Winter 12-13-2020

Creating Trauma Sensitive Classroom in the Early Childhood Setting

Janelle Elke
pe0428dh@go.minnstate.edu

Creating Trauma Sensitive Classrooms in Early Childhood Settings

Janelle Elke

Minnesota State University Moorhead

Table of Contents

Abstract

The purpose of this study is to ensure that our early childhood classrooms are trauma sensitive for our students that have been exposed or are experiencing trauma. Roughly 26 percent of children in the United States witness or experience a trauma before the age of 4(Briggs-Gowan et al. 2010). The study will be in three different phases. In the first phase, data will be collected on what strategies are presently implemented for students who have been exposed to trauma. In the second phase, strategies, techniques and tools will be introduced to help during stressful situations that may happen during class. In the third phase, data will be collected on what strategies, techniques and tools were the most useful, or did not work. Signs and symptoms of early childhood trauma can be easily mistaken for those of other developmental issues such as ADHD or autism spectrum disorder. Data will also be collected to see if the correct supports are being implemented. I believe that by implementing the correct strategies, techniques and tools in the classroom, and teachers understanding trauma and knowing what signs to look for, we will be able to support our students in our classrooms and possibly misdiagnosed students by providing them with the services and interventions that they need.

Creating Trauma Sensitive Classrooms in Early Childhood Settings

Chapter One

General Problem/Issue

Signs and symptoms of early childhood trauma can easily be mistaken for those of other developmental issues. Symptoms and signs can sometimes go unnoticed, misunderstood, or blamed on something else, such as emotional behavioral disorders, ADHD or autism. The child may not get the support needed to overcome their traumatic experience. Sometimes the symptoms are just brushed off as rowdiness or attention difficulties.

Roughly 26 percent of children in the United States witness or experience a trauma before the age of 4(Briggs- Gowan et al. 2010). We need to make our classrooms trauma sensitive from the first day a child starts an educational program. Our preschool classrooms need to be prepared and educated on what signs to look for to ensure we are supporting our students. Even if a student has not been exposed to trauma, but is in a classroom with someone who has been exposed to trauma, might be affected by their classmates traumas. A foundation in trauma research and response can help educators optimally support all children- including those whose traumas have been documented, those whose traumas have not been formally recognized, and those who might be affected by their classmates' traumas(Cole et al.2005).

As an early childhood special education teacher and consultant, I have witnessed behaviors of children who have been exposed to trauma, or that are currently experiencing trauma in preschool settings. I feel that many classrooms are not prepared or have the tools to make their classrooms trauma sensitive. I am wondering if students that receive special

education services would use the same techniques as general education students or if modifications or adaptions are needed?

Feeling positive and confident about school in the early years is important for children. To best support young children, teachers must understand the influence of early attachment patterns and the neurobiology of the early years. This knowledge can help teachers to have patience and compassion for all children-especially in their most challenging times.

Hypothesis

I predict that when we understand what trauma is, and how it effects children who have been exposed to trauma, especially how if effects their brain, we will be able to provide in our classrooms the supports needed. This will lend itself to ensure students are getting a trauma sensitive classroom that creates a safe, comfortable learning environment for all children. Children's brains have the ability to change and reorganize in response to new experiences. Therefore, having healthy and consistent interactions with early childhood educators can greatly influence their brain development and their ability to engage successfully in the early childhood setting.

Subjects and Setting

Description of subjects. The participants in the study are enrolled in an inclusive early childhood preschool program. Ages range from 3-6 years old. Five different preschool classrooms were used with approximately 18-20 students in each class. Two preschool classrooms are at the same location in an elementary school, the other three preschool classes are held in the high school. Presently, each classroom has 4 students who have an individualized

education plans(IEP). The participants come from diverse populations including, Black, Caucasian, East African, Asian, and Hispanic. All participants speak English as their first language, but several participants speak Somali, or Spanish at home as well.

Selection Criteria. Participants are either on my caseload, or in the same classroom as students on my caseload. Each classroom has at least one identified student that has been exposed to trauma. Classroom/school selection is based on the child's home address.

Description of setting. This study takes place in the largest school district in Minnesota. The study takes place at an elementary school and high school that provides classrooms and resources for our inclusive early childhood preschool program. Our preschool program is growing so quickly, its hard to find classroom space. The district is presently in the process of building three new elementary schools, and adding on to high schools to accommodate the need for student placement.

Research Ethics

Permission/Informed consent/IRB approval. Permission was obtained from the Institutional Review Board at Minnesota State University Moorhead and the Anoka- Hennepin School District. Permission was also received from the building principals at both schools, as well as the classroom teachers where the research was conducted.

Protection of human subjects participating in the research was assured. Confidentiality was protected by numbering participants without identifying information. There is no anticipated increase of risk associated with the study with the participants. The probability and magnitude of harm or discomfort anticipated in the study are not greater than those ordinarily encountered in daily life. Participants had the choice to participate or withdraw from the study at

any time. All participants are minors, so parent/guardian permission was received for each participant before beginning the study. Parents/guardians were asked to give their written consent for their child to participate in the study and given a copy that also included contact information if they had questions or concerns.

Definition of terms. For the purpose of this study, the following terms are defined:

The Pyramid Model: a positive behavior interventions and supports model, might be an effective tool for guiding the development of trauma-informed classroom setting because its multi-tiered design(which includes universal, preventive, and intervention components) espouses the key elements needed(nurturing and supportive relationships, high quality environments, targeted social and emotional strategies, and individualized strategies) to shape supportive environments for children who have experienced trauma. (Cummings, 2017, p. 2739).

Trauma: Trauma may include early loss or lack of consistent caregivers; emotional, physical, or sexual abuse; domestic violence; various forms of neglect; natural disasters; medical and surgical procedures; and serious accidents (Siegel 2012).

Stress response: brain research demonstrates that when children encounter a perceived threat to their physical or mental safety, their brains trigger a set of chemical and neurological reactions- known as stress response- which activates their biological instinct to fight, freeze, or flee(Wright 2014).

Chapter Two

Review of Literature

Existing research. Trauma research demonstrates that all types of trauma can undermine children's abilities to learn, create healthy attachments, form supportive relationships, and follow classroom expectations. Further, trauma has negative behavioral, emotional, neurobiological and developmental repercussions through out school and adult life.

Neural development. Children's brains develop in the context of their earliest experiences; their neural development and social interactions are inextricably interconnected(van der Kolk 2015). Children who have secure attachments learn to trust their emotions and trust their understanding of the world around them. Children's early experiences of feeling listened to and understood help instill confidence in their ability to make good things happen, and to seek out individuals who can support them in finding a solution when they do not know how to handle a difficult situation.

Brain research demonstrates that when children encounter a perceived threat to their physical or mental safety, their brains trigger a set of chemical and neurological reactions- know as stress response-which activates their biological instinct to fight, freeze, or flee(Statman-Weil, 2015, p 73).

Overtime, such chronic stress produces neurobiological changes in the brain, which researchers have linked to poor physical health and poor cognitive performance(Terrasi & Crain de Galarce, 2017, p. 36). Students are " too scared to learn". They may be unable to trust their environment and the people in it, and they often have difficulty forming relationships, interpreting verbal and nonverbal cues, and understanding other people's perspectives. We need

to help our students in our classrooms, and know what signs to look for and understand what trauma may look like.

Symptoms and effects of trauma in children. It is imperative that early childhood setting be safe, trauma-sensitive spaces where teachers support children in creating positive self-identities. To best support young children, teachers must understand the influence of early attachment patterns and compassion for all children-especially in the children's most challenging times. Children's brains develop in the context of their earliest experiences; their neural development and social interactions are inextricably interconnected(Statman-Weil, 2015, p. 73).

If a loud toy or certain noise, such as a baby crying could trigger a stress response for a child that has been exposed to trauma. It reminds the child of an event or sensation and their body responds as if they are experiencing the trauma all over again. The child has the psychological reaction appropriate for a serious threat, which inhibits them from being able to use the higher, more complex area of their brain to recognize that the loud noise or the baby crying surprised them or it was pretend. The student may scream or yell because they are re-experiencing the stress response, which mimics their response during a trauma. When children live in a constant state of fear and are not supported in the regulation of their emotions, the amygdala(the brain's regulator of emotions and emotional behaviors) tends to be overused, causing it to overdevelop. This can result in children being highly impulsive and reactive and unable to complete higher-order thinking tasks. The hippocampus- the part of the brain that puts a potential threat in context- tends to be underdeveloped in children who experience trauma because it is underused. Children who have experienced trauma may respond as if they are in danger, because the hippocampus is unable to override the stress response their brains so frequently employ as a means of survival (Statman-Weil, 2015, p. 74).

Children may have impairments across the developmental domains-physical, cognitive, social-emotional, and language and literacy- they are manifested by difficult and troubling behaviors in the classroom. Signs and symptoms of early childhood trauma can be easily mistaken for those of other developmental issues, such as attention-deficit /hyperactivity disorder or autism spectrum disorder (Statman-Weil, 2015). If a child receives a wrong diagnosis, or if symptoms are explained away as simply rowdiness or attention difficulties, the child may not get the support needed to overcome his or her traumatic experience.

As mentioned before, a typical reaction to a traumatic experience is hyperarousal(fight, flight or freeze response). Overtime, such chronic stress produces neurobiological changes in the brain, which researchers have linked to poor physical health and poor cognitive performance. Hyperarousal manifests as difficulty concentrating, hypervigilance, exaggerated response, anxiety and depression. Trauma may also show signs of avoidance. Avoidance symptoms involve efforts to avoid people, places and activities that bring about memories of the trauma and also loss of developmental skills, such a toileting and speech.

Common emotional-behavioral signs include aggression, clinginess, demandingness, violent, attention-seeking, low self-control. pestering and hypervigilance and signs of depressions(Cummings, 2017,p. 2733).

Children raised in highly stressful homes or social circumstances are prone to delays in the normal development of executive function. It is essential that kindergarten teachers and other early childhood educators understand and appreciate that these delays can result in disruptive classroom behavior that does not reflect conscious, willful disobedience on the part of the child(Barr, 2018, p.44)

Our classrooms need to know what techniques to use and how to provide the appropriate classroom environment to help support our students that have been exposed to trauma.

Techniques and tools to use in the classroom. All traumatic events are a violation of a sense of safety in the world and with others. People and places that are supposed to be attuned to the needs of children are often the ones that violate trust through abuse, neglect and violence. Abusive parents and caregivers, violence in communities, and shootings in schools are all too commonplace in American culture. The presence of traumatic stress has long lasting negative impact on children, and when severe and prolonged, it can be so toxic that it leads to neurological and biological health problems(Dombo & Anlauf Sabatino, 2019, p. 18).

Classrooms that feel safe to children are those that have clear expectations, well-defined routines, time for transition, choices whenever possible, and attuned teachers. Specific events in the classroom can serve as reminders of previous traumatic and therefore unsafe experiences. These current events trigger reminders of past events. Some examples of triggers in the classroom setting that can prompt a child to react form a place of traumatic stress and feeling unsafe are:

* sensory reminders of the trauma- smells, sounds or images that remind the child of a person, place or time that is connected to the traumatic event.

* touch-whether to focus the child with a gentle hand on the shoulder or a physical restraint of a child who is a danger to others. Touch that is unwanted or unexpected can be a trauma trigger.

* fighting, arguing or yelling, whether between children or between adult and a child(Dombo & Anlauf Sabatino, 2019, p. 19).

Safety is felt through connections with people who have a calm and focused presence. Children who have had traumatic experiences inflicted on them by adults learn that adults cannot be trusted. Children entering a new school or a new classroom will be careful around adults and will watch closely for indications that they need to protect themselves. This sense of hypervigilance and wariness will make it difficult for them to connect with adults in a school setting, but connection is essential for the development of trauma-informed settings.

Emotional arousal can feel scary to a child who has not been taught how to self-sooth and calm down. Children need to be taught how to identify and appropriately express emotions. They also require guidance on how to tolerate distressing emotions and calm themselves through self-soothing and self-regulation. In a classroom setting, adults can help children by:

* labeling the emotions you see the children demonstrating

* place emotion faces with identifying label around the classroom

* provide an opportunity to reflect on the behavior and feelings exhibited

* work with the child to calm down, this is also know as co-regulation

* add calming and mindfulness exercises for all the kids in the class during times of transition

* use times of emotional dysregulation and distress as an opportunity to educate children about how their brain works and how we can all get overwhelmed by feelings(Dombo & Anlauf Sabatino, 2019, p.21).

In some situations, the classroom might be the only safe, secure setting the child experiences throughout the day. Teachers should try to keep all interactions as positive as they can. Be respectful to the child as often as possible, as well as to incorporate love when

applicable. This is especially important when a child may not have access to that much love and respect at home. At the very least we know we can provide these interactions in the classroom.

The Pyramid Model, a positive behavior intervention and supports model, might be an effective tool for guiding the development of trauma-informed classroom setting due to its multi-tiered design(which includes universal, preventative, and intervention components) espouses the key elements needed(nurturing and supportive relationships, high quality environments, targeted social and emotional strategies, and individualizes strategies) to shape supportive environments for children who have experienced trauma(Cummings, 2017 p. 2739).

Chapter Three

Research Questions

As an early childhood special education teacher and having students that have been exposed to trauma, I want to make sure I am giving them the best supports they need. It my job as their teacher to make sure they are feeling safe, and getting their needs met in the classroom, and teaching them coping and self-regulation techniques that will help them outside of the classroom as well. During this study I want to find out:

1. As a consultant, how can I as a special education teacher best support general education teachers who are working with students on my caseload?
2. Do we use the same strategies for everyone, and for the entire class?
3. Can all classrooms use the same strategies and techniques?
4. What is the effect of trauma on students in early childhood classrooms?

I want to know what strategies are most successful and if the strategies used help the student self-regulate and self-soothe and help to reduce negative behaviors that are displayed in the classroom at times of stress for all students. Many students in the classroom may not have been exposed to trauma, but they are witnessing behaviors in the classroom from a student that has been exposed to trauma.

Methods and Procedures

Instrumentation/ Data Collection Tools

Checklists, observations, questionnaires, parent and teacher survey's as well as anecdotal records, attendance records, classroom observations and individual observations were conducted. Data was collected through three phases.

Process used to gather information/Data Collection Procedures

Data was gathered through three phases. Through survey's and questionnaires, I collected baseline data in phase one. This was done with paper questionnaires and surveys. During phase one I collected data from classroom teachers. I would like to know what they presently do in their classrooms to help support children that have been exposed to trauma. Secondly, I collected information through a parent survey. I'd like to find out if parents/guardians feel the classroom is supporting the needs of their child if they have been exposed to trauma. Also, if parents/guardians have a child that has been exposed to trauma if they feel comfortable sharing that information with the school. Or if they would share that information if asked by the school. Next, I made classroom observations on behavior. Specifically, behaviors that are often seen in children who have been exposed to trauma. During this phase, I also collected baseline data on

the number of students that have been exposed to trauma, attendance, specific strategies already in place in the classrooms. I also have a checklist for staff to fill out on trauma sensitive schools.

During phase two, I started implementing suggested strategies into the classroom. I collected data on what strategies were used, and the results of what happened when the strategy was implemented. I also collected data on parent surveys, parent reports, teacher reports, and teacher surveys. For the teacher surveys I would like to specifically know if they think the Pyramid Model is useful for helping our students that have been exposed to trauma.

During phase three, data was collected from parents, teachers and staff working with the students exposed to trauma. I used the same checklist, and surveys from the previous collection. I also included a question in the survey if they noticed a difference once the strategies were in place, and if they would change anything or had any other comments or concerns.

I also collected data to see if the same strategies that were used with the general education students, worked the same with the students that are receiving special education services. This helped me to determine if different implementations, modifications, or accommodations would have to be made for our early childhood special education students, to ensure we are meeting their needs as well.

Timeline/frequency

Data was collected at each session I am in the classroom as a consultant. Data was collected over a six week period. Phase one was two weeks. Phase two was two weeks, and phase three was two weeks. This will allow for dates to be made up is a student is absent.

Research Design

The design of this research study involves different groups(classrooms) that are all receiving the same interventions and implementations. The participants are already assigned their classrooms before the study begins. The design is survey research and also causal-comparative.

Data Analysis Procedures

After collecting data from the questionnaires, checklists, survey's, and observations, it was all compiled together to look for peaks, common responses, and red flags that may stand out. Simple tabulation and presentation results was also conducted. An analysis was used that is appropriate for comparing interventions that were successful and interventions that were not successful.

Limitations/De-limitations

A limitation that I do not have control over is attendance, as well as students that may start school late, or that move.

I intentionally plan to implement the interventions throughout the rest of the school year, if they are working in the classrooms. It may take longer for some interventions if the student misses a lot of school.

Ethical Issues

Protection of Human Subjects

Protection of human subjects participating in research was assured. Confidentiality was protected by numbering participants without identifying information. There is no anticipated increase of risk associated with the participation in this study. All participants are minors, so parent permission was received for each participant before beginning the study. Participants have the choice to participate or withdraw from the study at any time.

Researcher Bias/other ethical issues

A possible ethical issue would be how each classroom teacher allows for interventions and implementation into their classroom, and the availability of similar tools or calming/self-soothing tools that are being incorporated into the interventions. Should any of these issues arise, I will deal with them appropriately and accordingly.

Chapter 4

Data Analysis and Interpretation

Description of Data.

Question 1: As a consultant, how can I as a special education teacher best support general education teachers who are working with students on my caseload?

Results/Findings.

Table 1

Supporting Classroom Teachers Working With Special Education Students

Classroom A	Classroom B
* monthly team meetings	* weekly team meetings
* what to do with difficult behaviors	* communication between families, consultant, classroom teachers and staff-

	making connections.
* finding space in classroom for calm down area	*outside resources available such as social and mental health workers.
* providing tools/supplies needed	*providing tools needed in classroom- getting grants/scholarships for set up.
* implementation with special ed para/ general ed para and classroom teacher and other staff(speech, OT, PT, etc.)	*education on how the tools work and when to use them and with who.
	*Introduce to entire class as a lesson: 1.breathing/safe/calm place 2.zones of regulation

Conclusions/Implications.

Through teacher survey's and questionnaires as well as team meetings with both classrooms, it was determined that each classroom was requesting different supports. Classroom A was not as open to the idea of implementing strategies or a calming area in the classroom for students that show signs of trauma. One reason being the classroom is small, and there is a small area in the classroom already for students to "take a break" if they are having behaviors in the classroom. Another reason being, lack of knowledge/ education and training on the effect of trauma in the early childhood setting. Once the importance of the strategies and techniques and how they are used and implemented was explained in further detail, the general education staff

was on board. In classroom A, this is the first year that special education students have been included in the classroom. Presently in this classroom, there are 4 special education students and 1 speech only student in a classroom of 18.

In classroom B, the teacher is a former special education teacher and was on board immediately with the proposal. In fact, she immediately wrote a grant to help us get financial support to help implement the supportive environment needed to support children who demonstrate behaviors of trauma. The classroom B general education teacher further went to invite me to do a lesson on breathing strategies and how to make our bodies calm to the class that I was proposing. As well as introducing the zones of regulation.

I did not encounter any problems with the tools used for data collection in this area. Both teachers had the survey's or questionnaire's returned to me by the next school day.

I was not expecting to have any resistance from classroom staff to introduce and implement simple strategies to help all children in the classroom who may be displaying behaviors related to trauma. The techniques used, actually help with several behaviors that come up in the classroom, not just children who have been exposed to trauma. However, when a child started late in the program, who displayed behaviors that are typical with trauma, the strategies were welcome in the classroom, after their typical strategies were not working with him, and actually making his behaviors worse.

Question 2: Do we use the same strategies for everyone, and for the entire class?

Results/Findings.

Table 2

Strategies To Use For Individuals And Strategies To Use For Entire Class

Strategy	Individuals	Entire Class
Safe/Calm Space(Dr. Becky Bailey)	yes	yes
Zones of Regulation	yes	yes
Mindfulness	yes	yes
Visuals	yes	yes
Provide Choices	yes	yes
Familiar Adult	yes	no
Space	yes	no

Conclusions/Implications.

Most of the strategies can be implemented equally with an individual who has experienced trauma and as an entire class. The exception being with the entire class needing a familiar adult to do the strategy and the entire class being sensitive to personal space. In this case, the entire class does not need to have a familiar adult to be successful in completing a strategy. If a substitute teacher in subbing for the general education teacher, the student will still be able to complete the strategy. However, if the student has been exposed to trauma, the student will need a familiar person that they feel comfortable with in able to complete the strategy successfully. A person exposed to trauma should never be left alone with a safe, unfamiliar adult(like a substitute teacher) as this could lead to impulsive, reactive behavior. As the literature states, when a child lives in a constant state of fear, and are not supported in the regulation of their emotions, the amygdala(the brain's regulator of emotions and emotional behaviors) tends to be overused, causing it to overdevelop. This results in children being highly

impulsive and reactive and unable to complete higher order thinking tasks. This also applies to touch/space. A child who has been exposed to trauma should be asked first if it is ok to give a high five or helping them to put their jacket on. Some students will be sensitive to this touch and some will crave it and try to get it inappropriately.

Question 3: Can all classrooms use the same strategies and techniques?

Results/Findings.

Table 3

Can All Classroom Use The Same Strategies and Techniques?

Classroom A	Classroom B
When teachers are willing and understand the technique and strategy	Yes- especially in early childhood
When teachers know the appropriate technique to use	Some techniques need to be used universally
When teachers know which student needs a specific strategy	Yes, with proper education and knowledge of techniques; when , how, who to use with.

Conclusions/Implications.

It has been determined that yes, all classrooms can use the same strategies and techniques universally when implemented correctly in the early childhood settings. Once the techniques and strategies were demonstrated by modeling in specific circumstances, on several occasions, the

techniques were being used successfully and correctly. One strategy was already in place in a classroom, using mindfulness to help with refocusing after transitioning from lunch or a gross motor activity that may have revved up their body. Research confirms that for children, mindfulness can : mitigate the effects of bullying, enhance focus of children with ADHD, reduce attention problems, improve mental health and wellbeing, and improves social skills when well taught and practiced in children and adolescents. Mindfulness can nurture inner peace, improve the quality of exercise, enhance self-confidence, and facilitate more meaningful relationships with others. All can help with regulating our bodies, especially those who have experienced trauma.

I wasn't sure at first if all classrooms could use the same strategies and techniques since each classroom is set up different has different classroom management styles. However, since I were used the same in both classrooms. I gave support and redirection in specific situations when there were questions on what to do with specific strategies and techniques for certain students.

Question 4: What is the effect of trauma on students in early childhood classrooms?

Results/Findings.

Table 4

Effects Of Trauma in Early Childhood Settings

What I observed in the early childhood classrooms:	Effects in early childhood classrooms overall:
Fight, flight or freeze- neurological response to a stressor	Delays in language and communication

Difficulty regulating emotions	Delays in building relationships
Difficulty making body calm	Difficulty in social and emotional regulation
Difficulty playing with peers appropriately	Difficulty with imaginative and creative play
Excessive hugs or attention	Impacts school performance
Hard time listening and concentrating; Inability to focus and complete work by desired time.	Interfere with effective problem solving and/or planning
excessive temper- disrupts classroom	overwhelming feelings of frustration and anxiety
statements about death	

Conclusions/Implications.

It is imperative that early childhood settings be safe, trauma-sensitive spaces where teachers support children in creating positive self-identities. Feeling confident and positive about school in the early years is important for children. Early on, children decide whether they view

themselves as learners, and by age 8 most children are on the academic path they with follow throughout their schooling. To best support young children, teachers must understand the influence of early attachment patterns and the neurobiology of the early years. This knowledge can help teachers to have patience and compassion for all children- especially in the children's most challenging times.

Research provides preliminary evidence that negative impacts can be transmitted across generations. Toxic stress experienced by women during pregnancy can negatively affect genetic " programming" during fetal development, which can contribute to a host of bad outcomes, sometimes much later in life. Infants born to women who experienced four or more childhood adversities were two to five more times likely to have poor physical and emotional health outcomes by 18 months of age. ("Intergenerational Transmission of Trauma," 2017)

Some children show signs of stress in the first few weeks after a trauma, but return to their usual state of physical and emotional health. Even children who do not exhibit serious symptoms may experience some degree of emotional distress, which may continue or even deepen over a long period of time. Children who have experienced traumatic events may experience problems that impair their day-to-day functioning.

Chapter 5

Action Plan and Plan for Sharing

Plan for Taking Action

This study has impacted my professional practice as a consultant, by knowing how I can support my co-workers and staff working with my students and preschool classrooms as a whole. The information that was discovered during this study will be shared with other preschool staff, so they can also include in their classroom effective strategies that will help students with trauma in their classrooms. I would like to encourage the early childhood department and early childhood special education department to look further into getting our classrooms trauma-informed by attending trainings and getting certified to be a trauma- informed classroom.

As I was conducting this study and collecting data on trauma sensitive classrooms, I came across a huge problem that I plan to tackle in the future. The problem is identifying children who have been exposed to trauma, at the early childhood level. At preschool screening, and even at initial evaluations for special education, we do not have a screening tool, or questionnaire to ask specific questions about a child being exposed or identified as experiencing trauma in their life. This is a huge hole that needs to be filled. We can better serve our students and provide them with the supports they need if we have this information, instead of guessing or treating it as something else, even being misdiagnosed.

Plan for Sharing

My first step in my plan is to share with other co-workers the results from my study. As a consultant, I visit many preschool classrooms across the district, which makes it easier to spread the word and results of my study. Many classroom are already using some form of self-regulation tool or mindful activities, so it will be an easier transition to implement supplemental tools in the preschool classrooms. During my research, a classroom was able to attain money

through a grant, which will be helpful for the classrooms that may need more tools and supplies to incorporate into their classroom.

Secondly, my biggest plan it so locate our students exposed to trauma at preschool screening or initial evaluation for special education. I want to come up with a screening tool and/or questionnaire or survey to parents or guardians to help us and them get the supports that the child needs. I will need the support of administration, and preschool screeners and evaluators to follow through with this plan, with my support and recommendations. It will need to be a collaborative effort to create a successful trauma-informed classroom model. One of my main priorities after this study it to identify our students in the early childhood years to ensure they are getting the services and supports needed to be successful in the early childhood classrooms and using those tools independently beyond preschool.

References

Ackerman, C. (2016). Mindfulness Activities for Children. Retrieved from www.positivepsychology.com

American Journal of Orthopsychiatry. (2015). Teaching with strengths in trauma- affected students: a new approach to healing and growth in the classroom. , *85*(1), 3-9. http://dx.doi.org/10.1037

Barr, D. A. (2018). When Trauma hinders learning. Retrieved from kappanonline.org

Brunzell, T., Waters, L., & Stokes, H. (2015). Teaching with strengths in trauma-affected students: a new approach to healing and growth in the classroom. *American Journal of Orthopsychiatry*, *85*(1), 1-9. http://dx.doi.org/10.1037/ort0000048

Cummings, K. P. (2017, May 2017). Creating supportive environments for children who have had exposure to traumatic events. *Journal of Child & Family Studies*, 2728-2741. http://dx.doi.org/10.1007/s10826-017-0774-9

Dombo, E. A., & Anlauf Sabatino, C. (2019). Trauma care in schools. *American Educator*, *43*(2), 18-21.

Fry v. Napolean Community School District. (2016). Retrieved from https://www.wrightslaw.com

Intergenerational Transmission of Trauma. (2017). Retrieved from www.childtrends.org/publications/prevalence-adverse-childhood-experiences

Mahajan, M. (2018). Neurobiology of childhood trauma and its implications for therapy. *Indian Journal of Health and Wellbeing*, 849-853.

Mainstreaming (LRE) and FAPE in 2018: Analysis of L.H. v. Hamilton County Department of Education. (2018). Retrieved from www.wrightslaw.com

Special Education: Children with autism. (2005). Retrieved from www.gao.gov

Springer. (2017, May 13). Creating supportive environments for children who have had exposure to traumatic events. *Journal of Teacher Education*. http://dx.doi.org/10.1007/s10826-017-0774-9

Statman-Weil, K. (2015, May 2015). Creating Trauma Sensitive Classrooms. *Young Children, 70*(2), 72-79.

Statman-Weil, K. (2015, May 2015). Creating Trauma Sensitive Classrooms. *Young Children, 70*, 72-79.

Terrasi, S., & Crain de Galarce, P. (2017). Trauma and learning in America's classrooms. *Emotional life and learning, V98 N6*, 35-41. Retrieved from kappanonline.org

Texas State Teachers Association. (2019). Our students the survivors. *Advocate, 37*(4), 30-31.

Woolfolk, A. (2018). *Educational Psychology* (14th ed.). Upper Saddle River, NJ: Merrill.