Toward Trauma Sensitive Practices in the Classroom:

A Compassionate Teacher's Responsibility

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A Research Paper Submitted in

Partial Fulfillment of the

Requirements for the Degree of

Master of Science in Education

Special Education

At

The University of Wisconsin - Eau Claire

December 2018
Graduate Studies

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Toward Trauma Sensitive Practices in the Classroom:
A Compassionate Teacher’s Responsibility

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The University of Wisconsin-Eau Claire, 2018
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Findings on the high prevalence of childhood trauma, the detrimental effects relating traumatic stress can have on school functioning, and resulting negative potential adult life outcomes presents a tremendously dire vision for student survivors. This requires today’s classroom teachers to become better prepared to holistically support students’ needs to assist in trauma recovery and future protection. Teachers must become informed about childhood trauma and gain the ability to recognize the impact traumatic stress has on students’ abilities to progress in school. Once trauma-informed, it is a compassionate teacher’s responsibility to implement trauma sensitive practices in the classroom and prioritize the movement of becoming a nation of Trauma Sensitive Schools.

Resumaig Battalio
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Date

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INTRODUCTION

*Student Anecdotes (All names are pseudonyms)*

At age ten, Luke was described as an angsty teenager in a young boy’s body. He meandered sluggishly through the hallways, showing little affect and no interest in anything school-related. If he worked on an assignment, it was illegible or incomplete, leading to failing grades in most subjects and a regular seat in Friday afternoon detention. Luke particularly struggled with writing and math, which he tried his best to avoid by making somatic complaints when it came time for those class periods. He rarely initiated social interaction, keeping to himself during recess. Luke’s regular education teachers decided he was just lazy, that he didn’t want to do well and had already given up on school, so what more was there to do for him? During his fifth grade year, Luke confided in his new special education teacher life was just too hard, he was never going to be happy, and he would be better off dead—just like his father who had committed suicide inside their family’s garage a few years prior. At age 22, Luke was sentenced to ten years in federal prison for drug trafficking methamphetamine across state lines.

When Michael was nine, he was removed from his biological parents and placed into custody of the child welfare system. After several changes of foster placement and significant time out of school, he successfully transitioned into half-day, self-contained special education programming to remediate low academic skills. But within a few short weeks, his current parents and social worker determined that the violent screaming outbursts Michael was demonstrating in the home were too much to handle. It turned out, the outbursts were just one symptom of the Traumatic Brain Injury Michael suffered as a result of years of physical abuse. Yet, unbeknownst to him, and with minimal notice given to the special education teacher he loved seeing every day, Michael was picked up from school at lunchtime, with his few possessions already packed in the
social worker’s car, and driven to a residential treatment center four hours away so that his “aggressive behavior” would not negatively impact the other foster children in the home. The move also meant being separated from his younger siblings, without even a chance to say goodbye.

From early childhood through second grade, Shawn was shuffled back and forth between his mother’s trailer home and his grandmother’s neighboring, one bedroom trailer home, whenever mom just “couldn’t take it anymore.” Though he was an intelligent student, Shawn was always tired at school and had terrible difficulty focusing on academics or completing what his teachers deemed as satisfactory work. During school conferences, this was explained away by his family due to his misbehavior of getting up in the night, and finding a place to hide in the home to watch videos on You-Tube. Social skills lessons were initiated to address proper sleep habits and dispositions of a good student. Yet, in third grade, Shawn’s inattention worsened, his classroom teacher became increasingly concerned about his lack of success on a daily behavior chart, and a referral for special education was discussed. Only too late, after he molested a young girl in his trailer park and entered the juvenile justice system, it was discovered that the reason Shawn was hiding out and distracting himself in the late night hours, and why he consequently struggled in school, was because he was attempting to escape the one bed he was forced to sleep in and the repeated sexual abuse of his grandmother.

By the time he was in fifth grade, Sam was the middle child of six siblings, all with different biological fathers (though he was the only one who didn’t know who his father was). All throughout his childhood, Sam struggled with deciding whether to love or hate the men who came and went from his home and life. Along with his mother, they continually made big promises- a better home to rent, home cooked family meals, engagements, the latest X-Box,
birthdays spent at the waterpark - that never came to fruition. Instead, engagements were broken, the siblings learned to prepare and sustain themselves on ramen noodles and frozen pizza, eviction notices were delivered, excuses were made, and the men eventually disappeared, typically landing in jail for domestic violence. By the time he was ten, mom ended up incarcerated, too, and Sam ended up with a Conduct Disorder and Bipolar diagnosis. He no longer trusted anyone, even sabotaging the relationship with his mentor he had cherished since kindergarten, and if he was not sleeping when at school, he was lashing out aggressively. The school’s crisis response team was responding daily to his physical attacks, until he was moved from self-contained Emotional Behavior Disability programming to an alternative day treatment school.

Julie appeared to make a smooth transition into a new school during her fifth grade year. She was quiet at first, but always had a glowing smile on her face and a kind greeting for her teachers and peers. She was easy to teach and eager to learn, any teacher’s model student who blended in with the rest of the class. As time went on though, it became evident that smile was a mask. Julie’s incessant desire to please her teachers and to succeed gave way to fearful or emotional reactions when she experienced any social or academic challenge. Truancy became an issue for her younger sisters, and Julie became more withdrawn as school staff learned about her dysfunctional home life – the temporary housing with the utilities turned off and the continual lice infestations that led Julie’s father to shave off her long, golden hair; her mother’s attempted suicide in front of the children and her subsequent psychiatric hospitalization; the forthcoming incarceration of her father for grand theft of construction site materials to sell for drug money; and the abuse of Julie, who was shunned by her father while her sisters were treated like princesses. All of this culminated in foster care placement, as neither parent was mentally or
physically capable of caring for Julie and her sisters. Julie's smile returned, but it was much
dimmer than before.

These stories offer only a slight glimpse into the complex lives of these students. They
represent only a mere fraction of the students arriving in today's classrooms dealing with such
experiences and the teachers confronted by these issues. The reality is that every single day,
students like these are showing up to schools across the country. Teachers should understand
how these traumatic backgrounds are impacting their students so they are prepared to provide the
most effective support possible during the school day.

*Role of Today's Classroom Teacher*

The role of the 21st Century classroom teacher has become multifaceted, going well
beyond implementing effective whole group instruction allowing students to master specific
academic subjects and pass achievement tests. Today's educators are no longer required to
merely dispense knowledge using traditional methods to all students in the same manner.
Academic learning is now student-centered, differentiated to meet diverse needs and learning
styles, to reach students in a variety of ways that inspires a true love of learning and future
success in society. To accomplish this, teachers must get to know each student as an individual to
be able to understand their unique needs, backgrounds, interests, and abilities. Concurrently,
teachers are continually growing as professionals, being trained to be an effective educator who
can meet new standards with data-based decision making, adapting to ever-changing curricula,
incorporating the latest technology, collaborating on the next initiative, and attending meeting
after meeting. All of this innovation and demand can lead to teachers feeling overwhelmed and
fatigued.
Moreover, just as teachers’ roles have shifted in the academic realm primarily from constructing meaningful educational experiences that extend beyond the walls of the classroom into the community and world to schools now being a place of life-long social learning. With students spending six to eight hours daily at school, teachers are poised to be one of the most influential people in a student’s life. The teacher’s role in social-emotional development is no longer that of custodial child care and disciplinarian. Perhaps the most important role of a teacher today is to serve as a positive role model and mentor committed to creating a safe, inclusive learning environment and encouraging all students to live their lives to the fullest potential and to discover the best qualities within themselves. While teachers may feel conflicted about dedicating instructional time to addressing students’ social-emotional well-being or unsure of their place in championing mental health, the essential foundation to quality education is a close relationship between a knowledgeable, compassionate teacher and a secure child.

This is especially true for students who have experienced trauma. How may the outcomes have been different for Luke, Michael, Shawn, Sam, and Julie if they had felt safe in their learning environments and experienced trusting, empathetic relationships with educators all throughout their school age years? What if all the educational professionals in their lives had been able to recognize the challenges exhibited at school as indicators of past or ongoing trauma experiences? Could these children have been empowered to make better decisions in their personal lives or been enabled to contribute meaningfully to society? In an age when students are arriving to school carrying heavier weight on their shoulders than their backpacks, and teachers are feeling overworked and exhausted, we must prioritize preparing teachers and schools to effectively address childhood stress and trauma. Susan Craig writes,
Until schools acknowledge the seriousness of this problem and commit to resolving it, the failure of other educational reform initiatives will continue. Trauma is not just a mental health problem. It is an educational problem that, left unaddressed, derails the academic achievement of thousands of children (Trauma Sensitive Schools, 2016, p. 101).

*The Trauma Sensitive Schools Movement*

In the mental and physical health professions, the significant impact of stress and trauma has been at the forefront of discussion and scientific inquiry for the past 25 years. This focus provides:

Well-documented evidence that support the need to strengthen prevention initiatives and intervention strategies focusing on children and their families. Translating this information (both research and practice) is an important task for those of us who work with children in preschool, child care, and kindergarten-elementary school settings where many (if not most) of the children affected by stress are located (Peterson, 2014, p. 8).

Yet, the Trauma Sensitive Schools movement is only about a decade old - but quickly gaining momentum. Although some traumatized children do well in school, a growing body of research provides substantial evidence supporting the relationship between early trauma and academic failure. Historically, educational reform “ignored the high prevalence of unresolved trauma among the student population,” in passing standards and test-based accountability legislation like *No Child Left Behind*, then in raising standards and focusing on teacher effectiveness in *Race to the Top* as potential answers to improve struggling schools (Craig, 2016, p. 9). However, after years of attempting to support the reentry to school for the surge of students who had been expelled under “Zero Tolerance” policies, and coming to the realization that much
of the behavior of these students resulted from traumatic stress, Massachusetts Advocates for Children and Harvard Law School partnered to create the Trauma and Learning Policy Initiative (TLPI). The TLPI mission is to “ensure that children traumatized by exposure to family violence and other adverse childhood experiences succeed in school” (About TLPI, n.d.). Thus, *Trauma Sensitive Schools* became defined as “the school climate, instructional design, positive behavioral supports, and policies traumatized students need to achieve academic and social competence” and now, multiple states, including Wisconsin, are attempting “to draw national attention to the prevalence of trauma among school-aged children and the need to include the creation of trauma-sensitive environments in future reform efforts” (Craig, 2016, p. 9). As a promising step to that end, in 2015, Barack Obama signed into law the *Every Student Succeeds Act*, including grant funding program provisions that could assist districts providing school based mental health services and supports and staff development on trauma-informed practices. Prewitt (2016) stresses:

The *Every Student Succeeds Act* has the potential to accelerate the movement toward trauma-informed schools as long as the states and local school districts use their new authority and trauma-informed principles to guide reforms locally. It also will require Congress to fund the new and reauthorized programs at sufficient levels and for the Department of Education to write rules and regulations that address the academic, social, and emotional needs of all students. Advocates for trauma-informed schools will need to engage skillfully and energetically with policymakers at all levels as the new law is implemented (para. 8).
Purpose of Research Paper

The purpose of this research paper is to address the following questions: How is trauma defined and how prevalent is childhood trauma for school-age children? What are the long-lasting effects of experiencing trauma as a child, and how does traumatic stress affect students’ functioning in school cognitively, academically, and social-emotional-behaviorally? What problems exist with traditional classroom views on academic and behavioral difficulty and with discipline practices implemented with students who exhibit behavioral challenges? With the movement to become more trauma sensitive in schools, what are some initial steps that classroom teachers can take to promote recovery for students who have experienced trauma?
DEFINITION OF TERMS

Acute Stress: Normal response or reaction to stress lasting four to six weeks

Acute Trauma: Trauma that results from a single, unanticipated event

Adverse Childhood Experiences (ACEs): A traumatic experience in a person's life occurring before the age of 18 such as physical, sexual, or emotional abuse, neglect, domestic violence, substance misuse within household, household mental illness, parental separation or divorce, or incarcerated household member

Child Traumatic Stress: When children and adolescents are exposed to traumatic events or traumatic situations, and this exposure overwhels their ability to cope

Chronic Trauma: The cumulative effect of traumatic experiences that are repeated or prolonged over time, such as domestic violence or abuse

Compassion: A feeling of deep empathy and respect for another who is stricken by misfortune and the strong desire to actively do something about it; The human quality of understanding the suffering of others paired with the desire to do something to alleviate it

Complex Trauma: The exposure to varied and multiple traumatic events, often of an invasive, interpersonal nature

Externalizing Symptoms: Characterized by disruptive behaviors, aggression, hyperactivity, and defiance

Fight Response: Physiological arousal and aggression; irritability, anger, trouble concentrating, hyperactivity, or silliness
Flight Response: Withdrawal and escape; social avoidance and isolation

Freeze Response: Stilling and constriction; restrained emotional expression, quiet or static behavior, over compliance, and denial of needs

Internalizing Symptoms: Characterized by sadness or depression, anxious feelings, withdrawn behaviors, and low self-esteem

Posttraumatic Stress: Exaggerated and prolonged stress response beyond four to six weeks, which can persist even years later, resulting in dysregulation of stress chemistry and increased activation of the Sympathetic Nervous System

Resilience: The ability to adapt to adversity and develop positive coping strategies to deal with crisis and stress

Trauma: Any experience that leaves a person feeling hopeless, helpless, fearing for their life/survival, their safety (This experience can be real or perceived)

Trauma-Informed: An approach that refers to how an organization or community thinks about and responds to children and adults who have experienced or may be at risk for experiencing trauma

Trauma-Sensitive School System: One in which all teachers, school administrators, staff, students, families, and community members recognize and respond to the behavioral, emotional, relational, and academic impact of traumatic stress on those within the school system
LITERATURE REVIEW

Overview of Research Paper

This paper will first review existing research defining childhood stress and trauma and its impact on the developing child. Next, statistics of childhood trauma prevalence will be presented, followed by the implications of these experiences on students' ability to function in school. Then, the paper will explain problems with how teachers have traditionally viewed student misbehavior and the detrimental effects of schools' historical mishandling of students with behavioral challenges. After exploring the inherent resiliency of children and the hope this affords for intervention, the author will implore teachers to adopt a trauma informed perspective to create safe, inclusive learning environments that provide today's students with the positive relationships required for success in school and in life.

Defining Childhood Trauma and Stress

Childhood trauma refers to experiences that happen from birth to the age of eighteen which are frightening, dangerous, or violent events that threaten or cause harm to the child’s emotional or physical well-being. The threat may be real or perceived. According to the National Child Traumatic Stress Network (2003), traumas may occur in a multitude of ways: (a) Trauma can result from events outside of the family’s control, such as a natural disaster, accident, community violence, terrorism, or war; (b) Trauma may involve a life-threatening illness, sudden loss of a loved one, substance abuse within the family, incarceration of a family member, parental separation or divorce, or living in chronically chaotic environments with unstable housing or finances; (c) Traumas can also be intentional, such as physical, emotional, and sexual abuse, domestic violence, or neglect.
Childhood trauma exposure happens in four ways: as a victim, witness, peer or sibling, or by listening to the details of the trauma. In the *Children of Trauma Guidebook*, The National Institute for Trauma and Loss in Children (TLC) describes the victim as “a person who is directly impacted by an event that leaves a person feeling hopeless, helpless or fearing for their safety or survival,” as with abuse or neglect. A witness is defined as “a person who witnesses someone else being traumatized, who can also experience trauma symptoms and reactions,” such as viewing domestic violence or having a family member with addiction. Peer or sibling exposure may include having a brother, sister, or friend who completed suicide or experienced a chronic illness. Listening to the details of a trauma can occur by viewing events on the media (Soma, 2016, p. 6).

Some traumatic experiences occur once in a lifetime, and are labeled as acute. However, many children experience multiple traumas, which leads to complex trauma or trauma is a chronic part of their lives. “While various types of trauma exist at different degrees of intensity, it is the individual’s stress associated with each trauma that affects how he or she responds to and behaves following a traumatic event” (National Center for Mental Health Promotion and Youth Violence Prevention, 2012, p. 2). It is also important to remember that not everyone exposed to what might be considered to be a traumatizing event actually experiences trauma symptoms. Since trauma may result from violent and non-violent situations, as Steele and Kuban (2013) explain, “perhaps it is not the situation that induces trauma but how that situation is being experienced that leaves children and youth vulnerable to trauma” (p. 4).

Developmentally, children are faced with mild or positive stressors that may provide motivation to push forward, or moderate stressors that cause temporary concern or anxiety which normally developing children have the skills or disposition to manage without lasting negative
impact. Acute stress, typically lasting four to six weeks, is a normal response to a single or limited stressful or traumatic situation. Children may be observed to have (a) trouble sleeping or making somatic complaints, (b) not wanting to be left alone or seeking safety spots in their environment, (c) easily startled by sensations similar to those at the time of the event, (d) hypervigilant about safety or they may become more accident-prone, (e) irritable or aggressive, (f) withdrawn, forgetful or having difficulty concentrating, and (g) losing their resilience or developing a pessimistic world view (Soma, 2016). When these stress responses persist beyond six weeks, for months or years following traumatic exposure, it becomes post-traumatic stress (Soma, 2016). Chronic stress results from accumulation of multiple or ongoing and pervasive experiences that fail to allow the child time to recover. This “leads to significantly greater negative outcomes. Of greater concern for many researchers and other clinical professionals is the understanding that much of the chronic stress children experience is at the toxic or traumatic level,” with chronic exposure leading to more problematic development than episodic exposure (Peterson, 2014, p. 17).

When arousal is prolonged from repetitive activation of stress response, without intervention, changes within the brain in turn result in changes to the survivor’s physical, cognitive, behavioral, and emotional development. The developing organization of the brain’s networks are use-dependent, meaning

Throughout life, the brain is sensing, processing, and storing patterns of neuronal activation (i.e. making memories) that correspond to various sights, sounds, smells, tastes, and movements. Using various modes of memory (e.g. cognitive, emotional, motor) the brain stores these patterns, making associations among multiple sensory
stimuli and creating templates of experience against which all future experience is matched (Perry & Polland, 1998, p. 38).

Thus, human beings become a reflection of the world from where they develop. A child who experiences positive relational attachment with a primary caregiver has greater opportunity for optimal development to reach their full potential. This is especially true when stimulating interactions occur within a predictable, enriching, and nurturing environment. However, we know that not all children experience safe and stable upbringings. As Perry (2004) emphasizes, “The very biological gifts that make early childhood a time of great opportunity also make children very vulnerable to negative experiences: inappropriate or abusive caregiving, a lack of nurturing, chaotic and cognitively or relationally impoverished environments, unpredictable stress, persistent fear, and persisting physical threat” have highly adverse effects (Disrupted Development section, para. 2).

Exposure to a trauma inducing event releases a surge in stress hormones that creates changes in the brain, activating an adaptive response designed for survival, either hyperarousal, dissociative response, or a combination of both. Perry (2004) states that hyperarousal responses occur more often with older children, males, and when the trauma has involved witnessing or playing an active role in the event. A child responding with hyperarousal is in a persistent “fight or flight” state and may “display defiance, easily misinterpreted as willful opposition... they often display hypervigilance, anxiety, panic, or increased heart rate” (Adaptive Response to Threat section, para. 2). Perry (2004) continues to explain, a dissociative response is more likely with young children, females, and with traumatic events characterized by pain or inability to escape. “The dissociative response involves avoidance, withdrawing from the outside world, and focusing on the inner...Children may be detached, numb, and have a low heart rate. A
dissociative child is often compliant (even robotic)” (Adaptive Response to Threat section, para. 3).

Traumatized children have less capacity to tolerate typical daily demands and stressors. Their perpetual reactions of fear lead them to retrieve information differently, and to use the lower, more primitive parts of the brain.

A child with a brain adapted for an environment of chaos, unpredictability, threat, and distress is ill-suited to the modern classroom or playground. It is an unfortunate reality that the very adaptive responses that help the child survive and cope in a chaotic and unpredictable environment puts the child at a disadvantage when outside that context (Perry, 2004, Differential ‘State’ Reactivity section, para. 1).

When misunderstood, these manifestations of trauma are mistakenly interpreted as misbehavior or rejection by teachers. Cognitively, a traumatized student might have difficulty sustaining attention, processing language, making decisions, activating memory, or using executive functioning skills necessary to complete assignments, which may be seen as laziness or lack of motivation by those who are not trauma-informed.

What we do know is that stress-inducing experiences for children are different from those experienced by adults. These varying reactions are the result of the unique developmental characteristics that children possess. As children vary in age, temperament, experience, and cognitive style, they will differ in how they respond to stress (Peterson, 2014, p. 20). How a child perceives the experience matters, and adults must refrain from making inaccurate judgements about the child’s response. “Young children are not capable of ‘thinking through’
stress and traumatic experiences; consequently, they receive a more intense effect than adults do” (Peterson, 2014, p. 20).

*Trauma as a Sensory Experience*

For the past 20 years, The National Institute for Trauma and Loss in Children (TLC) has promoted the following message in advocating for child victims: “If you don’t think what I think, feel what I feel, experience what I experience, see what I see when I look at myself, others and the world around me, how can you possibly know what is best for me?” (Steele & Kuban, 2013, p. 5). We are prone to view trauma as an event. Trauma is in fact an experience. As Kuban (2012) explains:

> While exposure to many events can be potentially traumatizing, it is only when the child perceives that experience as terrifying that it should be labeled traumatic. For example, having an incarcerated parent for one child may be traumatizing, but for another, it may be a relief if that parent was verbally or physically abusive (p.15).

What we do know is that when a child experiences trauma, or that previous trauma is triggered by feelings, images, environments, or associated sensations, the brain does not shut down. Instead it shifts, with the reasoning part of the brain giving way to the more primitive part of the brain intent on survival because the child has a real or perceived sense of impending danger.

Survival behaviors are also formed, driven and repeated because of how children experienced past traumatic situations and how they are experiencing their current situation, environment and people in their environment. If they feel unsafe, threatened or powerless, their trauma related survival behaviors may be activated (Steele & Kuban, 2013, p. 10).
In this mindset, cognitive processes become limited, children are guided by the sensory memories of their experiences, and behavior is focused on feeling safe. For children, reason and logic, the ability to make sense of what has happened and act accordingly, simply are not accessible in trauma. For this reason we must direct our efforts at helping children with the experiences they are having, with the way they now see themselves, others and the world around them as a result of their exposure to trauma. We must engage them in experiences that allow them to “rework” their traumatic experiences and memories in ways that now allow them to see themselves as survivors and thrivers, others as helpful and supportive rather than threatening and unsafe, and life as promising rather than continually painful (Steele & Kuban, 2013, p. 8).

Prevalence of Trauma Experiences

Childhood trauma is substantially more common than most people realize, and these negative childhood experiences have dire immediate and long lasting effects. One of the largest investigations ever conducted to assess correlations between childhood maltreatment and adult health and well-being was completed in 1995 and 1997 by the Center for Disease Control (CDC) and Kaiser Permanente. More than 17,000 adult participants were surveyed about adversities experienced before age 18 in the areas of household dysfunction, abuse, and neglect using the Adverse Childhood Experiences (ACE) Scale developed by researchers Drs. Robert Anda and Vincent Felitti. The scale results in a score ranging from zero, if no category of events occurred in life before 18, up to a possible score of 10. Under the category of “Household Dysfunction,” total respondent results specified the following experiences in the home: 27% substance abuse, 23% parental separation/divorce, 19% mental illness, 13% violence between adults, and 5% had an incarcerated family member. Of those surveyed, 28% indicated having suffered physical
abuse, 21% were victims of sexual abuse, and 11% reported being emotionally abused. Emotional neglect was present in the lives of 15% and physical neglect impacted 10% of participants. Sixty-seven percent of subjects had experienced at least one ACE, with 16% experiencing four or more. The presence of ACEs was then compared with adult life outcomes, leading to the discovery that victims of childhood trauma faced serious health outcomes later, including but not limited to alcoholism and substance abuse, depression, suicide attempts, heart, lung, and liver diseases, early onset of smoking and related disease, violent relationships, adolescent or unplanned pregnancy, sexually transmitted diseases, and early death (Felitti et al., 1998). Findings also indicated that higher ACE scores, particularly including being subjected to abuse or neglect or witnessing intimate partner violence, leads to even higher impact levels on future health and behavior. For example,

Participants who were sexually abused as children were more likely to experience multiple other ACEs, the ACE score increased as the child sexual abuse severity, duration, and frequency increased and the age of first occurrence decreased, and women and men who experienced child sexual abuse were more than twice as likely to report suicide attempts (Middlebrooks & Audage, 2008, p. 8).

The original ACE study presents limitations in interpretation for today’s students, as the subjects were mostly Caucasian, middle class, and college educated, and the survey did not account for the intensity or duration of all events, rather just the variety and total number of adversity types encountered in childhood. However, this landmark investigation led to replications in numerous states seeking to determine how their own populations have been impacted by trauma, and how better data could improve prevention and intervention efforts to
reduce exposure and ameliorate effects of ACEs, including Wisconsin. The results have remained consistent:

ACEs are common, they are strong predictors of adult health risk behaviors and disease, and they are related to the 10 leading causes of death in the United States. Finally, ACEs have a cumulative effect: the higher the ACE score, the greater the risk for numerous health and social problems throughout the lifespan (O’Connor, Finkbiner, & Watson, 2012, p. 9).

Subsequent research continues to indicate high prevalence of childhood trauma. The National Survey of Children’s Exposure to Violence (NatSCEV) of 2008 looked at children’s exposure to several major categories of violence by directly asking children and their caregivers about their experiences. Findings indicate that in the prior year:

- More than 60 percent of children were exposed to at least one type of violence
- Nearly one-half (46.3%) of children and adolescents were assaulted at least once
- More than 1 in 10 (10.2%) were injured in an assault
- 1 in 4 (24.6%) were victims of robbery, vandalism, or theft
- 1 in 10 (10.2%) suffered from child maltreatment
- 1 in 16 (6.1%) were victimized sexually
- More than 1 in 4 (25.3%) witnessed a violent act and nearly 1 in 10 (9.8%) saw one family member assault another
- More than one-third (38.7%) experienced two or more direct victimizations, 1 in 10 experienced five or more, and 1 in 75 experienced 10 or more direct victimizations in the previous year (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009, p. 1-2).
Further analysis from the survey explains that in comparison to the past year, lifetime exposure to violence is even higher by as much as one-third to one-half, children who are exposed to one type of violence are “at far greater risk of experiencing other types of violence” during their lifetime, and that “children in the United States are more likely to be exposed to violence and crime than are adults” (Finkelhor et al., 2009, p. 2). Strengthening the understanding of how common childhood trauma is, a second survey using an updated Juvenile Victimization Questionnaire was completed in 2011 (NatSCEV2). Though it provided greater desegregation of exposure types by demographic, overall statistics remained stable to the previous study, meaning children and youth are frequently exposed to violence, crime, and abuse on an annual basis and over the course of their childhoods (Finkelhor, Turner, Shattuck, & Hamby, 2013). The Center on the Developing Child (2012) provides specific attention to the prominence of neglect, in comparison to physical and sexual abuse, which tends to get more national attention. Their research concludes:

In 2010, more than half a million documented cases that met state or federal definitions of neglect were reported in the United States, which accounted for 78% of all maltreatment cases nationwide. This rate far exceeded all other forms of child maltreatment (some of which included both overt abuse and neglect), including physical abuse (17.6%), sexual abuse (9.2%), and psychological abuse (8.1%) (p. 2).

While these studies relate the frequent occurrences of exposure to violence, crime, or abuse, we must also consider other significant events in a child’s life that may induce trauma, beyond expected grief. Examples include, but are in no way limited to: (a) death or illness of a family member, friend, or close acquaintance; (b) an accident, natural disaster; war, and (c) even media exposure to the details of a trauma via TV or the internet. In a summary of an extensive,
systematic review of 25 years’ worth of research on student traumatic event exposure and traumatic stress symptoms, Perfect, Turley, Carlson, Yohanna, and Saint Gilles (2016) concluded that “school personnel must recognize that approximately two out of every three children are likely to have experienced at least one or more traumatic events by age 17” (p. 8).

*Impact of Trauma on School Functioning*

The research on ACES has taught us that negative childhood experiences have tremendous, lifelong effects on health and quality of life. More immediately, changes to brain development as a result of heightened stress means trauma can significantly impair how a student functions at school. Professionals within school systems must realize the potential impacts of traumatic stress on cognitive, academic, and social-emotional-behavioral functioning.

*Cognitive Functioning*

Research tells us that early trauma affects every aspect of children’s cognitive development. Multiple studies found “the presence of traumatic stress symptoms (e.g. dissociation, re-experiencing) and their severity have been found to relate to even lower IQ scores” and Kira et al. (2012) explained “youth who were abandoned and in the foster care system (trauma exposure) performed lower on non-verbal intelligence subscales when compared to normative data” (as cited in Perfect et al., 2016, p. 12). As Park et al. (2014) discovered, “visual, verbal, spatial, and/or working memory among youth who had been exposed to traumatic events” can be impaired and the work of Kocovska et al. (2012) “found that a language disorder was much more common among youth who had been maltreated than those without maltreatment histories” (as cited in Perfect et al., 2016, p. 23).

With the high prevalence of both childhood trauma and Attention Deficit Hyperactivity Disorder (ADHD), and overlapping symptomatology of ADHD and PTSD, it is probable that
exposure to childhood trauma either leads to increased vulnerability for ADHD, or “it is likely that PTSD diagnosis is underrepresented because trauma symptoms have been mislabeled as ADHD symptoms, which are more external and easier to detect” (Szymanski, Sapanski, & Conway, 2011, p. 56). Therefore, the delayed executive functioning skills, difficulty concentrating, distractedness, restlessness, impulsivity, irritability, detachment, anger outbursts, and hypervigilance observed in the classroom may be correlated to traumatic stress.

*Academic Functioning*

According to the Trauma and Learning Policy Initiative (TLPI), trauma can hinder many foundational skills necessary for learning, including development of both verbal and nonverbal language, ability to process oral and written information, sequential organization and memory, critical thinking, and self-regulation (Trauma and Learning, n.d.). Without these, and other prerequisite skills previously mentioned such as attention, students are unable to engage in learning, thus adversely affecting academic achievement. The National Children’s Advocacy Center (2013) outlines eight key ramifications of childhood trauma on academic attainment:

1. Children exposed to maltreatment are at increased risk of educational underachievement, including lower verbal and math scores.

2. Neglected children have poorer academic performance than physically maltreated children.

3. Maltreated children have higher rates of absenteeism from school than non-maltreated peers.

4. Maltreated children are at substantially higher risk than non-maltreated children of repeating a grade.
5. Maltreated children are at increased risk of dropping out of school before high school graduation.

6. Maltreated children are more likely to be referred for special education services.

7. Maltreated children are more likely than their peers to exhibit poor social skills and classroom behavior problems.

8. A child’s risk of poor academic functioning is substantially heightened by multiple victimizations (p. 1).

Plus, traumatic stress can induce sensory and motor difficulties, unusual responses to pain or discomfort, a weakened immune system leading to students being sick more often, or frequently making psychosomatic complaints and visiting the school health office more often. All of this takes a toll on academic engagement and learning.

*Social-Emotional-Behavioral Functioning*

Childhood stress and trauma also has detrimental effects on social, emotional, and behavioral development. When past experiences have been void of secure attachment, it interferes with the brain’s coping mechanisms, and for children whose stress response systems and baseline state of arousal has been altered, they can remain in a physiological state of alarm, commonly referred to as “fight, flight, or freeze.” When faced with stressors at school, trauma victims may respond with fear and emotionally reactive responses aimed at survival, rather than thoughtful ones. Their hypervigilance causes the perception that everyone and everything is a potential threat to safety. Without trust in their environment and the people in it, children “often have difficulty forming relationships, interpreting verbal and nonverbal cues, and understanding other’s perspectives;” What’s more, is “psychologically, they have a fragmented sense of self and are vulnerable to anxiety and depression; behaviorally they are prone to the extremes of
withdrawal or serious acting out behaviors” (Terrasi & Crain de Galarce, 2017, p. 36). Studies show that “youth who experienced violence were more likely to be rated by their teachers as exhibiting more externalizing behaviors such as aggression and hyperactivity” and “teacher reports reflected higher levels of internalizing symptoms among youth who had been maltreated compared to those who had not” (Perfect et al., 2016, p. 30 & 37). Students may be hyperactive, have poor impulse control, be oppositional, engage in dangerous behaviors, lie, steal, or be dishonest. Students may also have difficulty labeling or describing their feelings, expressing their wants and needs, be anxious or seem to over react, self-harm, attempt to be overly helpful or compliant, and have difficulties with sleep or eating. Self-concept suffers with students lacking a sense of self; having low self-esteem or poor body image; feeling shame, guilt, or blame; or feeling worthless, as if nothing they do matters. Students who have experienced trauma may yearn for a sense of control, can be either clingy or detached, have unhealthy personal boundaries, and lack empathy.

In summary, The National Institute for Trauma and Loss in Children list externalizing “fight” behaviors that teachers report as verbal attacks, aggressiveness, assaultive behavior, and defiance. “Flight” behaviors observed at school can be either externalizing or internalizing, including running away, refusal to talk, avoiding previous relationships and activities, dissociation, and numbing out. (“Flight” responses also include substance usage, eating disorders, depression, suicidal tendencies, and engaging in other at-risk behaviors). “Freeze” behaviors seen can include inability to make decisions, being unable to care for oneself, lethargy; non-responsiveness, and inability to interact or sustain relationships. (Steele & Kuban, 2013, p. 10).

*Teacher Perspectives and Responses to Challenging Behavior*
Responding appropriately to the needs of students who have been exposed to trauma is just as critical as recognizing what difficulties they may face. Unfortunately, due in part to long-standing beliefs about the source of students’ misbehavior, reactions to problems with academic learning or to challenging behavior has not traditionally been done with the knowledge of how trauma impacts students’ cognitive, academic, and social emotional skills. As Greene (2008) proposes,

Kids who haven’t responded to natural consequences don’t need more consequences, they need adults who are knowledgeable about how challenging kids come to be challenging... We’ve learned a lot about children’s brains in the last 30 years. It’s time for our actions to reflect our knowledge (p. 167).

This requires setting aside false assumptions regarding why students misbehave like wanting attention, wanting their own way, trying to manipulate the teacher, lack of motivation or having a bad attitude, intentionally making bad choices despite the potential consequences, or placing blame on a mental illness or lack of proper discipline (Greene, 2008).

This also forces a reexamination of punishment and discipline. Research explains that for traumatized students, reactive responses to stress are not rational. “This doesn’t mean that teachers should excuse or ignore bad behavior. But it does explain why harsh punishments so often prove ineffective in motivating troubled young people to succeed” (Tough, 2016, para. 21). Punitive measures such as time out and out of school suspension replicate elements of shame, past rejection, and withholding of positive love and attention, as experienced in trauma. These types of punishment reinforce to the traumatized child that adult approval is conditional, and are counter-productive to establishing positive school connectedness and the strong, caring relationships with educators that students yearn for and need to recover. Plus, discipline does not
teach students how to manage stress and self-regulate in order to demonstrate appropriate behavior.

Yet, according to the National Center for Educational Statistics, in 2006, United States schools suspended a staggering 3,328,750 kids, and expelled 102,080 more. (The number of actual incidents is likely significantly higher, as a student is counted only once in the data, even if suspended more than once during that same school year). Given “the alarming school suspension rate across the country, American children lost almost 18 million days of instruction due to these actions,” and with disadvantaged student groups substantially more likely to be thrown out of school, this only widens the achievement gap (Kiema, 2015, para. 1). Even still, “a belief that schools would be safer and more effective if they had ‘zero tolerance’ for violence, drug use, and other types of misbehavior led to a sharp rise in suspensions” (Tough, 2016, para. 22). But, “only 5% of all out-of-school suspensions were for weapons or drugs...the other 95% were categorized as ‘disruptive behavior’ and ‘other’, which includes cell phone use, violation of dress code, being ‘defiant’, display of affection, and, in at least one case, farting” (Stevens, 2012, para. 11).

The nation is starting to recognize “that policies intended to make schools safer and less chaotic often backfire” (Kolodner, 2015, para. 7), not working for students or for schools. Studies now show:

Higher rates of out-of-school suspension correlate with lower achievement scores. They don’t work for the kids who get kicked out. In fact, these ‘throw away’ kids get shunted off a possible track to college and onto the dead-end spur of juvenile hall and prison (Stevens, 2012, para. 13).
Schools must address how to keep students from this “school to prison pipeline,” but for that to happen, “Teachers need a lot more support and training for effective discipline, and schools need to use best practices for behavior modification to keep these kids in school where they belong” (Elias, 2013, p. 40). Increasing the use of Positive Behavior Interventions and Supports (PBIS), adopting more compassionate, trauma-informed responsive approaches to discipline such as restorative justice, and teaching self-regulation and resilience are a start.

Resiliency in Children and the Need for Intervention

The findings on the high prevalence of childhood trauma and the detrimental effects relating traumatic stress can have on school functioning and adult life outcomes presents a tremendously dire vision for students. But, for a teacher with a compassionate desire to help students affected by trauma, all hope is not lost. “It is important to understand that the brain altered in destructive ways by trauma and neglect can also be altered in reparative, healing ways” (Perry, 2004, Decreasing the Alarm State section, para. 1).

Following adverse experiences, some children have shown to be remarkably resilient, and their developing brains are still flexible. “Resilience refers to the ability to adapt well to adversity, trauma, tragedy, threats, or even significant sources of stress. Resilience equips children with the ability to face, encounter, and overcome traumatic circumstances and environments” (National Center for Mental Health Promotion and Youth Violence Prevention, p. 6). It cannot be refuted that many factors contribute to each individual child’s level of resilience, such as age, temperament, IQ, family characteristics, and type of trauma experienced, and “statistical likelihood is not fate” (O’Connor et al., 2012, p. 26). The development of resilience has as much to do with innate qualities as the presence of supportive relationships, like that between a teacher and a student. To protect all children, and to begin the healing process for
those impacted by trauma, “It is paramount that we provide environments which are relationally enriched, safe, predictable, and nurturing. Failing this, our conventional therapies are doomed to be ineffective” (Perry, 2004, Decreasing the Alarm State section, para. 3). With this goal in mind, personally becoming trauma-informed and supporting the movement of Trauma Sensitive Schools must be the priority.
DISCUSSION

Luke, Michael, Shawn, Sam, and Julie were just a few of the students on my large caseload when I was just beginning to establish myself as a professional educator. As a new, idealistic, elementary, multi-categorical special education teacher, I relied on my inherent empathy and compassion to help me meet the complex needs of these students and so many others. While my college preparation and preservice experiences afforded me some knowledge and skills with behavior management and social-emotional learning, I hadn’t imagined that the majority of my young caseload would have already experienced so much turmoil in their lives. Though I poured my heart into my work, at the end of every day, I always felt that there was more I could be doing to effectively support these students.

Fortunately, I worked in a district that liked to be on the forefront of educational reform. When PBIS began to take hold in Wisconsin, I was one of the first in my building to be trained and helped develop our school’s Tier I and Tier II systems. When the opportunity presented itself to complete Wisconsin’s Department of Public Instruction’s Trauma Sensitive Schools training, I volunteered to become a Trauma Champion for my district. Everything I was learning resonated with me, and I once again felt invigorated and equipped with the knowledge I knew I needed to truly make a meaningful impact on not only my students in special education, but school-wide.

My district and building were still in the early stages of becoming trauma-informed, reevaluating current practices, assessing our readiness for implementation including promoting
buy-in from staff, and action planning at the universal level. Becoming a Trauma Sensitive School is a dynamic, ongoing process that in the end, requires trauma-informed practices to be implemented as a school-wide vision by all staff collaboratively to most effectively reach all students and to be sustainable. By definition:

A trauma-sensitive school is one in which all students feel safe, welcomed, and supported and where addressing trauma’s impact on learning on a school-wide basis is at the center of its educational mission. It is a place where an ongoing, inquiry-based process allows for the necessary teamwork, coordination, creativity, and sharing of responsibility for all students, and where continuous learning is for educators as well as students (Cole, Eisner, Gregory & Ristuccia, 2013, p. 17).

Single attributes of a Trauma Sensitive School will work better as part of the interrelated whole. However, as a teacher, there are still actions that need not wait for the entire system to be in place, including becoming trauma-informed, changing perspective by using a trauma-sensitive lens, supporting social-emotional learning in a safe environment, modeling self-regulation, and most importantly, fostering caring supportive relationships with students.

Initial Steps for Teachers

Awareness is the critical first step. The statistics on the pervasiveness of trauma and the evidence on its effects on children cannot be disputed. Teachers need to become trauma-informed to “understand that adverse experiences in the lives of children are exceedingly common and that the impact of these traumatic experiences on child development can play a major role in the learning, behavioral, and relationship difficulties faced by many students” (Cole
et al., 2013, p. 18). With awareness, educators must reflect upon their traditionally held beliefs and assumptions about children and behavior. As Craig (2016) explains:

A belief in children’s innocent unawareness of the more vulgar aspects of existence makes it hard for teachers to accept the high prevalence of trauma and adversity in their students’ lives. Similarly, the belief that children are willful and in need of correction makes the awareness that children’s recalcitrant behavior is often due to injuries sustained by caregivers difficult to bear. Both beliefs and the behaviors that flow from them are potential barriers to a trauma-sensitive approach unless recognized and resolved (p. 101).

Educators come into contact with students daily and may be the only adults consistently present enough to observe children’s behaviors and emotions. When trauma is better understood, this puts teachers in the ideal position to distinguish trauma-related symptoms in a child’s disposition, to advocate for children who have experienced trauma, and to assist in their recovery. But, becoming trauma-informed has the potential to help all students, whether they have experienced trauma or not.

Changing Perspective to Using a Trauma Sensitive Lens

Teachers who are already feeling stretched too thin may view the task of implementing trauma-sensitive practices as one more initiative too many. Initially, teachers may feel conflicted about their role in meeting social-emotional or mental health needs of specific students, or torn between intervening for the urgent needs of individuals versus the whole group. Teachers may not want to give up their current “tried and true” strategies.
Teachers can be reassured that in becoming trauma sensitive, there is no prescribed set of interventions or strategies to implement, no new curriculum to learn. Rather, it starts with a change in perspective, viewing current strategies for instruction, interactions, and managing student behavior through a new lens. This allows teachers to take inventory to determine which strategies are working well and should be continued, versus which are merely in place because “we’ve always done it this way” that could be made more effective or should be stopped. It helps teachers to understand the underlying needs of students and fosters a student-centered learning environment for all by identifying gaps and selecting strategies to be implemented universally that would help students learn and behave their best. A trauma-informed view adheres to the philosophy that students want to do well, but are possibly lacking the necessary skills to get their needs met (Greene, 2008). Looking through a trauma-sensitive lens ensures that classroom or school strategies meet core values that “do no harm” – they will not stigmatize or contribute to re-traumatizing students. Changing perspective is the individual teacher’s responsibility. However, analyzing current systems and strategies to effect change is best done as a collaborative team, often in connection with PBIS.

*Adopting the Trauma Informed Care Core Value of Safety*

When preparing to implement practices in the classroom, it is not unnatural for teachers to get hung up on wanting to know which specific students have experienced trauma in order to teach them in a more trauma-informed way. While it is important to learn to identify traumatic stress symptoms and intervention needs for students needing extra support, and to fulfill the responsibility of mandatory reporting of suspected abuse or neglect, trauma-informed practices can be used universally with all students because they benefit them all. The truth is, we may never know definitively which of our students have experienced trauma and which have not for a
variety of reasons. However, when trauma-informed strategies are used with all students, a teacher can ensure that even unidentified victims of trauma are still receiving protective supports.

Trauma-informed care prescribes to five core values that should be reflected in learning environments created by teachers in school: Safety, trustworthiness, collaboration, choice, and empowerment. At the core of trauma is the overwhelming sense of powerlessness and absence of a sense of safety. Therefore, restoration of a sense of safety must be the immediate focus to help traumatized children heal. But, teachers cannot just tell children they are safe. Teachers must create a learning environment that provides the experience of feeling physically, academically, emotionally, and socially safe. This can be accomplished in a myriad of ways too great to list herein. However, a sample of ideas to consider include:

- Physical safety:
  - Ensuring basic biological needs of hunger, thirst, and proper dress are met
  - Providing flexible seating and allowing for movement and exercise
  - Considering the sensations of the physical environment including sights, sounds, and smells
  - Creating “safe spaces” within the classroom with tools to assist a student in calming
- Academic safety:
  - Providing engaging instruction that recognizes student’s current level and allows them to progress towards high expectations without frustration
  - Respecting individual thinking and promoting participation in an environment where students do not fear failing or being wrong, but also do not feel forced to share orally if uncomfortable
• Emotional safety:
  o Ensuring all students feel valued and supported
  o Creating a climate where students feel listened to, and where they can freely express their feelings, both positive and negative
  o Using consistency in expectations, limits, and routines
  o Consider the tone and volume of your voice as potential triggers

• Social safety:
  o Teaching empathy and adopting bullying prevention procedures
  o Modeling coping strategies and self-regulation

Gaining a sense of safety allows students to connect with others in meaningful relationships, including educators and peers, and once safety is established, students can access cognitive skills to thrive socially, emotionally, and academically and the remaining core values can be addressed.

*Social-Emotional Learning and Self-Regulation*

It is clear that trauma has a negative effect on learning. However, learning can help to undo the effects of trauma by teaching students how to recognize emotions and manage them in healthy ways. Social-emotional learning involves a continuum of interventions to address a multitude of barriers to learning and healthy development. Prevention and early intervention are ideal best practice. In the school setting, trauma-sensitive practice recommends taking approaches that benefit all students, whether or not their trauma history is known.

One way teachers can support social-emotional learning is by adhering to PBIS practices, whose three-tiered system of support aligns with those of Trauma Sensitive School practices. Teachers can begin by universally promoting “school-wide behavioral expectations and consistently responding to students’ positive and problem behaviors to create predictable
environments in which students feel safe, secure, and supported” (Zakszeski, Ventresco, & Jaffe, 2017, p. 316). From there, explicit instruction for targeted students can address specific social skill deficits in coping skills, anger management, conflict resolution, and self-regulation. Lipscomb (2016) also recommends supporting students with instruction in the core competencies identified by the Collaborative for Academic, Social, and Emotional Learning (CASEL): Self-awareness, self-management, social-awareness, relationship skills, and responsible decision making (p. 245).

When something triggers a traumatic memory, children may be unable to think clearly to control their reactions. Reactions are often driven by worry, fear, or anger, and while a child may later express “knowing better,” in the moment they are feeling powerless to manage their behavior. Therefore, teachers must help students learn to identify feelings and how to utilize tools to better control them. With traumatic memories being sensory in nature, coaching students to become aware of body sensations in relation to feelings improves a child’s ability to name and cope appropriately with those feelings. Allowing opportunity to engage in this practice over time will enable students to make better choices regarding how to deal with uncomfortable sensations, and to seek healthy ways to self-regulate behavior. Educators can assist by providing a sensory rich environment with a variety of tools that provide children with the input needed to lower stress arousal and become calm. In addition, one of the best ways to help the extremely dysregulated child is to remain calm and regulated yourself, and to openly model self-talk and coping in front of your students.

Compassion and the Importance of Relationship Building

One of the most important things you can do for a child who has experienced trauma is provide a caring, safe relationship, which fosters resilience and empowers the students’ ability to
succeed. “Although negative early life relational experiences have the ability to shape the child’s developing brain, relationships can also be protective and reparative” (Ludy-Dobson & Perry, 2010, p. 37). The foundation of these relationships is unconditional positive regard. It is defined as:

The various ways an adult shows genuine respect for students as persons. Students struggling with the trauma don’t need another adult to tell them what is wrong with them. What they do need, what helps them thrive, is an adult who treats them with simple sustained kindness, and adult who can empathize with the challenges they face (Wolpow, Johnson, Hertel & Kincaid, 2009, p. 72)

One key point in unconditional positive regard is to act with empathy and compassion, not just sympathy. Expressing care or concern, or feeling sorry for a student and their situation is not enough. Rather, teachers must seek to understand students’ emotions from their perspective, withhold judgement, and with that shared understanding, act to alleviate strong feelings and suffering. Trauma-informed care poses the question “What happened to you?” as opposed to “What is wrong with you?” and then seeks to help the child through their experience.

Another key point in relationship building is that traumatic events make it difficult for students to trust, “especially with children who have experienced terrible things at the hands of adults who were supposed to protect them from harm” (Johnson, 2017, Trustworthiness section, para. 1). That trust must be earned so students come to believe that not all adults pose a threat to their safety or well-being. One way to earn trust is to be predictable, to do what we say we are going to do. Another is to maintain high expectations. Lowering expectations for students who have faced adversity can send negative messages that inadvertently result in increased traumatic affect. As explained by Wolpow et al. (2009):
Consistent expectations, limits and routines send the message that the student is worthy of continued unconditional positive regard and attention. Consistency in your classroom will allow students to begin to differentiate between the arbitrary rules which led to their abuse and purposeful ones that assure their safety and well-being (p. 73).

Teachers who are informed on the effects of trauma on relationships and learning can use that knowledge to engage students in exploration of their environment, to build from students’ individual strengths and interests, and to engage students in learning that balances the right amount of challenge while controlling for earlier experiences with failure to teach children how to cope with everyday successes and stress. In turn, this will help children to reshape their perceptions of themselves and their world.

Finally, teachers can help students attain healthy attachments by serving as a relationship coach. By routinely teaching students how to get along, instructing students how to appropriately interact with a variety of adults, and providing ample opportunity for social practice, we can build a positive learning environment and community where all students feel welcomed and safe. Focusing on building relationships to help students feel connected and supported is the cornerstone of recovery and allowing students to engage more in actual academic learning.

Having established a strong, positive relationship and knowledge of students, beyond the classroom, an educator’s role may continue by advocating for student needs and securing appropriate supports school-wide, referring identified trauma symptoms to a school counselor or school based mental health provider, communicating regularly with families, working in conjunction with medical or behavioral health providers, and promoting continuing efforts in developing a school-wide approach in becoming more trauma sensitive for all students.
CONCLUSION

The primary mission of schools and teachers has been to support academic achievement. However, before students can be fully engaged in academics, they need to feel safe and supported. Thus, the role of schools and classroom teachers is evolving. The expanse of research provides significant support for the adoption of trauma informed approaches within schools. As trusted figures in children’s daily lives, teachers are in the ideal position to be change-makers and advocates for the high number of children entering their classrooms who have experienced trauma.

When becoming a Trauma Sensitive School, a tiered, school-wide approach offers the greatest opportunity for creating meaningful and sustainable changes that reach the most students at each level of intervention need. But, becoming trauma sensitive is an ongoing process requiring systemic change in policies, procedures, and mindset. However, while districts and schools work to integrate a trauma-informed framework into existing systems, such as PBIS and school-based mental health, there are steps that teachers can implement now. Becoming trauma-informed to more fully understand the nature of trauma, its prevalence, and the impact trauma has on child development and the ability to function at school is the first step. By adopting the core values of trauma informed care and changing their own lens to become more sensitive to student needs, teachers can adapt their daily classroom instruction, routines, behavior
management strategies, and climate to effectively support both academic and social emotional learning. Placing emphasis on building compassionate relationships with students is paramount. After all, “You can’t teach the mind, until you reach the heart.”

References


[Accessed 12 Nov. 2017].


