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LOYOLA UNIVERSITY CHICAGO

UNDERSTANDING TEACHER REPORTED EXPERIENCES OF TRAUMA
PROFESSIONAL DEVELOPMENT/TRAINING

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN SCHOOL PSYCHOLOGY

BY

MAYRA A. GAONA

CHICAGO, IL

AUGUST 2022

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ACKNOWLEDGEMENTS

I always dreamed about writing these acknowledgments and now the time has come. First and foremost, I would like to thank Dr. Pamela Fenning, my advisor and dissertation chair. None of this would have been possible without your support. Through all the obstacles of this dissertation, you have always been a phone call or text away. I appreciate you always believing in me, even on days where I struggled to do so on my own. Next, I would like to thank the rest of my dissertation committee members. Dr. Rosario Pesce, thank you for taking me under your wing since the beginning of this program. Your passion for working in communities and supporting students and families in a genuine manner is something that you've inspired in me. Thank you so much for all your wisdom and for always keeping it real with me. Dra. Aurora Chang, while I have known you for a short time, you are nothing but an inspiration. Having you on my committee, as a Latinx woman, gives me such hope. You have paved the way for many women in our community, and I hope to follow in your footsteps. I would also like to thank all the faculty in my program and supervisors I have had throughout my doctoral journey. You all have helped shaped me and have given me the experiences and tools to become the psychologist I am today.

Finalmente, quiero darle las gracias a mi familia. Ustedes han sido y continuaran siendo mi motivación más grande en la vida. Gracias a mi papi y mami, Bentura y Rebeca, por tantos sacrificios y por darme la vida que tengo, llena de tantas oportunidades que ustedes no tuvieron. Los amo tanto y este doctorado es dedicado a ustedes. A mis hermanas, Yvette y Liliana, gracias

por su paciencia, por escucharme todos los días y por siempre creer en que podría llegar a ser,
Dra. Gaona. Siempre las apoyare en sus sueños, de la misma manera que han hecho conmigo.

Dedicated to all my fellow Latina mujeres on their journey to becoming a doctora.
¡Que seamos las primeras, pero no las ultimas!

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ABSTRACT

The purpose of this descriptive study was to obtain a better understanding of the varying levels of exposure to trauma professional development and training within school settings and the reported impact of this professional development/training, specifically (a) what is the relationship between the level of exposure to trauma training/PD and the extent to which teachers can identify trauma; (b) what is the relationship between the level of exposure to trauma training/PD and the likelihood that teachers will report implementing trauma-informed strategies in the classroom; and (c) what is the relationship between the level of exposure to trauma training/PD and whether teachers observe changes in student behavior due to the classroom strategies they report implementing. It was hypothesized that teachers who reported higher levels of exposure to trauma training and professional development would also report having higher levels of knowledge and awareness about the trauma experiences of their students and how these experiences impact their students' daily lives. Further, it was also hypothesized that teachers who reported higher levels of exposure to trauma training/PD would also report implementing trauma-informed strategies in the classroom with a higher likelihood. Finally, teachers who reported higher levels of exposure to trauma training/PD would also report perceived improvements in student behavior due to utilizing these strategies. Survey data was collected from teachers (n = 29) employed within the state of Illinois who have some level of exposure (little, moderate, a lot) to trauma training or professional development. While the hypotheses were not supported and correlational relationships were unable to be determined, descriptive data

reveals that there are in fact, varied levels of exposure to trauma training and professional development in the state of Illinois. In addition, regardless of the level of exposure to trauma training/PD (little, moderate, a lot), participants reported that they could identify trauma to a great extent, implement trauma-informed strategies, and reported improvements in student behavior due to the trauma-informed strategies they implemented.

CHAPTER ONE

INTRODUCTION

Background of the Problem

Many children experience trauma throughout their lives. One out of every four children attending school has been exposed to an event in their lives that has resulted in trauma: thus, affecting their learning and behavior (National Child Traumatic Stress Network, 2008). Childhood trauma is defined as something that occurs when a child perceives themselves or others around them to be threatened by serious injury, death, or psychological harm. That threat can be physical, emotional, or mental and usually leads to negative emotions such as shame, fear, or guilt (National Child Traumatic Stress Network, n.d.; Rossen & Hull, 2012). Trauma can occur after many experiences, including violence, abuse, neglect, the loss of a loved one, and parental deportation and incarceration. However, it is imperative that we also recognize race-based trauma or racial trauma in our current society due to systemic racism and inequalities in our society. In addition, the COVID-19 pandemic has created traumatic conditions for some children and their families due to experiences such as financial difficulties and the loss of loved ones (Henderson et al., 2020; Phelps & Sperry, 2020). Given the range of traumatic experiences that exist, it is important to note that an experience that may be considered traumatic by one child may not be regarded as traumatic by another child (Wiest-Stevenson & Lee, 2016). Moreover, experiences that can be traumatic for a child and that occur early on in a child's life are often considered *adverse childhood experiences* (ACEs).

Research indicates that trauma can have a long-lasting impact on a child's brain structure and development. The National Institute of Mental Health (n.d.) describes that everyone who experiences a traumatic experience will likely experience a range of symptoms and reactions after this experience. Some children may even experience post-traumatic stress disorder (PTSD). Under the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), PTSD is a clinical diagnosis that may be given to children and adolescents that experience trauma if they meet specific diagnostic criteria (American Psychiatric Association, 2013). Specific trauma symptoms that can manifest in the daily lives of children include appearing depressed, anxious, having difficulties with self-regulation, flashbacks, nightmares, and problems sleeping and eating (National Child Traumatic Stress Network, n.d). Traumatic experiences could also impact child development in areas crucial to academic success in the school setting (Diamanduros et al., 2018; National Association of School Psychologists, 2015; Ridgard et al., 2015). These areas include communication skills, sense of self, coping skills, peer and adult relationships, attending to classroom tasks and instructions, organizing and remembering information, and understanding cause-and-effect relationships (National Association of School Psychologists, 2015).

Trauma symptoms can also be manifested in the classroom. Symptoms can be separated into the following categories: physical, behavioral/social, emotional, and cognitive (Bell et al., 2013; Diamanduros et al., 2018; Perfect et al., 2016; Rossen & Hull, 2012). One physical manifestation of trauma in the classroom includes a student repeatedly complaining of somatic symptoms. These include a stomachache, lightheadedness, headaches, or other illnesses (Bell et al., 2013). Further, behavioral and social manifestations of trauma can lead to inappropriate behavior, such as externalizing (e.g., fighting, talking back, getting out of seat) or internalizing

behaviors (e.g., shutting down, withdrawing, not interacting with peers) (Bell et al., 2013; Diamanduros et al., 2018; Perfect et al., 2016; Rossen & Hull, 2012). An emotional symptom of trauma can be an inconsistency in emotions, as demonstrated by mood swings. Finally, a cognitive symptom of trauma can include a student's inability to focus (i.e., fidgeting, looking around the room). This inability to focus can stem from worries about their safety or feelings of guilt (Bell et al., 2013; Diamanduros et al., 2018).

Impact of Trauma in Schools

Teachers are the primary individuals in schools faced with understanding their students' trauma and supporting them through this trauma. There are many roles that teachers can play in supporting students who have experienced trauma. They can be critical to recognizing trauma symptoms in their students and making a referral to the school counselor or mental health professional present in the school, participating in a school-based trauma team, and supporting students through the therapeutic process (Bell et al., 2013; Kataoka et al., 2012). However, there are many barriers that teachers may encounter when supporting students who have experienced trauma. These barriers include doubt and uncertainty about providing support, balancing the different demands placed on them within their school buildings, and struggling with defining their role and to what extent their tasks should go beyond teaching academic skills (Alisic, 2012; Gubi et al., 2019; Luthar & Mendes, 2020; Reinke et al., 2011).

One way that teachers can be supported to overcome these barriers is through teacher professional development and training on trauma. Professional development and training on trauma are often an integral component of trauma-informed schools (Chafouleas et al., 2016). It is important to note that this term has become increasingly more popular over the years. A

trauma-informed school is a school where school staff, including administrators, teachers, staff, and parents, can recognize and respond to students who have been impacted by traumatic experiences (Guidelines for Developing, n.d.). It is important to note that trauma-informed schools is often a term used interchangeably with trauma-aware schools or trauma-sensitive schools. Being trauma-aware or trauma-sensitive suggests that you are aware of the trauma but maybe not quite doing anything about it yet (“Module 3,” n.d.). Trauma Sensitive Schools states that “the term “trauma-informed” arose in the behavioral health field” (n.d., para. 4). It seems that trauma-informed suggests a more comprehensive approach that demands the incorporation of policy and practice, as well as collaboration from outside behavioral health providers, whereas “trauma-sensitive” or “trauma aware” may not (Trauma Sensitive Schools, n.d.; “Module 3,” n.d.).

While it appears that schools are increasingly becoming more trauma-informed, and teachers may be receiving more professional development and training on trauma than they used to, there is limited research focused on how teachers apply the information they receive during professional development and training on trauma. Generally, factors such as acceptability to training, quality of student-teacher relationships, and higher relational capacities have been examined as an outcome of professional development and training on trauma; however, applications have not been examined (McIntyre et al., 2019; Parker et al., 2020; Whitaker et al., 2019). Exploration of applications such as strategies implemented in the classroom due to information learned in trauma professional development/training is needed.

Statement of the Problem

Professional development and training on trauma with teachers usually vary and looks differently across school settings. Some researchers argue that professional development or training on trauma can be more *knowledge-based*, based on educating teachers and staff on the basic definitions and impact of trauma (Loomis & Felt, 2020). However, it can be more *skills-based*, meaning that it focuses on how teachers and staff can manage trauma-related behaviors in the classroom and within the school setting in general (Loomis & Felt, 2020). Nevertheless, the core of all teacher training on trauma should establish a common language and understanding of the definition of trauma and the effects of trauma on students (Dorado et al., 2016; Loomis & Felt, 2020).

Policy and Law in Educator Training in Trauma

While professional development and training on trauma seem popular in education, there is currently a lack of policy and law around trauma professional development and training for teachers that would allow this to be implemented more consistently across school settings. In addition, teacher prep programs do not have any requirements to include trauma training (Brown et al., 2020). Given the prevalence rates of childhood trauma, this information is troubling, suggesting that students may need to be in classrooms where teachers have training in trauma-informed classroom practices and how trauma may impact classroom performance and behavior.

Evaluation of Trauma Training with Teachers

Several training programs and courses on trauma that have been documented in the literature include *Enhancing Trauma Awareness* (ETA) and *Compassionate Schools* (Parker et al., 2020; Whitaker et al., 2019). These training programs and courses on trauma have led to

increased knowledge and awareness of trauma, acceptability to training, better student-teacher relationships, and higher relational capacities. However, limited studies have examined other factors such as additional professional development that teachers and staff have sought out and strategies implemented in the classroom due to trauma professional development and training. As stated by Bell et al. (2013), “Educators have an opportunity and a responsibility to be advocates for children who have experienced trauma” (p. 140). There is a need to understand teacher reported experiences and outcomes when receiving trauma professional development and training; for example, how teachers apply the information received in trauma professional development and training. In addition, varying levels of exposure to trauma professional development and training have not previously been examined in the literature, especially not in connection to outcomes. Outcomes have traditionally been evaluated after one single instance of trauma professional development or training course (McIntyre et al., 2019; Whitaker et al., 2019).

Purpose of the Study

The purpose of this study is to obtain a better understanding of the varying levels of exposure to trauma professional development and training within school settings and the reported impact of this professional development and training, specifically (a) what is the relationship between the level of exposure to trauma training/PD and the extent to which teachers can identify trauma; (b) what is the relationship between the level of exposure to trauma training/PD and the likelihood that teachers will report implementing trauma-informed strategies in the classroom; and (c) what is the relationship between the level of exposure to trauma training/PD and whether teachers observe changes in student behavior due to the classroom strategies they

report implementing. It is hypothesized that teachers who report higher levels of exposure to trauma training and professional development will also report having higher levels of knowledge and awareness about the trauma experiences of their students and how these experiences impact their students' daily lives. Further, it is also hypothesized that teachers who report higher levels of exposure to trauma training/PD will report implementing trauma-informed strategies in the classroom with a higher likelihood. Finally, teachers who report higher levels of exposure to trauma training/PD will also report perceived improvements in student behavior due to utilizing these strategies.

An increasing number of schools are becoming trauma informed. A trauma-informed school is a school in which school staff, including administrators, teachers, staff, and parents are able to recognize and respond to those students who have been impacted by traumatic experiences ("Guidelines for Developing," n.d.). When schools initiate efforts to become more aware of the trauma that affects their students, one of the components they may start with is the training of teachers on the impact and prevalence of trauma. However, the research does not account for the outcomes of schools adopting specific trauma-informed school components, such as teacher training on trauma (Maynard et al., 2019; Wiest-Stevenson & Lee, 2016). When a school becomes trauma-informed, there is an expectation of seeing changes in day-to-day routines. Perhaps, students would be exposed to more friendly, warm environments that provide comfort and security. As a result, we may see changes in student behaviors, such as decreased trauma symptoms, decreased disciplinary referrals, and increased attendance. Unfortunately, not much of this is addressed in the literature. This study would explore teacher reported experiences when receiving professional development and training on trauma. Knowledge of the perceived

outcomes of trauma professional development and training would be beneficial, as reported by teachers. This knowledge could be the evidence that schools need to develop a sense of urgency to train their teachers on this critical topic. Further, there is a potential that if and when educational leaders, such as state education agency leaders, learn about the benefits of trauma training and professional development for teachers, it may be something that can be required on a broader scale in all school districts at the statewide level.

Significance of the Study

The findings of this study, first and foremost, may provide information on the varying levels of exposure to trauma professional development and training within school settings. There is very little knowledge of this information, and it can guide us in the manner that we continue to advocate for trauma-informed work in schools. Second, the findings may provide information that school stakeholders and administrators can use as evidence for the need to adopt a trauma-informed approach and thus provide opportunities for teachers to become trauma trained. If this study demonstrates that there are, in fact, positive outcomes as reported by teachers based on the professional development and training, they receive on trauma, there would be powerful implications for the need to provide trauma training with teachers on a broader scale. It is important to note that this study is also being conducted during a time when the experience of trauma in children may be high. Children are dealing with the effects of the COVID-19 pandemic, ongoing police brutality, acts of White supremacy, and racism; thus, addressing trauma in the school setting is more relevant than ever. Through this study, the hope is that any professional who works in the school setting can realize that trauma is present in students' lives, especially in BIPOC and LGBTQ students. There is much harm perpetrated to students by our

own systems; thus, it becomes crucial to reflect on our own school systems and if we are causing harm to our students. Schools may be perpetrators of trauma and cause retraumatization to students. An excellent first step is to reflect and become aware. But then, schools must do more. They must do more by evaluating their current school policies and practices and enacting change when they see wrongdoing. That is the overall hope of this study. If teachers are becoming trained on trauma, the hope is that they can utilize this training to become aware and then enact change in their classrooms. Change in the classroom is the first step; changing the whole school culture is next to becoming trauma-informed in an authentic manner.

Expected Findings

This study is expected to help obtain a better understanding of the varied levels of exposure to trauma professional development and training within school settings and the reported impact of this professional development and training. The expected outcomes include identifying associations between the level of exposure to trauma training/PD and the extent to which teachers can identify trauma, the likelihood that teachers will report implementing trauma-informed strategies in the classroom, and report perceived improvements in student behavior. More specifically, it is expected that teachers who report higher levels of exposure to trauma training and professional development will also report having higher levels of knowledge and awareness about the trauma experiences of their students and how these experiences impact their students' daily lives. Further, teachers who report higher levels of exposure to trauma training/PD will report implementing trauma-informed strategies in the classroom with a higher likelihood. Finally, teachers who report higher levels of exposure to trauma training/PD will also

report perceived improvements in student behavior, such as school engagement, disciplinary referrals, and trauma-specific symptoms, resulting from using less punitive strategies.

Definition of Terms

This section includes definitions for terms that are specific to this study. To establish an understanding, the terms are defined below.

Childhood trauma. Childhood trauma is defined as something that occurs when a child perceives themselves or others around them to be threatened by serious injury, death, or psychological harm (National Child Traumatic Stress Network, n.d). Trauma is usually an outcome of exposure to adversity (Bartlett & Sacks, 2019). A child can go through a traumatic or adverse experience such as a car accident but may not experience trauma due to this adversity.

Traumatic experience. A traumatic experience is typically a frightening, dangerous, or violent experience that poses a threat to the child. That threat can be physical, emotional, or mental and usually leads to negative emotions such as shame, fear, or guilt. Typically, if these experiences occur early in a child's life, they are also *considered adverse childhood experiences*. Examples of traumatic experiences include physical, sexual, or emotional abuse, domestic and community violence, sudden loss of a loved one, natural disasters, motor vehicle accidents, deportation, and parental incarceration (National Child Traumatic Stress Network, n.d.; Rossen & Hull, 2012).

Trauma-informed. A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices;

and seeks to actively resist re-traumatization. (Substance Abuse & Mental Health Services Administration, 2014, p. 9)

Trauma-informed school. A school in which school staff, including administrators, teachers, staff, and parents, are able to recognize trauma signs and symptoms and respond to those students who have been impacted by traumatic experiences (“Guidelines for Developing,” n.d.).

Trauma professional development and training. Professional development and training that establishes a common language and understanding of the definition of trauma and the effects of trauma on students (Dorado et al., 2016).

CHAPTER TWO

LITERATURE REVIEW

This literature review provides information on the context of this study. The literature review will cover the definition of trauma and continues with information on the prevalence of trauma, emerging trauma research, trauma experienced in minoritized communities, risk and protective factors for childhood trauma, impact of trauma in children, how trauma is manifested in schools, trauma-informed schools, the role of teachers and school professionals in addressing trauma, and trauma professional development and training for teachers.

Definition of Trauma

According to the National Child Traumatic Stress Network (n.d.), childhood trauma is defined as something that occurs when a child perceives themselves or others around them to be threatened by serious injury, death, or psychological harm. Traditionally, trauma can occur after experiences such as violence, abuse, neglect, loss of a loved one, natural disasters, motor vehicle accidents, and deportation and parental incarceration. However, it is imperative that we also recognize race-based trauma or racial trauma due to the systemic racism and inequalities that continue to persevere in our society. Traumatic conditions have also been historically perpetrated by systems of white supremacy within Black, Indigenous, and people of color (BIPOC) communities (Bissonette & Shebby, 2017; Bryant-Davis & Ocampo, 2005). However, these forms of trauma are not nationally recognized or acknowledged, even under the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (Jernigan & Daniel, 2011). These forms of

trauma will be discussed more in-depth in a subsequent section. While race-based trauma is not acknowledged under the *DSM*, a diagnosis of post-traumatic stress disorder (PTSD) can be considered a result of a direct experience of racism via the *International Classification of Diseases (ICD)* criteria (Williams, 2019).

Typically, if these traumatic experiences occur early in a child's life, they are also considered *adverse childhood experiences*. Before discussing trauma, we must differentiate the terms *adverse childhood experiences (ACEs)* and *trauma*. These terms are often used interchangeably, but there are important differences between them. An adverse childhood experience (ACE) refers to an event or circumstance that poses a serious threat to a child's physical, psychological, and emotional well-being (Centers for Disease Control and Prevention, n.d. -a; Bartlett & Sacks, 2019). Further, trauma is usually an outcome of exposure to adversity (Bartlett & Sacks, 2019). A child can go through an adverse experience such as a car accident but may not experience trauma due to this adversity (Temkin et al., 2020).

Trauma is usually separated into acute, chronic, and complex trauma. What differentiates each category is the occurrence, if it occurs repeatedly and over time (National Child Traumatic Stress Network, n.d.). In general, trauma does not discriminate with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation; the experience of trauma is not uncommon and is universal (Bell et al., 2013; Substance Abuse and Mental Health Services Administration, 2014). Although traumatic experiences are universal, each individual's experience is unique. Rossen and Hull (2012) state that "trauma is complex, consisting of numerous dimensions on which traumatic experiences may vary" (p. 6). Trauma can be perpetrated by an act of nature, by trusted others, or by strangers. Finally, it may occur early on

in life or later on in life, and it may have long-lasting effects or have minimal impact (Rossen & Hull, 2012). Before analyzing the effects and impact of trauma, it is important to examine how common trauma is within the child population. The prevalence of trauma is explored more in-depth in the next section.

Prevalence of Childhood Trauma

Children experience trauma at high rates. Perry and Szalavitz (2006) estimate that about 40% of American children will have at least one traumatizing experience by age 18. Even more shocking is that 26% of children in the country may witness or experience a traumatic event before turning four years old (Substance Abuse and Mental Health Services Administration, 2011). In 2015 alone, the national average of child abuse and neglect victims was 683,000, or 9.2 victims per 1,000 children (Substance Abuse and Mental Health Services Administration, n.d.). Further, each year, 10 million children in the country are believed to have exposure to domestic violence, and 4% of children under the age of 15 experience the death of a parent. In addition, 800,000 children each year will spend time in foster care, and millions more children will experience a natural disaster or a car accident (Perry & Szalavitz, 2006). Across different states of the United States, ACE prevalence rates vary. The most common ACEs in all 50 states include economic hardship and parental divorce or separation (Sacks et al., 2014). Moreover, prevalence estimates have also been established for children of different races and ethnicities. “Nationally, 61 percent of Black children and 51 percent of Hispanic children have experienced at least one adversity, compared with 40 percent of white children and only 23 percent of Asian children” (Murphey & Sacks, 2019, p. 9). While the prior paragraph mentioned that trauma experiences are universal, these prevalence estimates prove that trauma is not experienced equally.

Overall, the above statistics only account for some examples of traumatic experiences, not all of them. The list of possible traumatic experiences is quite exhaustive. Further, it is important to remember that the above statistics are only *estimates*. Some experiences of childhood trauma go unreported, specifically those surrounding child abuse (physical, sexual, emotional), neglect, and domestic violence. Besides understanding the definition of trauma and its prevalence among the child population, it becomes important to understand the emerging research on trauma and ACEs.

Emerging Trauma Research

In the past years, trauma has become a topic of increased research attention and focus. Trauma became much more widely known due to the Adverse Childhood Experiences (ACEs) study (Felitti et al., 1998). To fully understand trauma and its development over time, it is important to examine one of the most impactful studies that brought awareness to the connection between childhood trauma, stress, health, and well-being. This landmark study was conducted in 1998 and was based at the Kaiser Permanente's San Diego Health Appraisal Clinic (Felitti et al., 1998). The researchers examined the concept of adverse childhood experiences (ACEs) and whether or not there was an association between these childhood experiences and adult risk behavior, health status, and disease in a large population ($n = 19,000$) of Kaiser Health Plan members who had previously undergone physical examination.

Results showed that more than half of survey respondents (52%) experienced one or more types of adverse childhood experiences. Further, 6.2% of survey respondents had experienced four or more adverse childhood experiences. The results also documented that as the number of adverse childhood experiences increased, the prevalence and risk of engagement in

risky behavior such as smoking, alcoholism, illicit drugs, and suicide attempts also increased.

Finally, as the number of adverse childhood experiences increased, so did a greater risk exist for the presence of adult diseases such as cancer, heart disease, liver disease, and various others.

This study's findings provide evidence for the prevalence of trauma and the direct link between childhood trauma and specific adult outcomes related to health, risk behavior, and disease.

Concerns with Original ACEs Study

Kaiser Permanente was one of the first health care organizations to recognize the link between trauma and health through their landmark study, conducted with the Center for Disease Control and Prevention (CDC). Currently, Kaiser Permanente is launching new research efforts to provide additional insights on ACEs ("Kaiser Permanente Commits," 2019). The ACEs study is the largest, most notable study on the impact of adverse childhood experiences and trauma. However, it is essential to note that though a notable study, it is not generalizable. The original ACEs sample was very homogeneous and comprised White, middle class, and persons of older ages. This study sample does not represent the general U.S. population, which is much more diverse. As of 2019, the current distribution of the U.S. population by race and ethnicity is as follows: White: 60.1%, Hispanic: 18.5%, Black: 12.2%, Asian: 5.6%, Multiple Races: 2.8%, American Indian/Alaska Native: 0.7%, and Native Hawaiian/Other Pacific Islander: 0.2% (Kaiser Family Foundation, 2019).

There have been many replications of this study on a smaller scale- in various communities, countries, and populations representative of our current society (Mersky et al., 2013; Merrick et al., 2018). One of these replications includes a study investigating the consequences of ACEs in early adulthood among a diverse sample in Chicago. Mersky et al.

(2013) used data derived from the Chicago Longitudinal Study, which tracked the development of a cohort of racial and ethnic minority children ($n = 1,539$) born into urban, low-income families in 1979 or 1980. The development was tracked by collecting records from various public databases and survey data gathered periodically since 1985. This study looked at data for participants who responded to a survey between the ages of 22 and 24, from 2002 to 2004. Results demonstrated that increased exposure to ACEs was associated with an increased likelihood of poor health, mental health, and substance use outcomes in early adulthood for a sample of diverse participants. In addition, for this sample, ACEs were even more prevalent. “At least one adverse event was reported by approximately 64% of respondents in the ACE Study, compared to nearly 80% of CLS participants” (p. 7). These findings confirm what was found early on by Felitti et al. (1998) in the original ACES study; however, it extends the findings to a different population. Specifically, the sample was not comprised of a population that was predominantly white (75%), high school graduates (93%) with private health insurance, nor were they in midlife or late adulthood.

Moreover, a more recent study that included an updated prevalence estimate of adverse childhood experiences was that of Merrick et al. (2018). These researchers collected data through the Behavioral Risk Factor Surveillance System (BRFSS), an annual, nationally representative telephone survey that tracked health-related behaviors, health conditions, and use of preventative services of a sample of 248,934 adults older than 18 years from 2011-2014. This sample, similar to the previous one, also included a diverse sample. Results showed that about 38% of the sample reported experiencing zero ACEs; about 24% reported experiencing one ACE; about 13% two ACEs, about 9% three ACEs, and about 16% four or more ACEs. Higher ACE scores

were manifested among women and younger adults in this sample. Other significant findings were that individuals who identified as multiracial reported the highest level of overall ACE exposure. Those identifying as gay/lesbian and bisexual also had significantly higher ACE exposures. These are significant findings that address the limitations of the original ACE study by Felitti et al. (1998). Moreover, these findings from additional research conducted after the original ACEs study better reflect the current demographics of our country. These are just a few of the replications conducted based on the original ACEs study; there are many more that have been conducted beyond what is reported here (Burke et al., 2011; Lantos et al., 2019; Metzler et al., 2017; Oral et al., 2016; Wade et al., 2014).

Another concern with the original ACEs study is that it only considers conventional ACEs such as physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, substance abuse, and parental mental illness. Researchers like Mersky et al. (2017) propose a new generation of ACEs. Seven potential *new* ACEs are family financial problems, food insecurity, homelessness, parental absence, parent/sibling death, bullying, and violent crime (Mersky et al., 2017). It is believed that these new ACEs are as prevalent as the conventional ACEs and are associated with each other. Expanded ACEs is another term used to define a new generation of ACEs (Cronholm et al., 2015). It is important to acknowledge the context in which the Felitti et al. (1998) study was conducted and how perhaps a new generation of ACEs is warranted as our current context has changed.

Furthermore, due to the ACEs study, the ACEs score is increasingly being used as a screening tool for trauma. The score is currently being used to determine what support an individual who has experienced trauma might need. Currently, concerns are being raised against

using this ACEs score for various reasons. The biggest reason is that there are limitations to using this tool with individuals who have experienced trauma. The ACEs score can tell us the number of adverse experiences someone may have gone through, but not if trauma was endured due to these experiences (Winninghoff, 2020). An explanation of the differences between these terms was provided earlier in this literature review. Also, an ACEs score cannot tell us the frequency, intensity, or chronic exposure to an adverse childhood experience (Anda et al., 2020). The ACEs score has the potential to be a useful clinical tool for professionals. However, caution is advised if there is a desire to use it diagnostically, given the discussed limitations.

Overall, the occurrence and outcomes of ACEs have been heavily researched and acknowledged within the adult population. Retrospective studies have captured ACEs that adult participants may have experienced in childhood. Given that many of these studies have been retrospective and participants have already endured trauma during their childhood years, we must recognize what can be done to support children who have experienced trauma at the moment, not many decades later. As demonstrated by early ACEs literature, there is much harm that adults can go through if trauma is not addressed. As professionals, we have the potential to address and buffer many of the effects of trauma in childhood, so these children do not go on to become adults that experience poor outcomes (e.g., increased likelihood of poor health, mental health, and substance use outcomes). The impact of trauma can be more profound in communities historically marginalized, so particular attention is warranted to individuals within these communities.

Trauma Experienced in Minoritized Communities

While experiencing trauma tends to be a universal experience, the effects of trauma are often most impactful and profound in BIPOC and LGBTQ communities. These communities often do not have the mental health resources and supports that would allow them to recover from trauma (as cited in Bryant-Davis & Ocampo, 2005). Furthermore, when these mental health resources and supports are available, they are provided by White mental health providers, who may not be culturally sensitive, making it difficult to establish trust (Bryant-Davis et al., 2017). In addition, the trauma of individuals in these communities is experienced continuously. Racism and discrimination can have a daily traumatic effect on individuals in minoritized communities. This is because racism and discrimination are embedded across multiple domains (Conradt et al., 2020). Racism and discrimination can be experienced at an individual level through common day-to-day microaggressions and race-based harassment. However, it is also common at a more systematic level in how BIPOC individuals are selected for jobs or secure housing (Conradt et al., 2020). This type of trauma, experienced from race-based events, can be best defined as racial or race-based trauma (Bryant-Davis & Ocampo; 2005; Jernigan & Daniel, 2011). Though this type of trauma is likely not experienced in one day (e.g., through a single event), small, ongoing distressing experiences can culminate into traumatization (Saleem et al., 2020). Racial trauma can result in negative psychological, psychosocial, and physiological effects, including cardiovascular and psychological reactivity, psychological distress, lower self-esteem, and depressive symptoms in BIPOC individuals (as cited in Bryant-Davis & Ocampo; 2005).

Beyond present-day trauma, these communities may also have to overcome the effects of trauma passed down to them by their parents and ancestors. Intergenerational trauma (also

known as historical trauma) is known as a type of trauma that is passed down through multiple generations as a result of ancestors' experience of severe traumas such as war, extreme poverty, dislocation, enslavement, and genocide (Bryant-Davis et al., 2017; Curry, 2019). Individuals within these communities may want to break down the cycle of intergenerational trauma. Still, due to the point made earlier about lack of resources and support, they may be unable to.

Furthermore, the LGBTQ community (especially youth) also experiences trauma at higher rates, and identity-affirming support may be unavailable to members of this community (McCormick et al., 2018). Thus, it is vital that in conducting trauma-focused research, we do not exclude these communities and overlook the disproportionality in the impact of communities that have traditionally been marginalized. The following section will discuss additional risk and protective factors for childhood trauma.

Risk and Protective Factors for Childhood Trauma

As was mentioned previously, while many children will experience adverse experiences or events, not all will experience traumatic stress due to these experiences. Whether or not a child will experience traumatic stress will depend on various factors, such as the child's age, temperament, and the developmental stage that the child is in when the experience occurs (Rossen & Hull, 2012). The intensity and duration of the adverse experience or event also matter (Venet, 2021). However, there are also many protective factors for a child, such as their level of resilience and the different support they receive from family, friends, and community (Rossen & Hull, 2012). If, for example, a child has the care and support of their parents after an adverse experience, they may overcome the psychological distress and not experience that trauma. It may even be that events that we think could be traumatic for children may end up being positive or, at

the very least, somewhat beneficial (Calmes et al., 2013). For example, parental divorce is often believed to be traumatic for children; however, this may be beneficial from a child's perspective because there is less stress at home, per se. Every child and their perception of what experiences constitute as traumatic is different. It is not up to us to determine what counts as trauma for another individual.

Impact of Trauma in Children

Traumatic experiences tend to impact the lives of the children who experience them, no matter how small or big that impact is. Rossen and Hull (2012) discuss that adverse experiences experienced during early childhood often result in more significant daily functioning challenges than adverse experiences occurring later on in life. Some of the challenges that could be experienced in daily functioning, as described, can be difficulty managing and organizing emotions, body sensations, thoughts, behaviors, and relationships. Post-traumatic stress disorder (PTSD) is often the most common term connected to trauma. It is not uncommon for children to experience PTSD. "Approximately 4-6% of youth in the general population will meet criteria for a diagnosis following a traumatic event, including symptoms such as poor concentration and intrusive thoughts, which can also severely interfere with school functioning" (Kataoka et al., 2012, p. 2). In most literature, the effects of trauma are viewed using a more diagnostic lens (e.g., the child meets the criteria for PTSD). However, Rossen and Hull (2012) propose that a single diagnosis does not capture the breadth of the impact and that the effects of trauma should be viewed through a developmental lens.

Children are expected to go through much of their major development during childhood and learn many of the basic skills that will shape them and allow them to be successful adults

much later in life. Different experiences usually influence children's development, and they learn to respond to these experiences in ways that help them cope and be successful. As Rossen and Hull (2012) perfectly describe it,

The influence of trauma may be thought of as twofold: first, the prioritization of developmental factors that support the child's successful adaptation to his or her world—in this case, those factors that support safety and need fulfillment—and second, the de-emphasis of those developmental competencies that are less immediately relevant to survival. (p. 8)

This means that when a child goes through one or more traumatic experiences, this child's brain learns to prioritize the skills needed for survival rather than any other developmental skills (Morton & Berardi, 2018).

Neurobiologist Bruce Perry from the Child Trauma Academy explains that the most developed areas of a child's brain are those areas that are used most often. Suppose a child consistently has to use the area of their brain responsible for their stress response that enables survival strategies, such as those described above. In that case, this area of the brain can become overdeveloped. Thus, this part of the brain may direct all behavior even if it would not be appropriate or warranted (Cole et al., 2005). This would explain why we often see children who have experienced trauma and continue to experience trauma lack other skills needed to succeed in school. The subsequent section will discuss how trauma manifests itself in schools.

How Trauma is Manifested in Schools

ACEs have previously been linked to a variety of negative school outcomes such as poor school attendance, lack of school engagement, behavioral issues, and underachievement in areas of reading, math, and writing, and retention (Bethell et al., 2014; Blodgett & Lanigan, 2018; Porche et al., 2016). These negative school outcomes can start to be seen during early childhood

and kindergarten (Jimenez et al., 2016). To identify whether or not a student has experienced or continues to experience ACEs and trauma, it is important to understand symptoms of trauma that can manifest in the classroom. If symptoms can be identified, there is a way to prevent some of these negative school outcomes from occurring.

The impact of trauma on the lives of children is overarching, so much that we can expect the trauma symptoms that children experience to be salient in the school environment. School staff and teachers can expect to see a variety of symptoms manifest in the classroom. It is important to note that one student's symptoms may differ from what another one displays. Symptoms typically are separated into the following categories: physical, behavioral/social, emotional, and cognitive.

Physical Symptoms

First, a physical symptom of trauma and an example of their manifestation in the classroom can be a student repeatedly complaining of somatic symptoms. Somatic symptoms can include a stomachache, lightheadedness, headaches, or other sicknesses. Another physical symptom a student can experience is hyper-vigilance or a heightened startle reaction. This means that a student can constantly look around the room, check around oneself, or appear to be “jumpy” (Bell et al., 2013). Another common physical symptom is changes in sleep (sleeping too much or not enough, experiencing nightmares). Though a teacher might not physically see these changes in sleep, a student consistently coming late to class and appearing unrested can demonstrate this (Bell et al., 2013).

Behavioral and Social Symptoms

Further, some behavioral and social symptoms and examples of their manifestation in the classroom include regression. Children may regress to previous developmental behaviors such as difficulty sleeping, thumb sucking, nightmares, or bedwetting (Bell et al., 2013; Diamanduros et al., 2018). Internalizing symptoms such as social isolation and withdrawal from family and friends are also common in students who have experienced trauma. Typically, students who have experienced trauma can isolate and withdraw due to mistrust, avoiding appearing vulnerable, and being misunderstood (Diamanduros et al., 2018). Another behavioral symptom can include engaging in more risk-taking behavior such as substance abuse and perhaps even simply acting impulsively without thinking about the consequences of their behavior (Bell et al., 2013; Diamanduros et al., 2018). Increased externalizing behaviors such as aggression and hyperactivity are also common (Bell et al., 2013; Perfect et al., 2016; Rossen & Hull, 2012).

Emotional Symptoms

In contrast, an emotional symptom of trauma and how it may be manifested include inconsistency in emotions. This inconsistency can be exemplified by mood swings in a student, in which they can become easily angered or irritated (Bell et al., 2013). Another emotional symptom can be stress, in which the student is easily overwhelmed by new projects or be late or not turning in assignments (Bell et al., 2013). Distrust is also a widely recognized emotional symptom. Because of distrust, the student may be unwilling to work with partners or in groups. They may also choose to sit entirely apart from other peers (Bell et al., 2013). Finally, a lack of self-confidence or self-esteem can manifest through a lack of effort in schoolwork (Bell et al., 2013).

Cognitive Symptoms

Finally, cognitive symptoms of trauma and examples of their manifestation in the classroom can be a student's inability to focus (e.g., fidgeting, looking around the room). This inability to focus can stem from worries about their safety or feelings of guilt (Bell et al., 2013; Diamanduros et al., 2018). Studies have also found that students who have experienced trauma may experience impairments in their working memory and other types of memory (Perfect et al., 2016). Dissociation, in which the student appears to “blank out” and split off from current consciousness, is also common (Bell et al., 2013). Overall, changed attitudes about people, life, and the future can also be observed. Students may view the world as “bad” and lack planning for the future (Bell et al., 2013).

Given how trauma symptoms can manifest within the school setting and students come to school every day carrying a “heavy load,” schools play a critical role in the lives of students who have experienced trauma.

Trauma-Informed Schools

Definition

It is known that schools can be safe, warm spaces for students and allow them to have an environment where they can develop positive relationships with their teachers and peers.

However, schools should strive to be more than just positive spaces where students can build relationships. A term that has gained increased popularity in recent years is *trauma-informed schools* (“Guidelines for Developing,” n.d.). A trauma-informed school is a school in which school staff, including administrators, teachers, staff, and parents, are able to recognize and respond to those students who have been impacted by traumatic experiences (“Guidelines for

Developing,” n.d.). Research has demonstrated that when a system adopts a “trauma-informed approach,” it should be based on the following core principles: creating a sense of safety; practicing trustworthiness and transparency; peer support; employing collaboration and mutuality; practicing empowerment; fostering voice and choice; and recognizing cultural, historical, and gender issues (Substance Abuse and Mental Health Services Administration, 2014).

It is important to acknowledge that *trauma-informed schools* is often a term used interchangeably with *trauma-aware schools* or *trauma-sensitive schools*. Trauma Sensitive Schools (n.d.) states that “the term “trauma-informed” arose in the behavioral health field.” It seems that trauma-informed suggests a more comprehensive approach that demands the incorporation of policy and practice, as well as collaboration from outside behavioral health providers, whereas “trauma-sensitive” or “trauma aware” may not (Trauma Sensitive Schools, n.d.; “Module 3,” n.d.). However, other researchers seem to disagree with this. The use of the term *trauma-sensitive* seems to be preferred by some others due to its emphasis on the importance of school-wide culture and policies (not only behavioral health services) in helping children feel safe and supported (Gherardi et al., 2020). While there are mixed opinions, the term, *trauma-informed schools*, was chosen for this dissertation study.

Policy and Law

Trauma-informed school practices of varying types have been introduced into legislation. For example, between 1973 and 2015, 49 bills have been introduced that explicitly mentioned trauma-informed practice. In at least 17 states, trauma-informed approaches have been implemented at the school, district, and state-wide levels (as cited by Maynard et al., 2019).

Furthermore, at the school level, more specifically, the *Every Student Succeeds Act (ESSA)* -- section 4108, has explicit provisions for schools to implement training of school staff and educators. It also establishes grant funding to support services based on trauma-informed practices that are evidence-based and well researched (Maynard et al., 2019). A study conducted by Jones et al., (2019) analyzed state policies related to trauma-informed schools. They found that 28% of states did not have a policy or guidelines related to trauma-informed schools. 22% of states were in the “Developing” stage or beginning to think about developing policy or guidelines on trauma-informed schools. Further, 16% of states were found to be in the “Progressing” category or beginning to establish goals and outline a policy or guidelines related to trauma-informed schools. Finally, 34% of states were “Established,” meaning that the state has a policy or guideline related to trauma-informed schools. Though one could say that a significant percentage of schools are starting to develop (or starting to think about developing) policies or guidelines around trauma-informed schools, this study determined that most of the policies are discipline policies that touch on trauma.

Moreover, in more recent times, we have also seen federal court cases such as *Peter P. et al. v. Compton Unified School District, et al.* (2015). In this case, several students and teachers filed suit against their school district, claiming that they failed to respond appropriately and support students who have experienced trauma (Reinbergs & Fefer, 2018; Volk et al., 2016). These sorts of legal pressures can be expected to continue to be seen as litigation requiring schools to become more trauma-informed and for teachers to receive training on trauma given the current state of our society (e.g., pandemic, racism, etc.). The COVID-19 pandemic, for example, has created new trauma for some students but exacerbated past or ongoing trauma for

other students. Students and their families are experiencing many difficulties, including financial hardship and losing loved ones (Henderson et al., 2020; Phelps & Sperry, 2020). Many students have returned to the school settings amidst continued COVID-19 concerns. Teachers and school professionals have been met with demands to meet the needs of students. Thus, professional development around trauma and classroom practices to support students who have experienced trauma may be warranted immediately. If and when schools adopt a trauma-informed approach, a logic model like the one described below can help guide school administrators and significant stakeholders.

Logic Model for a Trauma-Informed School

A logic model is described as “a graphic depiction (road map) that presents the shared relationships among the resources, activities, outputs, outcomes, and impact for your program” (Centers for Disease Control and Prevention, n.d.-b, para.1). In this case, the program is trauma-informed schools. Plumb et al. (2016) present a logic model for creating trauma-informed schools. This model includes four areas: resources, activities, outputs, and outcomes. The first area, *resources*, refers to allocating resources necessary to serve the needs of students who have experienced trauma. These resources include a school leadership team, school-based mental health professionals with an appropriate caseload, and a program assessment tool to assess the school district's general areas of strength and need. Next, the second area, *activities*, refers to the actions taken toward creating a trauma-informed school culture. These activities can include assessing the current school culture, evaluating current disciplinary procedures and practices, creating a school crisis plan, identifying a social-emotional curriculum, and educating staff on the prevalence and impact of trauma. Further, the area of *outputs* describes the consequences of

actions taken, such as increased educational attainment, decreased disciplinary referrals, and increased school attendance. Finally, *outcomes* refer to the model's last area, which is significant for more long-term effects over time. These can include an improved school climate, improved mental health outcomes, and decreased intergenerational trauma. This logic model can guide school districts in creating a framework within their district and individual school buildings to address the needs of students who have experienced trauma.

As the researchers mention, this model can be individualized by each school district to meet the needs of their students and community; however, the following five components should be included in each model: (1) training faculty and staff on the impact and prevalence of trauma; (2) adopting a school-wide perspective shift; (3) creating healing relationships among staff, students, and caregivers; (4) maximizing caregiver capacity; and (5) facilitating student empowerment and resiliency. In this logic model, one crucial area is *activities*. Tiered systems of support could help schools further develop this area.

Tiered Systems of Support – Trauma-Informed Schools

Tier 1

At Tier 1, it is suggested that supports should include programs that target all students, regardless of whether or not they have experienced trauma. Tasks that a school building can lead at Tier 1 using a multi-tiered system of support include assessing school-wide trauma-informed practices and policies and establishing protocols for considering trauma exposure. Furthermore, this can include professional development for school professionals, psychoeducation for students and parents on the effects of stress on trauma, and establishing a crisis response plan (Chafouleas et al., 2016; National Child Traumatic Stress Network, 2017). At Tier 1, it is imperative to

promote a safe school climate and predictable learning environment for all students. In order to do this, teachers can adapt their classrooms and teaching strategies. For example, Wiest-Stevenson and Lee (2016) describe building coping techniques and relaxation skills into the curriculum. Teachers can take some time each day leading deep breathing with their students or taking a small timeout to regroup.

Further, classroom changes can be made to foster a warm, secure environment that supports students with trauma. Considerations can be made around arranging desks a certain way, selecting specific colors used to decorate the room, the amount of light, the inclusion of music, and the scent. Teachers should aim to foster a community culture in the classroom and include students who have experienced trauma and may be demonstrating symptoms of trauma as much as possible (Wiest-Stevenson & Lee, 2016).

Universal trauma screening. A particular Tier 1 support described above was establishing protocols for considering trauma exposure in students. One way to do that is through universal screening for trauma. Screening for trauma has picked up much energy in recent times as well. Dr. Nadine Burke Harris, the author of the book *The Deepest Well* and the Surgeon General of California, is a professional who advocated for the state of California to begin screening for early childhood trauma. In January 2020, this push became a reality; California became the first U.S. state to screen for adverse childhood experiences. All health care providers are encouraged to screen children up to the age of 18 for ACEs (Underwood, 2020). While this applies to the medical field, it is unknown how this translates to schools and how school professionals can screen for trauma (or if they should). A recent article by Pataky et al. (2019) presents a school-based universal childhood trauma screening protocol developed by Wediko

Children's Services in collaboration with partner schools. This article supports using the Adverse Childhood Experiences (ACE) questionnaire in schools. Moreover, this protocol is unique because it focuses on screening that makes sense for schools; thus, it relies on collaboration and communication.

It is important to note that a variety of other screening options (paid and unpaid) are available, such as the Behavioral and Emotional Screening System (BESS) and the Strengths and Difficulties Questionnaire (SDQ) (as cited in Reinbergs & Fefer, 2018). Schools should examine screening tools and select the most appropriate and feasible tools for their buildings. Effortful planning should be conducted before screening students to determine how screening results will be utilized. Overall, Tier 1 supports, such as universal screening, set the foundation for student support and allow all students, despite experiencing trauma or not, to feel safe and secure.

Tier 2

Moreover, at Tier 2, we expect to see supports that target students at risk of experiencing trauma, such as psychoeducation on traumatic experiences and the importance of social support. There is existing literature on various evidence-based, trauma-informed interventions implemented in the school setting with students who have experienced trauma. Trauma-informed interventions should be an important component of trauma-informed schools. These interventions are likely to fall under Tier 2 or 3 if a tiered model of support was in place. Implementing these interventions with students who have experienced trauma alone does not mean that a school is trauma-informed; thus, schools should be mindful of this. There are a variety of supports that schools can and should supplement these interventions with.

Nevertheless, it is important to become aware of the different evidence-based trauma-focused interventions that have been previously used to support students. While many students who have experienced trauma can receive services and supports *outside* of the school, some will also be identified to receive services and support *inside* the school. Chafouleas et al. (2018) note that schools have become standard settings for delivering interventions. There are documented benefits of implementing interventions within the school setting. One benefit is that students are more likely to receive and follow through with services (e.g., interventions, for example) than if they received services outside of school. Previous studies have shown that when students receive initial referrals to receive mental health services within a school, nearly 96% of students follow through (Ormiston et al., 2020). “Schools have a significant impact on youth well-being, being the most common institutional entry point to mental health services” (as cited in Crosby, 2015, p. 224). That can be because students are required to attend school; therefore, it makes it easier to find a student and have them “show up” to receive services.

One of the most well-recognized interventions to help support students who have experienced trauma is cognitive-behavioral therapy (CBT). CBT is a well-established, effective intervention typically delivered on a group basis but can also be delivered individually. CBT includes the following six components: (1) psychoeducation about trauma and the intervention; (2) emotion regulation training; (3) imaginal exposure; (4) in vivo exposure; (5) cognitive processing; and (6) problem-solving. A parent involvement piece is usually incorporated into CBT (Chafouleas et al., 2018). Additional school-based interventions for trauma include Cognitive Behavioral Intervention for Trauma in Schools (CBITS), Bounce Back, Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems

(MATCH-ADTC), and Trauma-Focused Coping in Schools (TFC)/Multimodality Trauma Treatment (MMIT). Depending on the individual school, these interventions are typically implemented by a school psychologist, social worker, or outside clinician. Other school staff and educators are often looped in to reinforce what students are learning and working on during these intervention sessions.

Besides implementing these interventions at Tier 2, there are additional tasks that a school building can take on using a multi-tiered system of support. These include trauma-informed behavior support plans, teaching students social skills, establishing a comprehensive threat assessment protocol, and establishing in-school supports for educators (Chafouleas et al., 2016; National Child Traumatic Stress Network, 2017).

Tier 3

Finally, at Tier 3, supports would be provided to students who have experienced trauma and are already displaying trauma symptoms. An example of support at this level would again include cognitive-behavioral therapy (CBT) and more wrap-around care (as cited in Fondren, 2020). At Tier 3, a school would likely seek to support a student more intensely. Traditionally, Tier 3 supports in a school encompass wrap-around services and referrals to outside community agencies/organizations. Schools should expect to become partners with community agencies (e.g., therapy providers, non-profit organizations) to help them meet their students' needs. Additional Tier 3 tasks that a school building can take on using a multi-tiered system of support include ongoing assessment or monitoring of traumatic stress, considering trauma-informed special education services, and referring/consultation for outside services (National Child Traumatic Stress Network, 2017). Tier 3 services are often beyond the scope of a school building

but should be monitored to support a student continuously. If a student works with an outside provider, teachers and school professionals likely want to stay in communication with the provider and aid them in whatever they need. There are other roles that teachers and school professionals can play in supporting students who have experienced trauma.

Role of Teachers and School Professionals in Addressing Trauma

Teacher-Student Relationships

Teachers and school professionals can play a critical role in supporting students who have experienced trauma by aiding in relationship building. Generally, schools can provide a safe space for students, where they can create caring relationships with peers and adults.

Unfortunately, in many cases, these relationships are not so easy to develop for students who have experienced trauma. Traumatic experiences typically involve some sort of betrayal, which leads to this sense of mistrust and the inability to develop and maintain relationships in students who have experienced trauma (Diamanduros et al., 2018, Dombo & Sabatino, 2019). It is then plausible that students who have experienced trauma may challenge adults, particularly their teachers, to obtain a sense of control that will enable their safety (Cole et al., 2005).

Relationships with peers are also not necessarily easy to develop. Students who have experienced trauma may lack the skills to interact with peers and develop healthy relationships appropriately. In addition, they might also feel distrustful of peers. These students' relationships would be a significant protective factor if these difficulties could be overcome.

An article by Dods (2013) presents aspects needed to develop school-based relationships that are viewed as beneficial, as reported by students who have experienced trauma. The identified aspects are (1) teacher-driven, (2) authentic caring, (3) attunement to students'

emotional states, and (4) individualized. Teacher-driven refers to students wanting their teacher to sense the need to connect and initiate a conversation with students. In the experience of various students, they would like teachers to go out of their way to ask if they are okay or how things are going. They may not necessarily be looking for a heart-to-heart or an intense conversation, but they seek that connection and availability from a teacher. Further, authentic caring refers to the quality of the interaction. For a relationship to be built, students believe it needs to be based on actual listening, an understanding attitude, and validation of the student's feelings. Next, attunement to students' emotional states refers to teachers being observant of overt and covert behavioral cues in a student and being responsive and adaptive to any particular student's needs. Students noted that they want teachers to look beyond lack of academic success and externalizing behaviors; they want teachers to notice subtle details such as facial expressions and signs of distress. Teachers should support students and not "blow them off" when they notice these details. Finally, individualized means that students are treated like actual people in a relationship, and teachers get to their level instead of acting as authority over them. In addition, these relationships have to be sustained over time. One student in this article noted that he had little trust in adults but that in order for adults to earn his respect, they had to talk to him as an individual, not as a student (Dods, 2013).

The four aspects noted in this article demonstrate various factors that have been identified as necessary for teachers to build trauma-informed relationships with students who have experienced trauma. Students seek out these relationships in the school environment, despite what their actions may be showing. It is always important for teachers to be patient, genuine, and aware of what we demonstrate to our students. When we can earn their trust, we will build

relationships and help support them in the best way possible. Building relationships with students who have experienced trauma in the school setting is an essential first step.

Identifying Trauma Symptoms

Identifying trauma symptoms and referring students who manifest trauma symptoms is another role that teachers can take on. Teachers are usually close in proximity to a student's environment; thus, they would be able to observe trauma symptoms. However, one of the most significant troubles with identifying trauma symptoms may stem from the view that teachers and school professionals have about whether or not they should play a role in the mental health needs of their students. There is a common belief often held by teachers and school professionals that it is the sole responsibility of the social worker and school psychologist to intervene and play a role in the mental health needs of students in a school (Alisic, 2012; Reinke et al., 2011; Rossen & Hull, 2012). While social workers and school psychologists may be perceived to have the training or understanding of trauma, this may not be the case (Gubi et al., 2019).

Another difficulty that teachers and school professionals may have in identifying students who have experienced trauma is that they may be scared and nervous, to be perceived as intrusive to students' personal lives and experiences. For those students who have experienced a traumatic event, it certainly may not be easy to admit and reveal to anybody that they went through something traumatic, and the different feelings associated with the experience. Students may choose to stay silent and perhaps not even identify their experience as "traumatic" (Rossen & Hull, 2012). Several other difficulties in identifying traumatic experiences in students include the various "faces" of trauma, their presentation, and the lack of adequate resources and services to support students (Rossen & Hull, 2012).

The role of teachers in identifying students who have experienced trauma and knowing when to refer these students is crucial as behavior that stems from trauma may be misinterpreted. Students who have experienced trauma may be quickly mislabeled as “oppositional” or “defiant” without regard for underlying distress and difficulties (Luthar & Mendes, 2020). Thus, the degree to which teachers can identify trauma, and respond in a trauma-informed manner, may influence whether students are referred for special education eligibility or disciplinary action at higher rates (Rossen & Hull, 2012). Besides identifying students who have experienced trauma, teachers may be in a position to provide actual support to students who have experienced trauma.

Teacher Perspectives on Providing Supports Related to Trauma

While much information is found in the literature regarding what teachers can do to support students who have experienced trauma, there is not much exploration of teachers’ perspectives on providing actual support to students who have experienced trauma. One study that has examined these perspectives is a study by Alisic (2012). Alisic examined a sample of elementary school teachers’ perspectives on providing support to children after a traumatic experience. It was found that some teachers expressed confidence in working with children after a traumatic experience; however, in most teacher reports, there was some doubt and uncertainty about providing support. Some teachers struggled with defining their role and to what extent their tasks should go beyond teaching academic skills. Additional findings from this study demonstrated that teachers struggled with balancing the different demands and needs present in their classrooms (e.g., an individual student’s needs vs. whole classroom needs). Further, teachers reported that they wanted to be there for the student but not overlook other student experiences and accomplishments. Finally, teachers reported that it was difficult to balance

caring, staying committed, helping the student who just went through a traumatic experience, and establishing boundaries and distance to avoid emotional burnout.

Similar perspectives were found in a research study by Luthar and Mendes (2020). Teachers reported several barriers to supporting students who have experienced trauma, such as compassion fatigue (also known as secondary trauma), feelings of inadequacy and fearfulness that they might not be responding in the most appropriate manner, and concerns about their safety (Luthar & Mendes, 2020). Though teachers report the mentioned barriers, teachers can support students who have experienced trauma due to their proximity to a student's environment; they can develop skills and be provided support to overcome many of the difficulties described. Teachers, however, are not the only ones responsible for supporting students who have experienced trauma. In order to truly be able to support students who have trauma, there needs to be a change in the culture of a school. Sandra Bloom, an expert in trauma, stated that to "implement trauma-informed processes without first implementing trauma-informed culture change is like throwing seeds on dry ground" (as cited by Luthar & Mendes, 2020). The role that administrators can play is discussed briefly in the next section.

Role of Administrators

All school professionals, not just teachers, must contribute to the development of a trauma-informed approach. However, administrators play a different role in creating a trauma-informed approach because they do not work directly with students in the classroom. Nevertheless, they still play a significant role in implementing a trauma-informed school. As referenced earlier in this literature review, administrators can lead trauma-informed efforts in their buildings via a logic model such as that of Plumb et al. (2016). As part of that logic model,

administrators should allocate resources to support the needs of students who have experienced trauma by identifying key staff to join a leadership team that will assist in security procedures. In addition, administrators can also lead activities such as a comprehensive threat assessment of the school (as cited in Wiest-Stevenson & Lee, 2016) and ongoing education for teachers and school staff on trauma.

Trauma Professional Development and Training for Teachers

One component acknowledged as an integral part of trauma-informed schools is professional development and training on trauma for teachers and staff. Though this is considered a Tier 1 support, this section will examine this component more in-depth since this study focuses on examining professional development and training on trauma. This type of professional development or training can be considered a Tier 1 support because all teachers and school staff should receive this training to support all the students within a school.

Professional development or training on trauma can look very different across school settings. Some of the literature notes that professional development or training on trauma can be more *knowledge-based*, that is, based on educating teachers and staff on basic definitions and general knowledge of trauma (prevalence, impact, etc.). Moreover, *skills-based* professional development or training focuses on how teachers and staff can manage trauma-related behaviors in the classroom and school settings (Loomis & Felt, 2020). There seems to be agreement that the purpose of training or professional development on trauma is to “increase staff knowledge about the prevalence and effects of trauma and associated cognitive, behavioral, and socioemotional effects of trauma. Moreover, professional development is intended to increase staff’s ability to recognize signs and symptoms of trauma and improve skills in appropriately

responding to students exhibiting trauma symptoms so that staff can more effectively address student behavior and make appropriate referrals from our targeted services” (Maynard et al., 2020, p. 7). Finally, professional development or training should also incorporate knowledge on secondary trauma and skills for teachers to cope with it. Secondary trauma is something real that can occur when serving students who have experienced trauma. Secondary trauma refers to “the experience of caretakers who are in close proximity to, and have relationships with, others who are experiencing trauma and toxic stress (TTS) but who do not have sufficient supports to manage the trauma of the other person” (Blitz et al., 2016), p. 523). While teachers may not be directly experiencing trauma, they can take on the emotional burden of their students' trauma. The above are all possible components of trauma professional development and training. Now, we will discuss existing policy and law around trauma professional development and training for teachers that would make implementing this in schools more feasible.

Policy and Law around Trauma Professional Development and Training

Currently, there is not much known regarding mandates on trauma professional development and training within school settings. A report by the Education Commission of the States (2020) provides insight into different state requirements around trauma training for K-3 teachers. In Indiana, for example, it is required for teacher prep programs to consider using curricula that include training on recognizing signs of trauma, understanding the impacts of trauma, and recommendations for creating a trauma-informed classroom. No other states seem to require the inclusion of trauma education into teacher prep programs. This report shows that any state's mandates around trauma training typically require teachers to engage in professional development while already in practice.

A study conducted by Brown et al. (2020) explored the impact of trauma training incorporated into a teacher prep program on teacher candidates' attitudes, knowledge, and skills. It was found that this training positively impacted teacher candidates by increasing their knowledge and skills surrounding trauma and working with students who have experienced trauma. Many of the teacher candidates in this study had previously stated that they wished for trauma training during their prep programs; thus, this training met the needs of these teacher candidates. This can suggest an existing need for teacher prep programs to incorporate trauma professional development or training to serve student populations better.

Given the higher rates of attrition for new teachers, particularly in schools serving primarily students of color or students in poverty, adequate teacher preparation is a necessity. Preparing teacher candidates to work with students with traumatic exposure may help address some of the stress, burnout, and teacher turnover among new teachers. (as cited in Brown et al., 2020, p. 15)

Overall, it is evident that there is currently a lack of mandates that would allow for professional development and training on trauma for teachers and school staff to be implemented more consistently across school settings. In addition, teacher prep programs do not have any requirements to include trauma training. This is troubling due to the previously stated prevalence of childhood trauma and the current needs of our student population. There is emerging evidence of the benefits of trauma professional development and training for teachers.

Outcomes of Trauma Professional Development and Training

Several training programs and courses have been documented in the literature. One of them is a specific course named *Enhancing Trauma Awareness* (ETA) (Whitaker et al., 2019; Herman & Whitaker, 2020). The ETA professional development course content includes theories of trauma and recovery, knowledge about trauma and the effects of trauma, and skills for how to

respond to trauma. In a study conducted by Whitaker et al. (2019), 48 preschool teachers received this professional development course. The researchers' primary hypothesis was that those teachers who went through the professional development course would report an increase in the quality of student-teacher relationships after the course, as evidenced by a reduction in conflict. The secondary hypotheses were that teachers would report higher relational capacities (higher rates of empathy, emotional regulation, and attitudes) and improvements in health and well-being. Through survey data, it was found that teachers who went through the professional development course did not report an increase in the quality of student-teacher relationships or an increase in relational capacities. However, through focus groups, an impact was found. Researchers attributed these mixed findings to the fact that surveys could not accurately capture the changes after going through the course (Herman & Whitaker, 2020).

Moreover, another training program found in the literature is *Compassionate Schools* (Parker et al., 2020). This program is part of a larger *Compassionate Schools* initiative that has existed since 2008. The training program encompasses an introduction to the *Compassionate Schools* framework, education on the ACEs literature, training in recognizing signs of abuse and neglect, and education on social-emotional learning (SEL) and resilience skills. Researchers Parker et al. examined the impact of *Compassionate Schools* on participants. The participants who received this training were school professionals (not limited to teachers/educators). Participants who went through the training reported changes in mindset and behavior in response to training, though it was not explicit if these changes were negative or positive. Furthermore, participants who went through the training were generally supportive and receptive to the training (e.g., acceptability). It is important to note that this training was not specific to teachers,

in contrast to the previous study, which is telling. As mentioned previously, all school professionals should contribute to the formation of trauma-informed schools; thus, this could explain why some schools may choose to deliver trauma training to all their staff.

Furthermore, a study conducted by McIntyre et al. (2019) demonstrates the effects of a two-day professional development training on trauma for teachers. The training content was structured around the SAMHSA guidelines for trauma-informed systems. The specific learning objectives were to “create a common understanding of trauma and its impacts, build consensus for trauma-informed approaches, and highlight key principles of trauma-informed care and their application to create safe and supportive environments for all students and teachers” (p. 4).

Through pre- and post-measures, it was found that teachers who went through training experienced increased knowledge of trauma-informed approaches and increased acceptability. An additional factor explored through this study was *system fit*, incorporating factors such as perceived administrator and colleague support and the presence of system facilitators/barriers. For those teachers who perceived better system fit, increased knowledge was associated with increased acceptability for trauma-informed approaches. However, increased knowledge was associated with decreased acceptability among teachers perceiving less system fit. This is another study that provides initial evidence for trauma professional development and training for teachers but does not explore any other valuable outcomes, such as how teachers utilize this training. Pre- and post-measures make this a short-term analysis that does not yield any implications for the future and what the training can provide on a more long-term basis. In other words, outcomes were evaluated after the one instance of a trauma professional development of training course; however, it is uncertain to say whether these outcomes would look the same over

time. In addition, varying levels of exposure to trauma professional development and training have not previously been examined in the literature, especially not in connection to outcomes.

Overall, training programs and courses are supported in their use because they enact change in the way educators view trauma in their students. Trauma professional development and training have the power to shift educator attitudes and bring awareness that perhaps would not be there if training or professional development was not experienced. Beyond awareness, acceptability, and changes in attitudes, however, there are no heavily documented outcomes of trauma professional development or training. There is also a lack of awareness of outcomes related to varying levels of exposure to trauma professional development and training.

Gaps in the Literature -- Trauma Professional Development and Training

While trauma professional development and training is an essential component in trauma-informed schools, only a few training courses and their outcomes have been examined. To date, there is not much knowledge on the state of professional development and training; whether there are varying levels of exposure, what this trauma professional development or training looks like, and where school professionals may be receiving it (within their school building, outside their school building, etc.). In addition, considering the studies above, it is evident that when discussing trauma professional development and training, factors such as acceptability to training, quality of student-teacher relationships, and higher relational capacities have been examined as an outcome of this professional development and training. However, factors such as additional professional development that teachers and staff have sought out, strategies implemented in the classroom, and specific changes in student behavior such as school

engagement, disciplinary referrals, and trauma-specific symptoms as a result of classroom strategies implemented have not.

Summary of Literature

Much research exists on childhood trauma and its impact on students, specifically within the school setting. Further, there is much literature on trauma-informed schools and general supports that can be implemented to support students at risk of experiencing trauma or who have experienced trauma. However, an essential component of trauma-informed schools is providing professional development and training to teachers and school staff on trauma. While an important component, there is limited literature on this topic. The existing research has examined common professional development and training components, a few specific training programs and courses, and some primary outcomes of this trauma professional development and training on teachers, such as acceptability to training and awareness levels. However, there is very little knowledge on the actual state of professional development and training in K-12 school settings; whether there are varying levels of exposure, what this trauma professional development or training actually looks like, and where school professionals may be receiving it (within their school building, outside their school building, etc.). Furthermore, other outcomes related to strategies implemented in the classroom and specific changes in student behavior such as school engagement, disciplinary referrals, and trauma-specific symptoms as a result of classroom strategies implemented have not. This will be the focus of the current study. The specific research questions that will be answered through this study include specifically (a) what is the relationship between the level of exposure to trauma training/PD and the extent to which teachers can identify trauma; (b) what is the relationship between the level of exposure to trauma

training/PD and the likelihood that teachers will report implementing trauma-informed strategies in the classroom; and (c) what is the relationship between the level of exposure to trauma training/PD and whether teachers observe changes in student behavior due to the classroom strategies they report implementing.

CHAPTER THREE

METHODOLOGY

This study examined teachers' varying levels of exposure to trauma professional development and training within school settings and the reported impact of this professional development and training. This chapter includes information on the research design, the research questions, and a description of the sample recruited for participation in this study. Further, it consists of a description of the data collection process, the measures used to collect data, and a data analysis plan. This study will contribute to the literature in that it will help us understand the varying levels of exposure to trauma professional development and training that Illinois teachers have and the outcomes of this professional development and training. Specifically, the study will examine relationships between teacher-reported levels of exposure to trauma professional development and training and the extent to which teachers report that they can identify trauma, the likelihood that teachers will report implementing trauma-informed strategies in the classroom, and whether teachers observe changes in student behavior due to the classroom strategies they report implementing.

Research Design

The purpose of this study was to obtain a better understanding of teachers' varying levels of exposure to trauma professional development and training in Illinois and the reported outcomes of this professional development and training, specifically (a) what is the relationship between the level of exposure to trauma training/PD and the extent to which teachers report that

they can identify trauma; (b) what is the relationship between the level of exposure to trauma training/PD and the likelihood that teachers report implementing trauma-informed strategies in the classroom; and (c) what is the relationship between the level of exposure to trauma training/PD and whether teachers report observing changes in student behavior due to the classroom strategies they report implementing. A correlational study design had been selected initially since all the research questions of this study were ‘what is the relationship’ type questions. A correlational study design also “examines the relationship between two or more variables but does not test causality” (Adams & Lawrence, p. 20). However, given the study's sample size ($n = 29$), a correlational study design was not feasible, and a descriptive study design was used instead. A descriptive study design “describes the who, what, when, where, and how but does not examine relationships among the who, what, when, where, and how” (Adams & Lawrence, 2015, p. 20). Descriptive designs can be exploratory and help researchers understand an area of research or phenomenon that is new or has not been heavily examined in-depth. Analyzing data through this lens helped the researcher identify patterns, frequencies, trends, and categories. The researcher closely examined initial patterns that could predict a correlational relationship in future research.

Further, the chosen method for this descriptive study design was survey research. Creswell and Creswell (2018) report that survey research “provides a quantitative or numeric description of trends, attitudes, or opinions of a population by studying a sample of the population” (p. 12). One benefit of using survey research is that the researcher gets insight into how the participants see themselves and their thoughts and feelings, which could otherwise not

be directly observable (Adams & Lawrence, 2015). Survey research was also selected, given its feasibility within the educational setting.

Positionality Statement

I would like to acknowledge that my educational background and experiences influenced how I conceptualized the process of collecting and analyzing my dissertation data. I am currently a fifth year PhD candidate and completing a predoctoral internship in School Psychology. I have been aware of my identity as both a researcher and a practitioner throughout my doctoral journey. It is appropriate to say that I mainly relied on my identity as a researcher throughout this process, especially at the beginning of it. I relied on all the literature I have read, webinars and professional development I have attended to form an idea of what trauma-informed work in the school setting looks like in an “ideal world.” In Chapters One through Three of this dissertation study, I positioned myself utilizing the lens of an outside researcher. I mention the role, supports, and practices that teachers can take to support students who have experienced trauma without acknowledging the factors out of their control that would make it difficult for them to do this. These factors include teacher preparation requirements, policy and law, resources, funding, building support, and systemic influences. In theory, we can read all the literature, hear a lot of information on a given topic, and think we are well versed on an issue; however, this may not be the case. At the beginning of this process, I thought I knew much about trauma-informed work in the school settings based on what I read and researched, but I soon realized that I had to shift my lens and draw on my experiences as a practitioner as well. I began drawing on my experiences throughout my doctoral internship. I discovered a mismatch between much of what I was reading in the literature and what I saw in practice. That led me to think through this process more

strategically and realize that while it had not been what I had envisioned, my data reflected what was happening in schools. In sum, teachers can support students who have experienced trauma. However, they might not be able to due to a variety of factors, especially at a time when there are increased expectations and when teachers might be experiencing their own trauma. It is crucial to engage in genuine collaboration with teachers to avoid that this work falls on ‘the shoulders’ of one individual.

Procedures

Upon receiving Loyola University Chicago IRB approval, the researcher recruited teachers through convenience snowball sampling by publicly sharing a flyer and announcement (see Appendices A & B) to obtain research participants. Convenience sampling is a type of sampling in which participants are selected based on convenience and availability. Convenience samples are obtained in a variety of ways, such as advertising for volunteers, asking a group of people within a school cafeteria to participate in a study, and even asking friends and family to participate (Creswell & Creswell, 2018; Adams & Lawrence, 2015). Further, snowball sampling is a type of sampling in which study participants recruit others into the sample (Adams & Lawrence, 2015).

The recruitment flyer and announcement included a survey link/QR code and was shared on various social media accounts, including Facebook, Instagram, and Twitter. Individuals who had access to the original posts made on the different social media accounts were asked to share the flyer and announcement with family, friends, and acquaintances who might (1) be interested in participating, and (2) meet the criteria to participate. The criteria to participate were to be a teacher within Illinois and to have some level of exposure (little, moderate, a lot) to trauma

training or professional development. This method was utilized first and foremost with the intent that this post would be spread widely across Illinois and allow the researcher to obtain a larger sample, including participants who are diverse in gender, ethnicity, grade levels taught, and location of employment.

Once accessing the survey, participants read passive consent procedures (see Appendix C) and acknowledged that they provided consent for participation by agreeing to the survey. Each participant was assigned a participant number. Once providing passive content to complete the survey, participants navigated the survey process by completing the different questions described in the next section. After completing the survey, participants had the option to enter their contact information in a separate survey to be entered into a drawing for a chance to win a gift card. Gift card responses were collected separately from survey data, given that these responses contained contact information and the researcher did not want to associate any contact information with a given participant's responses.

The survey was designed to take no more than 30 minutes to complete. The researcher closely monitored the survey results. Additional advertising and sharing of the recruitment materials were repeated at various times during the data collection window. The data collection window was approximately one month and two weeks. All survey results were collected through the identified online platform that only the researcher had access to. Once the researcher exhausted all recruitment efforts and a sample size of 29 participants had responded to the survey, the researcher closed the survey. The Qualtrics survey data were exported to Statistical Package for the Social Sciences (SPSS), a statistical analysis program, which was used to conduct the analysis. The separate survey containing contact information was also closed at the

same time. The drawing and distribution of gift cards took place within two weeks after the survey closed using a random lottery process. Each gift card entry was labeled using numbers one to 21. These numbers were used to aid the researcher in selecting gift card winners using the Google number generator. Five gift card winners were selected and earned a \$25 gift card.

Participants

To be eligible for participation, participants were required to be a teacher in Illinois and have some level of exposure (little, moderate, a lot) to trauma training or professional development. All participants were identified to meet these criteria (n = 29). Teachers practicing in Illinois were recruited as the researcher has knowledge on trauma professional development and training requirements in Illinois, given that the researcher resides and studies in the state of Illinois.

Demographic data indicates that the majority of participants identify as female (89%, n = 26), White (69%, n = 20), and hold a master's degree (69%, n = 20). Further, teachers most reported having 5-9 years of experience teaching (41%, n= 12), are general education classroom teachers (52%, n= 15), are employed in suburban school sites (52%, n=15) and teach elementary school-age students, (48%, n=14). Table 1 provides a summary of demographic data. This is a sample that, while not very diverse, reflects the current educator population within the state (Illinois State Board of Education, 2020)

Table 1. Participant Demographics

Demographics	<i>n</i>	% of Total
<i>Gender</i>	29	
Male	3	10
Female	26	89
<i>Race/Ethnicity</i>	29	
White	20	69
Black or African American	0	0
American Indian or Alaska Native	0	0
Asian	0	0
Native Hawaiian or Pacific Islander	0	0
Hispanic/Latino	9	31
<i>Highest Degree of Education Completed</i>	29	
Bachelor's Degree	8	28
Master's Degree	20	69
PhD/EdD Degree	1	3
<i>Total Number of Years Teaching</i>	29	
0-4 years	10	34
5-9 years	12	41
10-14 years	3	10
15-19 years	2	7
20+ or more years	2	7
<i>Current Job Title</i>	29	
General Education Classroom Teacher	15	52
Special Education Classroom Teacher	8	27
Specials Teacher (Art, Music, Gym)	2	7
Other	4	14
<i>Level That You Teach</i>	29	
Early Childhood	0	0
Elementary School	14	48
Middle School	8	28
High School	7	24
<i>Location of Employment</i>	29	
Rural setting	2	7
Urban setting	12	41
Suburban setting	15	52

Measures

A researcher-developed survey instrument (see Appendix D) consisting of a series of Likert-scale, multiple-choice, multiple-response, and open-ended questions was utilized to assess teacher-reported levels of exposure to trauma professional development and training. The survey instrument included 42 survey items divided into various sections to assess levels of exposure to trauma professional development and training, the extent to which teachers can identify trauma, the likelihood that teachers report implementing trauma-informed strategies in the classroom, and whether teachers observe changes in student behavior due to the classroom strategies they report implementing. In addition, this instrument was used to examine relationships between teacher-reported levels of exposure to trauma professional development and training and the extent to which teachers can identify trauma, the likelihood that teachers will report implementing trauma-informed strategies in the classroom, and whether teachers observe changes in student behavior due to the classroom strategies they report implementing. Feedback on the survey instrument was sought from the researcher's dissertation director. Out of the 42 survey items, eight were demographic questions, and ten were questions about the professional development and training on trauma previously received.

The demographic section of the survey was developed using examples of demographic questions the researcher had access to. Demographic questions that teachers responded to included questions on gender, age, race/ethnicity, highest degree of education completed, number of years teaching, current job title, grade level being taught, and location of employment. The following section focused on examining levels of exposure to trauma professional development and training, and additional details on the training/PD previously received.

Participants were asked to report whether they had little, moderate, or a lot of exposure. In addition to this information, participants were asked to report the titles/topics of training or professional development sessions, where they received this professional development or training, how useful it was, and if they are actively looking for additional trauma professional development or training opportunities. The remaining sections of the survey are briefly described below.

Assessing the Extent to Which Teachers can Identify Trauma

To assess the extent to which teachers can identify trauma, this survey included seven survey items about teachers' perceptions of how many of their students have been exposed to trauma, what types of traumas their students have experienced, and how they recognize trauma in their students. At the beginning of this section, a prompt was provided to aid participants in responding to these questions. The prompt read, "For the following questions, please reflect on the trauma training or professional development you have received. As a result of trauma training or professional development..." This survey section included five items adapted from the Teaching Traumatized Students scale (TTS) by Crosby, Somers, Day & Baroni (2016). Permission was requested and granted for utilizing this scale and modification of items. Two items used from this scale were modified to say *I can recognize*, and *I realize* instead of *I am aware*. The researcher decided that the *I am aware* statement could lead participants to guess what this survey section was measuring. The questions were answered on a five-point Likert scale, 1=strongly disagree, 2=disagree, 3=neutral, 4=agree, and 5=strongly agree. An additional two items included in this portion were multiple-choice and multiple response. The researcher realized it was important to have these two questions (not from the TTS scale) in this section

because asking participants about the percentage of their current students that have been exposed to trauma and what types of traumas their current students have been exposed to, experienced, or witnessed allowed the researcher to better understand the specific knowledge teachers had about trauma experiences of their students.

Assessing the Likelihood that Teachers will Report Implementing Trauma-Informed Strategies in the Classroom

Next, to assess the likelihood that teachers will report implementing trauma-informed strategies in the classroom, the survey included 16 items about how participants respond to student behavior consistent with trauma and what they utilize as strategies within their classrooms. This section included all the Teacher Responses to Student Behavior scale (TRSB) questions (Crosby et al., 2016). Similarly, permission was requested and granted to utilize this scale and modify items for the TTS scale. This scale includes two sets of eight questions each, and the questions focus on student “acting out” and “shutting down” behaviors. Modifications were made to this scale to name these “externalizing” and “internalizing” behaviors. These adaptations to the language used to describe these behaviors were necessary to avoid potential miscommunication. Examples of different externalizing and internalizing behaviors were also provided to participants to clarify and prevent any confusion.

Before each of these questions, a prompt was provided on externalizing and internalizing behaviors. Before the questions focused on externalizing behaviors, the prompt read, “As a result of the trauma training or professional development you have received, how much more likely are you to use the following teaching strategies with students who display EXTERNALIZING BEHAVIORS (e.g., fighting, talking back, getting out of seat, swearing).” Similarly, before the

questions focused on internalizing behaviors, the prompt read, “As a result of the trauma training or professional development you have received, how much more likely are you to use the following teaching strategies with students who display INTERNALIZING BEHAVIORS (e.g., shutting down, withdrawing, not interacting with peers).” It is important to note that modifications were also made to these prompts, as the original read, “How much do you use the following teaching strategies with students who ACT OUT?” and “How much do you use the following teaching strategies with students who SHUT DOWN?” These modifications to the prompt were required because it was important to present participants with a prompt that would allow them to reflect on the trauma training or professional development they received and how much participants are using the strategies mentioned because of this training/PD. Participants were asked to rate how much they use specific teaching strategies (e.g., breaks, wait time, sensory outlets) with students who display externalizing and internalizing behaviors. Some rewording was also made to the statements listing the strategies to ensure they read appropriately with the new prompts. Similar to the TTS, the items in this section were to be answered on a five-point Likert scale. Possible responses include 1=never, 2=sometimes/less than half the time, 3=often/about half the time, 4=most of the time/more than half the time, and 5=always.

Assessing Whether Teachers Observe Changes in Student Behavior Due to the Classroom Strategies they Report Implementing

Finally, one item was developed to assess whether changes in student behavior have been observed as a result of the classroom strategies teachers report implementing. A yes or no response was required. If participants responded yes, they were asked to provide a specific example of this behavioral change(s). The researcher developed this item considering the

literature stating that the implementation of trauma-informed strategies has the potential to yield changes such as increased student engagement, achievement, and significant reductions in office referrals and suspensions (as cited in Koslouski & Stark, 2021).

Validity and Reliability of Scales

This section includes information on the reliability and validity of the scales utilized in this study. Validity and reliability needed to be established before using the TTS and TRSB scales developed by Crosby et al. (2016). Validity refers to the extent to which one can draw meaningful and useful inferences based on the scores of an instrument (Creswell & Creswell, 2018). There are several kinds of validity, such as content, predictive or concurrent, and construct validities. In contrast, reliability refers to the consistency or repeatability of an instrument (Creswell & Creswell, 2018). There are also several forms of reliability, such as internal consistency and test-retest reliability.

For both the scales, reliability was established by calculating a Cronbach's alpha to measure internal consistency. For the TTS scale, the Cronbach's alpha was found to be $\alpha=.91$. For the TRSB scale, the Cronbach's alpha was found to be $\alpha=.79$ for acting out behaviors and $\alpha=.81$ for shutting down behaviors. For a scale to be considered reliable, a Cronbach's alpha between .7 and .9 is optimal (Creswell & Creswell, 2018). This information would then allow us to deduce that these scales have adequate reliability and are good scales to utilize.

Furthermore, validity was established in a series of ways. First, Crosby et al. (2016) began with a literature review on childhood trauma and several other topics related to this topic. Then, a list of concepts related to the major constructs of school staff perceptions of, awareness of, and responses to student trauma was developed due to this literature review. Finally, a group

of trauma-trained experts in child welfare and school psychology and school administrators was recruited to help enhance this list of concepts. Scales were created with the feedback and support of school administrators, who could speak on behalf of teachers and school staff.

Thus, overall internal consistency (reliability) and content validity was established for the scales to be utilized in this study. Other forms of validity, such as concurrent, convergent, and discriminant validity, could not be shown since similar measurement tools are not available to date. Finally, it was determined that additional research should assess test-retest reliability and predictive validity (Crosby et al., 2016). It is important to note that the reliability and validity information discussed in this section are based on Crosby et al.'s data; however, the same reliability and validity may not apply to the given study given the modifications made to scale items.

Data Analysis

Survey data were analyzed using Statistical Package for the Social Sciences (SPSS), a statistical analysis program. SPSS was used to assess levels of exposure to trauma professional development and training, the extent to which teachers can identify trauma, the likelihood that teachers report implementing trauma-informed strategies in the classroom, and whether teachers observe changes in student behavior due to the classroom strategies they report implementing.

Before running any descriptive statistics, determining a *Total Awareness* and a *Total Strategies* score was necessary. To determine a *Total Awareness* score for each participant, a mean was calculated for each participant's responses to five out of seven survey items corresponding to assessing the extent to which teachers can identify trauma. Further, a *Total Strategies* score was determined for each participant by calculating a mean for each participant's

responses to 16 items that corresponded to implementing trauma-informed strategies; strategies both utilized with students who display *externalizing* behaviors and *internalizing* behaviors. In addition, to explore potential differences in the implementation of strategies with students who display *externalizing* vs. *internalizing* behaviors, a *Total Externalizing Strategies*, and a *Total Internalizing Strategies* score were developed for each participant. This was conducted by taking the mean of each participant's responses to the survey items surrounding *externalizing* and *internalizing* behaviors.

To address the research questions, descriptive statistics, including mean, standard deviation, and range, calculated for the survey responses. Group comparisons based on teachers' level of exposure to trauma training/PD (little, moderate, a lot) were made in relation to the extent to which teachers can identify trauma, the likelihood that teachers report implementing trauma-informed strategies in the classroom, and whether teachers observe changes in student behavior due to the classroom strategies they report implementing. While the intent was to establish correlational relationships using non-parametric tests, such as a chi-square or Mann Whitney, this was not possible given the study's sample size. This is identified as a limitation and discussed more in detail in Chapter Five of this study.

Additional survey items that were not necessarily connected to any of the research questions were analyzed closely for patterns to inform future research. The researcher heavily relied on percentages to determine the majority responses to specific questions. In addition, open response questions were analyzed via content analysis to determine any common themes. The results from the analyses described are presented in the next section.

CHAPTER FOUR

RESULTS

The findings presented here will focus primarily on reporting descriptive results. While the intended data collection plan was to utilize a correlational study design, the sample size did not allow the researcher to examine any correlational relationships between variables.

Limitations to data collection and analysis will be discussed later in this dissertation.

The Current State of Trauma Training and Professional Development

One important aspect this study sought to explore was the current state of trauma training and professional development in Illinois, specifically, the varying levels of exposure to trauma professional development and training. Findings showed that 38% of participants (n = 11) reported having *little exposure*, 52% of participants (n = 15) reported having *moderate exposure*, and 10% (n = 3) reported having *a lot of exposure*. When asking participants to report how many training or professional development sessions on childhood trauma they had completed using a numeric quantity (e.g., one session), participant responses ranged from one to 20 sessions. Figure 1 provides a summary of participants' reported levels of trauma training or professional development.

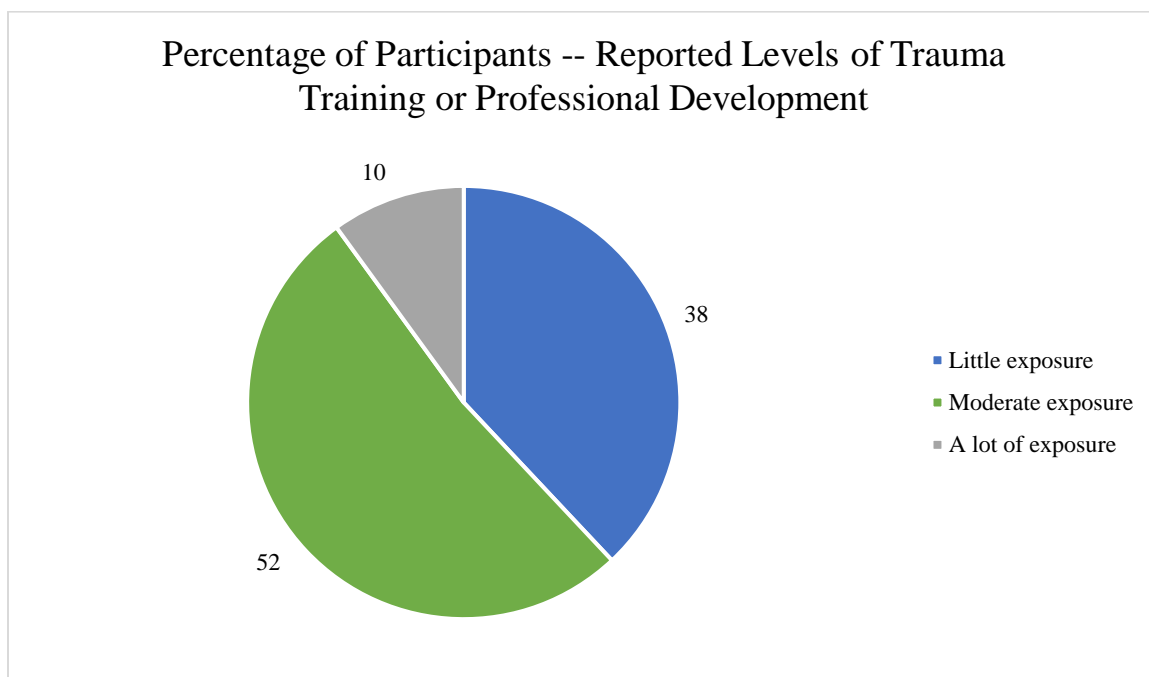


Figure 1. Levels of Trauma Training or Professional Development Graph Results

Beyond the varying levels of exposure, the researcher was also interested in exploring additional details regarding the trauma professional development and training the participants received. When asking participants to list the titles/topics of training or professional development sessions, the following examples were provided: trauma-informed care, trauma-based practices, adverse childhood experiences (ACEs), and childhood trauma and the brain. Additionally, 45% of participants ($n = 13$) reported receiving this training or professional development formally via continuing education workshops or courses, 41% ($n = 12$) reported receiving this training via independent study or self-paced, while 14% ($n = 4$) reported receiving this using a combination of these methods. 62% of participants ($n = 18$) received this training in their school building or district, while 21% ($n = 6$) received it outside their school building or district. An additional 17% of participants ($n = 5$) received this training both at their school building or district and outside of it. To provide some examples, some participants indicated that they received trauma training or

professional development through mandatory trauma response training twice a year or a required Global Compliance Network (GCN) training. Other participant responses also suggested that their participation in trauma professional development or training occurred due to partnerships with hospital/university settings, such as Lurie Children's Hospital and Northwestern University. In contrast, others mentioned doing "personal research."

Further, participants were asked to indicate how useful this trauma training or professional development was using a five-point Likert scale, 1=Not useful at all, 2=A little useful, 3=Somewhat useful, 4=Very useful, 5=Extremely useful. The mean response for participants was 3.52 ($SD = 1.02$), indicating that most participant responses fell within the categories of "Somewhat useful" to "Very useful." Moreover, 89% of the participants ($n = 25$) responded that they would like additional trauma training or professional development opportunities. When asking participants if they are actively looking for additional trauma training or professional development opportunities, 62% of participants ($n = 11$) indicated "Yes." If participants indicated "Yes," they were asked to provide why this may be the case by selecting one of the following answers: (a) previous training prompted me to want to learn more, (b) experiences with students/families, (c) spoke to a colleague, and (d) this is a popular topic. Experiences with students/families was a common response for seeking additional training, as reported by 60% ($n = 18$) of participants. Finally, 97% of participants ($n = 28$) indicated that they believe that all teachers should be required to receive some trauma training or professional development. Participants were allowed to provide an open response answer as to why they believed this. Content analysis of these responses revealed commonalities among participants.

- **Building better student-teacher relationships:** Responses included, “*Understanding how to work with a student with trauma can help build the student/teacher relationships & may aid in improved academics/learning*” and “*Teachers need to be aware of how external factors impact their students in order to gain empathy and understanding.*”
- **Meeting student needs in the classroom:** Responses included, “*Students are so much more than academic learners. Trauma is the number one factor that impacts a student's ability to learn. We as educators have the responsibility to teach emotional regulation and to meet the needs of our students*” and “*Knowing a student's trauma can help you know what they need from the teacher in the classroom.*”
- **Making learning more responsive, accessible & equitable:** Responses included, “*Trauma informed practices help make learning accessible by ensuring students are provided with the tools, resources, and guidance needed to cope and manage their experiences*” and “*Students come from a diverse background with their own stories, therefore a one-size fits all approach would not be the most equitable.*”

Research Question 1: What is the relationship between the level of exposure to trauma training/PD and the extent to which teachers can identify trauma?

The researcher hypothesized that teachers who report higher levels of exposure to trauma training and professional development would also report having higher levels of knowledge and awareness about the trauma experiences of their students and how these experiences impact their students' daily lives. The mean *Total Awareness* score for all participants was 3.87 ($SD = 0.51$). Given that the survey items on this scale were on a five-point Likert scale, 1=strongly disagree,

2=disagree, 3=neutral, 4=agree, 5=strongly agree, a score closer to 5 indicates a higher level of awareness. Participants had *Total Awareness* scores ranging from 2.40 to 5.00. It appears that a little over 50% of participants had scores equal to or higher than 4. When looking at patterns of responses, participants who reported having little exposure to trauma training or professional development did not have a notably different *Total Awareness* score ($M = 3.76, SD = 0.42$) than participants who reported having moderate exposure to trauma training or professional development ($M = 3.96, SD = 0.59$) nor from participants who reported having a lot of exposure to trauma training or professional development ($M = 3.80, SD = 0.40$). It appears that there was little variability in the *Total Awareness* scores. In general, while a correlational relationship could not be calculated to statistically examine the association between level of exposure (little, moderate, a lot) and the total awareness score, the pattern of descriptive responses found in Figure 2 show that the participants perceive that they are able to recognize trauma and how it impacts their students in the school setting to a great extent. There did not appear to be a pattern based on participants' reported trauma professional development/training exposure levels. Figure 2 demonstrates *Total Awareness* scores for the sample of this study.

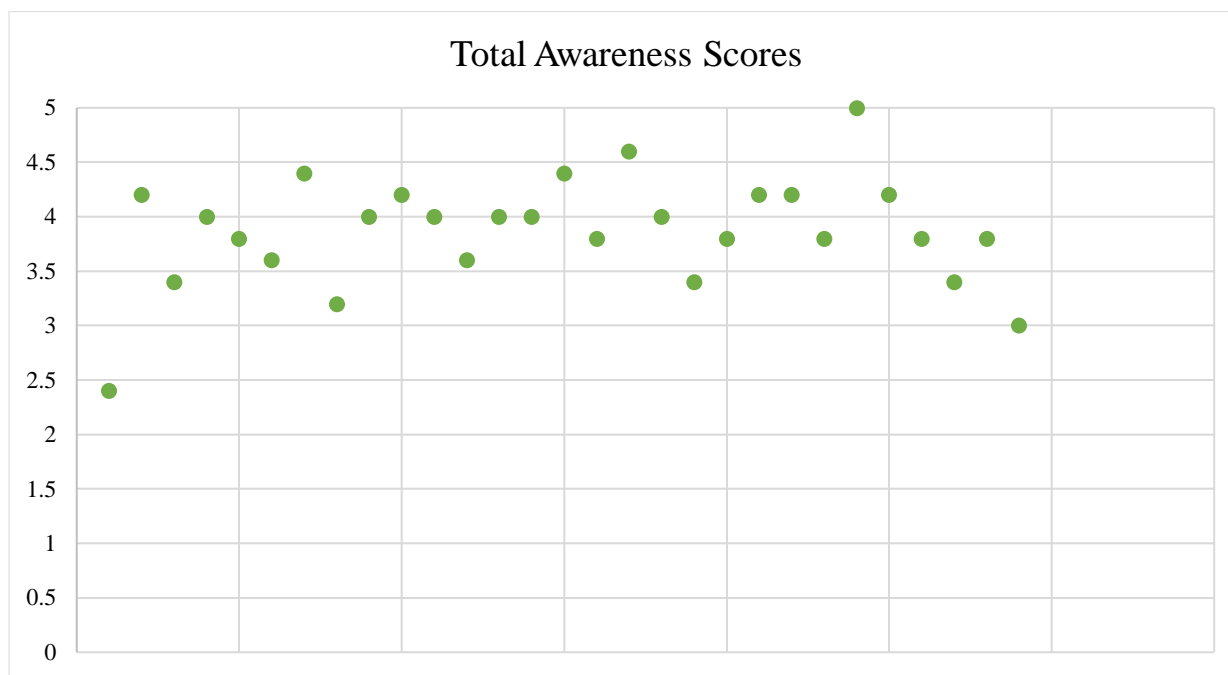


Figure 2. Total Awareness Scores for Participants

The two remaining items not included in the *Total Awareness* score were about the participants' reported percentage of their current students that have been exposed to trauma and if so, the types of traumas their current students have been exposed to, experienced, or witnessed, allowing the researcher to understand more specific knowledge that participants may hold about the traumatic experiences of their students. In response to the percentage of current students the participants perceive have been exposed to trauma, there was a wide range of responses from 0 to 100%. When asking participants what types of traumas they think their students have been exposed to, experienced, and/or witnessed, the following types of traumas were identified with the highest frequency: Poverty ($n = 22$), race-based trauma ($n = 20$), and emotional abuse ($n = 20$).

Research Question 2: What is the relationship between the level of exposure to trauma training/PD and the likelihood that teachers will report implementing trauma-informed strategies in the classroom?

The researcher hypothesized that teachers who report higher levels of exposure to trauma training/PD would report implementing trauma-informed strategies in the classroom with a higher likelihood. The mean *Total Strategies* score for all participants was 3.92 ($SD = 0.62$). These survey items were once again on a 5-point Likert scale, 1=never, 2=sometimes/less than half the time, 3=often/about half the time, 4=most of the time/more than half the time, 5=always. A total score closer to 5 indicates a higher likelihood of utilizing trauma-informed strategies. Participants had *Total Strategies* scores ranging from 2.68 to 5.00. It appears that about 65% of participants had scores equal to or higher than 4. In reviewing these patterns of responses, participants who reported having little exposure to trauma training or professional development did not have a markedly different *Total Strategies* score ($M = 3.84$, $SD = 0.62$) than participants who reported having moderate exposure to trauma training or professional development ($M = 3.87$, $SD = 0.62$). However, there was a pattern showing that participants who reported having a lot of exposure to trauma training or professional development did have a higher *Total Strategies* score ($M = 4.54$, $SD = 0.42$). It appears that there was little variability in the *Total Strategies* scores given that the overall sample mean for using strategies was close to “most of the time/more than half the time.” Again, while it was not possible to calculate a correlational relationship to analyze the association between level of exposure (little, moderate, a lot) and the total strategies score; the pattern of responses demonstrate that the participants perceive that they are consistently implementing some of the trauma-informed strategies presented in the survey

such as: using frequent breaks, using wait time after giving a direction, having sensory outlets available in the classroom, using repetition, using structured & interactive games in the classroom setting, providing students access to a safety zone/safe space, adjusting lessons in ways to accommodate, and physically rearranging the classroom. There did not appear to be a pattern based on participants' reported trauma professional development/training exposure levels. Figure 3 demonstrates *Total Strategies* scores for the sample of this study.

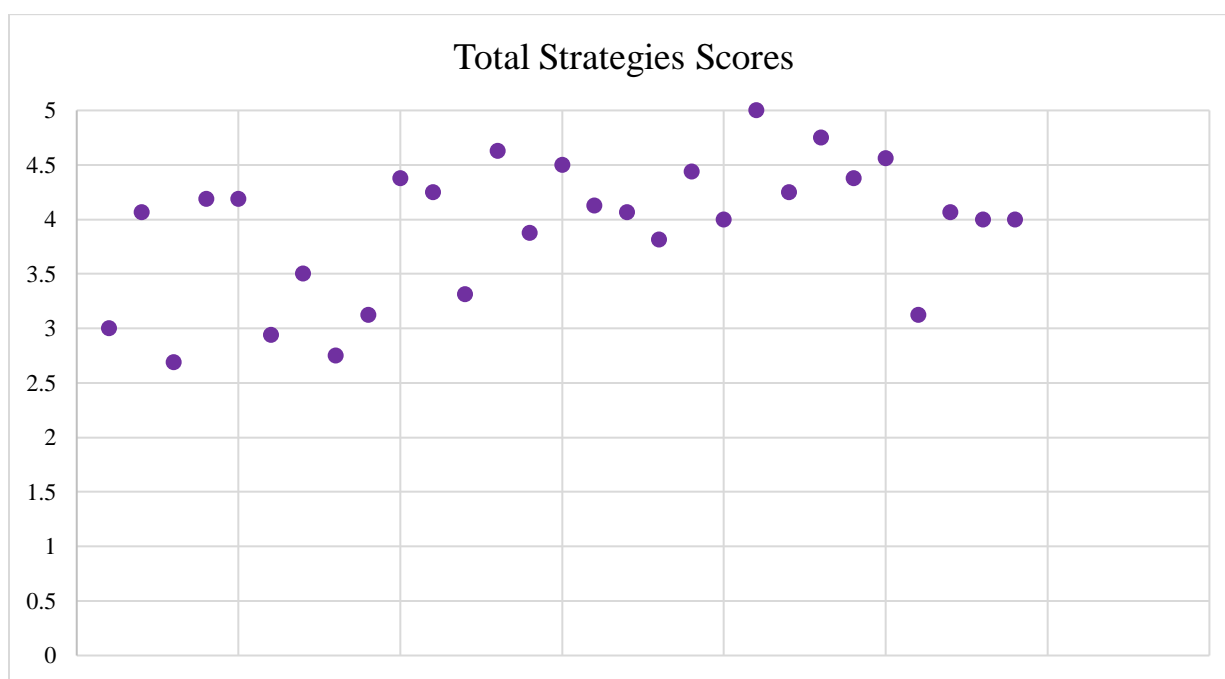


Figure 3. Total Strategies Scores for Participants

While *Total Strategies* scores were created for each participant, and the mean and standard deviation of the entire sample was determined, it was also important to determine separate scores for the two different sets of items based on *externalizing* and *internalizing* behaviors. This allowed the researcher to explore possible differences in the implementation of strategies with students who display *externalizing* vs. *internalizing* behaviors. The mean *Total Externalizing Strategies* score for all participants was 3.84 ($SD = 0.65$). Participants had *Total*

Externalizing Strategies scores ranging from 2.50 to 5.00. In contrast, the mean *Total Internalizing Strategies* score for all participants was 4.00 ($SD = 0.68$). Participants had *Total Internalizing Strategies* scores ranging from 2.63 to 5.00. There appeared to be no remarkable differences in these scores. These results suggest that participants report using trauma-informed strategies with equal likelihood with students who display externalizing and internalizing behaviors. Figure 4 provides a visualization in the patterns of scores showing the total number of strategies implemented with students who display externalizing behaviors versus internalizing behaviors.

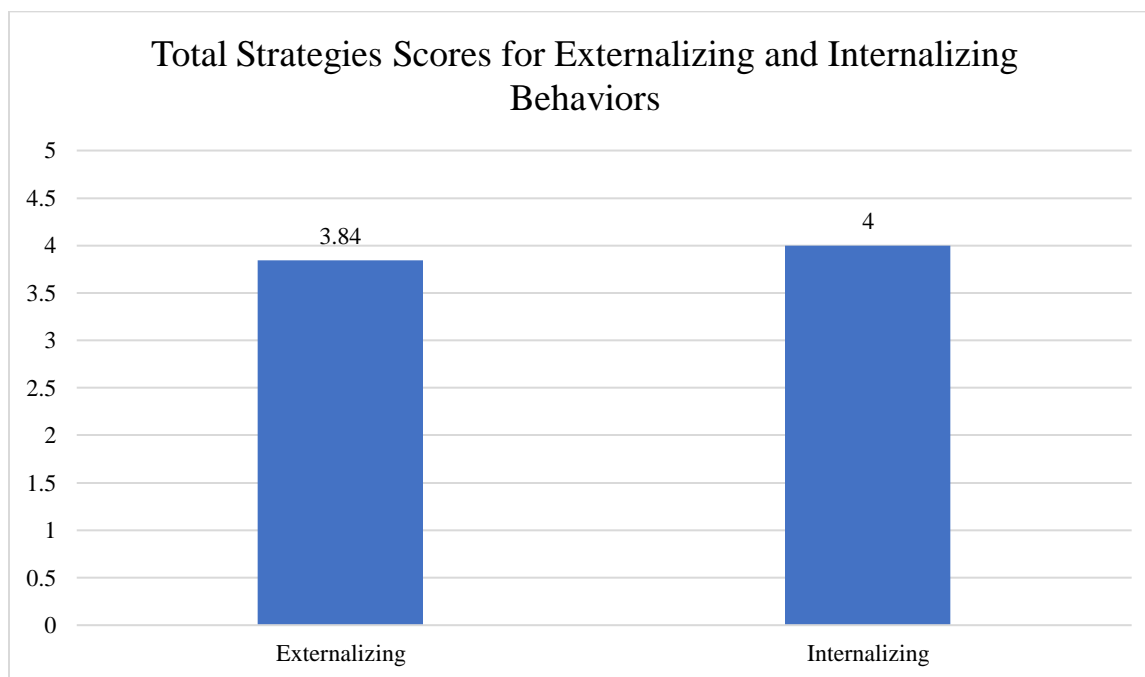


Figure 4. Total Strategies Scores for Externalizing and Internalizing Behaviors

Research Question 3: What is the relationship between the level of exposure to trauma training/PD and whether teachers observe changes in student behavior due to the classroom strategies they report implementing?

The researcher hypothesized that teachers who report higher levels of exposure to trauma training/PD would also report perceived improvements in student behavior due to utilizing trauma-informed strategies. One item regarding whether behavioral changes have been observed in students was presented to participants. A simple “yes” or “no” response was required. If participants responded “Yes,” they were asked to provide a specific example of this behavioral change(s). About 86% of participants (n = 25) reported seeing behavioral changes. One important thing to note when measuring behavioral changes in this study is that when participants responded “yes” to observing behavioral changes, some participants often could not state what changes they had explicitly observed. Figure 5 provides a visualization of these results.

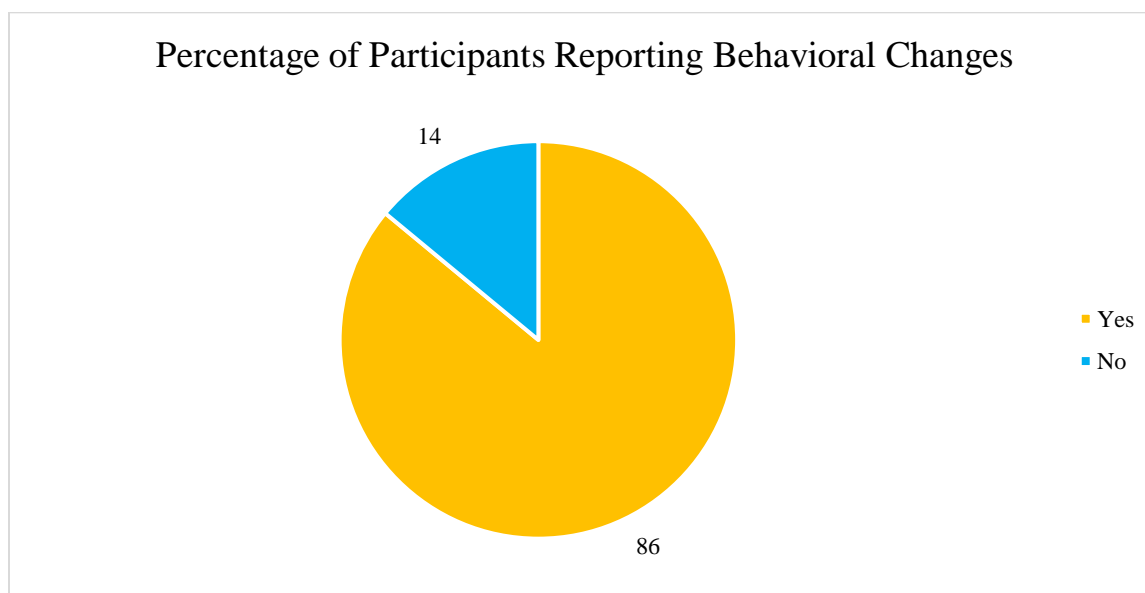


Figure 5. Behavioral Changes Reported Graph Results

For those that reported behavioral changes, some examples of these changes included: students being more responsive, more likely to take ownership (complete classwork, participate in class discussion, help others, fewer interruptions during mini-lessons or 1:1 conferences), attend class more regularly, and engage better in work/activities. Based on visual examination of the calculated means, participants who reported having little exposure to trauma training or professional development did not observe considerably different behavioral changes ($M = 1.18$, $SD = 0.40$) relative to participants who reported having moderate exposure to trauma training or professional development ($M = 1.13$, $SD = 0.35$) nor from participants who reported having a lot of exposure to trauma training or professional development ($M = 1.00$, $SD = 0.00$). Again, while it was not possible to calculate a correlational relationship to statistically examine whether there was an association between level of exposure (little, moderate, a lot) and reported perceived improvements in student behavior due to utilizing trauma-informed strategies; the responses demonstrate that this sample perceives improvements in student behavior as a result of the trauma-informed strategies they implement. There did not appear to be a pattern based on participants' reported trauma professional development/training exposure levels.

Table 2. Total Awareness, Strategies, and Behavioral Changes Score Results

Variable	<i>M</i>	<i>SD</i>
Total Awareness Score	3.87	0.51
Total Strategies Score	3.92	0.62
Behavioral Changes	1.18	0.40

Summary of Results

Overall, correlational relationships could not be calculated between the level of exposure to trauma training/PD and the extent to which teachers can identify trauma, the likelihood that teachers will report implementing trauma-informed strategies in the classroom, and report perceived improvements in student behavior, due to the sample size of this study. However, descriptive results demonstrate various levels of exposure to trauma training and professional development in Illinois. The sample of this study also seems to be invested in this study, as shown by the lack of variability in scores. Because of this, in general, participants reported that they perceived that they could identify trauma to a great extent, implement trauma-informed strategies, and reported improvements in student behavior due to the trauma-informed strategies they implemented. Future directions and implications of the findings are presented next in the discussion.

CHAPTER FIVE

DISCUSSION

The purpose of this study was to obtain a better understanding of the varying levels of exposure to trauma professional development/training within Illinois school settings and the reported impact of this professional development and training, specifically (a) what is the relationship between the level of exposure to trauma training/PD and the extent to which teachers can identify trauma; (b) what is the relationship between the level of exposure to trauma training/PD and the likelihood that teachers will report implementing trauma-informed strategies in the classroom; and (c) what is the relationship between the level of exposure to trauma training/PD and whether teachers observe changes in student behavior due to the classroom strategies they report implementing?

While it was not possible to calculate correlational relationships due to the small sample size, the descriptive results demonstrate various levels of exposure to trauma training and professional development as reported by Illinois teachers in this sample. In addition, teachers reported that they perceived that they could identify trauma to a great extent, implement trauma-informed strategies, and reported improvements in student behavior due to the trauma-informed strategies they implemented. However, this was not related to higher levels of exposure to trauma training/professional development. Only 10% ($n = 3$) of participants reported having a lot of exposure, while most participants reported having only moderate exposure. The researcher noted some inconsistencies in how participants reported their perceived levels of exposure (little,

moderate, a lot) and the actual number of trauma training or professional development courses/sessions completed. For example, a participant might have indicated that they had a moderate level of exposure but indicated that the number of training sessions they had participated in was two. The researcher might argue that a moderate level of exposure is at least three sessions. However, that is currently difficult to estimate since the literature has not previously explored and defined what a little, moderate, or high level of exposure trauma training/PD is. Loomis & Felt (2020) note that there is not a standardized way to measure the receipt of trauma-informed training/PD, including the dosage and content. This is an issue within the trauma training and professional development literature which should be explored in future research.

Moreover, the rest of the descriptive findings of this study have been explored to some degree in previous research and are somewhat more consistent with what has been examined to date. At least one instance of trauma professional development or training can increase knowledge and awareness of trauma and trauma-informed approaches (McIntyre et al., 2019; Law, 2019). However, outcomes such as the likelihood of implementing trauma-informed strategies have not been as heavily studied in the literature. The researcher identified only one study, a dissertation conducted by Law, which explored teachers' likelihood of implementing trauma-informed strategies after they participated in trauma training/PD. Law found that teachers who had participated in trauma professional development training reported improved intent to put trauma-informed practices into place. Another study that has examined the utilization of trauma-informed care practices as a result of trauma professional development or training is one by Connors-Burrow et al. (2013). This study, however, focused on child welfare frontline staff

and not teachers in schools. They found that their staff reported an increase in the use of trauma-informed care practices in their work after completing this training. Finally, reported improvements in student behavior due to implemented trauma-informed strategies have not been documented in the research. Initial evaluations of trauma-informed schools suggest increased staff understanding, student engagement, achievement, and significant reductions in office referrals and suspensions (as cited in Koslouski & Stark, 2021). However, a specific evaluation of the improvements in student behavior due to the implementation of trauma-informed strategies has not been documented. There is a need for continued research in several areas of trauma-informed work in school settings, including the ones described here.

Implications

Teacher Preparation Programs

This study examined varying levels of exposure to trauma training or professional development. One of the requirements to be a part of this study was to have some level of exposure (little, moderate, a lot) to trauma training or professional development. The sample size of this study was 29 participants. While there are various reasons why teachers may not have wanted to participate, one hypothesis is that there is a relatively large group of teachers who have not received any trauma training or professional development. The researcher had interested teachers reach out and express that they wished they had trauma training or professional development because they think it is important in school settings. While anecdotal, there seems to be an existing sentiment among educators that this is important training to have, as supported by the study findings as well. However, there seems to be a disconnect between the type of

training/PD teachers feel is important to have more knowledge about and what is actually being provided or incorporated in their roles.

As was reviewed in Chapter Two, a study by Brown et al. (2020) revealed that teacher candidates wished for this training during their preparation programs, given that it could prepare them to better support students who have experienced trauma. In addition, this training could help mitigate and address the stress and burnout that they may feel in working with students who have had these experiences. A report by the Education Commission of the States (2020) around state requirements on trauma training for K-3 teachers demonstrates that Indiana is one example of a state that currently requires teacher prep programs to *consider* using curricula that include training on recognizing signs of trauma, understanding the impacts of trauma, and recommendations for creating a trauma-informed classroom. Further, Ohio currently requires teacher preparation programs to include a course on the impact of trauma, toxic stress, and other environmental variables on learning behavior, among other topics, for all students pursuing a license to teach in pre-K through fifth grade. Finally, Oklahoma also requires that teacher candidates in preservice programs study, in existing coursework, trauma-informed responsive instruction. No other states seem to require the inclusion of trauma education into teacher prep programs.

When discussing trauma training or professional development being incorporated into teacher prep programs, it is also important to consider what content it should incorporate. Given what was mentioned previously in a study by Brown et al. (2020), one important topic it should include is compassion fatigue, or secondary trauma. Secondary trauma is something that can affect educators who learn about and support the trauma that their students have (Lawson et. al,

2019). Furthermore, through this study, participants indicated that they believed that poverty, race-based trauma, and emotional abuse were the most frequent types of traumas their students have been exposed to, experienced, and/or witnessed. Given that these types of traumas are commonly being seen by teachers, they should be emphasized in trauma training/PD for incoming teachers. Felitti et. al., (1998) continues to be a heavily cited research study and incorporated as part of trauma training/PD, as observed by the researcher. However, as stated in Chapter Two, the study does not seem to be as relevant anymore. The first reason is because sample of this study was very homogeneous and comprised White, middle class, and persons of older ages. In addition, this study only considers conventional ACEs such as physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, substance abuse, and parental mental illness. It is important to view the trauma that current students are experiencing through a new lens and research-base, especially as it may better reflect the student population we serve which is much more diverse in terms of demographics, but also in terms of experiences (National Center for Education Statistics, 2022; United States Census Bureau, 2018).

Policy and Law

Policy continues to play an important role in implementing trauma-informed school practices, particularly trauma training and professional development for educators. In February 2021, a bill was introduced in Illinois (IL SB 2109). It requires each member of a school board and the district superintendent to complete a course of instruction approved by the State Board of Education regarding the adoption and administration of a trauma-informed school standard on an annual basis. The course of instruction needs to include information on (a) the recognition of and care for trauma in students and educators, (b) the relationship between educator wellness and

student learning, (c) the effect of trauma on student behavior and learning, (d) the prevalence of trauma among students, including the prevalence of trauma among student populations at higher risk of experiencing trauma, and (e) the effects of implicit or explicit bias on recognizing trauma among various racial or ethnic groups of students. This bill was approved, and its effective date is January 1st, 2023. With this approval and a course of instruction being required for members of a school board, future research could also examine data regarding the impact of this training, specifically around trauma-informed school standards.

The passage of this Illinois legislation is an example of how changes in state laws and policy can influence the requirements around trauma-informed practices in schools. While this is just an example of a requirement placed on school boards, this could potentially be a requirement for all teachers in Illinois. Currently, other states have existing requirements for teachers (Education Commission of the States, 2020). There is an existing need to continue to advocate for trauma education, training, or professional development for educators, especially as students continue to encounter different types of traumas, as the ones indicated in this study by participants. Additional types of trauma not included in this study are important as well, including but not limited to the trauma experienced in the aftermath of the recent COVID-19 pandemic and mass school shootings.

Resources and Funding for Trauma-Informed Work

One important thing noted by the researcher when conducting this study is how resources and the allocation of funds could impact the implementation of trauma-informed strategies. Trauma-informed strategies that have been identified in the literature include having sensory outlets available in the classroom, giving students access to a safe space or zone, and considering

seating arrangements (Crosby et al., 2016; Honsinger & Brown, 2019). The survey utilized in this study, assessed the implementation of some of these strategies. The researcher acknowledges that some teachers may have reported implementing some of these trauma-informed strategies with less likelihood due to financial limitations, particularly when working in schools with limited resources.

Funds may also be necessary for continued education on trauma for school professionals. Outside consultants or speakers could be hired to deliver professional development or training on trauma-informed topics. In addition, individuals who can provide coaching and support the implementation of trauma-informed strategies could also be hired, however, schools could have financial limitations in place that would not allow this to happen. In general, when we discuss issues of resources, we may also find differences across a variety of school settings (e.g., urban vs. suburban schools). Much more is known about funds for public schools, but it would also be interesting to explore in future research what funding for trauma training/PD looks like in private schools, and the capacity for these schools to be able to implement trauma-informed strategies. Advocating for funds is important because it makes trauma-informed work in school settings more accessible for teachers and the students they serve.

Supporting Teachers in Trauma-Informed Work

Chapter Two of this dissertation study explored teacher perspectives on providing support related to trauma based on the existing research to date. Overall, some barriers identified by teachers in supporting students who have experienced trauma included balancing the different demands and needs present in their classrooms and experiencing compassion fatigue, also known as secondary trauma (Alisic 2012; Luthar & Mendes, 2020). These are all real and valid barriers

that should be acknowledged. The COVID-19 pandemic, however, exacerbated some of the barriers that already existed. Demands for teachers increased even more during this time. Teachers had to adapt quickly to school closures and changes in the work environment, requiring them to shift to online learning. In addition, teachers were tasked with contacting students and families, documenting their work, attending meetings, training students and caregivers to engage with online learning, and more (Baker et al., 2021). The increased job demands and stressors have impacted teachers' mental health and well-being and produced increased feelings of stress, anxiety, and burnout (Baker et al., 2021; Kim et al., 2022). Besides job demands, teachers have also had to navigate their own personal lives during these unprecedented times. Some examples of things they have had to navigate include health struggles, caring/providing for others, losing loved ones, and financial hardships. These can also be examples of potentially traumatic experiences that our students have also been through. Validating the traumatic experiences of teachers is equally as important as validating those of our students. The needs of students cannot be met if educators do not take care of their own needs first. However, they cannot take care of their own needs without appropriate support. As Venet (2021) mentions, "teacher wellness is not the sole responsibility of individual teachers, and to suggest as such blames teachers for the systemic conditions in schools that cause their stress" (p. 128).

Trauma-informed work in schools should not just focus on students but also on the adults supporting the students. As previously mentioned, teachers' working conditions and environments have created increased stress, anxiety, and burnout. What are ways to support teachers and fix this issue? Commonly, teachers are provided training on self-care and burnout and, essentially, told to "self-care" their way out of some of these real, more significant issues.

When you ask teachers how they may have been supported or been shown appreciation for in the past, they might say they were offered donuts for staff appreciation week or given a thank you card at the end of the school year. While these things are very much appreciated and make teachers feel cared for, they often make no difference in the long-term wellness of teachers (Venet, 2021). Want to really make a difference and impact the wellness of teachers? Focus on *time, money, support, and autonomy*. Time refers to something like canceling nonessential meetings to provide teachers with time that they could use however they prefer (e.g., classroom prep time). Further, money refers to giving teachers the compensation and benefits they deserve. Wellness can be compromised if teachers are not provided a livable wage or have adequate health care. Next, support means being able to aid teachers in whatever ways they need it, inside and outside the classroom. An example of support includes completing one-on-one check-ins with teachers if they could benefit from them. Finally, autonomy refers to trusting teachers and allowing them the freedom to exercise their professional judgement (Venet, 2021).

As stated previously, many of the things described in this section are barriers for teachers to engage in trauma-informed work and implement trauma-informed strategies. Future research can also explore these barriers more in-depth and target several areas to address these barriers.

The Role of the School Psychologist

School psychologists can be an additional source of support for teachers. School psychologists are broadly trained in various areas, including assessment, intervention, consultation, data-based decision making, crisis response, and evidence-based practices (as cited in Ormiston et al., 2020). This allows them to be critical collaborators in efforts surrounding trauma-informed practices in schools. They can consult and coach teachers and other school

professionals to coordinate care and supports for a student who may be experiencing trauma (Ridgard et al., 2015). School psychologists can also educate school personnel and families about trauma and provide teacher in-service training on trauma-informed classroom management practices (Ormiston et al., 2020).

At a more individual level, they can also become involved in identifying trauma in students through the implementation of trauma screening. They can also implement trauma-informed interventions, such as Bounce Back, CBITS & TF-CBT (Ormiston et al., 2020). A frequently identified barrier in the roles of teachers and school psychologists alike is the lack of support from other school personnel, including one another (Koslouski & Stark; 2021; Ormiston et al., 2020). While teachers play an essential role in responding to and supporting student trauma, we must not place unrealistic demands on teachers and have them carry the weight of this work when they already have so much to be responsible for. Collaborative efforts around trauma-informed work in schools are needed, and not just one person should be asked to take on this work.

Being Trauma-Informed Means Addressing and Treating Trauma at the Systems Level

Trauma is often viewed as an individual issue, not a structural, systemic issue. Viewing trauma through a structural, systemic lens means that we stop seeing trauma as a problem affecting only certain children, and we acknowledge that trauma can originate from inside and outside of the school (Venet, 2021). It is not uncommon in school settings to hear the statement “students bring trauma to schools” and disregard trauma that can occur in schools. It is often easy to resort immediately to blaming the home or community. Khasnabis and Goldin (2020) state, “Treating trauma only as an individual-level problem, when it is not, has the unfortunate

and perhaps somewhat predictable effect of blaming children and families for challenges they did not cause” (p. 46). Schools must reflect on the ways in which they perpetuate trauma and, in some cases, retraumatize students. There are many ways that students can experience harm in schools, including bullying and harassment, police presence and violence, and curriculum violence (Venet, 2021). We should be especially mindful when considering students from minoritized backgrounds and their experiences of trauma, as we can be complicit in the day-to-day experiences that perpetuate race-based or racial trauma. While it is generally believed and understood that the purpose of schools and the intention of school staff would never be to harm a student, there are current practices that likely are harming our students. It is important to be reflective. Moving forward, efforts around trauma professional development and training for educators should require a discussion on the systems that perpetuate and uphold trauma.

Limitations and Future Directions

There were a variety of limitations to this research study. First and foremost, one major limitation of this study was the sample size. The researcher shared the recruitment flyer and announcement across various social media sites and passed it on to potential participants via snowball sampling. Participants of this study were encouraged to invite other participants, including family members, friends, and co-workers who could potentially meet the criteria. While this was the case, recruitment efforts for this study were exhausted. Recruitment patterns may be indicative of the current climate of K-12 education and educational research. Due to the COVID-19 pandemic, restrictions have made it difficult for researchers to enter educational systems and collect data. In addition, educators are experiencing increased feelings of stress and burnout due to increased demands and expectations (Kim et al., 2022; Souto-Manning & Melvin,

2022), thus potentially affecting their willingness to participate in this study. Therefore, future research on this topic conducted with educators should address and help minimize barriers to participating in a research study like this one.

Furthermore, another limitation of this study is that the link to this survey was a public link on the announcement/flyer, was available to anyone, and not via invitation only. Due to this, the survey received a significant amount of bot responses. Bot responses were identified utilizing the *bot detection* function on the Qualtrics platform. Other functions such as the *prevent multiple submission*, *security scan monitor*, and *prevent indexing* functions were also enabled for this survey. A captcha verification question was also included at the beginning of the survey. Despite these functions being implemented, approximately 75 bot responses were deleted throughout the data collection process. Responses that were not identified via these functions were analyzed by looking at the pattern of responses. Given the state of our current society, in which the internet and technology are very advanced, protecting any data collection tools like surveys is incredibly important. This is because bot responses can damage the integrity of the data.

Next, another limitation of this study is that this sample of participants might represent a sample invested in trauma-informed work. When looking at the data, there was no extreme variation in scores. Most participants indicated that they found the trauma training or professional development useful. They believed all teachers should be required to receive some trauma training or professional development. While this is a very positive thing, it would be interesting to see a sample of participants that is very diverse in their experiences and likely their interest with trauma-informed work. It would also be interesting to capture participant responses that report why they do not believe the trauma training or professional development they

received was helpful and why they do not think teachers should be required to receive trauma training or professional development. This could also help guide researchers in a different direction with trauma-informed work. Perhaps, exploration is needed on what factors play into a lack of buy-in from educators regarding this topic.

Moreover, another limitation is that because of the COVID-19 pandemic, it was not possible to incorporate a qualitative component into this study. Qualitative data would have allowed the researcher to learn how educators apply trauma professional development and training in their classrooms. While this is a limitation of the current study, it is an opportunity for future research. Future research could also incorporate partnerships with a few different schools and school districts (e.g., Chicago Public Schools) to collect longitudinal data. It would be beneficial and intriguing to collect data when a school community first receives trauma professional development and training. Then data would be periodically collected on outcomes and the impact of the training over time.

Given the patterns and trends observed in these descriptive findings, if future work addressed the limitations described, there is potential to find a correlational relationship between levels of exposure to trauma training and professional development, teacher awareness levels, strategies implemented, and behavioral changes because of the strategies implemented.

Conclusion

The descriptive findings of this study provide information on the varying levels of exposure to trauma professional development and training within school settings. In addition, information is provided on potential outcomes of trauma professional development and training. Regardless of the level of exposure to trauma training/PD (little, moderate, a lot), participants

reported that they could identify trauma to a great extent, implement trauma-informed strategies, and reported improvements in student behavior due to the trauma-informed strategies they implemented. These findings suggest that trauma-informed approaches in schools are beneficial and can lead to positive outcomes. Further research is needed in this area of trauma-informed work in schools. As mentioned previously, only two studies have examined outcomes such as the likelihood of implementing trauma-informed strategies because of trauma-informed training or professional development received. Furthermore, there is no research surrounding reported improvements in student behavior due to trauma-informed strategies implemented.

While there were many limitations of this research study, the process of conducting this study and the descriptive findings allowed the researcher to reflect on how to continue in this work. From the implications section of this chapter, it is evident that many aspects of this work require attention and consideration. For the researcher, it has become a personal and professional mission to educate others on trauma-informed work in the school settings that is equity-based and acknowledges systemic issues. It is crucial to move forward from surface-level trauma-informed strategies and practices in schools. While they are excellent first steps and come from a good intention, they often do not result in real observable changes within the school setting for students and teachers alike.

APPENDIX A
STUDY FLYER



ARE YOU A CURRENT TEACHER IN ILLINOIS?

HAVE YOU PREVIOUSLY RECEIVED TRAUMA PROFESSIONAL DEVELOPMENT?

If you answered 'YES' you are invited to complete a survey about your experience with this PD and how it has impacted your understanding of students who have experienced trauma and your practice.

***This survey will take no more than 30 mins.**

***Participants will have the opportunity to enter a raffle for a gift card.**



Interested in participating?

Scan the QR code on this flyer or visit:

https://luc.col.qualtrics.com/jfe/form/SV_0fcGVIPZfUYvXJY

**Questions? Please email
Mayra Gaona at mgaona@luc.edu**



APPENDIX B
ONLINE RECRUITMENT SCRIPT

Online/Internet Announcement

Facebook:

Are you a current teacher in the state of Illinois? Have you previously received trauma professional development and training?

If so, you are invited to complete a survey about your experience with this PD and how it has impacted your understanding of students who have experienced trauma and your practice. The purpose of this dissertation study is to obtain a better understanding of the varied levels of exposure to trauma professional development and training within school settings in the state of Illinois and the reported impact of this professional development and training. The survey will take no more than 30 minutes to complete. Participants in this study, upon completion of the survey, will have the opportunity to enter a drawing for a chance to win one of five gift cards. If interested in participating, please visit the link below or scan the QR code on the flyer.

Please feel free to share this flyer and announcement with anybody you may know who might be interested in participating and meets the criteria to participate. Thank you! Feel free to direct message or email if you have any questions.

[LINK TO TEACHER SURVEY](#)

Twitter:

Please RT/SHARE: RECRUITING TEACHERS IN THE STATE OF ILLINOIS WHO HAVE PREVIOUSLY RECEIVED TRAUMA PROFESSIONAL DEVELOPMENT

Check out the flyer below. If interested in participating, please visit the link or scan the QR code on the flyer. Thank you!

Instagram:

Excited to finally be recruiting participants for my dissertation study! The purpose of this study is to obtain a better understanding of the varied levels of exposure to trauma professional development and training within school settings in the state of Illinois and the reported impact of this professional development and training. Please support me by completing this survey if you are interested in participating and meet the criteria to participate and/or by sharing with others. Thank you!

FOR PARTICIPANTS: Are you a current teacher in the state of Illinois? Have you previously received trauma professional development and training?

If so, you are invited to complete a survey about your experience with this PD and how it has impacted your understanding of students who have experienced trauma and your practice. The survey will take no more than 30 minutes to complete. Participants in this study, upon completion of the survey, will have the opportunity to enter a drawing for a chance to win one of five gift cards. If interested in participating, please visit the link or scan the QR code on the flyer. Feel free to direct message or email if you have any questions.

APPENDIX C
INFORMED CONSENT FORM

CONSENT TO PARTICIPATE IN RESEARCH

Project Title: *Understanding Teacher Reported Experiences of Trauma Professional Development/Training*

Researcher(s): Mayra Gaona, M.Ed.

Faculty Sponsor: Dr. Pamela Fenning, Ph.D.

Introduction:

You are being asked to take part in a research study being conducted by Mayra Gaona for a dissertation project under the supervision of Dr. Pamela Fenning in the School Psychology Department at Loyola University Chicago.

You are being asked to participate because you are a teacher in the state of Illinois and have received trauma professional development and training.

Please read this form carefully and ask any questions you may have before deciding whether to participate in this study.

Purpose:

The purpose of this study is to obtain a better understanding of the varied levels of exposure to trauma professional development and training within school settings in the state of Illinois and the reported impact of this professional development and training. We hope to understand if and how receiving this professional development and training has impacted your understanding of students who have experienced trauma and your practice.

Procedures:

If you agree to be in this study, you will be asked to:

- Complete a survey consisting of 42 questions:
 - These questions will ask about your demographics, including your gender, age, race/ethnicity, highest degree of education completed, number of years teaching, current job title, grade level being taught, and location of employment.
 - In addition, questions will be asked about the trauma training and professional development you received and your perceptions on it.
 - Finally questions regarding the identification of trauma, the implementation of strategies, and student behavior will be asked.
 - The survey will take no more than 30 minutes.
- Provide your contact information for a chance to win a gift card for your participation.

Risks/Benefits:

There are no foreseeable risks involved in participating in this research beyond those experienced in everyday life. Further, there are no direct benefits to you from participation, but the information provided will be utilized to understand teacher reported experiences after receiving trauma professional development and training. Understanding these experiences could provide our larger society and school settings, most importantly, potential evidence for the benefits of implementing trauma professional development and training in school settings.

Compensation:

Individuals who participate in this study, upon completion of the survey, will have the opportunity to enter a drawing for a chance to win one of five Amazon gift cards valued at \$25 each. The drawing and distribution of gift cards will take place within two weeks after the survey closes. Participants who withdraw at any point throughout the study, **will not** be prompted to enter their contact information to be entered into a drawing for a chance to win a gift card. A representative from the university who will distribute the e-gift cards will have access to your contact information, in addition to the researcher and faculty sponsor. If you do not wish to have your contact information shared for this purpose you can opt out of receiving the gift card. The winners will be drawn at random. Those who have won a gift card, will be notified via email within two weeks of the survey closing.

Confidentiality:

Confidentiality will be maintained to the degree permitted by the technology used. Your participation in this online survey involves risks similar to a person's everyday use of the Internet. However, the researcher will gather all information in a confidential and appropriate manner with minimal risk to participants. The following steps will be taken to ensure confidentiality:

- Each participant will be assigned a participant number, and information will be exported using these participant numbers only
- All survey results will be stored on a password protected computer only accessible by the researcher and sponsor. These results will be stored for up to one year from the completion of the study.

Further, contact information will *only* be collected if participants choose to be part of the drawing of a gift card. This contact information will be collected separately from survey responses and also stored on a password protected computer only. A representative from the university who will distribute the e-gift cards will have access to your contact information, in addition to the researcher and faculty sponsor. If you do not wish to have your contact information shared for this purpose you can opt out of receiving the gift card. This information will be stored up until gift card winners are selected.

Voluntary Participation:

Participation in this study is voluntary. If you do not want to be in this study, you do not have to participate. Even if you decide to participate, you are free not to answer any question or to withdraw from participation at any time without penalty. However, it is important to note that if a participant chooses to withdraw, it will not be possible to withdraw any completed responses from the data set given that there the researcher would be unable to identify the responses from those of other participants.

Contacts and Questions:

If you have questions about this research study, please feel free to contact Mayra Gaona at mgaona@luc.edu or faculty sponsor, Dr. Pamela Fenning at pfennin@luc.edu. If you have questions about your rights as a research participant, you may contact the Loyola

University Office of Research Services at (773) 508-2689.

Statement of Consent:

By clicking “Yes” below and advancing to the survey you are indicating that you have read the information provided above, have had an opportunity to ask questions, and agree to participate in this research study.

APPENDIX D
SURVEY INSTRUMENT

Survey*Demographic Questions*

Gender:

- Male
- Female
- Non-binary
- Prefer not to say
- Prefer to self-describe below:

Age:

Race/Ethnicity:

- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Pacific Islander
- Hispanic/Latino

Highest degree of education completed:

- Bachelor's Degree
- Master's Degree
- PhD/EdD Degree
- Other Advanced Degree

Total Number of Years Teaching:

- 0-4 years
- 5-9 years
- 10-14 years
- 15-19 years
- 20+ or more years

Current Job Title:

- General Education Classroom Teacher
- Special Education Classroom Teacher
- Specials Teacher (Art, Music, Gym)
- Other _____

Level That You Teach:

- Early Childhood School
- Elementary School
- Middle School
- High School
- Other

Location of employment:

- Rural setting
- Urban setting
- Suburban setting

Are you a teacher practicing within the state of Illinois?

- Yes
- No

SKIP LOGIC --- If no, take participants to the end of survey

Trauma Training/Professional Development Questions

Have you ever received training or professional development on childhood trauma?

- Yes
- No

SKIP LOGIC --- If no, take participants to the end of survey

How much exposure to trauma training or professional development would you consider that you have?

- Little exposure
- Moderate exposure
- A lot of exposure

How many training or professional development sessions on childhood trauma have you attended? (enter a number - e.g. 1)

List the titles/topics of training or professional development sessions on childhood trauma you have attended (please provide whenever possible)

What has this trauma training or professional development on childhood trauma looked like?

- Formal (e.g., continuing education workshops or courses)
- Informal (e.g., independent study, self-paced)
- A combination (formal & informal)
- Other:

Where did you receive this trauma training or professional development?

- In my school building or district
- Outside of my school building or district
If so, where? _____
- Both** at my school building or district & outside of my school building or district

How useful has the trauma training or professional development been?

- Not useful at all
- A little useful
- Somewhat useful
- Very useful
- Extremely useful

Would you like additional trauma training or professional development opportunities?

- Yes
- No

Are you actively looking for additional trauma training or professional development opportunities?

- Yes
- No

If yes, please indicate what is motivating you to look for additional trauma training or professional development opportunities:

- Previous training prompted me to want to learn more
- Experiences with students/families
- Spoke to a colleague
- This is a popular topic

Do you think that all teachers should be required to receive some trauma training or professional development?

- Yes
- Maybe
- No

Please provide a reason for your previous response:

Identifying Trauma Questions

PROMPT: For the following questions, please reflect on the trauma training or professional development you have received. As a result of this trauma training or professional development...

Approximately what percentage of your current students do you perceive have been exposed to trauma?

- 0-10%
- 11-20%
- 21-30%
- 31-40%
- 41-50%
- 51-60%
- 61-70%
- 71-80%
- 81-90%
- 91-100%

What types of trauma do you think your students have been exposed to, experienced, and/or witnessed?

(Check all that apply)

- Community Violence
- Domestic Violence
- Physical Abuse
- Sexual Abuse
- Emotional Abuse
- Traumatic Grief
- Natural Disaster
- Neglect
- Substance use in the home
- Parental mental illness
- Race-Based Trauma
- Parental Incarceration/Deportation
- Poverty

[TTS – Crosby et al. (2016) Questions]

I can recognize the effects of trauma on the behavior of students in my classroom.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

I consider my students' experiences with trauma as I design strategies to engage students in learning.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

I can identify traumatic responses in students.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

I realize which aspects of the school environment may trigger trauma reactions in students.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

I understand how the brain is affected by trauma.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

Implementing Strategies Questions – [TRSB – Crosby et al. (2016) Questions]

PROMPT: As a result of the trauma training or professional development you have received, how much more likely are you to use the following teaching strategies with students who display

EXTERNALIZING BEHAVIORS (e.g., fighting, talking back, getting out of seat, swearing)...

Use frequent breaks.

- Never
- Sometimes/less than half of the times
- Often/about half of the time
- Most of the time/more than half of the time
- Always

Deliberately use wait time (i.e., pauses) after giving a direction.

- Never
- Sometimes/less than half of the times
- Often/about half of the time
- Most of the time/more than half of the time
- Always

Have sensory outlets available in the classroom (i.e., stress ball, play dough, etc.).

- Never
- Sometimes/less than half of the times
- Often/about half of the time
- Most of the time/more than half of the time
- Always

Use repetition and compromises in my interactions with students.

- Never
- Sometimes/less than half of the times
- Often/about half of the time
- Most of the time/more than half of the time
- Always

Use structured, interactive, and interpersonal games in the classroom setting (i.e., music, ball toss, string game, etc.).

- Never
- Sometimes/less than half of the times
- Often/about half of the time
- Most of the time/more than half of the time
- Always

Provide students access to a safety zone/safe space when needed.

- Never
- Sometimes/less than half of the times
- Often/about half of the time
- Most of the time/more than half of the time
- Always

Adjust lessons in ways to accommodate.

- Never
- Sometimes/less than half of the times
- Often/about half of the time
- Most of the time/more than half of the time

- Always

Physically rearrange the classroom as a method to address student behaviors.

- Never
- Sometimes/less than half of the times
- Often/about half of the time
- Most of the time/more than half of the time
- Always

PROMPT: As a result of the trauma training or professional development you have received, how much more likely are you to use the following teaching strategies with students who display **INTERNALIZING BEHAVIORS** (e.g., shutting down, withdrawing, not interacting with peers)...

Use frequent breaks.

- Never
- Sometimes/less than half of the times
- Often/about half of the time
- Most of the time/more than half of the time
- Always

Deliberately use wait time (i.e., pauses) after giving a direction.

- Never
- Sometimes/less than half of the times
- Often/about half of the time
- Most of the time/more than half of the time
- Always

Have sensory outlets available in the classroom (i.e., stress ball, play dough, etc.).

- Never
- Sometimes/less than half of the times
- Often/about half of the time
- Most of the time/more than half of the time
- Always

Use repetition and compromises in my interactions with students.

- Never
- Sometimes/less than half of the times
- Often/about half of the time
- Most of the time/more than half of the time
- Always

Use structured, interactive, and interpersonal games in the classroom setting (i.e., music, ball toss, string game, etc.).

- Never
- Sometimes/less than half of the times
- Often/about half of the time
- Most of the time/more than half of the time
- Always

Provide students access to a safety zone/safe space when needed.

- Never
- Sometimes/less than half of the times
- Often/about half of the time
- Most of the time/more than half of the time

Always

Adjust lessons in ways to accommodate.

Never

Sometimes/less than half of the times

Often/about half of the time

Most of the time/more than half of the time

Always

Physically rearrange the classroom as a method to address student behaviors.

Never

Sometimes/less than half of the times

Often/about half of the time

Most of the time/more than half of the time

Always

Student Behavior Questions

Have you observed any behavioral changes (improvements or deteriorations) in your students due to any classroom strategies you have implemented due to the trauma training or professional development you have received?

Yes

No

If yes, please provide a specific example (e.g., my students participate with more/less frequency; my students attend class more/less often):

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VITA

Dr. Mayra A. Gaona was born and raised in the suburbs of Chicago, Illinois. She is the daughter of Mexican immigrants from Michoacan, Mexico. She is one of three daughters. Before attending Loyola University Chicago, she attended Dominican University, where she earned a Bachelor of Science in Psychology and a minor in Spanish Studies in 2017. Dr. Gaona continued to pursue her graduate education at Loyola University Chicago and received her Master of Education in Educational Psychology in 2018. While at Loyola, Dr. Gaona participated in Dr. Lynne Golomb and Dr. Markeda Newell's research teams, served as a teaching assistant for three graduate-level school psychology courses, and presented her work at the national level. Dr. Gaona served as the Chapter President for the Student Affiliates in School Psychology (SASP) organization at Loyola. Dr. Gaona was also a recipient of the Advanced Student Diversity Scholarship awarded by the American Psychological Association (APA) Division 16 in 2020. As a Latina, low-income student, her identity has guided her throughout her graduate journey. Currently, Dr. Gaona is completing her doctoral internship in School Psychology at Community Consolidated School District 15 in Palatine, IL. Upon graduation, she hopes to continue her work advocating for Latinx and Black youth in the Chicago community who have experienced trauma.