. Also, personnel should be trained to recognize triggers that may cause students discomfort, both physical and emotionally (Bath, 2008; Carello & Butler, 2015). This key feature is paramount in the mitigation of adverse effects (Chafouleas et al., 2016; Harris & Fallot, 2001; Phifer & Hull, 2016). Research suggests that establishing consistent routines and rules is one of the most effective rituals in creating a safe and respectful classroom (Shamblin et al., 2016).

Trustworthiness and Transparency

Establishing clear and appropriate missions and boundaries is the first step in creating a culture of trust between trauma victims and teachers (Dorado et al., 2016; McConnico et al., 2016). Another method of creating trustful relationships is teachers responding to a traumatized student in thoughtful and meaningful ways by providing coping strategies. Decision-making concerning TIC supports can involve students and guardians which has the potential to establish ownership.

Empowerment

Validation and affirmation are key to student empowerment by helping build resiliency needed to mitigate the effects of trauma (Harris & Fallot, 2001; Pappano, 2014; SAMHSA, 2014). School personnel are instrumental in providing skill-building opportunities for traumatized students. Focused skills are coping, self-regulation, and control. Also, a focus on resiliency is noted.

Personnel Support

Personal care and sustainably of all school personnel are benchmarks for successful TIC implementation in a school setting (Harris & Fallot, 2001). Systematic review of and provided resources focus on the short- and long-term well-being of those professionals who provide specialized support to those students who may need further attention to regulate emotions and behaviors (Chafouleas et al., 2016). Support to personnel could include professional development with mental health professionals, administrative assistance, and implementation of stress-reducing self-care activities (Butler et al., 2017; Craig, 2008; Craig, 2016). Furthermore, classroom consultation and peer-based mentoring can be scaffolds to personnel support (Holmes et al., 2015).

Collaboration

Collaboration among personnel is recognized as a strategy that encompasses all school employees as stakeholders who are instrumental in providing the trauma-informed care climate with invaluable data and knowledge (Harris & Fallot, 2001; Hopper et al., 2010). Increasing collaboration efforts multiply the work of individuals attempting to increase student support within the school (Ko et al., 2008). School counselors, social workers, special education teachers, and general education teachers all collaborate to recognize and mitigate childhood trauma symptoms. Interagency coordination also incorporates the juvenile justice system, mental health professionals, and child welfare services (Day et al., 2015).

Cultural Responsiveness

Cultural responsiveness in a school setting necessitates that positive representation of all cultures exist to promote pride and resilience (Cole et al., 2013). School personnel can maintain cultural responsiveness by examining possible stereotypes and biases with intention (Blitz et al., 2016; Hopper et al., 2010). Implementing strategies that encourage respect and acknowledgement while incorporating students' cultural customs, values, and beliefs is a cornerstone of cultural responsiveness. Determining areas strengths and needs by assessing student demographic data and community assessments can provide valuable insight into the cultures of the school (Plumb et al., 2016). Cole et al. (2013) suggested that teachers have the mindset of supporting students by making them feel safe, accepted, and welcome to participate in the school community.

Trauma-Informed Care Approach in the Classroom

As schools grapple for ways to best meet the emotional, physical, and academic needs of students, TIC approaches have filtered into the classroom environment throughout the country.

The widespread acceptance of the approach and understanding of ACEs has given way to numerous systems of therapeutic implementations. The surmounting evidence of the connection between childhood trauma and social and emotional health encourages schools to become the changing paradigm (SAMHSA, 2014). Classroom practices that acknowledge trauma is simply the foundation of helping heal the past and prepare for the future (Shapiro et al., 2008). Becoming aware of ACEs is the catalyst that many child psychologists, pediatricians, and educators hope will shift the paradigm in classroom management. The National System Center for Trauma Informed Care (n.d) notes the question "What is wrong with you?" is moving toward the inquiry of "What happened to you?". According to Masten et al. (2008), creating a safe environment through relationship building is key in offering students a foundation that will the needed structure for learning. Connecting with both fellow students and teachers alike enables the student to grow both emotionally and academically. According to Hummer et al. (2009), a trauma-informed classroom should encompass a focus on relationships that emphasize safety and trustworthiness. Hummer et al. also posited that engaging in choice and collaboration, as well as encouraging skill building and competence, encourages healing in the classroom. According to the National Child Traumatic Stress Network (2017), any system striving to create a healthy environment should integrate the four "R's" into a TIC framework: realizing, recognizing, responding, and resisting re-traumatization. Several researchers validate the beneficial aspects of this particular framework (Bartlett & Steber, 2019; Chafoulesa et al., 2016; Mirabito & Callahan, 2016).

Realization of Trauma Prevalence

Realizing and acknowledging that typically 1 in 4 students has experienced trauma is knowledge that is the basis of building bridges to recovery (SAMHSA, 2014). Assisting school

personnel in realizing the importance of implementing TIC throughout the school has been deemed imperative. Furthermore, realizing the effects that childhood trauma can have on the entire culture of the school may induce an acceptance of a TIC school (Butchart & Harvey, 2006). The goal is to bring an awareness to trauma and hope for healing.

Recognition of Signs

Recognizing the signs of trauma is key in identifying students who are in need of assistance (SAMHSA, 2014: Souers & Hall, 2016). This element encourages all personnel to not only recognize the signs of trauma in students but in families and other school-related employees as well. Bartlett and Steber (2019) contended that a child's negative behavior should be recognized as a possible protective barrier in response to a traumatic event and are a natural self-protective behavior. Furthermore, TIC involves recognizing that appropriately engaging in activities, following guidelines and rules, and interacting with friends and adults may be hindered by a child's exposure to trauma (SAMHSA, 2014).

Responding to Trauma

Responding to trauma must be included in all facets of the school (Harris & Fallot, 2001). Converting appropriate training into effective teaching practices as well as other school-based activities is instrumental in the success of a TIC school. Also, policies should reflect the appropriate method of responding to trauma. Furthermore, classroom and administration procedures should follow the same guidelines as well as school-wide practices. The SAMHSA (2014) recommends responding to traumatized children by making adjustments to the child's environment through policies, procedures, and practices that support recovery.

Resisting Re-traumatization

Resisting triggers that may retraumatize students is also key in providing students reprieve from unhealthy emotions while implementing policies and procedures (SAMHSA, 2014). Being knowledgeable of a student's personal situations can be helpful in knowing how to handle outbursts and unwanted behaviors. Teachers also should be mindful of tone of voice and their own behaviors. Also, reshaping a child's environment to avoid triggers such as smells, sights, sounds, objects, or certain people is imperative.

Professional Development

In addition to the framework for implementing TIC into a school, additional professional development concerning TIC should be provided (Lang et al., 2015; SAMHSA, 2014). Personnel should be given opportunity to increase training and professional development as new research emerges. Also, it is beneficial for personnel to reflect on the professional development so meaningful questioning and feedback can be produced. Staying abreast current research should prove invaluable when refining TIC programs. Another component is providing personnel with suggestions for self-care and coping strategies as working with childhood trauma victims can be daunting (Carella & Butler, 2015). Furthermore, it is imperative that mitigating secondary stress, a reaction to exposure to another victim's traumatic experience, should be addressed as self-care (SAMHSA, 2014). Another advantage to continuous professional development is the constant reminder of the benefits for positively maintaining a TIC school culture, which encourages trust-building between personnel and students. Also, having a common language equips all areas of service to apply a "trauma lens" when dealing with students (Cole et al., 2013). All these things will provide personnel the knowledge that is required to support such programs and maintain sustainability (Cole et al., 2013; Wolpow et al., 2009).

Researchers warn of vicarious traumatization, the indirect trauma that can occur when a person is exposed to disturbing traumatic descriptions of events second-hand (Cavanaugh, 2016; Lawson et al., 2019; Perlman & Saakvitne, 1995). Because teachers are in the position to hear about and respond to student trauma, stress and anxiety may add to the emotional burden of educators (Alisic, 2012; Blitz et al., 2016; Caringi et al., 2015). Lawson et al. (2019) noted adults working with trauma victims need to understand the secondary risks and vulnerability that are attached with mitigating trauma effects, while Borntrager et al. (2012) acknowledged that secondary traumatic stress (STS) may develop from vicarious trauma. STS can mirror PTSD stress reactions or symptoms and are often experienced by helping professionals such as teachers (Caringi et al., 2015; Hydon et al., 2015; Stamm, 2010). With the growing prevalence of trauma, those who work mitigating the effects are vulnerable and subject to depression, anxiety, disengagement, mood swings, and substance abuse (Cavanaugh, 2016). Principal and educator turnover rate may be due to STS, especially in high-poverty schools (Rangle, 2018; Holme et al., 2018). Caringi et al. (2015) noted that in a qualitative study exploring elements contributing to STS among teachers working with traumatized students, 75% of teachers expressed thoughts or plans to change careers or retire. As Lawson et al (2019) noted, those caring for or interacting with traumatized victims often need help themselves as they may develop STS. Perfect et al. (2016) reported on average 15 to 20 students in a classroom of 30 are liable to be impacted by trauma. Proper professional development in TIC may assist in preventing STS to those working with students.

Rationale for Trauma-Informed Care Approach in Schools

Research gives insight into the effects of trauma on learning, behavior, and brain development (McInerney & McKlindon, 2021). McInerney and McKlindon argued that schools

have a responsibility in providing stable spaces for students to be connected to attentive and compassionate adults, while Eccles and Roeser (2011) maintained that students' classroom experiences predict their overall well-being in school. Flook et al. (2013) also noted that educators not only facilitate learning but have great potential in influencing students' emotional and social development. TIC, according to Walters (2018), is indeed an approach that should be implemented in schools as students are often victims of trauma. Researchers also suggest that schools should create systems that promote trauma-informed practices since schools are the frontline support (Brunzell et al., 2018; Segal & Collin-Venzina, 2019). Smith (2012) maintained that TIC can provide extra support needed by traumatized learners by creating equity. By implementing TIC in an educational environment, the response to trauma by educators, school administration, and staff may be able to assist in mitigating and minimizing the effects of trauma.

Research suggests that an educational setting is ideal for implementing TIC because nearly 97% of nationwide schools employ at least one staff member who provides mental health services to students (Evans et al., 2014; Teich et al., 2008). These providers include social workers, psychologist, school counselors, and nurses. Also, because teachers ideally have consistent contact with students and a connection between the community and home life, educators can take on the role of direct facilitators (Perry & Daniels, 2016). Furthermore, schools are innately designed to have the ability to build upon the strength of students, bolster resiliency, and promote coping skills (Soleimanpour et al., 2017). Moreover, schools have the potential to provide supportive resources such as curricula and behavioral interventions that target trauma (McInerney & McKlindon, 2021). Educators have the potential to break the cycle of trauma while engaging the student in challenging endeavors through the lens of the TIC approach. Research suggests that without proper intervention, long-term adverse consequences of untreated

trauma may include substance abuse, suicidality, serious mental illness, and long-term physical health factors associated with premature death (Anda et al., 2009; Felitti et al., 1998). However, the effects of exposure to trauma can be minimized if the correct and appropriate supports are in place, especially early intervention (Smith, 2004). Research indicates a need for TIC implementation in schools (Carello & Butler, 2015; Plumb et al., 2016).

Research also suggests that TIC trained schools have the potential to make positive impacts on all student regardless of trauma history (National Association of School Psychologist, n.d.). Because TIC offers numerous objectives that align with educational, health, and behavior goals, the underlying belief system can intertwine seamlessly into the goals of a school (Hummer et al., 2010). Traumatic events such as bullying, deportation or migration, witnessing violence, and discrimination due to race, gender, sexual orientation, birthplace, and ethnicity are not confined to economic, social or ethnic social layers, schools. Areas of TIC that coincide with bolstering a positive school environment are coordination, critical thinking, restorative practices, safety concerns, community outreach, and home connection (NCTSN, n.d.). Venet (2019) added that teaching strategies and pedagogy should be supportive of all students, in which case a trauma-informed environment is beneficial to all learners (Cole et al., 2005; Wolpow et al., 2016). Venet also (2019) contended that supporting a trauma-informed framework and classroom strategies may bolster a successful climate for all students.

Studies also point out that it is imperative that teachers are adequately trained in TIC since educators have the potential to retraumatize a student unwittingly (Leitch, 2017; Venet, 2019). Addressing trauma inappropriately may cause additional emotional harm to the student (Venet, 2019). Venet contended that teachers must not take on the role of therapist but acknowledge certain actions and activities can indeed trigger stress.

Essential Elements of a TIC School System

The National Child Traumatic Stress Network (n.d.) has examined elements of establishing a trauma-informed system of care for a school system. NCTSN reported traumatic stress identification, assessment, addressing, and treatment is imperative to support organization. Also, trauma education and awareness, as well as creating strong partnership with students and families, are important to support TIC. Furthermore, mitigation continues with creating a trauma-informed, culturally responsive learning environment. To emphasize safety, emergency management and crisis response should be integrated into the system. Paramount to a successful TIC system is staff self-care and understanding secondary traumatic stress. NCSTN also recommends system leaders evaluate and revise discipline practices and policies while cooperating with other systems and forming partnerships. Harris and Fallot (2001) also recommended certain prerequisites to help achieve establishment and sustainability. Commitment to changing the paradigm must be supported by the administration section. Harris and Fallot noted a what could be considered a favorable approach is intertwining the commitment to TIC with the organization's mission statement. Furthermore, it is suggested that trauma screening occur routinely to provide a display of caring and concern. All staff should receive information and training as they will possibly interact with victims. Also, Harris and Fallot recommended designating chosen staff members who can manage and guide teams and treatments. Moreover, a review of present policies and procedures could assist in establishing a plan that aligns with TIC. A careful review should reveal if policies and procedures are consistent with the underlying concepts of trauma-informed care.

Benefits of TIC in a School System

The benefits of having a trauma-informed care approach in a school or district are numerous (Haas & Clements, 2019). Using and understanding trauma-related terminology could help mitigate the effects of trauma. Furthermore, recognizing the significance of resilience may add to an educator's ability to be a positive influence. An education or school related setting has opportunities for adults to become valuable points of contact for students, which may act as buffer or methods to interventions. A change in culture concerning ACEs is noted to be an essential part in reaping the benefits of TIC. Training in TIC provides a universal belief that everyone has a valuable part in mitigating trauma. Resilience in the school community will increase as will the reduction of trauma or re-traumatization rates.

Strength-based Practices

Although students' emotional and behavioral effects of trauma must be address, Cavanaugh (2016) noted the urgency in providing positivity throughout the school day for traumatized students. Strength-based practices allow for a student's strengths to become the focus and grow as a support system. Cavanaugh also recommended students be given opportunity to display strengths by engaging in interests. NCTIC (2015) contended strength-based practices mitigate trauma as well as other evidence-based interventions.

Promoting Resiliency

Promoting resiliency and resilience factors is an integral part of trauma-informed care approach in the classroom as these interventions may help to minimize a toxic stress response (Garner, 2013). Resiliency, despite negative conditions or events, is the ability to properly adapt to adversity (Franke, 2014; Hodas, 2006). Bartlett and Steber (2019) noted that resilience can be defined as positive outcome despite adversity, prevention of trauma recurrence regardless of high

risk for additional exposure or evading traumatic experiences altogether in the face of substantial risk. However, Masten (1994) pointed out that resiliency should not be considered as a personal trait. This construct could explain why some children develop trauma-related symptoms and other do not. Southwick et al. (2014) affirmed that the interest in creating resiliency in students has become widespread. Focusing on a student's strengths and gifts builds on self-efficacy and self-esteem while enhancing areas of need (Brunzell et al., 2015). Arastaman and Balci (2013) maintained that resiliency in students assist in lowering rate of absenteeism, increase grade point averages, and promote better problem-solving skills. Other researchers maintained that resilient children have higher IQs, calmer temperaments, empathy, social skill, and realistic senses of control (Cowen et al., 1996; Laporte et al., 2012; Miller-Lewis et al., 2013). Franke (2014) added that resiliency may act as a preventative buffer from experiencing the detrimental effects from toxic stress. Furthermore, resilience is on a continuum, changing over time depending upon the student who has been exposed to trauma (Southwick et al., 2014). The focus for educators then becomes teaching strategies that incorporates resiliency. Resiliency is dependent upon positive interactions and interfaces, which produces vital protective factors such as self-esteem and self-efficacy needed for healthy development (Zimmerman, 2013). According to Martineau (1999), a student that is resilient is noted as communicative, empathetic, friendly, and responsive, also defined as socially competent. Martineau also contended that schools are viewed as a protective shield for students.

Mindfulness

Mindful Based Interventions (MBI) have been found beneficial and may lend effectiveness to the TIC support system by providing a method to reduce anxiety and stress (Dimidjian & Segal, 2015; Khoury et al., 2013; Piet & Hougaard, 2011). Mindfulness is defined

as a paying attention to the living moment, on purpose and without judgement, utilizing a blend of self-care, stress-mitigation techniques, and prosocial skills practice methods to become more aware of thoughts, sensations, and emotions ("What is Mindfulness? Explained," 2017). Utilizing mindfulness in the school or classroom setting is a method of increasing the awareness of "living in the moment" experience, which assists in self-regulation and reflection (Schonert-Reichl et al., 2015; Zenner et al., 2014). Schonert-Reichl et al. reported both empirical and theoretical research demonstrates that mindfulness also promotes empathy and a caring attitude toward others. Chiesa and Serretti (2009) maintained that mindfulness has the potential to promotes health in nonclinical populations by intensifying immune functions, reducing stress, and strengthening a sense of well-being. Research and meta-analysis also suggest mindfulness can also foster personal development such as self-awareness and compassion, with an emphasis on perspective taking (Zenner et al., 2014). According to several studies, mindfulness might also increase academic performance by enhancing cognitive abilities and improving student behavior by supporting creativity, social-emotional learning, and increased attention spans (Bakosh et al., 2015; Bellinger et al., 2015; Ramsburg & Youmans, 2014; Zenner et al., 2014).

Restorative Justice Practices

Restorative justice practices, a type of conflict resolution, promote building positive relationships by using clear communication to resolving conflicts peacefully and fairly which is intertwined in TIC (Rasmussen, 2011). Zehr and Gohan (2003) postulated restorative justice practices are founded on three pillars: harms and needs, obligation, and engagement. Walpert-Gawron (2016) posited that a stronger school community can be created by utilizing restorative justice practices in place of more traditional discipline measures. Walper-Gawron maintained the victim acknowledges ownership of the offense, reconciles with the victim, and involves the

school community in assisting both the victim and offender. Walpert-Gawron further explained that empathy for all involved is crucial as the offender's past trauma may have influenced behavior. Also, the offender must make a great stride in correcting the transgression. Furthermore, all involved parties must communicate in order for growth to occur. Aligned with TIC, restorative justice practices recognize the victim may need help as well. Walpert-Gawron also reported that schools are vital in helping the offender understand why they participate in transgressions and how to reason beyond their emotional impulses. Walpert-Gawron noted educators need to be reminded of the area of the brain that manipulates impulse control does not reach its neural-revolution until the early 20s. Restorative justice practices, according to Rasmussen (2011), promotes a school culture to become a safe setting that is trauma-sensitive by building relationships through conflict resolution.

TIC in Mainstream Society

The onslaught of trauma research and understanding has possibly led to the integration of the trauma-informed care approach in numerous mainstream organizations and settings. The concepts of trauma-informed care procedures can now be observed in mental health providers, substance abuse programs, child welfare systems, and criminal justice institutions (Wilson, 2013). Public health providers and law enforcement have also delved into the benefits of implementing trauma-informed care settings and frameworks (Thomas et al., 2019). The field of dentistry also has begun using the TIC approach in dealing with patients. Raja et al. (2014) reported dentists frequently see individuals who have been expose to trauma and recognize the need to influence how patients engage in oral health care. Furthermore, religious sectors have also acknowledged the benefits of TIC (Santoro et al., 2016). Asmundson and Afifi (2020) reported that crisis and homeless shelters have also begun to understand the paradigm shift in

services and care. Asmundson and Afifi also posited that the growing awareness of the prevalence of adverse childhood experiences is commanding TIC to be the system of choice when providing services to those who have experienced trauma, especially children. The TIC approach in organizations can be a critical component to the success of program and clients because trauma is addressed effectively, minimizing the effects of trauma as well as costs for the organization (SAMHSA, 2014).

Tennessee Training: Building Strong Brains

Every Student Succeeds Act (ESSA), the national education law signed by President Barack Obama in 2015, supports funding to enable implementing effective, evidence-based TIC classroom practices (ESSA Pub.L. 114-95). ESSA promotes the expansion of school-based mental health services as well as positive supports and interventions to reduce exclusionary discipline practices. Furthermore, ESSA encourages professional development training that assists school personnel in understanding the effects of trauma and how to recognize when to refer a student for additional services (Prewitt, 2016).

The Tennessee Commission on Children and Youth [TCCY] (n.d.) defines adverse childhood experiences as stressful or traumatic events that affects a child, including physical, sexual, or emotional abuse, physical or emotional neglect, domestic violence, substance abuse, mental illness, parental separation or divorce, or incarceration. The Department of Education was charged with developing evidence-based training programs that include ACEs effects on mental, physical, cognitive, behavioral, and social development. Furthermore, development of trauma-informed care practices and principles for the classroom should include knowledge of how ACEs can affect learning and improve educational outcomes.

The Tennessee Department of Education [TDOE] (2019) has implemented a trauma-informed care approach discipline policy. Tennessee Code Annotated Title 39, Chapter 6, Part 41, has been amended to add a new section that reads (a) As a strategy to address adverse childhood experiences, as defined in 49-1-230, an LEA and public charter school shall adopt a trauma-informed care discipline policy. According to the TDOE, discipline policies in a Tennessee school must contain the following elements:

1. Balance accountability with an understanding of traumatic behavior.
2. Teach school and classroom rules while reinforcing that violent or abusive behavior is not allowed in school.
3. Minimize disruption to education with an emphasis on positive behavioral support and behavioral intervention plans.
4. Create consistent rules and consequences.
5. Model respectful, nonviolent relationships.

The implementation of TIC in the classroom has been noted to assist in handling discipline problems. Garcia and Weiss (2018) report that the actions of suspending and expelling students are not beneficial to the student and may lead to unwanted circumstances such as lower academic performance and engagement. Also, a lower connectedness culture has also been reported as well as a lower graduation rate.

Aligning with Tennessee's overarching philosophy, programs, policies and practices for children and youth, the TDOE developed a strategic education plan framework called Tennessee Succeeds. The TDOE, along with guidance from TCCY, established the training initiative, Building Strong Brains Tennessee, to identity and serve students who may have been victims to trauma and to create a supportive system that includes safe environments and vital learning

conditions. According to the TDOE, a goal of the training is to increase a child's potential to lead a productive and healthy life. Also, the training focuses on the effects ACEs could have on the economy of the state. Furthermore, the initiative hopes to bring awareness of ACEs to community members, educators, government officials, and the general public while working to reduce conditions that contribute to ACEs.

Chapter Summary

This qualitative study explores educators' perceptions of the impact of trauma-informed care training in three Appalachian elementary schools. The literature review of trauma-informed care approach revealed the background of trauma-informed care as well as the prevalence of adverse childhood experiences. There is a strong connection between trauma and the architect of the brain as disclosed through the neuroscience aspect. The rationale, research-based practices, and benefits of trauma-informed care in the school setting was included as well.

Chapter 3. Research Methodology

The purpose of this qualitative phenomenological study was to examine the lived experiences of participants who received the trauma informed care approach training provided by the Tennessee Commission on Children and Youth, entitled "Building Strong Brains Tennessee." Creswell (2014) defined methodologies of research as being procedural in nature, offering distinct, logical plans and strategies for obtaining data. De Vaus (2001) noted the research problem guides researcher to the type of appropriate method, meaning the methodology selection should occur after careful scrutiny of the research problem. Phenomenology, as explained by Creswell (1998), focuses on the lived experiences of individuals who have experienced the same phenomenon. Information is generally gathered through in-depth, open-ended questions through a conversational interview process (Ben-Eliyahu, 2017). The "universal essence" of the phenomenon was revealed through intense scrutiny of the data (van Manen, 1990). As Moustakes (1994) suggested, the researcher provided a description, not an analysis, of the lived experience of the phenomenon based solely on the participants' own experiences.

Research Questions

An overarching research question steered this qualitative phenomenological study: what are educators' perceptions of the quality of the implementation and subsequent outcomes of the trauma-informed care approach training in three Appalachian elementary schools? Additionally, the following supporting subsequent questions guided the study:

1. What was the perception of the level of knowledge about trauma-informed care prior to the trauma-informed care training of:
    a. Teachers
    b. Administrators
    c. Counselors

2. What was the perception of the factors in the trauma informed care training that assist in identifying a student's possible exposure to trauma of:
    a. Teachers
    b. Counselors
    c. Administrators
3. What was the perception of the factors in the trauma informed care training that assist in identifying and assisting students who have been exposed to trauma of:
    a. Teachers
    b. Counselors
    c. Administrators
4. What was the perception of the supports needed for the elements of the trauma-informed care training to be implemented of:
    a. Teachers
    b. Counselors
    c. Administrators
5. What was the perception of the level of knowledge about trauma-informed care after implementation by:
    a. Teachers
    b. Counselors
    c. Administrators

Research Design

In order to understand the essence of the lived experiences of the participants who received trauma informed training while employed by three Appalachian elementary schools, a qualitative transcendental phenomenology research design was chosen for the study. Qualitative research describes the observation or experience by participants to foster a new understanding of a phenomenon or theory (Anney, 2014) by allowing individuals to share their stories and have their voices heard (Creswell & Poth, 2018). Phenomenology is the specific method, or qualitative tradition, of conducting research as it seeks to understand individuals' lived experiences with a common phenomenon. Van Manen (1990) explained a "lived experience" as recognizing the differences between two people living, or experiencing, the same event, as the experience will reveal meaningful and significant insight into the phenomenon.

The philosophy of Edmund Husserl is the foundation for phenomenology, specifically descriptive, or transcendental, phenomenology and is considered the creator of this research method (Peoples, 2021). In order to uncover the essence of a phenomenon, the underpinnings of the Husserlian transcendental theoretical framework require the researcher to participate in bracketing, or epoche, to suspend judgements and preconceived ideas related to the subject of study. The Greek word, "epoche," means to abstain from viewing things as they are typically viewed, understood, or assumed (Patton, 2002). This suspension allows an analysis of an experience through an open-minded lens with unfaltering ideas. According to Peoples (2021), the transcendental theoretical framework of phenomenology requires other frameworks to be suspended in order to arrive at the essence of the phenomenon. When trying to understand a phenomenon through a transcendental framework, Husserl contended assumptions should not be

made. Moustakas (1994) noted that transcendental means that perceptions are new without preconceived ideas.

Site Selection

The research was conducted with three elementary schools located in the Northeast Tennessee region. Due to Covid restrictions, interviews were conducted via Zoom, an online video communication platform. Research suggests conducting qualitative research via communication technology offers advantages such as ease of use, data management features, cost and time effectiveness, flexibility, and security options (Hewson, 2008; Horrell et al., 2015). Sullivan (2012) posited video conferencing has unlimited potential as a research tool. Furthermore, findings also indicate that online methods may have the ability to replicate, complement, and improve upon in-person interviews (Braun et al., 2017; Cater, 2011; Deakin & Wakefield, 2014). Open-ended dialogue with open-ended interview questions guided the interviews. The recorded interviews occurred at times convenient to the participants, which took place during and after school hours in the 2021-2022 school year.

Population and Sample

The study included participants from the Northeast Tennessee school region during the 2021-2022 school year. Three school districts were invited to participate in the study. The population included elementary school educators who had participated in the "Building Strong Brains Tennessee" training.

As the goal of qualitative research is to make sense of lived experiences in a particular context with individuals, the sampling design is purposively designed (Johnson et al., 2020). Therefore, a purposeful sampling strategy was chosen for the study. Johnson et al. contended a purposive sampling allows the researcher to intentionally select the co-researchers to enhance data sources for answering the research questions. This strategy permits the researcher to select

individuals and sites of the study as those individuals can purposely provide information about a phenomenon (Creswell & Poth, 2018). Study participants were selected from three elementary schools who had received trauma informed care training provided by the Tennessee Commission on Children and Youth entitled "Building Strong Brains Tennessee."

The sample size of a qualitative study generally consists of a few sites and individuals who have experienced the same phenomenon (Creswell & Poth, 2018). Moreover, eight to 15 participants are needed for a phenomenological study as saturation is the goal for the study (Peoples, 2021).

Participants

The participants were certified staff and faculty members who received training in a trauma-informed care program. With purposeful sampling, the gatekeepers of the school, the principals, requested specific employees to participate in the study. Participants included three principals, three counselors, and six educators who had participated in the "Building Strong Brains Tennessee" training. All participants were employees of elementary schools.

Data Collection Strategies

In phenomenology, the role of the researcher is the instrument for data collection (Cassel, 2005; Rubin & Rubin, 2005). Interviews occurred via Zoom, a video conferencing platform and were of an in-depth, open-ended format to explore the participants' lived experiences. Seidman (1991) suggested semi-structured interviews guide the co-researchers without restricting responses. Furthermore, the semi-structured interview provided the participants with a framework for thought, feelings, and opinion expression (Drever, 1995). The interviews were untimed allowing the participants to ponder each question and answer accordingly. The interviews lasted 45 to 60 minutes. The researcher also kept observational memos during the

interviews to make note of nonverbal communication such as gestures, postures, and facial expressions. All interviews were recorded and transcribed. Informed consent was presented and gathered before each interview.

Sutton and Austin (2015) contended the primary responsibility of a researcher to the study's participants it to safeguard the data and the participants. Participants in this study were assigned codes in an attempt to provide anonymity. Data found on transcripts, notes, and other investigatory documents were stored digitally on a password and fingerprint recognition protected laptop. Digital copies were printed and stored in a locked filing cabinet located in the researcher's residence. Separate documents with identifying codes were also stored in a locked filing cabinet.

Data Analysis Strategies

The data analysis of a transcendental phenomenological study involves data organization, analyses, understanding, interpreting, and representing (Creswell, 2009). The focus is to identify the essence of a shared phenomenon in a human experience (Patton, 1990). Employing Moustakas' (1994) data analysis strategies, the researcher reviewed transcripts and journal notes. All transcripts were initially read to gain an over-all understanding, while a subsequent reading produced significant chunks of words, phrases, and sentences leading to common themes that pertained to the lived experiences of trauma-informed care training. Upon examining the themes, an in-depth narrative was created for a final description of the phenomenon. Specific participant quotes were used to add to the thick, rich description.

Moustakas' (1994) data analysis method of phenomenological data reduction consists of the following strategies:

1. Horizontalization

2. Clustering and Thematizing
3. Textural Description of the Experience
4. Structural Description of the Experience
5. Textural-Structural Synthesis

Horizontalization

The data analysis began with collected information from individual in-depth interviews via Zoom video conferencing sessions. To support rigorous analysis, interviews were transcribed verbatim by the researcher and reviewed by a peer doctoral candidate. The transcription began the process of horizontalization. Moustakas (1994) described horizontalization as listing every expression relevant to the experience studied, however, the researcher should eliminate overlapping, repetitive, and vague expressions or words. The researcher read and reread the transcripts and focused on significant statements. These remaining words and phrases are horizons, or textural meanings of the phenomenon.

Clustering and Thematizing

This reduction and elimination process determined the invariant constituents, those words or phrases that contained a moment of the experience and could be labeled. The invariant constituents of the experiences were then clustered into thematic labels which refer to a frequently used word or phrase (van Manen, 1990). This approach is also referred to as qualitatively coding, which assists in making sense of the phenomenon. Furthermore, classification of information through the coding process prevents confusion (Patton, 2002). Validation of the themes occurred when the invariant constituents were compared to the transcribed interviews.

Textural Description

A textural description was constructed using verbatim examples from the transcribed interviews to create rich, thick descriptions of the lived experiences of educators who received trauma-informed training. Specific quotes were included to enable a detailed description of the phenomenon. To assist readers in understanding the true meaning of the phenomenon, the textural descriptions described *the what* of the phenomenon.

Structural Descriptions of the Experience

A structural description was constructed based on the individual textural descriptions. A structural description's focus is "the how*"* of a phenomenon, which also includes the background. Moustakas (1994) contended the structural description assist readers in understanding how participants as a group experienced the phenomenon.

Textural-Structural Synthesis

A final composite description of the meaning and essences of the experience was constructed. The "how" and the "when" of the phenomenon was explained. The textural-structural synthesis utilized the data from interviews, memos, and reflection. Moustakas (1994) asserted the creation of the structures of the essence of the phenomenon is founded on reflection. The synthesis composed a culminated description of the lived experience.

Assessment of Quality and Rigor

Several criteria exist to establish rigor in phenomenological research**.** Guba and Lincoln (1994) reported four criteria for establishing the overall trustworthiness of qualitative research results: credibility, transferability, dependability, and confirmability. To establish credibility, the researcher provides supporting evidence that the findings represent accurate information. Transferability is recognized when the researcher provides an adequate description of the study

that would allow a reader to determine where the results could be applied to other situations. If the study is presented in a detailed manner that would allow replication, dependability of the research is present. Ensuring to the reader that finding are based on the information collected from the participant, free of researcher biases or interpretation, represents confirmability.

Credibility

Creating trustworthiness in phenomenological studies can occur through the process of member checking (Creswell & Miller, 2000; Lincoln & Guba, 1986; Stake, 1995); Creswell (2005) reported the process of member checking, also known as participant or respondent validation, allows one or more study participants to examine the accuracy of the findings. Creswell also noted the researcher should make inquiries such as whether the description is thorough and realistic, accurate themes, and fair and representative interpretations. Member checking can also serve as a means to corroborate evidence and findings (Yin, 2014). Lincoln and Guba (1985) claimed member checking is critical in establishing credibility as participants comment on the accuracy of raw data such as interview transcriptions. Furthermore, other evidence may surface that did not arise during the initial interview. Sandelowski (1986) maintained credibility is also established if the description of the phenomenon is easily recognized by those who lived the experience.

Transferability

The concept of transferability was achieved through thick description of the phenomenon in detail. According to Lincoln and Guba (1985), the description must be sufficient enough for readers to evaluate the findings and conclusions to determine if the research can be transferred to other times, situations, or settings. Sandelowski (1986) also noted that when a study's findings are viewed as meaningful and relevant to others' experiences, transferability of those findings

may “fit” into other contexts outside of the study. The results of this study may have possible transferability to other organizations who choose to offer training in TIC.

Dependability

To ensure dependability, consistency was adhered to the greatest extent possible. Consistency is a favorable attribute in research as to provide guidance for a replicated study (Anney, 2014). Koch (2006) posited that dependability can be further displayed if the findings can be replicated in other studies with like contexts and participants. Also, when the data and research process is audited and found accurate, dependability is evident (Tobin & Begley, 2004). To adhere to the focus of dependability, an audit trail consisted of thick descriptive interviews, transcripts, and thorough notes. Organized research practices also support dependability, which were audited by a doctoral candidate to confirm rigor and consistency.

Confirmability

Credibility, dependability, and transferability intertwines to create confirmability (Guba & Lincoln, 1994). Confirmability elements from this research include audio and video recordings of the interviews, detailed transcripts, and notes taken during interview process that revealed participants nonverbal expressions and postures, together creating a detailed audit trail of data analysis and interpretations from the data.

Ethical Considerations

Because research studies have the potential to create tension between the rights of the participates’ privacy and the aim of the research to reveal generalizations, following ethical research principals are imperative (Orb et al., 2001). Sanjari (2014) asserted anonymity, informed consent, confidentiality, and a researcher’s possible impact on participants can be challenges researchers face. Creswell (2012) reported ethical considerations should be taken in

all phases of the research process, beginning with data collection to the reporting of the findings. The researcher adhered to ethical practices and procedures throughout the entire research process.

The researcher in this study obtained approval from the three schools and the Human Research Protection Program at East Tennessee State University prior to beginning the research. The research study received approvals from all entities before beginning the exploration into the phenomenon of teacher perception of the impact of trauma-informed care in three Appalachian elementary schools. The researcher completed Conduct of Human Subject research training, a course in the ethical conduct of research involving human subjects. ETSU utilizes Collaborative Institutional Training Initiative (CITI) courses to provide research ethics education.

This qualitative phenomenological research study was voluntary and provided participants the option to give consent or decline to participate at any given time during the interviews. The participants' identities were kept confidential as each participant was labeled a non-identifying name that consisted of the word "educator" and a number.

Role of the Researcher

As the researcher is considered the instrument in a qualitative study (Patton, 2002), the prominent role of the researcher is to access the feelings, thoughts, and beliefs of study participants that may influence decision-making and behaviors (Sutton & Austin, 2015). Creswell (2002) noted the phenomenological approach is best applied when an in-depth understanding of common human experiences is desired in the study. Moustakas (1994) explained that transcendental phenomenology weighs heavily on the description of the experience rather than the researcher. The researcher determined a transcendental phenomenological approach of qualitative research was the appropriate method to uncover the

lived experiences of those educators who participated in the trauma-informed care approach training. As Groenewald (2004) posited, the aim of the researcher is to describe the phenomenon while abstaining from any pre-given framework. Peoples (2021) contended a researcher's role is to also disclose any personal or professional relationship with participants. The researcher and the participants are in the field of education; however, the researcher does not have a personal relationship with the participants nor is the researcher employed by the same school system as the participants.

Research denotes the importance in bracketing in transcendental phenomenology (Beech, 1999; Creswell & Miller, 2000; Drew, 2004; Giorgi, 1998; Starks & Trinidad, 2007). The researcher engaged in the bracketing process, also referred to as epoche and phenomenological reduction, to suspend judgements in order to focus on the studied phenomenon. Bracketing is the undertaking of separating the qualities that are associated with the researcher's experience of the phenomenon (Drew, 2004) including assumptions, theories, presuppositions, or biases (Gearing, 2004). The goal of the researcher is to observe the participants' accounts with as much of an open mind as possible (Starks & Tinidad, 2007). Biases are irrelevant and should be set aside (Peoples, 2021), and the bracketing method assists in mitigating the effects of preconceptions through active reflection and dialogue (Tufford & Newman, 2010). Tufford and Newman also ascertained that not only does the bracketing assist in mitigation of unfavorable effects of the research process, but it also fosters a deeper level of reflection in topic and population selection, interview design, data collection and interpretation, and reporting of findings.

Chapter Summary

The purpose of this qualitative phenomenological study was to examine the implications and outcomes of trauma-informed care approach training as perceived by educators. Qualitative research guides a researcher in building a complete picture of how a person's knowledge, feelings, actions, and thoughts relate to a phenomenon (Creswell, 1998). Phenomenology, specifically transcendental, is a methodology that is utilized to describe the essence of a lived experience. The phenomenological approach was selected to explore educators' perceptions of the impact of trauma-informed care training. The methodology used, along with rationale, is outlined in this chapter. The researcher's role, participation, sampling, and sampling selection are also discussed. Details of the data collection, measures of rigor, and ethical considerations are included as well as the analysis process, presentation, and data management.

Chapter 4. Results

Introduction

The purpose of this qualitative phenomenological study was to examine educators' perceptions of the quality of the implementation and subsequent outcomes of the trauma-informed care approach training. A phenomenological study focuses on how an individual experiences an event, or phenomenon, and the perception rendered by the experience (Ary et al., 2014). The Husserlian transcendental theoretical framework requires the researcher to suspend judgements and preconceived ideas related to the subject of study, which also requires other frameworks to be suspended in order to arrive at the essence of the phenomenon (Peoples, 2021). This theory is reinforced by Moustakas (1994), who noted that transcendental means that perceptions are new without preconceived ideas.

This study employed qualitative phenomenological research methods to explore the lived experiences of 12 educational practitioners from three elementary Appalachian schools regarding their training and strategies for implementing a trauma-informed care approach with students. A school in a county district, Elementary School A serves approximately 300 students in grades Pre-K through 2nd grade. Hosting grades Kindergarten through 5th grade, Elementary School B serves approximately 355 in a county district. A school in a city district, Elementary School C has approximately 180 students in grades Pre-K through 5th grade. All three schools participated in trauma-informed care training during the 2018-2019 school year. Information obtained through individual interviews formed the basis for the findings of this study. Aligning with the essential research question, "What are educators' perceptions of the quality of the implementation and subsequent outcomes of the trauma-informed care approach training?", the following five research questions guided the study:

RQ1: What was the perception of the level of knowledge about trauma informed care prior to the trauma informed care training of teachers, counselors, and administrators?

RQ2: What was the perception of the factors in the trauma informed care training that assist in identifying a student's possible exposure to trauma of teachers, counselors, administrators?

RQ3: What was the perception of the factors in the trauma informed care training that assist in identifying and assisting students who have been exposed to trauma of teachers counselor, administrators?

RQ4: What was the perception of the supports needed for the elements of the trauma informed care training to the implement of teachers, counselors, administrators?

RQ5: What was the perception of the level of knowledge about trauma informed care after implementation?

Data were collected through open-ended interviews with individual educators. The interviews were audio recorded and transcribed. Transcriptions were provided to the participants for review to ensure accuracy. Participants were given opportunity to make additional comments. The researcher reviewed, coded, and examined the final transcripts for emerging themes.

Table 2 represents the corresponding research question and interview questions. The interview questions in the right column addresses the research questions in the left column.

Table 2

Research Questions and Interview Questions Relationship

Research Question	Interview Question
What was the perception of the level of knowledge about trauma informed care prior to the trauma informed care training of teachers, counselors, and administrators?	4

What was the perception of the factors in the trauma informed care training that assist in identifying a student's possible exposure to trauma of teachers, counselors, and administrators?	5, 6
What was the perception of the factors in the trauma informed care training that assist in identifying and assisting students who have been exposed to trauma of teachers, counselor, and administrators?	7, 9
What was the perception of the supports needed for the elements of the trauma-informed care training to the implement of teachers, counselors, administrators?	8
What was the perception of the level of knowledge about trauma informed care after implementation?	11

Participant Profiles

Twelve elementary educational practitioners were identified to participate in the interview process through purposeful sampling. Participants had received training in trauma-informed care approach as well as implemented trauma-informed care practices. Table 3 provides demographic information pertaining to the participants.

Table 3

Interview Participants

Participant	Gender	Years at Study School	Years of Experience	Role
Educator 1	F	5	25	Prek-5 Teacher
Educator 2	F	30	30	Librarian
Educator 3	F	8	8	$4^{th}/5^{th}$ Teacher

Educator 4	F	5	31	Principal
Educator 5	F	28	28	2nd Grade Teacher
Educator 6	F	23	23	Counselor
Educator 7	F	20	20	5th Grade Teacher
Educator 8	M	8	21	5th Grade Teacher
Educator 9	F	9	22	Principal
Educator 10	M	11	11	Counselor
Educator 11	M	23	23	Counselor
Educator 12	F	24	24	Principal

Analysis of the Data

Data collected through participant interviews were transcribed and coded. Initially, the process of open coding was performed, with the researcher analyzing each line of the transcripts (Holton, 2007). Various categories emerged as codes were continually created until saturation in categories was reached. The researcher determined the most prominent categories.

The researcher identified themes through transcript analysis and coding. Research Question 1 identified the perceived knowledge level of trauma-informed care prior to the training. Research Question 2 revealed themes of increased knowledge of ACEs and increased awareness of identifying behaviors. Themes that emerged from Research Question 3 were an increase in relationship building, an increase in knowledge of ACEs, and implementing student support practices. Research Question 4 supported the themes of support of administrators, teachers, students, and parents, expectation consistency, and willingness to collaborate. Research Question 5 revealed themes of an increase in knowledge of ACEs, changes in classroom

management practices, and an increase in empathy toward students and teachers. The study results are organized by the guiding research questions.

Research Question 1

What was the perception of the level of knowledge about trauma-informed care prior to the trauma informed care training of teachers, counselors, and administrators?

This research question was designed to reveal the perceived knowledge of trauma-informed care of the participants before the participants received the training. Nine participants reported their level of knowledge of the trauma-informed care approach was minimal before the training. However, three participants perceived their level of knowledge approaching expert level. A characteristic of a novice learner is the feeling that knowledge and experience are lacking in a subject, whereas traits of an expert are the acquired substantial knowledge of a subject matter coupled with experience in the field of study (Pozo, 1989; Shuell, 1990). This research question established a baseline for the perceived knowledge the trauma-informed care approach before receiving the training.

In response to defining a level of understanding of trauma-informed care, Educator 1 stated:

> Before the training, I would have said that I had a basic understanding that kids come to us with different forms of trauma. But I wouldn't have been able to go deeper than that. Like that there it is; that's what I would have known.

Reporting a lack of understanding of trauma-informed care, Educator 3 added, "I had absolutely zero understanding. I mean I kind of understood, you know that we have trauma, but I didn't really understand how it impacted our lives and our students lives."

When asked about previous knowledge of the trauma-informed care approach, Educator

Educator 6 added:

> The only type of knowledge I had was from a class that I had in my graduate studies program, which it wasn't focused on trauma informed, but I did a presentation on trauma informed schools, and so I was able to get a little bit of knowledge through that.

Educator 8 reported the status of understanding by stating, “With my background in special education, I was familiar with ACEs and trauma-informed care. I knew some about how it worked.”

Educator 9 also noted knowledge of trauma-informed care:

> I knew about what a Trauma-Informed School was a little bit before the training and had been to conferences where they mentioned them, but I had never seen the details behind what makes one. Also, I had ACE's training before, so I knew a little about brain architecture as well.

Reporting a strong understanding of trauma-informed care, Educator 4 posited:

> Prior to coming to School A, I had also worked in another Title I school that also had several students who were going through a lot that I would consider definitely trauma and ACEs. So my knowledge of ACEs was very strong. Just working with those students and the stories they shared and the trauma they went through.

Educator 10 further stated:

> Because of my background, which is in social work, I did have some knowledge coming into the training. The training certainly gave me a deeper understanding of what to look for in a student. I had, because of my background, being from mental health agency, I had some trauma informed knowledge. After the training, the brain architecture side of

things, and the side of that was completely was mind changing for me. My approach changed after getting the training and being trauma informed.

Research Question 2

What was the perception of the factors in the trauma-informed care training that assist in identifying a student's possible exposure to trauma of teachers, counselors, and administrators?

The themes that emerged when educators were asked what their perceptions were of the factors in the trauma-informed care training that assist in identifying a student's possible exposure to trauma are the increased knowledge of ACEs and an increased awareness of identifying behaviors

Increased Knowledge of ACEs

Twelve participants indicated that a factor in the trauma-informed training that assists in identifying a student's possible exposure to trauma is an increased knowledge of ACEs. Educator 4 stated:

> I think the ACEs component, and when they go through and share what the different kind of ACEs that are actually ours, and how that impacts the brain. And because of the impact on the brain and the emotion, the emotions, then there's definitely things that we're going to see happening in our students that are going through trauma. So that training was very strong with just a lot of good clear visuals. It was very user friendly and easy to understand.

Educator 6 posited:

> Increasing my knowledge of ACEs has been extremely helpful. If a kid comes in and they are yelling and screaming, it might not be because that they don't want to do the work, but maybe they experienced something at home. Or maybe they don't have a stable home

life, and so talking about those different factors of what could be going on at home and what those behaviors look like when they're showing up in the classroom.

Educator 1 added:

> Increasing my knowledge of ACEs has been helpful. Prior to the training, I knew students came to us with different types of trauma, but that is as far as my understanding went. Understanding the ACEs gives me the opportunity to go a little deeper in trying to find out the source of the issue and going from there.

Increased Awareness of Identifying Behaviors

Ten participants indicated that a factor in the trauma-informed training that assists in identifying a student's possible exposure to trauma is an increased awareness of certain behaviors.

Educator 4 stated:

> I look for the way they dress, the way they interact with other kids, and the way they interact with adults. Especially their interactions with me. I can think of one time, but I wasn't being mean, but I just kind of dropped a book on the table, I noticed if the kids just like totally had a severe fear reaction to that sort of thing. Food instability is also a factor in identifying trauma. I would also say cleanliness. Or going to see the nurse all the time as well as not going to say the nurse when they need to go see the nurse.

Educator 3 added:

> We talked a lot about physical responses to stimuli so noticing like where they get tense and where they begin to get flushed or begin to sweat or begin to talk excessively. Things like that, which was very eye opening, and it's made me more aware of watching for those triggers because a lot of stuff triggers kids that I would never think of because I

> don't have that same trauma. Listening for listening for things that they say because I feel like kids are really fascinating when they will share their trauma with you. Discreetly at first, they'll just kind of barely slip it into a conversation and then it's up to us to pry deeper. Prior to the training, I would just literally be like okay that's weird and then just move on, but like now it's like my ears are perked up and listening for those little identifying factors of things that don't sound just right.

Educator 10 posited:

> You should just assume everyone has been exposed to trauma. The training focused on how an educator perhaps could get caught up in the event and lose perspective of what might really be going on with the student. It was extremely helpful in reminding one to connect with the student on a personal level and build that relationship with the student. One's eyes and ears must stay on alert to identify a student who may have been exposed or is still being exposed to trauma. I am always looking for an unkept appearance, clothes and personal hygiene, even odors. If a student is constantly wanting to go to the nurse or to see the counselor, I really try to give that student extra attention.

This was reinforced by Educator 1's comment:

> I also observe how students interact with other students. If that student is bullying or verbally abusive, I try to find out about the home life. Oftentimes, that student is being abused at home and just does not know the proper way to be social and interact appropriately. Another observation I try to do is to notice how that student interacts with adults. Is that student being disrespectful, or on the flip side, is that student too clingy or needed or wanting attention all the time? There is usually an answer for the behavior.

Research Question 3

What was the perception of the factors in the trauma-informed care training that assist in identifying and assisting students who have been exposed to trauma of teachers, counselors, and administrators?

The themes that emerged when educators were asked their perceptions of the factors in the trauma-informed care training that assist in identifying and assisting students who have been exposed to trauma were building relationships, increasing the knowledge of ACEs, and the implementation of student supportive classroom practices.

Increase in Relationship Building

Eight participants indicated that building student and teacher relationships is a factor in identifying and assisting student who have been exposed to trauma.

Educator 1 noted:

> At our school, whenever we identify students that have been exposed to trauma, the first and foremost thing that we do is just honestly listen to them, and if they're ready to share, we listen and let them share with whatever adult that they want to share with. If that trauma needs immediate intervention, we make plans for that. If that trauma is manifesting in difficult behaviors, then we work with the student to craft an individual plan for them where they think about the things that they need to work on and we help hold them accountable. We also really try to just love them, and you know share amazing things about them and try to build them up, because a lot of times they're so closed off. They just struggle with accepting love in general, that we just try to pour as much into them as possible and really encourage them to be great leaders. I think just providing stability for kids where they may not have stability.

Educator 8 reiterated:

> We are big on relationships and feel it enhances the learning. A lot of nurture vs. nature comes into play with this. I actually help get the students out of the car and take them to the cafeteria. I talk to each one of the students. I know at least 10 to 12 or 13 things about each kid. In the classroom, everyone gets a hug, a high-five, or just a hello. Sometimes they say I don't want anything, and that's ok. Then I try to do another check-in later in the day. Building relationships builds our classroom family. We have the expectation that we will take care of each other. It was very obvious those teachers who spend time building relationships because you can see the rapport. Even when I had parent/teacher conferences on the phone, the students still wanted to talk to me even though they had just seen me.

Educator 6 supported the theme of relationship building:

> It's good to go and pull those students and just have a conversation with them. They're going Okay, what is going on, and because they have the opportunity to kind of step away from the class, sometimes it is just that they need a break, because there's a lot of instruction that's going on.

Adding to the theme, Educator 7 stated:

> I have Morning Meetings with my students. I never deviate from this. I spend this time to build relationships. I probably know about 10 to 15 things about my students. I believe in building rapport and respect and the students respond to this. The students listen and respond to the Morning Meetings. This is a non-negotiable at the school. It truly works with the students. we spend a lot of time building this relationship. The

> student talk to me and I talk to the students. They know they can talk to me. The student needs a routine, and this has become a priority.

Increase in the Knowledge of ACEs

Eight participants indicated increasing their knowledge of ACEs is a factor in identifying and assisting student who have been exposed to trauma.

Reflecting upon the benefit of understanding the repercussions of adverse childhood experiences, Educator 6 stated:

> Knowing about adverse childhood experiences is helpful. Okay, if a kid comes in and they are yelling and screaming, it might not be because that they don't want to do the work, but maybe they experienced something at home. Or maybe they don't have you know, a stable home life, and so talking about those different factors of what could be going on at home and what those behaviors look like when they're showing up in the classroom.

Adding insight into the value of recognizing ACEs, Educator 9 noted:

> The ACE's and Building Strong Brains trainings were very beneficial to understanding a student's exposure to trauma. They gave us look-fors that are practical for staff members to use when identifying students that have had major trauma exposure. They also taught us that all brains are not fully developed until the age of 26, so even the students that we think may not be having any issues could just be better at coping than other students are.

Implementing Student Support Practices

Ten participants indicated implementing student supportive classroom practices is a factor in identifying and assisting students who have been exposed to trauma.

Supporting the theme of implementing student support practices, Educator 1 posited:

> It's truly been a game changer for school, which has been really cool. We used to have a lot of behavior issues and we used to have a lot of office referrals. Whenever we started implementing our trauma-informed practices we started using restorative circles, instead of punitive punishments. We started using really logical consequences like that the kids help craft and come up with. If they are being told things at home that are unkind to come to school and they say unkind of things to each other. We do a lot of restorative circles with unkind words where the kids you know talk about the things that they said and how it made them feel, what happened, who had it effected. With each other, they face each other, and they really speak openly, and it's built such a beautiful relationship because a lot of the times they are very open and share things with each other. They ultimately find they have something in common that they weren't able to recognize before.

Commenting on the implementation of student supports, Educator 2 stated:

> I do have a cooldown station. I call it the "Regulation Station." I think any child feels like they can go, they are not just children that have a blow up or something like that. I think it's for everyone and it's not just a place that the bad kids go; it's like for anyone that just needs to get away for a minute. And it's just a little like a little station that set up. I have a journal in there and they can write things. It's kind of like a little cubicle so it kind of blocks them out from the rest of the classroom. And just a place that they can feel like they can get it together, no matter what's going on with them. Most of our teachers here have that in their classroom. They have some kind of a calming station or a relaxation station, sometimes they call it different things, but I think that most of our teachers have some.

Additionally, Educator 6 posited:

> We use the calming corners and so each classroom has calming corners in there. So I would say, for those teachers that have really utilized it, it has been a help to them. And help for the students. Of course, you're going to get some students that might try to abuse the approach. But that's why we explain to the kids what it is for. And then also if they need the calm corner, we give them a specific time frame of how long they need to be in there. And so, given that student opportunity to kind of just breathe and talking to them about ways of what is a better way or better choices that we can make when we are feeling like this.

Educator 4 reiterated the importance of implementing supportive classroom practices:

> We really work as a team in this building. And we created what we call our peace corners or our calm down areas. And we've taught our children," Okay, when you're feeling that anxiousness or that frustration coming on, you can go to this area for two to five minutes. And there's signage in the area, reminding them of breathing strategies. They may use playdough and there are fidgets; we've just put different tools depending on if it's a primary student or intermediate student, in each of the piece corners of our rooms. Every classroom has that now, and we greet our kids in the morning. That's an expectation building wide, from every adult. We have music playing as they're getting out of the cars and getting off the bus. We're saying good morning. They know that our learning environments are about learning and being safe spaces.

Educator 7 shared:

> We will spend weeks on learning classroom routines. This is so important that leaning comes second because learning will happen when the students feel 'they love us" and

> they fell loved and cared for. They realize our classroom is a safe space. We use the first six weeks of schools to establish routines. Students need to know who a safe person is.

Educator 7 also added:

> I think getting them the resources, whether it be talking to the guidance counselor, who we fortunately now have a mental health counselor not just a guidance counselor- it's like next level. This is his first year here, and I can already see a difference in some of the conversations that are being had. I feel we try to provide for them what they need. Our school because it is small, and we are a title one school, we are basically the only thing closest thing to an inner-city school. The closest thing to an inner-city school that our area has is our school. So we provide clothes, we provide food, we provide help in the home. For instance, if they don't have a mattress, then we call our family resource center, and they can help the family get a mattress.

Research Question 4

What was the perception of the supports needed for the elements of the trauma-informed care training to successfully implement TIC of teachers, counselors, administrators?

The themes that emerged concerning the perceived supports needed to successfully implement a trauma-informed care approach were support of the administration, teachers, parents, and students, expectation consistency, and a willingness to collaborate.

Administrative Support

Nine participants indicated the support of administration is needed to successfully implement TIC. Endorsing the support of administration, Educator 2 stated, “Administrators would have to be totally on board for the implementation to actually work. The administrators

are the leaders of the school, so it is extremely important that they have the buy-in necessary to transform the school."

Advocating for administrative support for the successful implementation of a trauma-informed care approach, Educator 7 added:

> There must be 100% buy-in from the administration at the school. It all starts at the top, and the administration must sell it to the staff and be relentless in the implementation. From experience, I have seen how the Trauma-Informed approach can transform a school. When you get buy-in from administration and staff, you can make major inroads to helping students cope with exposure to trauma and give them tools to use in overcoming issues for the rest of their lives.

Educator 8 also posited:

> Buy-in is important. The ones who have not bought in, do not see what trauma-informed care is. You have to have support. It has to come from the supervisor, counselor, and whoever handles discipline. This is not punitive and should not be looked at it like it is. But you have to have the buy-in and support from the administrators.

Teacher Support

Ten participants indicated the support of teachers is needed to successfully implement a trauma-informed care approach. Educator 4 added to this theme by stating, "As you start the implementation, make sure you're sharing that out with staff, high expectations, but trusting, trusting your staff to know."

Educator 5 revealed:

> I think, by far, the staff was our biggest problem. I think what hindered us is we are all about the same age. I think just you have to have teacher buy-in. I think teacher buy-in is definitely where we hit the wall.

Educator 6 discussed:

> We know that even though that everyone might not on board, but you just focus on that majority. You know, working and allowing that administrator, which we know the administrators can set the climate of the school, to set the climate. Teachers must support each other.

Educator 9 added:

> Also, you must take the time to properly train all staff members and help them understand the why behind it and give them tools to use with implementation. When the entire staff buys in, and it changes the culture of the school, student learning is buoyed by the positive culture and positive interactions among students and staff.

Parental Support

Six participants also indicated the support of parents is needed for the elements of the trauma-informed care training to successfully implement TIC.

Commenting on parental support, Educator 3 shared:

> Initiating these practices within ourselves has been so calming and our parents understand, and our parents are open to it. We have reflective conversations with them. And just bringing them into the folds of it helps to do really wonderful things at the school. You know how people are always like oh it's just one more thing; it's not like anything extra. It's just conversation instead of management. It's making a huge difference.

Adding to the sentiment of Educator 3, Educator 7 reiterated:

> You not only think "what happened to you," toward the students, but you also think about that with the parents. Parents also recognize this. I had 18 families show up for parent/teacher conferences out of twenty. I think parents see how I deal with the students, and they also feel safe and feel they are not being judged.

Student Support

Six participants indicated the support of students is needed to successfully implement trauma-informed care.

Educator 4 agreed that student input is crucial and stated:

> When you get the right students in there and get them excited about having the ownership of their school, that can be very powerful. And our student leadership team members had input on ours. We are retraining students with the correct behavior and making them own what they've done but doing it in a way that's logical. Like what is logical for the behavior we've seen? And what is the restorative conversation that needs to be had? And, also involving them, giving them voice in what the consequence should be. When you put the ownership back on them, I think it's much more powerful than just me as the administrator saying, okay, you're going to have this happen because of this behavior. Students are often far harder on themselves than we are.

Expectation Consistency

Eleven participants indicated the support of expectation consistency is needed to successfully implement the trauma-informed care approach.

Discussing the importance of expectation consistency, Educator 2 posited:

> We go over each one of what we expect in the classroom, what we expect it to look like in the cafeteria, and even how do we walk down the hall. And we do that every single year. And so they get that at the first of the year from K all the way through. So they know what our expectations are. So, whenever something happens, it's like we went over this and we know you know exactly what we expect and what we're supposed to be doing.

Aligning with Educator 2, Educator 4 added:

> But culturally, too, we've worked very hard as a school to establish school-wide expectations. So we have common hallway expectations, common bathroom and cafeteria, just etiquette in general, throughout the building. So every teacher, the first eight weeks of school, embeds that in our Leader-in-Me program. And we teach and reteach those expectations school wide, because what we learned is when students have a common language, it really just makes everything much more simple for them to understand. So if I'm saying to you remember, level zero voice in the hallway, you automatically know that that we're not going to have any kind of talking occurring at that time. Versus you might say, to a group of kids, no talking and then I might be saying level zero. But when we all agree that we're going to use level zero, and we've taught the children what level zero means. And level one and level two. So we have a voice chart in the hall, along with our expectations, which are posted in all areas. And we've just worked super hard to agree as a team. Okay, here's the language we're using. And that has created a calm throughout the building. Our students know our expectations, and they can tell you those expectations.

Adding to the importance of consistent expectations, Educator 9 added, “Students have

the school-wide expectations reinforced multiple times throughout the school year by all of the teachers, and they want to follow the expectations."

Willingness to Collaborate

Eight participants indicated a willingness to collaborate is needed to successfully implement the trauma-informed care approach.

Discussing the topic of collaboration among peers, Educator 7 revealed:

> Give each other grace and support each other. You can throw in a calming corner and take away behavior charts, but it takes patience for change to happen. I think it takes a couple of years to establish the system and learn the verbiage, so everyone is using the same words. It might be hard for some teachers to take down the discipline charts because they feel it has always worked for them. Change takes time.

Educator 9 noted the willingness to collaborate as being an integral part of the process by stating, "I do believe it has kind of redefined my role though from more of an authoritarian to a coach and helper for both the students and the staff."

Revealing that collaboration is important in building relationships, Educator 1 stated:

> Relationships are important. Even though I may not see eye to eye to a teacher upstairs, that teacher is always fighting hard for her kids and what they need. So those things can be put aside when you're dealing with taking care of your kids and doing what's best for your kids. I think if kids feel safe at school, they're more likely to be able to learn at school.

Research Question 5:

What was the perception of the level of knowledge about trauma-informed care after implementation?

Twelve participants indicated an increase in the level of knowledge about trauma-informed care after implementation. Themes that emerged were an increase in the knowledge of ACEs, changes in classroom management practices, and an increase in empathy toward students and teachers.

Increase in the Knowledge of ACEs

Twelve participants indicated an increase in the knowledge of ACEs after the trauma-informed care implementation.

Educator 1 stated:

> I think I understand different forms of trauma and things that I hadn't even thought about that are considered trauma. But as we were going through different things, I was like, oh I didn't even think about that, yes, of course, yeah so trauma isn't just physical abuse. Which might have been a misconception.

Educator 3 felt the level of knowledge increased with the training:

> I would have to say it's better. It's kind of like when you go from zero to 100. It's like you have such a better understanding of what trauma looks like and how it can manifest within myself and within the kids. I think it's been really helpful, too, because I don't get as frustrated with the students because I am able to separate them from the behavior itself and understanding that there's an underlying reason why they're doing what they are doing. Instead of just being like oh my gosh, you're choosing to be disrespectful right now. I feel like I am able to really recognize the difference that it's not the child that is doing it to be intentionally disrespectful or to be unkind or to have an outburst. It's really coming from a place of not being able to regulate their emotions and regulate their

strategy usage in that moment. So it's been very eye opening as an educator and I've really enjoyed the training. I really like still learning about it.

Educator 4 reported the training added to her expertise by stating, "It definitely solidified what I felt I knew, but then gave me definite research-based practices and great tools to also use to train the staff."

Educator 5 further noted:

> I think I had a pretty good understanding of what ACEs was, and after the training, I kept going to some meetings here at our school, so I think I have a much better understanding. I feel like it was an effective training.

Changes in Classroom Management Practices

Eight participants indicated changes in classroom management practices after the trauma-informed care implementation.

Revealing a change in traditional classroom management practices, Educator 1 stated:

> Before all the training, I would do clip charts and things like that that were visible means of classroom management and behavior management. Now I don't do that at all because I'm more aware of the public perception and the stress that it'll cause. Of course, I knew that it caused stress before, which was the point, right. But I see it differently now. I learned more about the long-term damage of embarrassing the kid rather than just the short term. So classroom culture is different; we have not done that, yet this year just because this year is different from every year.

Educator 1 further added:

> Right now my classroom management is better just based on how I deal with kids. Maybe it's not impacted my teaching but it's impacted the way I interact with kids, which

does impact your teaching. Am I a better teacher now than I was before, yes, because I have a better understanding of what my kids need or don't need. And I have a better understanding of how to manage behavior and discipline a student in a more effective manner. Whether they've got trauma or not, of course, they all do, but whether they are extremely traumatized or barely. It's definitely had a positive impact on the school and has had a positive impact on me, as a person and as a teacher.

Supporting the comments of Educator 1, Educator 2 posited:

> And so I think the behavior and the way we handle the behavior helps by giving them an opportunity to get away from the other students for a minute to calm themselves down, and we're teaching a lot of things. We have one student who we ask how do you calm yourself, what are some things that you can do, what are some coping mechanisms that you can use to for your stress level, and we're honest with him and say sometimes we have to do it, too. We tell the student that we certainly have stress and my stress level right now is at an eight. And, you know, I need to take a minute to smell the roses and light a candle. Deep breaths. And so, you know, just having that time and then I think something that we're doing to was just given the children opportunity to have brain breaks instead of trying to teach for an hour. We're taking, you know, little segments and then take a brain break; that's something that we've done in the last few years with the trauma informed care.

Educator 4 also supported this theme:

> Since then, there's more ownership in classrooms because teachers feel more confident in strategies and approaches to handling minor behaviors. We have a minor versus a major-a graphic that teachers use to determine when it's something that they likely can handle in

the classroom versus when it's an automatic office referral, and that's when I will step in. And so now if it gets to me, they fill out an office referral, and it's a triple copy. I can write on there exactly what I've done. I've either communicated with the parent, there's been a loss of a privilege, there's been detention, there's been in school suspension, you know, whatever it is that's been assigned. So that that's quick communication back to the teacher for me as well, because based on, when I sent out a survey, that's something that was lacking, they felt that they weren't sure what the consequences were what I was doing, once children were being sit down here, because we didn't have that layer of communication built in. But it makes so much sense because we often are bringing our own beliefs and how we were raised in school and discipline and those pieces to the table. And then the conversation of consequences, what's appropriate versus how can we move to a more restorative approach?

Educator 7 discussed:

> The training gave us different outlets and resources. I had a behavior chart in my room and used the traffic light with red, yellow, and green. It was so easy to just say "turn your card to yellow." I can tell a big difference now; it's been around four years since the training. I have a better understanding of how to help a student regulate. They can walk, drink water, look at the ceiling, or have flexible seating. Some teachers might like a cookie cutter classroom, but it does not bother me if a student who has ADHD stands to do his work. As long as he is doing work, good for him. If I have some behavior issues, they become less and less. They know they will get logical consequences and a conversation. We are transparent. I had a substitute teacher, and the students were not on their best behavior. I read the note the sub left me, and we had a conversation about

the behavior. I could tell the students were sorry for their behavior. One student in particular had tears in his eyes. We talked about it, but we went on and had a good day.

In support of this theme, Educator 8 added:

> Administration knows it is a real behavior issue if we seek help from them. It's major. We are able to handle discipline. We handle discipline problems right then and there. Our age group needs immediate attention, and we can't wait because to them, it's like a million years. Discipline issues are minor. Sometimes they just need my visual cue. They feel comfortable and safe, and they want to do what is right. The training takes away the rigid old school perception of punishment. For example, even if a child does not join circle time but wants to sit elsewhere, I look at it knowing he is listening, and he may join later. I let the student sit where he is without making a big deal out of it. It is not punitive thing. I don't want them to think of me as a punitive person. It is about finding a safe space.

Educator 9 also added:

> Office discipline referrals have been cut more than in half since we implemented the program. Students are spending less time out of the classroom. This allows them to be exposed to more ELA and Math instruction. Also, teachers are provided with the tools to handle smaller situations in the classroom before they escalate into larger situations. This helps to head off student behavior issues many times before they even start.

Increased Empathy Towards Students and Staff

Eight participants indicated an increase in empathy towards students and staff after the trauma-informed care implementation.

Describing an increase in empathy, Educator 10 added:

> We need to go beyond the outer layer of the student and try to empathize with that might be happening in those home lives. When a student sees we, the adults, being more empathetic, those behaviors, hopefully, will wear off on the student. Also, another realization for me is the fact that teachers may have been exposed to trauma, and those teachers may still be living in situations that are traumatizing. It is just professional and humane good practice to look at people with open hearts.

Furthermore, Educator 11 also posited:

> One thing I did not think about was that some of my collogues may have been exposed to trauma. It has helped me not to be so defensive towards certain co-workers because I do not know what they have to go home to or how they were raised. It reminded me that all adults were not raised with loving parents the way I was. It really makes you think about what the students go home to at 3:00 every day or what home is like during the holidays.

Conclusion

Understanding the underpinnings of trauma-informed care and an increase of knowledge of adverse childhood experiences were reported as being prominent effects of the training. Building relationships, both with students and staff, were also deemed important. A support group consisting of the stakeholders of administration, faculty members, parents, and teachers was considered imperative in the successful implementation of TIC. Student support systems assisted in changing classroom management techniques, which increased the level of empathy in both teachers and students.

Chapter Summary

The purpose of this qualitative phenomenological study was to examine the implications and outcomes of trauma-informed care approach training as perceived by educators. Chapter 4

includes the findings of this study. The researcher collected data through open-ended interviews with individual educators. The interviews were audio-recorded and transcribed. Interview transcripts were provided to all participants for final approval of accuracy. Participants also were given the opportunity to make additional comments. Data and emergent themes were extrapolated through reviewed, coded, and examined transcripts. Themes, along with the supporting evidence, were reported in this chapter. Chapter 5 presents an in-depth discussion of these findings.

Chapter 5. Discussion, Conclusions, and Recommendations

Statement of Purpose

The purpose of this qualitative phenomenological study was to examine the implications and outcomes of trauma-informed care approach training as perceived by educators in three Appalachian elementary schools. A phenomenological study focuses on how an individual experiences an event, or phenom, and the perception rendered by the experience (Ary et al., 2014). Aligning with the essential research question, "What are educators' perceptions of the quality of the implementation and subsequent outcomes of the trauma-informed care approach training?", the following five research questions guided the study:

RQ1: What was the perception of the level of knowledge about trauma informed care prior to the trauma informed care training of teachers, counselors, and administrators?

RQ2: What was the perception of the factors in the trauma informed care training that assist in identifying a student's possible exposure to trauma of teachers, counselors, administrators?

RQ3: What was the perception of the factors in the trauma informed care training that assist in identifying and assisting students who have been exposed to trauma of teachers counselor, administrators?

RQ4: What was the perception of the supports needed for the elements of the trauma informed care training to the implement of teachers, counselors, administrators?

RQ5: What was the perception of the level of knowledge about trauma informed care after implementation?

Findings were presented following the analyzation of data. Emergent themes were extrapolated from the interview transcription through the process of horizontalization and

coding. Researcher notes from a reflective journal added to the findings. Creswell (1995) maintained coding is essential to discover regularities in the data and is foundational in qualitative research. According to Creswell, coding attaches meaning to particular words or chunks of word, enabling the researcher to easily index the data. The researcher performed an initial line-by-line coding followed with a second round of coding. Themes emerged through clustering and were grouped accordingly. A rich, thick description of the findings are included in the study.

Findings from the interviews are reported in Chapter 4. Chapter 1 introduced the topic. Chapter 2 presented a review of literature related to the topic. Chapter 3 reported the detailed account of the research methodology.

Discussion

The participants' responses indicated the perceptions of the level of knowledge about trauma-informed care before the training were varied, ranging from perceptions of novice, proficient, and nearly expert. Not possessing a great level of knowledge or experience in a subject is a characteristic of a novice learner, whereas traits of an expert are the acquired substantial knowledge of a subject matter coupled with experience in the field of study (Pozo, 1989; Shuell, 1990). All participants reported the information gleaned from the training was beneficial.

The participants who presented themselves as novice learners revealed that their baseline of knowledge was nonexistent or minimal at best. Before the training, trauma-informed care had not been included in their professional repertoire while attending school or fulfilling the role of educator. The training seemed to add to the knowledge of trauma-informed care and the

willingness to implement this type of program. When educators are educated in trauma-informed care, they seem more apt to develop an intrinsic desire to continue learning.

In responding to his perception of his level of knowledge and trauma-informed care, an educator reported, “After the training, it's kind of like when you go from zero to 100. It's been very eye- opening as an educator, and I’ve really enjoyed the training. I really like still learning about it.”

Participants revealed they had preconceived ideas concerning student behavior as well as ways to deal with unwanted behaviors. Looking through the trauma-informed lens seems to add a level of understanding and a desire to approach behaviors in a manner that is not negative. The learning atmosphere continues to become more student-centered as behaviors are understood without a sense of judgement. Another educator added that the training encouraged her to look beyond the behaviors, an action she did not feel she did with her novice level of knowledge:

> I feel I was a little bit more understanding of their behaviors. And how to deal with those types of students instead of being so negative. I think learning about ACEs helped me understand why students acted maybe the way they did.

The willingness to learn more about a subject matter when the perception of the knowledge is great seems to enhance educator preparedness. Life-long learning adds to an existing knowledge base, especially when the concept is specific to problem-solving (Knowles et al., 2020). Educators generally report a desire to add to their own professional expertise, therefore, training that will enhance that knowledge base is welcomed. Expounding upon heightening a level of perceived expertise, one educator explained:

> It’s a much deeper level and it helped me to have a clearer understanding of how to unfold the training for staff and give them time to put certain practices into place, and

> reassess where we are, and then keep adding to our knowledge. The training gave me great tools to also use to train the staff.

Results from the research study found the participants' responses indicated an increased knowledge of ACEs and increased awareness of identifying behaviors were factors in the trauma-informed care training, which assisted in identifying a student's possible exposure to trauma. Aligning with the SAMHSA (2014) recommendations, educators should be given the knowledge to recognize the signs of trauma so they will be better equipped to focus on those who have been exposed to traumatic events. Recognizing these particular signs allows an educator to be abreast situations that may cause behavior, and consequently, learning issues. Targeting these issues early on can give a student a better chance of being successful in the classroom and beyond. Being a trauma-informed classroom is a setting that can allow the student the feelings of safety which are imperative for growth, both socially and academically. Being knowledgeable of ACEs is considered the first step in providing a solid foundation in trauma-informed care.

Adding to this sentiment, another educator reflected:

> The training helped heighten awareness and makes you wonder what has happened to them instead of what's wrong with them. The understanding helps you think before you react. A lot of teachers may think of an issue as a behavior problem. It is important the students see the classroom and us as safe havens. After they feel safe, they can learn to the maximum level.

Not only is understanding the ACEs factor beneficial for identifying student trauma, but this knowledge can possibly create stronger relationships within the staff itself. Relationship building is deemed as important for the entire culture of the school. Brunzell et al. (2018) posited

that genuine interactions within the school create both a positive learning and working environment, which equip educators with the ability to connect with each other and the students. In addition to understanding students' situations, an educator added:

> The big factor was learning about ACEs. And learning that not only do students have ACEs, but adults have those as well. The training helped with just being aware and how it affects the brain. If someone is dysregulated, there is always a "why." You try to figure out the why. I didn't realize how many of my friends and students have ACEs.

Other factors in the trauma-informed care training that assisted in identifying a student's exposure to trauma were physical and emotional cues. Educators indicated that they were now more aware of specific behaviors that could indicate traumatic experiences, which helps in dealing with unwanted conduct.

When asked about the level of knowledge of trauma after the training, one educator shared:

> Specifically, I think, the training helped just being able to identify if a child has been exposed to trauma. If a child is acting differently, or for instance, I have one little girl that seems like she just always wants to be covered. It's like her hair is always on her face and it's like she wants to be covered; and I may not have recognized that before. Those kinds of things I'm more sensitive to now than I was before. And then, you know what's going on with a kid instead of thinking why would you put your head down and try to see what's behind that. What's causing them to want to do those kinds of things. I think it's just maybe more aware of simple little things that I may not have picked up on. And then the communication, which being the librarian, I don't have as much communication with parents as I did when I was a classroom teacher. Just having the communication with them helps to see sometimes where the kids are coming from as far as what they are

> living through. And one thing that's great is with our related arts teachers is that we do lunch duty. And so during that time, I do get a chance to just sit down and talk to the kids and get to know more on personal basis and find out a lot of things. I try to understand where their coming from, and those situations, better than what I could just in the classroom. It's good to be more one on one and having that time.

Another educator shared her realization that a student may have a reason for a behavior:

> I think it helped me understand why students acted maybe the way they did. I feel I was a little bit more understanding of their behaviors. And how to deal with those types of students instead of being so negative.

The findings from the study indicated several factors in the trauma-informed care training assisted in identifying and assisting students who have been exposed to trauma. Relationship building deemed prominent, along with increasing the knowledge of ACEs and implementing student support practices. Building rapport with students is a crucial element of the trauma-informed care approach, creating an environment that is psychologically safe where students feel comfortable in sharing feelings. The findings align with the SAMHSA (2014) report that state relationships should render a sense of compassion and respect. However, Herman (1997) reported that when a student becomes astutely attune to his traumatizer's mood, it is difficult to have a positive outlook and cannot view the classroom as a nonthreatening environment. The supporting research and scholarly material indicated creating a positive bond with students is imperative to a successful classroom experience. When asked to elaborate on relationship building and its importance to the classroom, one educator commented:

> "Students need to know who is a safe person, and we spend a lot of time building this relationship. The students talk to me, and I talk to the students."

Another educator added:

> Providing that adult relationship as a teacher to the children help supports, but also just getting them somebody to talk in the appropriate manner or other resources. Because we know if they're not eating, not sleeping, afraid at home, then they're not performing at school.

Students who have experienced trauma often have a different view of the world which can consequentially have a negative impact on the classroom experience. Because a student's sense of hyperarousal can cloud his judgement and evaluative processes, it is beneficial that educators be aware of ACEs. A finding from the research revealed that an educator's increase in the knowledge of ACEs assisted students who may have been exposed to trauma.

One educator posited:

> I feel the process of learning about ACEs was extremely helpful to all involved. The first year of implementation was hard and very heavy load. Since the first-year behaviors have diminished and there have not been as many behaviors so my load is less.

A further finding from the research study indicated implementing student support practices as being a factor that assisted students who may have been exposed to trauma. This finding aligns with Shapiro et al. (2008), who found that classroom practices that acknowledge trauma is the foundation of helping heal the past and prepare for the future. As the Tennessee Department of Education (2019) maintains, positive behavioral support and behavior intervention plans minimize disruption to education. Creating behavior teams was mentioned as a valued student support practice.

One educator remarked:

> From an elementary perspective, what it helped us do, of course, is we formed our behavior team. We have a referral that teachers also can use if a child is struggling with behaviors, or if they're also struggling with academics or other concern. That form can be used so that we can sit down as that team and brainstorm what strategies can we put in place to support this child in that moment.

Another system that was referenced several times by the participants was the "check in, check out" strategy. The student "checks in" with a supportive adult for an opportunity to build rapport by receiving words of encouragement or a simple greeting. The same student will "check out" later in the day with a report of how his day went. Offering insight into how an educator needs to gauge how individual supports may benefit one student and not the other in order to reevaluate a plan, an educator stated:

"We also developed a strategy called "check in, check out" that we use. It works great for some kids, but not others. So in our classrooms, it really made us rethink."

Another strategy mentioned several times was creating a safe place in the classroom where students could go to help with emotion regulation. Mostly, this is a section in the classroom where a student may go for an allotted time to engage in calming procedures. An educator went on to say:

> Every classroom has a calming corner, and we discuss how everyone needs a minute away from time to time- be it stress, sadness, anger etc. We have idea posters to help them rate how they are feeling and labeling the emotion and then things that can help them calm down- yoga poses, breathing technics, play dough, pinwheels (to help with breathing), and even books about emotions and what to do with problems.

Data analysis indicated the participants agree that support is needed from stakeholders, coupled with consistent school-wide expectations and a willingness to collaborate, for the successful implementation of trauma-informed care. Participants' responses specified that administration must support the implementation first and foremost, followed with collaboration and cooperation from teachers, students, and parents. Harper and Temkin (2019) posited that supportive learning environments will assist in meeting the needs of children exposed to trauma. The researcher found participants' responses align with this notion.

Harris and Fallot (2001) recommended certain prerequisites to help achieve establishment and sustainability, with administration committing to changing the paradigm. When asked about what supports are needed for a successful implementation of trauma-informed care system in the school, one participant offered validation of administration support:

> They would have to be totally on board for it to actually work. So I think one thing that it's definitely essential is that your faculty and your staff are, not just the teachers, but also the staff and the school, that everybody's on the same page, and everybody's kind of trying to do the same thing, so that we're in it together, instead of having a couple of people trying to implement and also you've got a couple of people that are resisting.
>
> One educator remarked that an area of support that may seem small but is essential is "following up on rewards or consequences."

The implementation of a trauma-informed approach appears to be a smoother transition if the support of teachers is present. According to Durlak (2011), collaborating with those internal to the agency or organization is key in a successful implementation. Confirming the need for teacher support for successful implementations, one educator commented:

> You've got to meet each teacher where they are in their beliefs and their understanding. But they as a school, remember, we agreed that this is where we're moving and keep that encouragement going. It would be great to build in a system where really staff are holding each other accountable for the agreements or the goals that they've created. I just think there's power in that.

Offering insight into what may be deterrent in successful implementation of the trauma-informed approach, one participant stated:

> I think the counselors are a big thing: someone who knows how to talk to the children. We had a lady in a position, she's no longer here, but she would come and get the students and talk to them immediately. That kind of position helped us, but we don't have that anymore.

Adding an interesting take on the training, one educator reported:

> You really need teacher buy-in. I believe our entire staff should have been trained in stages rather than a train the trainer. This provided a situation where those teachers who were resistant blamed the trainers. Outside trainers would have had more experience and able to deliver the information without the push back.

Student ownership and participation in implementation also deemed essential in the process. A student's belief that he has input in his own educational endeavors is powerful. A sense of belongs can only perpetuate feelings of self-worth and confidence. In referencing student ownership and participation, an educator offered:

> If students have a voice in that, especially at the middle school level, is so important. The staff can work on a draft, but having some student leaders sit in with staff, and get their

feedback, is nice. I think that is a big help, and if we get those right, all the other little pieces fall into place.

Participants' responses also indicated the importance of parent's understanding the importance of a schools' adoption of trauma-informed care. The researcher's findings support the idea that parental support is a valued aspect of the successful implementation and sustainability of the program. Also, trauma education and awareness, as well as creating strong partnership with students and families, is important to support TIC. Furthermore, mitigation continues with creating a trauma-informed, culturally responsive learning environment.

When asked about the importance of parental support and understanding for TIC, an educator shared, "Parents realize their students are in a safe place that is nonjudgmental, and they feel the same way. Parents still value my input and view me as someone they can trust." Additionally, another participant revealed, "You almost take the trauma-informed care approach with the parents. Parents are more responsive to you."

Further analysis revealed participants reported a consistency with expectations is imperative to successful implementation of trauma-informed care. Enabling the students to have success seems to partly lie in establishing expectations early in the school year and consistently following those expectations. Supporting these findings is the SAMHSA (2014) recommendation of creating consistent rules and consequences. The findings also align with Shamblin et al. (2016) research suggesting that establishing consistent routines and rules is one of the most effective rituals in creating a safe and respectful classroom. When asked about an essential factor in implementation, one educator responded:

It's been positive because of how we're handling things in the classroom and getting the kids off on the right start. And we have the related arts teachers take the students the first

week or sometimes the first week and a half or so of school, and we meet with all of them and we go over our way expectations.

Participants' responses revealed the importance of the willingness to collaborate as being key in the successful implementation of trauma-informed care. Collaboration among personnel is recognized as a strategy that encompasses all school employees as stakeholders who are instrumental in providing the trauma-informed care climate with invaluable data and knowledge (Harris & Fallot, 2001; Hopper et al., 2010). Also, having a common language equips all areas of service to apply a "trauma lens" when dealing with students (Cole et al., 2013). All these things will provide personnel the knowledge that is required to support such programs and maintain sustainability (Cole et al., 2013; Wolpow et al., 2009).

The conceptual framework for providing a TIC approach in an educational setting as suggested by the SAMHSA (2014) views staff collaboration as a key factor. Collaboration among personnel is recognized as a strategy that encompasses all school employees as stakeholders who are instrumental in providing the trauma-informed care climate with invaluable data and knowledge (Harris & Fallot, 2001; Hopper et al., 2010). The supporting research of Ko et al. (2008) maintains that increasing collaboration efforts increase student support within the school. These findings align with Ko's reports of the importance of educators' collaboration assists in recognizing and mitigating childhood trauma symptoms. An educator remarked concerning stakeholder involvement: "It's a team effort; everybody has to be on board, and everybody has to be working."

Another educator said in referencing collaboration:

Having a common goal that the staff works to agree on is important. I think voice is very important. And knowing that in the beginning, people might not be sure it's going to

work, but I think it's always important to start here. And have very clear examples of why this work is critical. But then also success stories and making sure you're celebrating those along the way as they happen.

Additionally, an educator agreed:

"I think that's one of the big things is just making sure that everybody understands what we're doing and why it makes sense."

Participants' responses indicated an increase of the level of knowledge about trauma-informed care, changes in classroom management practices, and an increase in empathy toward students and teachers after implementation. Knowles et al. (2020) posited that adult learners are more apt to grasp new material if the knowledge is relevant. Learning and applying new material is more likely if it can provide solutions to issues; furthermore, adult learning is enhanced if the participant is internally motivated (Knowles et al., 2020). Because educators may face daily obstacles perpetuated by student trauma exposure, adaptation of trauma-informed care may provide the problem-solving anecdote that teachers seek.

Since trauma has been shown to be prevalent in children, it may be advantageous for all administrators, educators, and other personnel to use and understand identical verbiage when speaking of trauma matters as well as to recognize the significance of resilience (Sauers & Hall, 2016). Also, personnel should be trained to recognize triggers that may cause students discomfort, both physical and emotionally (Bath, 2008; Carello & Butler, 2015).

One educator revealed the training enhanced her position in the education field:

The training really prepared me to know what it looks like to be a trauma-informed school and what steps we needed to take to make that happen. We got to really complete

a deep dive into where our school currently fell short and what we needed to do to improve.

Analysis of the interview transcripts revealed upon implementation of trauma-informed care, educators were more likely to adapt classroom procedures that aligned to the SAMHSA trauma-informed care framework. Supporting changing classroom management practices, Garcia and Weiss (2018) reported that the actions of suspending and expelling students are not beneficial to the student and may lead to unwanted circumstances such as lower academic performance and engagement. Also, a lower connectedness culture has also been reported as well as a lower graduation rate. According to NCTSN (2010), the implementation of TIC in the classroom has been noted to assist in handling discipline problems. Furthermore, the NCSTN also recommends system leaders evaluate and revise discipline practices.

One educator revealed a newfound understanding of the importance of trauma-informed care practices in the classroom discipline policy:

> "It has established a safe space that is calming and nonjudgmental. This makes it accessible to learning. Trauma-informed care helps to have more conversations. Everything goes smoother. Consequences do happen but the students know it is for a reason."

Aligning with research found in the literature review, restorative practices change and enhance classroom management procedures. A stronger school community, according to Walpert-Gawron (2016), can be created by utilizing restorative justice practices in place of traditional discipline measures. Also, the Response to Instruction and Intervention- Behavior (RTI²-B) framework encourages supporting students through prosocial behavior skills such as relationship building and positive interactions (Tennessee Behavior Supports Project, 2020).

One educator reiterated:

> Another positive thing that came out of the training is we have a restorative playtime now where they do go and talk to people about their behavior. If they miss playtime, we don't necessarily have them stand, but we have them walk during playtime. We have more conversations now, I think, about their behavior than we did before. I do think that is a positive thing we took away from the training.

Another educator posited:

> We learned about having calming stations in each classroom for students to use when they need to regulate themselves. We also learned about the SRSS data collection and using the Tier 2 and Tier 3 interventions to help individual students that are struggling with dysregulation. We learned how school-wide Tier 1 interventions such as Morning Meetings can help all students regulate themselves before the academic day begins.

Maloney et al. (2016) posited that promoting empathy is derived from developing healthy relationships in a productive educational environment. Participant's responses indicated an increased degree of empathy toward students and fellow educators after implementation of trauma-informed care. Researchers assert the presence of a caring adult can establish senses of empathy as well as provide ways to process traumatic events and re-traumatization (Bartlett et al., 2017; Blaustein & Kinniburgh, 2010; Lieberman, 2004; NSCDC, 2014). Furthermore, Walpert-Gawron (2016) explained that empathy for all involved is crucial as the offender's past trauma may have influenced behavior.

One educator revealed that before the training, she did not realize other faculty members could have experienced trauma as well. She reported the importance in "giving each other grace and support."

Adding to the theme of empathy, another educator reflects:

> We have a much more student-focused and trauma-focused school culture since the implementation. More staff at our school now see things through a trauma and ACE's lens than before. Students are given the benefit or the doubt, and there is more patience among staff for students.

Recommendations for Practice

Following the analyzation of data collected and literature review, the researcher has made the following recommendations for practice:

- Administrators should prepare in-service presentations with meaningful activities as a precursor to the training. This may foster a greater interest in the training.
- Administrators should plan for ongoing training throughout the year to keep staff engaged and any new staff trained.
- A formation of a "TIC Team" consisting of school staff should occur to offer a support to all staff. This team should meet on a regular basis to discuss the school climate and ways to shift the climate if necessary. This team should also evaluate policies and procedures that do not align with the trauma-informed care approach and strategize to correct. The goals of the team should be clearly defined.
- The Community Involvement Plan, or other community outreach programs, should include inviting the community in learning about trauma-informed care through a variety of events, such as an open house or other specialty programs.
- The principles of trauma-informed care should be intertwined with the school's mission statement. This will clarify the purpose of the school and its intent to address trauma.

Recommendations for Future Research

The following recommendations for future research are based on the researcher's findings and conclusions of this research:

- A qualitative study could be designed to examine educators' perception of school culture after the implementation of trauma-informed care approach.
- A qualitative study could be designed to examine the perceptions of the school climate after the implementation of a trauma-informed care approach system.
- A quantitative study could be designed to measure the graduation rate of students who have attended a trauma-informed school.
- A quantitative study could be designed to examine the attendance and grades data before and after the implementation of trauma-informed care approach.

Conclusions

Educators undergo extensive training throughout their careers encompassing a large gamut of subjects. Oftentimes, teachers perceive trainings as not worthwhile or applicable to their present situations. The purpose of this qualitative phenomenological study was to examine the lived experiences of participants who received the trauma-informed care approach training provided by the Tennessee Commission on Children and Youth, entitled "Building Strong Brains Tennessee." The researcher found the perceptions of the impact of trauma-informed training in three Appalachian elementary schools revealed the training was a positive and meaningful experience. Through the researcher's analysis of the individual transcripts, the participants revealed the impact of the trauma-informed care training. The applications of the findings are limited to the three Appalachian elementary schools; however, the results of the study align with

the literature review. The results of this study may be added to the body of research regarding training and implementation of the trauma-informed care approach.

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APPENDIX: Interview Questions

1. How long have you been a teacher?
2. How long have you taught at this particular school?
3. Prior to the training, describe what you feel was your level of understanding of trauma-informed care?
4. Describe what you feel is your level of understanding of trauma-informed care now?
5. Describe your classroom culture after implementing trauma-informed care.
6. Describe the factors in the training that help you identify a student's possible exposure trauma?
7. Describe the factors in the training that could assist students who have been exposed to trauma?
8. As it pertains to trauma-informed care specifically, what factors would you say are essential for successful implementation in a school and classroom?
9. Without referring to individual students, please discuss how the trauma-informed care training has impacted student learning?
10. Without referring to individual students, please discuss how the trauma-informed care training has impacted student behavior?
11. Explain how you think the training has added (or not) to your teaching abilities?
12. Would you like to add any comments about the training that you believe is important for the research study?

VITA

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