

Spring 2018

Childhood Trauma and Implications for Teaching Young Students Who Have Experienced Trauma

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Childhood Trauma and Implications for Teaching Young Students

Who Have Experienced Trauma

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Special Education M. Ed Thesis

Spring 2018

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Abstract

A traumatic event that was experienced at an early age can affect an individual's ability to form relationships, brain development, and ability to learn. Research methodology included interviews with school professionals in a variety of roles in a rural Pennsylvania school district. Parents of four students completed a semi-structured questionnaire and observations of the students took place in a classroom setting. Results from this qualitative study included insight into the types of training professionals receive, level of support from administration, and behaviors exhibited from students. Four themes emerged from this mixed-methods research: lack of trauma training, high caseloads, compassion fatigue, and protective and risk factors that play a role in student's lives. The implications of this study's findings are significant as they describe teacher's experiences working with traumatized students, reveal specific behaviors a child might exhibit, and offer insight into inquiry for future research in the topic of traumatized students.

Keywords: childhood trauma, compassion fatigue, trauma training, student relationships

Chapter I: Introduction

In this thesis, the following topics will be discussed (a) brain development of young children who have experienced trauma at an early age, (b) academic and emotional development, (c) roles of families involved, (d) implications for general and special educators, and (e) treatments and therapies. This literature review will include four different and specific definitions of trauma. These definitions come from psychologists, educators, dictionaries, and the American Psychology Association.

The sources used in this literature review are from an assortment of books, articles, research studies, journals, dissertations, and reference books. These sources were found from a variety different means, such as ProQuest Dissertations and Thesis (PQDT) Open, Elton B. Stephens Company (EBSCOhost), Elizabethtown Interlibrary Loan, and Elizabethtown College Professors.

Definitions.

To lay the groundwork for this literature review, a discussion of the term trauma, and the specific use of the term, is necessary. Trauma is preverbal, present, and felt, and has an established, detrimental impact on the brain; yet it is difficult to describe and define. “Trauma” has multiple working definitions in the fields of education, psychology, and neuroscience. Trauma is defined in Merriam-Webster’s Dictionary in two ways, first as “an injury (as a wound) to living tissue caused by an extrinsic agent” (Merriam-Webster’s Collegiate Dictionary, 2012) and second as a “disordered psychic or behavioral state resulting from severe mental or emotional stress or physical injury” (Merriam-Webster’s Collegiate Dictionary, 2012). Van der Kolk (2014) describes it broadly by stating, “trauma, by definition, is unbearable and intolerable” (p.1). Trauma directly affects and alters the nervous system and “results in a fundamental

reorganization of the way mind and brain manage perceptions. It changes not only how we think and what we think about, but also our very capacity to think” (Van der Kolk, 2014, p. 21). Perry (2017), the author of *The Boy Who Was Raised as a Dog*, defines trauma as “a psychologically distressing event that is outside the range of normal childhood experience and involves a sense of intense fear, terror, and helplessness” (p. 231).

Within the field of psychology, the American Psychological Association states that trauma is “an emotional response to a terrible event like an accident, rape, or natural disaster” (American Psychological Association, 2013). Traumatic experiences are defined by the fifth edition of *The Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* (American Psychiatric Association, 2013) as events that involve experiencing or observing actual or threatened death, physical injury, or threat to physical integrity and that result in feelings of terror, horror, or helplessness. In all three definitions, trauma/traumatic experience is both caused by an external event and has an impact on an individual’s state of mind.

Purpose/Importance.

Teachers have a difficult job (Gray, Wilcox, Nordstokke, 2017). They are tasked with educating children of varying abilities, learning styles, personalities, and ways of relating often within the confines of decreasing school budgets and increasing expectations (Anderson, Northam, Wrennall, 2016). There is clear evidence in research (Gray et al., 2017) indicating the significant impact of teacher-child relationships on student success and well-being. An awareness of teacher effectiveness in relation to childhood development has also emerged (Gray et al., 2017). The root of a problematic teacher-child relationship might stem from an educator’s limited understanding of a child’s experience with lived trauma and its influence on teaching and learning (Gray, et al., 2017).

The purpose of this study is to investigate the impact of trauma in education of elementary-aged children and the implications for general education and special education teachers. Early childhood trauma and chronic stress has a lasting impact on a child's brain development, stress response, emotional development, and learning (Perry, Szalavitz, 2017). In a research article, Craig (2016) states that infants and young children "are the *most* at risk to stress and trauma due to their undeveloped nervous, motor, and perceptual systems," (Craig, 2016, p. 2). It is especially crucial for educators who work with children during the first five years of life to have an understanding of trauma, its impact on the brain and regulatory systems, how it impairs or distorts memory and learning, and how trauma may manifest in a child's behavior (Perry, Szalavitz, 2017). Therapy that is developmentally and individually appropriate is not enough for children dealing with trauma, and this intervention should, ideally, "extend to every influential person the child encounters" (Perry, Szalavitz, 2017, p. 43). When this intervention includes the child's early childhood educators and is appropriately integrated into the classroom, the child receives and benefits from this support and guidance on a daily basis (Perry, Szalavitz, 2017).

This thesis will address specific implications for general education and special education teachers who are teaching elementary-aged students who experienced trauma at a young age.

Prevalence.

The prevalence of trauma among young children has become increasingly higher over the years, as observed across the educational field. In a Nationally Representative Survey of Adolescents, youth aged 12 to 17, eight percent reported a lifetime prevalence of sexual assault, 17 percent reported physical assault, and 39 percent reported witnessing violence in their homes (NCTSN, 2017). Although this literature is focused on elementary-aged children who have

experienced trauma in their early youth, it is important to note the prevalence of adolescents who have also experienced a serious trauma and then developed Post-Traumatic Stress Disorder (PTSD). Fourteen and a half percent of adolescents who have encountered a serious trauma have developed a serious form of PTSD (NCTSN, 2017). Of those adolescents who developed PTSD, 20-63 percent are survivors of child maltreatment, 12-53 percent are in the category of medically ill, and 5-95 percent are disaster survivors. Events that young children face at an early age affect their development; and, as adolescents, they may carry those events in a form of PTSD. These statistics were concluded from the National Child Traumatic Stress Network (2016).

Chapter II: Review of Literature

Brain Development.

Brain development begins shortly after conception and continues throughout the lifespan; yet the most dramatic development changes occur during the first few years of life (Steiner, 2016). The first five years are especially crucial because of the significant nervous system growth and development (Steiner, 2016; Perry, 2017). During this time, “children rapidly develop foundational capabilities on which subsequent development builds” (Childhood trauma and its effect on healthy development, 2017). Throughout early childhood, the brain develops its capacity, emotional resilience, and the ability to self-regulate through the anatomical-neuronal shaping and pruning that takes place in the context of the face-to-face relationships and interactions between the child and caregiver (Childhood trauma and its effect on healthy development, 2017).

Due to the first five years of life being a critical growth period during which time the brain makes the majority of its “primary” associations and the core neural networks organize as a reflection of early experience, early developmental trauma, and neglect and it has disproportionate influence on brain organization and later brain functioning (Perry, Szalavitz, 2017). It can be concluded that the early life stressors and adverse experiences shape the brain in such a way that it impairs the neuroregulatory systems and causes brain dysfunction throughout the child’s life into adulthood (NCTSN, 2017). This will be discussed more in depth in later sections of this literature review.

Effect of Trauma on Development

Individuals with Disabilities Education Act (IDEA).

Evidence suggests that if a child experiences some form of trauma - abuse, death, neglect, violence, or witnessing natural disasters - the child may develop a different set of needs (Winder, 2015). The goal behind the Individuals with Disabilities Education Act (IDEA) is to provide all children, regardless of their disabilities, a Free and Appropriate Public Education (FAPE). The IDEA has thirteen disability categories under which a child ranging from three to twenty-one years old may qualify. One of the thirteen categories - Emotional Disturbance (ED) - in the IDEA is too vague to properly address the imperative needs of children who have faced trauma. Consequently, the IDEA does not adequately address the educational necessities of children with this particular set of difficulties, leaving schools and the education community without crucial guidance and unequipped to properly service this group of children (Winder, 2015).

In a study done by the Center for Disease Control and Prevention, respondents with the lowest educational attainment are the most likely to indicate they have experienced five or more adverse childhood experiences (SAMHSA, 2010). Research indicates that experiencing traumatic events can set a negative path for children in their educational development. Due to changes in the hippocampus activation, there may be deficits in memory tasks as well as deficits in verbal declarative memory (SAMHSA, 2010). Cavanaugh (2016), who conducted a study on Trauma-Informed Classrooms and Schools, provided several strategies and best practices for educators when teaching students who experienced trauma. Cavanaugh (2016) found that

“Traumatic events can interfere with a child’s ability to self-soothe and regulate their emotions; concerns at school can stem from this, as students who have experienced

trauma as a child have demonstrated less creativity and less flexibility in problem solving” (p. 43).

Children who have secondary trauma, such as witnessing violence in their home, also show deficits in abstract reasoning and executive functioning (Cavanaugh, 2016).

Academic Difficulties.

Creativity, flexibility in problem solving, abstract reasoning, and executive functioning are all things that young children exhibit in their learning process, but children who have experienced or witnessed a traumatic event, have shown delays and deficits in these main developmental areas, causing gaps and concerns during school (Steiner, 2016). The negative sense of self that is developed by children who have experienced or witnessed trauma also plays a role in their performance academically (Steiner, 2016). Students, who have experienced trauma, may have a hard time concentrating in school, may not complete work on time, or have difficulty understanding the material (Cole, Eisner, Gregory, & Ristuccia, 2013). If educators are unaware of the reasoning behind this, they may assume the child is lazy, slow, or just refusing to do work. This then plays into the self-esteem and self-worth of these students. Trauma can have a negative effect on the student’s self-esteem and their trauma experience can manifest in a variety of manners (Steiner, 2015).

Trauma can influence a child’s academic and classroom behavior in a variety of ways. Trauma can damage language and communication skills, disrupting the ability to process verbal information, or effectively utilizing language to communicate (Cole et al, 2013). In addition, students who have faced trauma often have issues with social and emotional communication, as they tend to build walls and use language that keeps others at a distance. A traumatized student

may also face difficulties with the ability to control impulsive reactions and behaviors (Cole et al., 2013). Attachments to adults and a positive approach to life are essential for a child to learn how to regulate emotions and perform adequately in a school setting.

Future Implications.

While there is evidence indicating trauma's effect on creativity, problem solving, and abstract reasoning which all relate to academic success and learning, there is limited research that defines the specific academic outcomes for all types of trauma experienced by children. However, there are a few studies (Hughey, 2016; Somers, Day, Baroni, 2016) indicating a link between physical abuse and neglect with academic and social difficulties (O'Neill, Guenette, Kitchenham, 2010). The link may not be caused directly by the exposure to the trauma, but rather the social and familial context surrounding the trauma (O'Neill et al., 2010; Steiner, 2016). In addition, staff rarely receive training on how to work effectively with traumatized youth (Crosby et al., 2016). Trainings for educators to effectively work with traumatized children would prove beneficial for the student and the teacher. Teachers can help by offering acceptable choices, acknowledging the child's feelings, utilizing sensory objects, using words and/or phrases that de-escalate, and praise publicly.

There are a few emerging trainings for educators, such as Multiplying Connections, Making SPACE, and Flexible Framework (Crosby, 2015). Multiplying Connections (Perry, 2017) provides a framework for helping teachers and school support staff to become trauma-informed. This model charges school staff with five tasks: remain "Calm," be "Attuned," stay "Present," be "Predictable," and "Don't let children's emotions escalate your own" (CAPPD) (Crosby, 2015). Additional research is needed in order to fully understand the relationship

between academic performance and traumatic experiences. Trauma can undermine a child's ability to learn and grow in the classroom and it is imperative for educators to see the worth in each student and build from his or her strengths (Souers, 2017).

Emotional Development.

Emotional development is the ability to identify and regulate emotions and behaviors. It involves the way one feels about themselves, others, and the world (NCTSN, 2010). The results of an experience can become physically or emotionally harmful or threatening; and they can have a lasting adverse effect on the individual's functioning and physical, social, and emotional well-being (Trauma, 2017). Children who have experienced complex trauma often have difficulty identifying, expressing, and managing behaviors (NCTSN, 2010.). Emotional responses may be unpredictable or explosive. Children tend to react to a reminder of a traumatic event with trembling, anger, sadness, or avoidance. Difficulty managing emotions is pervasive and occurs frequently, causing a challenging task for educators and caregivers (Trauma, 2017). Children become easily overwhelmed since they never learned how to calm themselves down once they are upset (NCTSN, 2010.). Students who have experienced early traumatic events have an increased likelihood of being fearful all the time and in many situations.

When a person experiences a traumatic event, the event activates the human fear of death or serious harm to the individual, triggering the human primal instincts of fight, flight, or freeze (Van der Kolk, 2014). In the feeling of helplessness, the primal responses are activated in the body (Hughey, 2016). Van der Kolk (2014) explains the pain of a traumatic event as,

“A defense survival tool in the face of an unresolved threat, a conditioned survival response and perception rendered ineffectual because the physiological response of

freeze/dissociation has literally blocked the survival brain from instinctively ‘realizing’ that the threat is over” (p. 121).

The imprint the trauma leaves on the mind, body, and brain has a unique impact on the survival behaviors of a trauma survivor in the present.

The fight, flight, or freeze response is utilized by individuals in stressful situations when faced with an opportunity to make a decision about their response to the particular situation. The fight or flight response is about survival. Individuals activate the fight or flight response when there is a chance to outrun or outfight “attackers” (Stress Stop, 2017). The freeze response, however, becomes activated when an individual believes there is no hope in traumatic situations. Sometimes when the odds of a particular circumstance are overwhelming, a person does not fight or flee, but rather simply freezes (Hughey, 2016). Individuals who have experienced a traumatic event may experience flashbacks, nightmares, and other implicit memory fragments that can continue to haunt them for years afterwards (Stress Stop, 2017).

Role of Families

The role of everyone who has direct contact with adolescents who have experienced trauma in their life is critical to the adolescent’s development, especially their families. Human connections are important to help the healing process. “The greater the strength of the human bonds connecting the individual to others, and the more these bonds are accessible in times of danger, the better the individual can cope with the trauma and recover” (Brom, Pat-Horenczyk, Ford, 2009). The support from the people and adults in the children’s lives can shape the way they view adults and other people later on in their lives. Flexible, family-centered interventions

should be designed to empower parents at these critical times, so they can provide a healing setting for these children (Brom et al., 2009).

PTSD and Depression in Children Who Have Experienced a Traumatic Event

More research is available that links traumatic experiences with children's mental health outcomes. There is a clear relationship between trauma experienced in childhood and the development of mental health issues, particularly Post-Traumatic Stress Disorder (PTSD) and depression (NIMH, 2016). Each individual who has experienced trauma develops differently. Not every traumatized person develops chronic, or even acute, PTSD. Symptoms of PTSD usually begin within the first three months after the incident, but in some cases, symptoms do not emerge for years afterwards (NIMH, 2016). There are four major symptoms an individual must exhibit in order to be diagnosed with PTSD as being defined by the Diagnostic and Statistical Manual.

These include at least one re-experiencing symptom, at least one avoidance symptom, at least two arousal and reactivity symptoms, and at least two cognition and mood symptoms (Post-Traumatic Stress Disorder, 2016). Symptoms may cause problems in a person's everyday life. Individuals can become triggered by words, objects, situations, and/or one's own thoughts and feelings (NIMH, 2016). Re-experiencing symptoms include flashbacks, bad dreams, and frightening thoughts. Avoidance symptoms include avoiding thoughts/feelings, and staying away from places, events, or objects. Arousal and reactivity symptoms include easily startles, feeling tense, difficulty sleeping, and angry outbursts. Lastly, cognition and mood symptoms include trouble remembering major features of the event, negative thoughts about oneself or the world, feelings of guilt or blame, and loss of interest in enjoyable activities (NIMH, 2016).

Depression, another potential mental health outcome of experiencing trauma, is a serious mood disorder that affects the way an individual feels, thinks, and handles daily activities, such as sleeping, eating, or working (NIMH, 2016). Several symptoms vary between individuals. The severity and frequency of symptoms is unique to each individual and their particular illness. Symptoms may include, persistent sad, or anxious, moods, feelings of hopelessness, irritability, guilt, worthlessness, or helplessness, loss of interest or pleasure in activities, decreased energy or fatigue, moving or talking slowly, feeling restless or having trouble sitting still, difficulty concentrating or sleeping, and/or appetite/weight changes (NIMH, 2016). In order to be diagnosed, symptoms need to be present for most of the day, nearly every day, for at least two weeks (NIMH, 2016).

The symptoms of these two disorders influence a child's ability to focus during instruction, retrieve learned information, and manage behavior in the classroom. Teachers cannot successfully facilitate these children's success in the classroom if they are unaware of the links between PTSD, depression, and learning. There is a clear relationship between trauma experienced in childhood and PTSD diagnoses (NCTSN, 2017).

DSM-V Criterion.

PTSD has been placed into a new stress response category in the *Diagnostic and Statistical Manual of Mental Disorders* (2013). PTSD is included in a new category in *DSM-V*, Trauma- and Stressor-Related Disorders. All of the conditions included in this classification require exposure to a traumatic or stressful event as a diagnostic criterion. Students who experience a traumatic event at an early age often experience forms of PTSD later on (PTSD: National Center for PTSD, 2016). The revisions to the *DSM-V* include eight different criterion

that students must possess. The National Center for PTSD provides an explicit list of criteria with defining measures.

Criterion A has four subparts - the person was exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence - in which two are a minimum requirement. These include direct exposure, witnessing the trauma, learning that a relative or close friend was exposed to trauma, or indirect exposure to aversive details of the trauma, usually in the course of professional duties. The second criterion is the traumatic event is persistently re-experienced in one of the following ways: intrusive thoughts, nightmares, flashbacks, emotional distress, or physical reactivity. The third criterion, avoidance of trauma-related stimuli after the trauma is required in one of two ways: trauma related thoughts, feelings, or trauma-related reminders. The fourth criterion is related to negative thoughts or feelings that are worsening after the trauma has occurred. There are seven subparts and the individual must possess two - inability to recall key features of the trauma, overly negative thoughts about oneself or the world, exaggerated blame of self or others, negative affect, decreased interest in activities, feeling isolated, or difficulty experiencing positive affect. The fifth criterion, trauma-related arousal and reactivity that began or worsened after the trauma, has six subparts, in which a minimum of two has to be experienced by the individual. These include irritability or aggression, risky or destructive behavior, hypervigilance, heightened startle reaction, difficulty concentrating, and difficulty sleeping. The last three criterion are required in full by the individual in order to be considered diagnosed with PTSD. These are symptoms lasting for more than one month, symptoms create distress or functional impairment, and symptoms are not due to medication, substance use, or other illness, respectively (PTSD: National Center for PTSD, 2016).

Effects on Educators

As previously mentioned, teachers have a large role in the lives of children who have experienced a trauma. Implementing trauma-informed practices in educational settings can minimize negative academic and emotional outcomes of trauma (Child Trauma Toolkit for Educators, 2016). Collaboration is a major factor in the implementation of these practices. Educators, administrators, colleagues, and other health professionals are all imperative in the implementation of trauma-informed practices. Teaching practices include maintaining usual routines, providing choices, offering a safe place, and understanding that children cope differently (Child Trauma Toolkit for Educators, 2016).

Maintaining routines communicates that a classroom is safe. Providing children choices allows the individual to gain control over something. A safe place for the child is a place where the child feels comfortable talking about what happened (Child Trauma Toolkit for Educators, 2016). Setting aside a time and place for sharing helps the child know that it is acceptable to discuss what happened to them. Not all children cope in the same manner; however, most cope by re-enacting trauma through play or interactions with others (Child Trauma Toolkit for Educators, 2016). Recognizing a child in a classroom who had experienced a traumatic event and implementing trauma-informed practices is not an easy task, but it is one in which can provide support and accommodation to the child for higher success rates.

Bronfenbrenner's ecological theory on human development describes the various systems that play a role in an individual's life (Sincero, 2012). Bronfenbrenner divided the environment into five different levels. The microsystem is the most influential, has the closest relationship to the person, and is the one where direct contact occurs. The mesosystem consists of interactions

between a person's microsystems. These systems will be discussed and evaluated in the following section to determine how each system affects a student in school and how the various systems and their different environments influence a traumatized student.

Bronfenbrenner's Ecological Model of Human Development.

As mentioned, Bronfenbrenner's theory describes how different environments that individuals encounter throughout their lives influence their behavior in varying degrees. The first system, the microsystem, is the most direct environment people have in their lives. Family, friends, classmates, teachers, neighbors, and others with whom a person has direct contact with are included in the microsystem (Sincero, 2012). The second system, the mesosystem, involves relationships between the microsystems in one's life. Next, the exosystem is the setting where there is a link between the contexts where in the person does not have any active role. The fourth system is the macrosystem. This system is the actual culture of an individual. The cultural context involves the socioeconomic status of the person/family, his/her ethnicity, or race, and where the person is living (Sincero, 2012). Finally, the fifth and last system is the chronosystem. The chronosystem includes the transitions and shifts in one's lifespan (Sincero, 2012). An example of the chronosystem is a parental divorce. This does not only affect the two adults involved, but the child's behavior, as well.

We can examine individual teachers within the broader context of a school system and look at how this system affects a student who has undergone a trauma early in life. A teacher's microsystem consists of a multitude of classroom variables. A special education teacher brings individual abilities and qualities that interact with the classroom variables (e.g., number of students served, diversity of learning needs) (DuBois, 2010). The microsystem includes that

teacher's immediate setting and all of the interactions (e.g. student to teacher, teacher to paraprofessional, teacher-to-teacher) that occur in that setting. The mesosystem includes the relationship of multiple workplace variables, such as colleague and administrative support. The teacher's exosystem is often affected by decision-making at a higher level, which significantly influences teachers' day-to-day responsibilities. Salary, job benefits, and service delivery systems are also components of the teacher's exosystem. The exosystem includes the socio-economic levels and diversity of the community. The macrosystem includes cultural beliefs, school budgetary issues, and community ideologies (DuBois, 2010).

All of these systems have a direct impact on the educational process occurring within a classroom. If a teacher is working in a low-socioeconomic, culturally diverse school with children frequently immersed in chaos and potentially traumatizing situations, the personal tolls on the teachers can become significant (Crosby, 2015). A rise in single parent households, child abuse, poverty, and diverse needs are all factors that teachers face daily. Management for all of these various factors and systems can become overwhelming and stressful for an educator (Crosby, 2015). Special education teachers have even more factors that relate to their stress and high levels of burnout. Educational training, preparations, experiences, and support all contribute to a special educator's willingness to stay in the field (Ferry, 2012). These several factors can contribute to teacher burnout rates and provide explanations for why educators are experiencing burnout (Crosby, 2015). In the following section, teacher burnout is discussed in further detail.

Teacher Burnout.

Educators who teach traumatized students face the unique challenges of understanding the academic and emotional impacts of traumatic experiences on children, implementing trauma-informed classroom practices, and sustaining ongoing collaborative networks of support (Child Trauma Toolkit for Educators, 2016). This adds further stress to the teacher's already stressful jobs, creating the potential for burnout. "Burnout is a result of frustration, powerlessness, and inability to achieve work goals. Burnout can result from the toxic nature of work stressors themselves, or from ordered pressures, constraints, and lack of understanding" (DuBois, 2010). Burnout can be described as a response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled or having problems (Crosby, 2015).

Some of the contributing factors for higher burnout rates include number of students in a classroom, lack of control over decision-making, experiencing a lack of rewards, conflicting values, and lack of fairness (Ferry, 2012). When dealing with educator burnout, some of the factors that contribute to higher burnout rates include caseload numbers, years of experience, level of education, role identification, lack of resources, lack of administrative support, salary, school climate and colleague support, paperwork, and stress (DuBois, 2010). On top of all of these common factors, special educators have even more stressors that add to a quick burnout. Special education teachers are required to keep up with and maintain requirements. They have additional paperwork, extra meetings, lack of parent and public support, responsibility of coordinating schedules, data collection, and collaborating with general education teachers and paraprofessionals (Ferry, 2012).

An educator, regardless if special or general education, when faced with a young child who has experienced trauma, will be adding an additional stressor to their already stressful lives (DuBois, 2010). The effect of children's trauma on special education teachers and learning to cope with these various traumas can leave a lasting impression on the teacher, creating the potential for trauma of their own, which is often referred to as compassion fatigue or secondary trauma (DuBois, 2010, p. 64). Compassion fatigue has been described as "the cost for caring" for others in emotional and physical pain (Mathieu, 2007, p. 1). Each individual will have their own warning signs that indicate that they are experiencing compassion fatigue. These include exhaustion, anger, and irritability, dread working with certain individuals, diminished sense of enjoyment of career, impaired ability to make decisions and care for certain individuals, and problems with intimacy and personal relationships (Mathieu, 2007). Souers (2017) stated

"Caring educators know that responding to what's causing distress at home is part of keeping each kid healthy, safe, engaged, supported, and challenged" (p. 35).

Children cannot learn if they do not feel safe. Educators put time, energy, and resources into supporting their students while providing a positive, safe, and inviting environment. However, these educators need to ensure they are taking care of themselves, as well.

Treatments/Therapies

Treatment Goals.

Childhood trauma can impede the hierarchical maturation of the brain, impair memory, and affect learning (Stien & Kendall, 2004). There are numerous treatment goals doctors and psychologists keep in mind when implementing treatment, interventions, and therapy. Early intervention with traumatized children and positive life experiences (e.g. healthy relationships,

movement/exercise, and symptom reduction) may be able to reverse some of the brain impairments now linked to chronic stress (Stien & Kendall, 2004). Treatment goals can be broken into three categories: psychobiological, psychological, and family (Stien & Kendal, 2004). Psychobiological can be defined as the study of biological foundations of the mind, emotions, and mental processes. Goals in this category include enhancing integrative functions by helping the child to process experience through the various modes of experience and build, reorganize, and strengthen new brain circuitry through experiences that generate new ways of thinking, feeling, and behaving (Stein & Kendall, 2004). Psychological trauma is defined as a type of damage to the mind that occurs as a result of a severely distressing event. Goals in this category include learning to regulate emotions, acceptance of painful feelings, healthy relationships, and enhance motivation for growth and future success (Stein, Kendall, 2004). The last treatment category, family, involves the individual's direct family members. Goals in this category are focused towards the family members and the individual who has encountered trauma. Family goals include patterns of communication, reinforcement of all behavior, acceptance of responsibility, enhancement of attachment, and acceptance of all emotions (Stein, Kendall, 2004).

In the book, *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*, written by Van Der Kolk, McFarlane, and Weisaeth (1996), the authors explain the intentions of treatment and therapies for young children who have experienced a trauma in their early life. The overall aim of therapy with traumatized children is to help them move from being haunted by the past and interpreting subsequent emotionally arousing stimuli as a return of the trauma, to being present in the "here and now," capable of responding to current demands to their fullest potential (Van Der Kolk et al., 1996, p. 491). Children who have encountered

trauma early in their lives must learn to regain control over their emotional responses and place the trauma in the larger perspective of their lives - as a historical event that occurred at a particular time and in a particular place. The goal of treatment for individuals who are overcoming a traumatic event is for them to expect it to not recur if they can learn to take charge of their lives (Van Der Kolk et al., 1996).

Cognitive Behavior Therapy.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a components-based model of psychotherapy that addresses the unique needs of children with PTSD symptoms, depression, behavior problems, and other difficulties related to traumatic life experiences (TF-CBT fact sheet, 2017). This method of treating individuals is a short-term treatment approach that can prove to be effective with a minimum of twelve sessions. Based upon the child and family needs, there may be longer periods of time for therapy as well. This intervention is appropriate for children ranging from three to eighteen year old. Through this approach, distorted beliefs and attributions that are related to the trauma are supported and addressed in a safe and comforting environment.

The Trauma-Focused Cognitive Behavioral Therapy Fact Sheet (2017) provides an acronym that describes the specific components of CBT. PRACTICE stands for:

“P-psychoeducation and parenting skills, R-relaxation techniques, A-affective expression and regulation, C-cognitive coping and processing, T-trauma narrative and processing, I- in vivo exposure, C-conjoint parent and child sessions, and E-enhancing safety and future growth” (p.1).

Individuals who participate in TF-CBT show significant gains in many areas including the ability to cope with reminders of trauma, reductions in depression, anxiety, behavior problems, and trauma-related shame, development of improved personal safety skills, and are more prepared to cope with future trauma reminders (TF-CBT fact sheet, 2017).

Cognitive Behavior Therapy in schools is a skills-based, group intervention that aims to treat different types of trauma including; witnessing or being victim of violence, being in a natural or man-made disaster, being in an accident, or being physically abused and/or injured (Dierling, 2015). This particular type of therapy includes group sessions, individual sessions, and homework assignments to reinforce the skills learned throughout the sessions. Through structured sessions, participants learn about the effects of trauma and are guided through problem-solving techniques (Dierling, 2015). Individuals also develop a narrative of their traumatic experience and learn skills that focus on relaxation, how to challenge upsetting thoughts, and process their memories and/or grief (Dierling, 2015).

Cognitive Behavior Therapy is an evidence-based intervention for children who have experienced trauma. This intervention shows improvement in trauma symptoms; however, it requires many sessions to fully implement in order to show the highest rates of success (Dierling, 2015). Although research shows this as an effective treatment approach, it is also important to have brief, yet effective, interventions. These interventions help support students who have experienced trauma learn how to maintain and control their emotions and/or behaviors relating to traumatic experiences (TF-CBT fact sheet, 2017).

Neurodevelopmental Treatment.

The Neurodevelopmental Treatment Association (2016) defines neurodevelopmental treatment as “a model of problem solving to assess activity and participation, identifying and prioritizing impairments as a basis for establishing achievable outcomes.” Neurodevelopmental treatment (NDT) is a hands-on treatment approach used by physical therapists, occupational therapists, speech-language pathologists, and psychiatrists (Neuro-Developmental Treatment Association, 2017). This type of treatment was developed with the understanding that patients with brain injuries have a limited repertoire of movement patterns. Neurodevelopmental theorists recommend sensory and creative activities as part of biologically respectful treatment (Homer, 2015).

Perry (2017) noted that the therapeutic activity utilized to replace traumatic experience must be both developmentally and age appropriate. There are six core elements to creating a developmental, educational, and therapeutic experience, referred to as the six R's – relational (safe), relevant (developmentally matched), repetitive (patterned), rewarding (pleasurable), rhythmic (resonant with biology), and respectful (child, family, and culture) (Perry, Szalavitz, 2017).

Current neurodevelopmental research suggests that chronic and highly stressful environments and experiences have a strong negative impact on the overall brain development in young children (Ryan, Lane, Powers, 2017). A multidisciplinary team is required when meeting the needs of children and their caregivers with the neurodevelopmental approach. Evidence based practice suggests interventions which provide safe, rational, playful, and repetitive qualities meet the needs of these children (Neurodevelopmental Treatment, 2017).

The neurodevelopmental approach to therapy uses guided, or facilitated, movements as a treatment strategy to ensure correlation of input from tactile, vestibular, and somatosensory receptors within the body (Neurosequential Model of Therapeutics, 2017). During treatment interventions, repeated experience in movement ensures that a particular pattern is readily accessible for motor performance. The more an individual performs certain movements, the easier these movements become. Without these interventions, children will likely develop a limited set of movement patterns that the individual will apply to all tasks (Neurosequential Model of Therapeutics, 2017).

This approach to therapy of traumatized children utilizes what professionals know about brain development to create patterns and repetitive activities that help develop the child's capacity for self-regulation. Perry (2017) states that NDT is not a specific technique or intervention, but an approach to structure interventions in a way that will truly meet the needs of individuals. Several additional interventions are utilized in conjunction to NDT, including music, yoga, art, massages, Eye Movement Desensitization and Reprocessing Therapy (EMDR), and drama (Perry, Szalavitz, 2017). This approach focuses on the need for consistent, repetitive, sensory input and movement therapies, as well as the need for a stable relational environment with positive, healthy adults providing safe, healing environments. The neurodevelopmental approach incorporates techniques that are useful for helping children's brains grow and develop (Neurosequential Model of Therapeutics, 2017).

Therapists require extensive training in neurodevelopmental treatment to properly assess and treat the variety of individuals they will encounter. Trained therapists work collaboratively with children, families/caregivers, and other members of a multidisciplinary team.

Art and Music Therapy.

Adding an art and/or music piece to an individual's response to trauma often lets more advanced thinkers express themselves creatively while classmates respond well, but in a simpler fashion (Perry, Szalavitz, 2017). Students engage in reenactments of their previous experiences. They are most likely to do this through the use of fantasy style art. Often times, individuals retreat into their own safe worlds, and utilize fantasy style art, while doing this as well. Some students seem "ignored" by teachers when they are quiet and viewed as unengaged in classroom activities. When allotted time to express their emotions through art, professionals can learn a great deal of information about an individual's feelings, emotions, grief, and outbursts.

Perry (2017) also utilizes other approaches to treatment of students who may be reluctant to verbalize their experiences. In one case, the approach of appropriate touch plays a role in the success of getting closer to individuals (Perry, Szalavitz, 2017). Sometimes in education, educators have to touch, without touching. Educators must learn how to get close, lower stature, speak softly, and laugh together - ultimately forming an unbreakable bond (Perry, Szalavitz, 2017). A student's teachers can "touch" students in class when music and rhythm become part of instruction. Sensory breaks that involve walking, balancing, dancing, or rhythmic hand movements are therapeutic to everyone in the class, especially for students who struggle with self-regulation - and students who have experienced lived trauma most often struggle with self-regulation (Perry, Szalavitz, 2017). The usage of music and art improves rhythm, which also targets needs in both the brainstem and the midbrain (Perry, Szalavitz, 2017), which fixes holes in an individual's neuroregulatory system and closes the gaps in brain dysfunction and leads to growth in the appropriate developmental brain delays.

Summary

This chapter examines the literature relating to the impact of trauma on childhood development, the effect of children's trauma on special and general educators, and treatment for individuals who have experienced traumatic events. Bronfenbrenner's Model of Ecological Development provides the necessary framework in order to understand the role that various structures play in the maturation of a child (Crosby, 2015). Adverse childhood experiences can have far-reaching, long-lasting physical and intellectual consequences, which affect not only the child, but also all who come into contact with that child (Boucher, 2012).

An individual who has experienced a traumatic event, such as maltreatment, violence, natural disasters, neglect, or abuse, before the age of four have serious and lasting effects on their development. A child's brain may actually stop growing, thus leading to academic difficulties in school (Childhood trauma and its effect on healthy development, 2017). Students may have a hard time concentrating in school, may not complete work on time, or have difficulty understanding content if they have experienced a traumatic event.

When faced with a child who has encountered a traumatizing event, it is important for educators to be conscious of student behaviors and actions and ensure that educators are taking the appropriate self-care arrangements to protect themselves from burnout. The first thing educators should do once they become aware of a traumatized student in their class is create a trauma-sensitive classroom (Childhood Trauma Toolkit for Educators, 2010). This includes predictable classroom routines, utilizing written and verbal instructions, using visual prompts for multi-step directions, and short movement breaks (Childhood Trauma Toolkit for Educators, 2010).

There are many evidence-based interventions for children who have experienced trauma. Three were discussed in this literature review: Cognitive Behavior Therapy, Art/Music Therapy, and Neurodevelopmental Treatment. All three of the interventions discussed show improvements in trauma symptoms, but they require many sessions to fully implement. Knowledge of ways to relax for students who have experienced trauma is essential in the school setting. Research addresses that exposure to traumatic events deregulates children and they may not have the correct coping skills to deal with all of their emotions.

Often times, teachers are unaware of trauma-sensitive classrooms, thus putting additional stressors on the individual with trauma and the educator. Teachers need to take the appropriate steps to ensure that their safety/career is not at risk due to an individual student in their classroom. Along with assisting traumatized children in a classroom, teachers need to take care of themselves. Trauma takes a toll on children, families, school personnel, and communities. Any educator who works directly with traumatized children is vulnerable to the effects of trauma, also called compassion fatigue (Child Trauma Toolkit for Educators, 2017). Educators, professional school counselors, and administrators must be compelled to develop a deeper understanding of trauma. This should include a thorough understanding of the effects of trauma on the children in their care, as well as, identifying the signs that school personnel may be experiencing burnout, secondary traumatic stress, or compassion fatigue as a result of working with a high-risk population (Boucher, 2015). Educators should learn to recognize the signs of compassion fatigue, seek help, talk to professionals, and participate in self-care activities (Child Trauma Toolkit for Educators, 2017).

Therefore, this research study examines the relationship between general and special education teachers and children who have experienced a traumatic event in their lives. The impact of trauma in education of elementary-aged children will be investigated. In conclusion, this research will take place through the use of parent and teacher interviews, along with student observations, to determine how lived experienced affect a child's education.

Chapter III: Methodology

Research Design

This research investigated the impact of a traumatic event on a child and how it affects the individual's education in general education and special education settings. Prior to collecting data, an Institutional Review Board (IRB) appraised the methods proposed, the school principal provided consent, and all participants signed a consent form (See Appendix A). Participants were teachers who have experience working with students who have undergone a traumatic experience, parents of children, and children in Lebanon, Pennsylvania. More specifically, this research looked at what teachers' experiences are, how they view their traumatized students and their relationships with them, and what aspects of interventions and strategies are utilized as coping mechanisms for their students. This research also examined the classroom behavior that children who had experienced trauma exhibited to determine if a child's behavior is similar across multiple settings. This was accomplished through classroom observation of behavior and a parent survey. The research design was a mixed method design and included multiple types of data collection - teacher questionnaires and four case studies. The case studies included surveys from parents and child observations.

Approach

Participants were recruited from the researchers' student teaching placements and included four children, four parents, and seven staff professionals. The first method of data collection was a questionnaire with professionals within an elementary school setting. These professionals included classroom teachers in special education and general education classes, school counselors, reading interventionists, and classroom paraprofessionals. The participants

are experts in the fields of early childhood, child development, brain development, and trauma. Seven school professionals participated in the research. Qualitative questionnaire interview participants were informed in a consent form (See Appendix B)

The next method of data collection included four descriptive case studies. The students' educational placement was in a Learning Support/Autistic Support classroom. The students were in a classroom that ranged from third grade through fifth grade. Two participants were in third grade and two participants were in fourth grade. No fifth grade students in the class were employed for this study. For the purpose of the case studies, student's parents were given a questionnaire to fill out regarding their child's behavior at home, type of trauma experienced, developmental concerns, and their child's typical mood and attitude. Once permission was granted from parents/guardians, observations of the child were conducted. Observations took place in a classroom setting during a typical school day. Observations were utilized to determine if behavior was similar across multiple settings. Behaviors observed included aggression, calling out/shouting, disruption, not completing work, and not asking for help from adults or peers. All four case study participants attend the participating elementary school. This elementary school houses all third, fourth, and fifth graders placed in a Learning Support/Autistic Support classroom. Due to this, the participating school may not be the home school for the students.

Participants

Professional School Staff.

Seven professional staff members of the participating school contributed in this research. Staff included an emotional support teacher, two first grade teachers, a reading intervention

teacher, a school counselor, a learning support/autistic support teacher, and a classroom paraprofessional for the emotional support classroom. Six professionals were female and one was male. Six professionals hold a bachelor's degree in early childhood education. One professional holds a bachelor's degree in special education. Six of the professionals also hold a Master's degree in various subjects – including Psychology, Teaching and Curriculum, Curriculum and Instruction, Teaching and Learning, and Special Education K-12. Two professionals have a reading certificate, one has a PhD in Education, and another has a certificate in school psychology. The length that school staff had been teaching ranges from one to 32 years, with an average of 18 years. Staff caseloads include a variety of different numbers. The two first grade teachers have 21 and 22 students each, the emotional support teacher has 10, the learning support teacher has 13, the reading intervention teacher has 41 students, and the guidance counselor has the entire school on his caseload – 560 students.

Each staff member described an instance that they had been confronted with traumatic material from one of their students. These incidents included the death of their student's best friend, a student in foster care who had experienced neglect, a long-term substitute whose student's teacher has been diagnosed with cancer and later passed, a violent step-father/biological father, violent threats between students, and death of siblings. Staff in this research will be identified by number. The table below provides a summary of the demographic information of the participants.

Table 1: Participant Demographic Information

Participant	Position	Years of Experience	Degrees	Classroom Assignment	Current Caseload
1	1 st grade teacher	15	B.A. Elementary Education M.Ed. Teaching and Learning	Self-contained	22
2	1 st grade teacher	22	B.S. Elementary Education M.A. Teaching and Curriculum Reading Certificate	Self-contained	21
3	Grade 3-5 Emotional Support Teacher	6	B.A. Elementary Education M.S. Curriculum and Instruction	Self-contained	10
4	Grade 3-5 Learning Support Teacher	20	B.S. Elementary Education M.S. Special Education PhD Education	Self-contained	13
5	Reading Intervention Teacher	32	B.S. Elementary and Special Education with a concentration in Social and Emotional Disturbance and Physical Disabilities M.S. Teaching and Curriculum Reading Certificate	Tier 2 Reading Intervention	41
6	Guidance Counselor	30	B.A. Special Education M.S. Psychology	School Counselor	560
7	Emotional Support Paraprofessional	1	Teacher Certificate grades 1-6	Self-Contained	10

Data Collection

Qualitative Surveys.

The qualitative survey incorporated a list of questions for participants to fill out. Parents/guardians received a list of sixteen questions (See Appendix C) to fill out. Questions included information concerning health issues, diagnosed disabilities, behaviors exhibited in a home setting, and how they perceive their child reacting to stressful situations in a home setting.

Teachers received a list of questions that included teaching assignment, emotions experienced after becoming knowledgeable about a child experiencing a traumatic event, and strategies implemented with children who have expressed traumatic stress after an event.

Student Observations.

Observations were conducted in the students' educational classroom, where the students spent the majority of their day. Observations lasted approximately thirty minutes per student across three consecutive days. Behaviors observed included aggressive behaviors, shouting/calling out, talking back, not consistently completing work, asking for peer/adult help, and positive peer/adult relationships. Observations included utilizing a checklist that lists adaptive and worrisome behaviors the student may exhibit. When the students showed a behavior listed on the checklist, a tally mark was placed under that specific student's column on the checklist. Names were not present on the checklist and data was recorded utilizing tallies on a checklist (See Appendix D). Students were identified by number only. During the observations, intervening, or implementing any strategies to change behavior were not utilized.

Data Analysis.

Qualitative results were reviewed in order to discover four emerging themes. These themes will be discussed in the next chapter. Results were analyzed to explore similarities and differences between the opinions of each participant in the study. In addition, behavior frequencies of participating student were compiled on the tally checklist. These were utilized and compared across section. Sections included calling out, disruption, and not completing work, among various other behavior observed. These were compared to determine if there was a parallel between behaviors in children with lived trauma.

Chapter IV: Results

Based on the interview responses, the following themes emerged: lack of training in trauma, high caseloads, compassion fatigue, and protective and risk factors that play significant roles in the student's lives. Participants in this study demonstrated a wide range of experience in their career development. Classroom teaching assignments were also diverse. Participants worked in a self-contained classroom, provided consultation services, or performed a combination of both. In addition, qualitative results showed a high frequency and range of student behaviors. These behaviors include, but are not limited to, calling out, not asking for help, and not completing work consistently.

Theme #1: Lack of Training in Trauma

Educator training, including undergraduate training programs, advanced degrees, and opportunities for professional in-service, has also been referenced in the literature as a risk factor for leaving the field. Each participant stated they recalled little, if any, training in the topic of trauma. Teacher and counselor training programs are not properly addressing the many issues presented by today's youth in the educational environment; therefore, teachers and school counselors are not equipped to address student needs effectively and to identify the signs of burnout, secondary trauma stress, and compassion fatigue that they might be experiencing as a result of the rigors of the job. Teachers and school counselors often seek support for dealing with complex mental health issues, from additional professional personnel, such as colleagues and administrators. Each participant in the study stated that they believe school administration support is of the utmost importance. However, administrators are often lacking the necessary training and knowledge base to provide adequate support and resources for the educators who

need it. In-service and professional development days for school staff and professionals lack resources and training related to the topic of trauma and creating a trauma-informed classroom for their students.

Professionals were asked to describe what portion of their teacher-training curriculum covered topics related to trauma. Of the seven participants, five stated they don't recall any part of their undergraduate courses to cover trauma topics, one stated they remembered several programs in their collegiate career as a part of their PhD degree, and one said they chose elective Pennsylvania Training and Technical Assistance Network (PaTTAN) courses that covered the topic. Staff #2 said, "None of my teacher-training courses covered trauma topics, but experience has made the difference." Staff #3 responded with, "I was not prepared for issues such as trauma from college, but we did learn about dealing with specific behaviors that has helped." In addition, staff #7 was able to recall most of her training in New York that covered the topic of trauma due to the commonality in her previous setting. She stated that,

"We are trained to provide our services to all students including children with and without trauma, how to engage them, and plan in assisting these children."

Despite the reported lack of training, the participants were asked to describe any coping skills utilized for their students after being encountered with traumatic material. Respondents identified a variety of coping strategies they employ with their students. Responses for this question varied and professionals stated a variety of mechanisms to help their students cope. The emerging theme for this question is to utilize the coping strategy that best fits the individual. Staff #1 responds with utilizing the school guidance counselor as a resource, implementing social skills, and kindness. Staff #2 says to talk about the situation with the children, being there for

them, and provide them with hugs, if hugs are appropriate for the situation. Staff #3 states that students need quiet time away in the classroom (independent time), allow students to take a walk around the school, talk to the student, and implement breathing exercises with the students. Lastly, staff #6 says, “it is important to not jump to conclusions or overreact when talking with the students.”

Participants were asked to identify strategies they implement so other students in their classroom were not affected by a peer’s experience with lived trauma or stress. Many emerging themes included specific literature relating to the topic, Planned Ignoring, building respect, and providing quieter workspaces for students. Staff #3 responded with,

“I use literature to help whenever I can. I use books that teach kindness and empathy and work on teaching students that we are all unique and special in our own ways, and how important it is to respect others, even if they are different than we are.”

Staff #2 stated, “reading books and implementing social skills can be very beneficial, along with class discussions and ignoring negative behaviors, when appropriate.” Similarly, staff #3 said, “isolating that student to one part of the room so we can each in the other part of the room, or if the student is physical, remove the student from the classroom so others can continue to work on track.” The guidance counselor, staff #6, responded with “small group or individual instruction, when capable, is necessary to teach students the appropriate skills they need to become successful.”

Theme #2: Caseloads

The number on a special educator’s caseload is often a reason for leaving the field of education. Participants in this study had caseloads ranging from 10 (Emotional Support Teacher)

to 560 (School Counselor). The issue of caseload number in this study is a risk factor, based on previous research of the literature; however, this topic was not explored in depth during teacher questionnaires. One participant, Learning Support Teacher, identified her caseload as overwhelming. This participant's classroom was designed to be a small group setting with her caseload set at no more than 12 students. Throughout the year, administrators increased this teacher's caseload to 20 students, which demolishes the small group-setting atmosphere. The size of classrooms can become overwhelming for educators, adding to the teacher burnout factors.

In addition to caseloads becoming overwhelming, administrative support can assist educators with the stress of their caseloads in various manners. The researcher asked the participants, in their opinion, how important administrative support is when dealing with high-risk populations and the issues associated with them. Every response from the staff stated the same thing – administrative support is extremely important. Staff #3 stated that, “Administrative support is exponentially important and as a team, it is nice working with administration that believes in you.” Staff #1 responds with,

“I think it is extremely important to have administrative support when dealing with high-risk populations. I think it's a team effort and we have to show families that the school team is working together for the best interest of the child.”

Theme #3: Compassion Fatigue

Compassion fatigue is a construct often examined in the field of counseling, but rarely in the field of education. The effect of children's trauma on educators and learning to cope with these precarious traumas can leave a lasting impression of the teacher, creating the potential for

trauma of their own. Each individual will have their own warning signs that indicate that they are experiencing compassion fatigue. These include exhaustion, anger, frustration, dreading work, impaired ability to make decisions and care for certain individuals, and diminished sense of enjoyment for their career.

When asked to describe an emotional part of work that is taken home with the staff members and the duration, each participant responded with similar answers, stating that as educators the emotional part of work is taken home frequently, if not daily. The first participant states, "Teaching is not a 9-5 job and we are constantly thinking about our students and how we can better our teaching practices." Staff member 2 reported that, "I often take the emotional part home. Teaching is not something where you can forget the kid's problems." Staff member 3 had a similar answer. She reported

"I take the emotional part of work home with me each day. There are so many elements of teaching emotional support, and it is hard to separate home life and school life when so many of my students do not have a good home life. I constantly worry about my students; I constantly overthink what happened that day; wondering what I could have done differently to change a specific situation. I think that is part of being a teacher, sometimes we can't help but take home our worries, struggles, and anxieties about our jobs and students."

Many of the other professionals had similar answers, stating that the emotional parts of their jobs are taken home "many, many times." Some staff still thinks about certain situations years later, or they took weeks to not bring home.

When asked about different emotions the staff had experienced after they had been confronted with traumatic material, each staff member had mentioned sadness as an underlying theme, along with various other emotions. Staff #2 stated, “It depended on the situation, but felt inspired, helpless, and utter sadness.” Other staff members mentioned anger, empathy, upset and afraid, horror, and frustration.

Along with severe emotions, staff members each stated they felt greater stress after being confronted with a traumatic incident from one of their students. When asked of ways that staff members manage the accumulative stress of these incidents, responses all included a form of talking the issues out with someone and having a person to vent to. These people included colleagues, administration, families, counselors, friends, and husbands. Other responses included yoga, praying, listening to music, exercising, and maintaining a balanced life.

Theme #4: Protective and Risk Factors

School professionals encounter a number of risk factors in the lives of their students throughout their career. This ranges from experiencing poverty, parental discord and divorce, deaths, and childhood abuse. All participants in the study believe that these experiences relate to the child’s personal development. Witnessing the effects of childhood maltreatment has the potential to activate the educator’s own personal history. Empathy is viewed as a protective factor, but empathy can lead to traumatic stress.

The researcher asked participants to describe changes in student profiles from the beginning of their careers up to this point. Responses varied greatly within two main categories – societal factors and student characteristics. Staff #1 stated that she had noticed a “dramatic decline in structures, loving two parent households.” Similarly, staff #2 describes her students

being “more entitled with their parents not holding them responsible for their actions and behaviors.” Staff #6 believes that the “socioeconomic status (SES) of the students had become more disparate over time.” On the other hand, staff #3 states,

“I have found students are much angrier and have so many odds stacked up against them already as 3rd, 4th, and 5th graders. The pressure that’s also placed on these students to take care of siblings or to be the parental role for their siblings has definitely increased as well.”

Staff #4 recognizes that student profiles include more labels and believes that educational expectations have increased significantly. She also states, “more and more students carry anxiety.”

Student Observations

Case study participant 1: “Natalie.”

Natalie is a nine-year-old girl, diagnosed with autism, general anxiety disorder, verbal apraxia, and is in a Learning Support/Autistic Support classroom at school. Natalie comes from a split family. She has two biological older sisters. Natalie’s mother remarried and now has an additional brother and sister. Natalie’s stepbrother is in the same educational setting as Natalie. He is also diagnosed with Autism and is in the third grade, as well. Natalie is a very social girl, makes friends easily, and always stays positive; however, Natalie reacts to stress poorly. Natalie stress eats, sneaks snacks, sucks her thumb, and chews her hair. The traumatic experience that Natalie undergone was parental divorce, big move, blending of families, and death of a family member.

Case study participant 2: “Austin.”

Austin is an eight-year-old boy diagnosed with Autism and has a severe speech impediment. Austin is in a Learning Support/Autistic Support class and is in third grade. Austin lives with both biological parents. Austin is also diagnosed with ADHD and becomes fixated on certain things very easily. Austin has several opportunities to socialize with family members and peers, but it can become difficult for Austin to determine an appropriate time to talk. Austin reacts to stressful experiences by talking about it repeatedly. The traumatic experience that Austin undergone was the loss of his grandfather.

Case study participant 3: “Caleb.”

Caleb is a ten-year-old boy diagnosed with Autism, anxiety, depression, and ADHD. Caleb lives at home with his mother. His parents are split and he sees his father every other weekend. Caleb has two older brothers that live with his mother, as well; however, they are both away at college and Caleb does not see them often. Caleb is a fourth grader in the Learning Support/Autistic Support classroom. Caleb exhibits behaviors in school when he becomes frustrated. He can become frustrated easily. When this happens, Caleb gets angry, shuts down, bangs his fist on his desk, and puts his head down on his desk. During an episode such as this, it is not helpful talking with Caleb; he will not pick his head up until he is ready. Caleb does his best to remain positive, has a very strong relationship with his mother, and strives to please everyone. However, Caleb does not like to be wrong, needs consistent routines, can be scared of new things, and does not like crowded places. The traumatic experience that Caleb undergone was the divorce of his parents. Along with the divorce, he lost two brothers to college and is now perceived as an only child.

Case study participant 4: “Siya.”

Siya is a ten-year-old girl in a Learning Support/Autistic Support classroom. Siya is Indian and has severe speech barriers. She lives at home with both parents and an older sister, Diya. Diya was also in the same educational placement as Siya. Both of Siya’s parents have limited English, which makes it difficult to communicate. Siya is not diagnosed with Autism, but has a Learning Disability and is diagnosed with Obsessive-Compulsive Disorder and ADHD. Siya is very impulsive and does not take time to think about her actions prior to acting. Siya is a very social girl, tries her hardest on schoolwork, and does not like to disappoint anyone. Her traumatic experience stems from the strong language barrier and the move from India when she was younger.

Table 2: Frequency of Behaviors Observed

Behavior	Student 1: Natalie	Student 2: Caleb	Student 3: Austin	Student 4: Siya
Aggressive	0	0	0	0
Quiet, Shy, Timid	0	5	0	0
Shouting	6	0	7	0
Calling Out	12	7	21	6
Talking Back	8	0	0	4
Disruption	4	0	0	0
Not completing work consistently	9	3	15	6
Not asking for help from peer and/or adults	0	17	4	0
Positive Peer and/or Adults	5	7	6	3

As indicated in Table 2, behaviors observed the most and least differed for each individual student. Behaviors most observed for Student 1 included calling out, talking back,

and not completing work consistently. The least observed behaviors included shouting, disruption, and positive relationships with peers and adults. Aggressive behaviors, quietness, and not asking for help were not observed.

Student 2 showed different observed behaviors. The most observed included not asking for help, positive relationships, calling out, and quietness. Behaviors not observed included aggression, shouting, talking back, and disruption. Student 3 indicated similar results, with calling out, not completing work consistently, shouting, not asking for help, and positive relationships being the most observed behaviors. However, student 3 had many not observed behaviors, including aggression, disruption, quietness, and talking back.

The researcher observed Student 4 calling out, talking back, not completing work, and indicating positive relationships with peers and adults the most. Student 4 did not show behaviors that included aggression, quietness, shouting, disruption, and not asking for help. Each student showed similar results in the sense that none of the students showed aggressive behaviors. Many of the behaviors were on the checklist but were not observed at the time the observations took place.

Chapter V: Discussion and Conclusion

Children in today's classrooms struggle with a multitude of personal issues that directly affect their access to education. Poverty, marital instability, parental mental health issues, crime, and abuse are only a few of the issues. School personnel, ranging from teachers to school counselors to administrators, are expected to meet the needs of every child successfully to ensure that learning objectives are mastered. More often than not, these caring professionals have not been given the appropriate tools to deal with the many difficult situations that arise. Teacher training and school counselor programs are effective at covering topics ranging from instructional methods to curriculum, but they rarely address controversial issues, such as the impact of trauma on children.

This study examined the lived experiences of a specific, professional population, but the participants reflect a much larger issue that is current in education. Educators, including teachers, school counselors, and reading interventionists, handle a multitude of complex tasks daily. These tasks can range from addressing familial concerns to curricular planning and interventions. In pursuit of meeting each child's educational needs, educators can and often do experience an emotional toll in caring for and educating the children in their care. Unfortunately, educators are rarely given the tools to identify if they personally are in distress. Secondary traumatic stress and compassion fatigue are critical aspects that define an educator's job.

The questions guiding this research study relate to children's behavior after they have experienced a traumatic event, how educators handle the various traumatic situations, and the effect these events leave on educators as it relates to their trauma training. All professionals

working in education continually search for the most effective methods to reach the children in their care. The numbers of children who are experiencing the effects of trauma increase by the day. It is imperative that the proper tools be made available for all educators to address the needs of this growing population. Well-trained professionals are needed to implement the necessary tactics to reach all children.

The purpose of this study was to examine the experiences of students, their families, and professionals within an elementary school. An examination of the findings in this chapter will highlight the emotional toll experienced by these teachers, their frustration with varying levels of support, lack of proper training, and factors that are outside of their control. Due to lack of training, stress and frustration levels increase because teachers do not know how to handle the situations effectively. They often seek support from administrators, colleagues, and support personnel who have also received little training in handling trauma.

Findings reiterate existing work that reports the levels of necessary teacher training in trauma, compassion fatigue due to high caseload numbers and lack of support, and risk factors that are out of the teacher's control.

Lack of Training

Exposure to trauma in childhood can affect individuals cognitively, social-emotionally, and physiologically throughout the remainder of their lives. Protective factors can help mediate the detrimental consequences of childhood trauma. The healthy development of protective factors in professionals can help neutralize the onset of secondary traumatic stress and compassion fatigue. On the other hand, research has demonstrated teacher and counselor training programs not properly addressing the many issues presented by today's youth in the

educational environment; therefore, teachers are ill-equipped to address student needs effectively and to identify to correct signs of burnout, secondary traumatic stress, and compassion fatigue that they might be experiencing (Van Der Kolk et al., 1996). These professionals are often lacking the necessary training and knowledge base to provide the adequate support and resources to individuals who require the support in order to be successful in an educational setting. If teacher and counselor training programs fail to recognize this matter and address it within their curricula, generations of teacher and school counselors will enter the field inadequately trained and underprepared to address the needs of their students (Van Der Kolk, et al., 1996). The ultimate goal in having a highly qualified, effective education staff is to provide the maximum educational support to the children on their caseloads.

There is a wide variety of trainings, therapies, and programs that schools can implement within the building to ensure the staff are helping students reach their fullest potential. These include Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Art and/or music therapy, Neurodevelopmental Therapy, and Eye Movement Desensitization and Reprocessing Therapy (EMDR). This aligns with the literature regarding effective strategies to implement within the classroom for students who have experienced lived trauma. Children who have encountered trauma must learn to regain control over their emotional responses and place the trauma in the larger perspective of their lives (Van Der Kolk et al., 1996). Responses to research found that many educators are unaware of creating a trauma-sensitive classroom and expanding on the current practices that educators implement daily can improve students' repertoire of skills (DuBoise, 2012).

Caseloads

Teacher attrition literature often includes a special education teacher's caseload number as a reason for leaving the field (Ferry, 2012). Participants in this study had a vast range of caseload numbers. The smallest, the Emotional Support teacher, was 10 students. The largest, the school counselor, was 560 students. The school only has one school counselor; therefore, this staff member encompassed a large caseload. Results regarding caseloads becoming overwhelming and causing teacher burnout is parallel to recent literature on the topic. Ferry (2012), stated that some factors contributing to higher burnout rates include caseload numbers, years of experience, level of education, lack of resources, lack of administration support, and stress of the job. This, along with other work examining the role educational professionals have with a student who has experienced lived trauma, indicate growing evidence that suggests staff members are becoming burned out easier and quicker, with caseload numbers being a large factor.

Compassion Fatigue

Signs of compassion fatigue are evident through a staff member's interview responses. Participants who show signs of compassion fatigue may exhibit decrease in their ability to concentrate, increase in feelings of apathy towards their job, and second-guessing their ability to make effective decisions, which undermines an individual's self-esteem. Sentiments of powerlessness, sadness, hypersensitivity, helplessness, and anger can also become evident when an individual experiences compassion fatigue. According to DuBois (2010), professionals working directly with others who have a history of trauma are just as likely to experience traumatic stress and related disorders. In addition, professional staff members need to take the

appropriate steps to ensure that their safety and career are not at risk due to an individual student on their caseload (Child Trauma Toolkit for Educators, 2017).

Protective and Risk Factors

Professionals in the field of education encounter a number of risk factors. Crosby (2015) stated that if a teacher is working in a low-socioeconomic, culturally diverse school with children frequently immersed in chaos and potentially traumatizing situations, the personal tolls on the teachers can become significant. A rise in single parent households, child abuse, poverty, and diverse needs are all factors that teachers face daily. The current study's findings support the literature regarding the sense of overwhelming and stressful situations these factors cause for an educator. These several factors can contribute to teacher burnout rates and provide explanations for why educators are experiencing burnout (Child Trauma Toolkit for Educators, 2017).

Limitations

A number of factors potentially limit the findings of this study. An effort was made to gain participation from school personnel and families of students in various stages of research. However, the largest limiting factor of this study is the number of participants in this study. The researcher worked with seven school staff and four families during the research of this study. In regards to professional school personnel, all participants were Caucasian, and all but one participant was female. The lack of diversity also impedes the data to other professional populations. The school staff was also limited to one elementary school in Lebanon, PA. This research could have been expanded to other varying grade levels and districts to increase the data numbers. There is also the potential that some of the participants may have influenced the study by providing information that they knew would be helpful to the researcher.

Implications

There is a strong need for additional training. None of the participants had experienced any formalized training in their undergraduate programs, and only one participant expressed they had remembered trauma-based training during their graduate program. All of the participants expressed a strong interest in obtaining additional information on the issues encompassed in this research. Further research could examine the positive effects on teacher and counselor trainees who receive trauma-related coursework; other coursework could examine the effectiveness of trauma-sensitive classrooms. Additional exploration related to the topic will continue to illuminate the prevalence of this issue in the field of education, possibly reinforce the findings of this study, and offer additional insight regarding the strong need for trauma education.

Finally, it would be useful to create a model for encouraging collaboration between teachers and counselors. This model should be adaptable to various levels, academic and professional, and should include how their collaboration creates a successful trauma-sensitive classroom. Activities for this model could include opportunities for staff to foster self-reflection and self-awareness, opportunities to further education and training on trauma, and a professional environment that encourages support from teachers, counselors, and administrators.

Recommendations

Several areas for future development have risen as a result of this study. Professionals need to develop awareness of the symptoms a child may have experienced a traumatic event. In addition, educators need to recognize the signs of compassion fatigue that follows the traumatic events. Access to professional workshops and training that promote coping strategies, education,

and training for teachers, school counselors, and administrative staff can help build a culture of awareness within the field of education.

Educators can also learn to create trauma-sensitive classrooms and settings for students who have experienced lived trauma. When faced with a child who has encountered a traumatizing event, it is important for educators to be conscious of student behaviors and actions and ensure that educators are taking the appropriate self-care arrangements to protect themselves from burnout. Educators should create a trauma-sensitive classroom for their students, which includes predictable classroom routines, utilizing written and verbal instructions, using visual prompts for multi-step directions, and allowing short movement breaks.

There are many evidence-based interventions for students who have experienced trauma. Often times, educators are unaware of trauma-sensitive classrooms, thus putting additional stressors on the individual with trauma and the educator. Educators, professional school counselors, and administrators must be compelled to develop a deeper understanding of trauma. This should include a thorough understanding of the effects of trauma on the children in their care, as well as, identifying the signs that school personnel may be experiencing burnout, secondary traumatic stress, or compassion fatigue as a result of working with a high-risk population.

The researcher also recommends that professionals develop awareness of the symptoms of compassion fatigue as a tool in preventing it. Educators must be able to competently identify the signs and symptoms associated with compassion fatigue, in addition to possessing a level of self-awareness that enable them to reflect on their practices to ensure they are maintaining a healthy balance of empathy. Access to professional workshops and training that promote self-

reflection and coping strategies, education, and training for teachers, counselors, and administration can help build a culture of awareness within the walls of the school building.

Conclusion

The purpose of this study was to examine the lived experiences of early childhood professional staff members working with students who have experienced traumatic stress at some time in their lives. Evidence in research indicates the significant impact of teacher-child relationships on student success and well-being (Grey et. al., 2017). The root of a problematic teacher-child relationship might stem from an educator's limited understanding of a child's experience with lived trauma and its influence on teaching and learning (Grey et al., 2017). The prevalence of trauma among young children has become increasingly higher over the years, as observed across the educational field. In a study conducted in 2017, eight percent of youth aged 12-17 reported a lifetime prevalence of sexual assault, 17 percent reported physical assault, and 39 percent reported witnessing violence in their homes (NCTSN, 2017). Adolescents who have experienced trauma at an early age are prone to developing PTSD later in their lives (PTSD: National Center for PTSD, 2016).

Trauma theorists have supported the ideas that the emotional impact of dealing with traumatic material also can be broadcasted through the process of empathy (Mathieu, 2007). To deal with these factors, the teacher needs a collection of protective behaviors to utilize. The stressful situations that occur after responding to a traumatic event can contribute to an educator's overall perception of the teacher's self-efficacy. This, in turn, leads to less effective teaching practices, quicker burnout rates, and dissatisfaction with their jobs (Crosby, 2015).

Several themes emerged as a result of this study. The first theme investigated the gaps in formalized training. For the participants in this study, formalized training concerning trauma, crisis intervention, and the lasting effects it has on students and educators did not exist in their undergraduate program and only a few had had one or two lessons during their graduate programs. Due to prevalence of trauma in American society, all participants expressed a strong desire to acquire additional information on the issues encompassed in this inquiry. Educators and school counselors who receive the necessary and proper education in identification of compassion fatigue, trauma-related issues in children, and constructive coping techniques may exhibit fewer symptoms than those without this training (Curtin, 2008). Some of the participants in this study truly believe there is a need to address this issue in education and that current teaching practices are not properly addressing it.

The second theme examined various levels of professional support available to this group of educators. As previously mentioned, the culture of an organized educational setting with strong support systems can set the expectations for how teachers address and deal with specific situations. No matter the reason, the data clearly indicated that the support of administration is a crucial one and administrators need additional training in order to address trauma issues in daily practices. Participants unanimously agreed that a professional, such as a school counselor, trained in trauma and crisis intervention and experienced in providing mental health services and support, would provide another layer of much needed support within the walls of the school. In addition, this theme supported the idea that teachers caseloads are too large to handle when faced with students who carry trauma backgrounds into their classroom along with them. A large caseload, which can become overwhelming and unmanageable, leads to higher burnout rates and compassion fatigue, which ties into the topic of the next theme (Ferry, 2017).

The next theme investigated the emotional toll educators experience while caring for young children who have experienced a traumatic event within an educational environment. Within this theme, the component of compassion fatigue was examined. None of the participants had received formal training in ways to cope with the stressors encountered daily. As mentioned, school counselors can minimize the impact of the emotional toll educator's face by providing teachers with organized activities that foster support in an effort to increase their protective factors (Dierling, 2015). However, these school counselors must also be prepared and trained for situations like these, or they cannot support their teachers. Traumatic stress that is unaddressed may result in compassion fatigue, which may have lasting, profound effects on an individual's personal and professional life (DuBois, 2010). One conclusion is that teachers, with the assistance of well-trained school counselors, need to develop tools, such as stress management techniques, to protect themselves from the effects of compassion fatigue.

The final theme relates to protective and risk factors. These are situations and occurrences that are outside of the educator's control. Many factors influence an individual's chance of developing a mental and/or substance use disorder (SAMHSA, 2017). Risk factors are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes (SAMHSA, 2017). Protective factors are characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact (SMAHSA, 2017). These factors contribute to a child's chances of enduring lived trauma and may be reasoning behind certain behaviors a child exhibits.

A conclusion arising from this discussion is that these issues need to be addressed in updating teacher training and school counseling curricula to include topics such as trauma, crisis

intervention, and the development of creating a trauma-sensitive classroom to protect educators and students from the effects of lived trauma (O'Neill, Guenette, & Kitchenham, 2010). As a part of the educational team, the school counselor can serve as a facilitator during small group meeting times to help foster an environment conducive to success within the educational field (Perry & Szalavitz, 2017). The current educational system is failing our children because it does not properly recognize and address topics fundamental to healthy child development and academic success.

Finally, educators should take the proactive steps to ensure they are creating a trauma-sensitive classroom to minimize negative academic and emotional outcomes of trauma. Collaboration is a major factor in the implementation of trauma-informed practices. Teaching practices include maintaining usual routines, providing choices, offering a safe place, utilizing relevant literature, and understanding that all children cope with traumatic stress differently (Child Trauma Toolkit for Educators, 2016). Utilizing these effective teaching practices proves beneficial for students who have experienced lived trauma; however, they are best practices for all students regardless of their background experiences.

Appendix A: Participant Consent Form

Dear Participant,

My name is Samantha Zarzaca, a Masters of Special Education student at Elizabethtown College. As part of my graduate research at Elizabethtown College and in conjunction with my Master's Thesis, I am conducting a study titled: **Childhood Stress and Implications for Teaching Young Students**. In order to get approval to conduct this study, I need parental or guardian permission to involve children. This study will enable me to research how stress affects an individual and implications for educators and children and the findings of this study will provide special education students with a better understanding of such research. It is my hope that this exploration will yield findings that both contribute to the education and psychology academic literature and are directly beneficial to teachers in the field.

If you are a recipient of this letter, you could assist me during my research on this topic – childhood stress. This topic includes a wide variety of definitions, such as change in the family, a move, blending of families, health/dietary issues, among various other situations. **If you believe your child/student fits into one of these categories or another situation not listed, but could still benefit this research, your feedback would greatly assist my research.**

I am reaching out to teachers, who will be interviewed using a semi-structured set of pre-written questions. I am also contacting parents and will be utilizing a questionnaire to be completed. Your participation is **completely voluntary, however it would benefit future educators better assist your child/student**. Additionally, there are no negative outcomes if you choose not to participate *or* terminate participation at any time during the process. While some individuals

may find it a bit uncomfortable to answer sensitive questions, observing and documenting, participation will be highly appreciated.

Your role as a participant in this study is to speak as honestly as possible about your experiences or relating to your child/student who has experienced stress. These interviews and/or questionnaires may be filled out and returned in a confidential envelope, or conducted in person. If you approve participation, results will be kept entirely anonymous. All information will be held in strict **confidence** within the limits of the law. However, as a **Mandated Reporter**, I am legally responsible to ensure a report is made if there is reasonable cause. To ensure that your identity remains anonymous, all participants will receive an identifying number that will be used to record the study findings and all associated reporting. The number system and identifying information will be secured by a locked, password-protected device. **These records will be destroyed as of May 20, 2018.**

Please indicate your approval of participation by completing the information below and forwarding it to Samantha Zarzaca at zarzacas@etown.edu, by **returning it to your homeroom teacher, Dr. White**. I hope you will be able to participate in my study, and thank you for your response. If you have any questions concerning this research study, please contact the research faculty member, **Dr. Shannon Haley-Mize** at mizes@etown.edu. If you have concerns about your rights as a participant, please contact the Elizabethtown College IRB Office at (717) 361-1133 or the IRB submission coordinator, **Pat Blough** at bloughp@etown.edu. If you would like a copy of the study results when it has been completed, please contact me at the email address provided below. Thank you for your interest; I value the unique contribution that you can make to my research and appreciate the possibility of your participation.

Samantha Zarzaca

zarzacas@etown.edu

Primary Investigator Name & Email

Dr. Shannon Haley-Mize

mizes@etown.edu

Faculty Member and Email

Enclosed you will find the questions to be completed if you will volunteer your participation.

Yes, I give permission to participate in the above-mentioned research study and affirm that I am at least **18 years of age** and have received a copy of the consent form for my records. I understand that the information will be used for learning purposes in conjunction with Special Education studies at Elizabethtown College. I also understand that the information gathered is confidential and that my child's name will not be used in discussing or writing about this study.

If you consent to help further my research in this topic, please return this consent form and the completed questions NO LATER THAN FRIDAY, FEBRUARY 17, 2018.

Parent/Guardian Signature

Date

Teacher Signature

Appendix B: Teacher Questionnaire

Teacher Questionnaire

1. Please state your educational degree(s) and teaching certifications.
2. How many years have you been teaching?
3. How many students are on your caseload?
4. What is your teaching assignment (self-contained, consultant, both)?
5. Describe an incident when you were confronted with traumatic material from one of your students.
6. How do you believe you handled the situation?
7. Describe a time when you took the emotional part of work home with you and what was the duration?
8. Describe the emotions that you experienced when dealing with this traumatic incident.
9. What helps you manage the accumulative stress of these incidents?
10. Describe the changes in student profiles from the beginning of your career up to this point.
11. What coping skills do you employ when encountering traumatic material that your students bring to school?
12. At work, who helps you de-brief from stressful situations?
13. In your opinion, how important is administrative support when dealing with high-risk populations and the issues associated with them?
14. What part of your teacher-training curriculum covered topics such as trauma?
15. What are different strategies you implement so other students in the classroom are not affected by a peer's experience of lived trauma or stress?

16. Can you describe some of the typical interactions, positive or negative, between you and the student?
17. How did you make sense of the child's behavior? If difficult, what made it so difficult?
What feelings came up for you in these experiences? How did you respond to the child?
18. Is there anything more that you feel is important for me to know about your experience teaching a student who has experienced a traumatic event or stress?

Appendix C: Parent Questionnaire

Family Questionnaire

Please answer these questions to the best of your ability and include as much information as possible and that you are comfortable in sharing. All information will be held **confidentially** and will not be shared with anyone else. All identifying features will be held **anonymously** and information will be destroyed when completed.

Please return to your child's homeroom teacher, Dr. White, when completed, no later than Friday, February 17, 2018.

Thank you for helping further research in this topic.

1. What is the current age of your child?
2. What is the stress that your child has experienced?
3. How does your child react to stress? Is this similar to how you react to stress?
4. What is the educational setting that your child is currently in?
5. Who does your child live with?
6. Is your child experiencing health issues that may impact their stress?
7. Does your child have a diagnosed disability?
8. How has your child's mood/attitude been since the stress occurred? Are they interested in things they typically are interested in?
9. Do you notice, or has a doctor reported any of the following in your child?
 - a. Thumb sucking

- b. Nail biting
 - c. Heart trouble
 - d. Overtired
 - e. Lack of appetite
 - f. Over/under weight
 - g. Headaches
 - h. Nightmares
 - i. Other
10. Has your child been diagnosed with a developmental concern?
11. Does your child have opportunities to play with other children?
12. Do you have opportunities to socialize and interact with family and friends? Please explain:
13. What frightens your child and what do you do to comfort them?
14. Does your child have behaviors that concern you?
15. How do you feel that your child acts in school?
16. Any additional information that you think would be beneficial to note about your child?

Appendix D: Student Checklist

Behaviors	Student #1	Student #2	Student #3	Student #4
Aggressive				
Quiet, Shy, or Timid				
Shouting				
Calling out				
Talking Back				
Disruption				
Not completing work consistently				
Asking for help from peer and/or adult				
Positive peer relationships				
Positive adult relationships				

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