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A Trauma Informed Schools Training for High School Educators

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A Trauma Informed Schools Training for High School Educators

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By

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Abstract

An increasing amount of research has emerged in the last decade emphasizing and imminent need to better meet the emotional needs of students, not only to be more successful in the classroom academically but to improve overall quality of life for their present and future selves. The average student spends approximately 1,080 hours at school in a 180-day school year, thus giving educators a primary role in recognizing and responding to students who appear to be struggling or showing signs of trauma (Nelson, 2022). Over half the US population has reported facing at least one adverse childhood experience, with a handful experiencing 4 or more (Childhood Domestic Violence Association, 2022)- a detrimental number, statistically speaking, to maintain an overall positive, and successful high school experience. Yet, our current education system does not require schools to become trained in trauma-informed approaches or at minimum, perform basic trauma assessment screening to indicate at-risk students. This literature review and training provides information necessary for recognizing signs of trauma in students, compares similarities of trauma to other popular (and rising) diagnosis, and provides evidence for a new perspective for educators to procure towards students who otherwise appear disengaged and uninterested in learning.

Keywords: Trauma-informed schools, adverse childhood experiences, student achievement

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Implementation of Trauma Informed Schools

Introduction

One way to define trauma is, “an overwhelming response to a profoundly distressing event(s) that limits one’s ability to cope” (Guevara et al., 2021, p. 1). What may be considered an excessively overwhelming experience to one individual may be perceived as manageable by another, therefore making trauma subjective and unique to a person by their own standards. This review of contemporary literature and included training addresses current gaps in our education system, through which a number of students fall due to the prevalence of trauma in their homes or community, and the impact it has on their learning experience. There is no seamless resolve to give all students an equal opportunity to thrive in school, however, school faculty members can commit to becoming trauma-informed to better recognize the at-risk students in that gap who would otherwise remain at a serious disadvantage. Schools remain the primary location to recognize signs of trauma in students, which stimulates a need for faculty members to become versed in trauma-informed signs and interventions (Crouch et al., 2019). One assessment tool discussed heavily throughout this literature review and training is the Adverse Childhood Experiences (ACEs) questionnaire, a great resource to indicate students currently at-risk by scoring the individual on a scale from 1-10 based on responses to types of trauma experienced before the age of 18. ACE scores may also predict future health conditions for individuals, and has proved to be extremely useful when assessing students for ADHD due to the overlapping symptoms of the two diagnoses (Brown et al., 2019). Currently, ADHD diagnoses rely heavily on teacher referrals, thus increasing the importance for awareness of these similarities. The implementation of trauma informed intervention in schools is not yet required, however they may arguably fit into the due diligence of the school counselor to ensure student’s emotional needs are being met, giving the school a fair chance at making a collaborative effort to implement them. Formally training all educators and faculty members on trauma-informed approaches, in combination with consistent collaboration, would produce a

uniformed school culture improving overall mental health. In turn, schools would most likely see positive impacts on academic successes while also benefiting students in all facets of their lives.

Literature Review

Motivation for Trauma-Informed Approaches

A significant motivator for trauma-informed approaches are adverse childhood experiences (ACEs), findings in Wales (through Public Health Forum) recognized nearly half their population had experienced at least one adverse childhood experience, and 1 in 7 people experienced 4 or more (Sweeney & Taggart, 2018). According to Sweeney and Taggart (2018), those who experienced significant trauma required particular counseling practices and methods to avoid revictimizing the individual which caused further harm. A trauma-informed approach would focus on the overall experience of the client, not solely the mental illness that is present (Sweeney & Taggart, 2018). Not only are tailored, evidence-based practices required to rightfully treat clients, but informed *school* approaches are of equal importance considering the prevalence of the population reporting ACEs.

Students who met three or more ACEs were more likely to enroll in special education classes, less likely to meet grade level standards, and held higher rates of suspensions, expulsions, and drop-out rates (Guevara et al., 2021). Only over the last decade has true research and action been taken to implement trauma-informed approaches (TIA) in the school setting, and is still not a requirement for schools to practice nationwide (Guevara et al., 2021). Schools that do utilize TIA better meet the emotional needs of students by implementing trauma-informed practices and procedures into all components of the school day (Weist-Stevenson & Lee, 2016; Walkley & Cox, 2013). According to the CDC, traumatic experiences amongst adolescents are widespread, with signs of continuation (CDC, 2019). In addition, the school setting is recognized as one of the primary places to identify trauma in adolescents,

however, many school systems have yet to implement a relevant system to screen for trauma and provide limited training on TIA to faculty members and educators (Guevara et al., 2021).

Many recent studies demonstrate the significant impact traumatic experiences have on the learning environment and cognitive functioning of adolescents (Slade & Wissow, 2007). There is significant evidence explaining the need to implement an inclusive trauma-informed instruction style in all school systems (Rumsey & Milsom, 2019). Moderate to high levels of trauma experienced by adolescents significantly impacted learning, specifically reading achievement (Duplechain et al., 2008). The study by Duplechain et al. (2008) studied how exposure to community or worldwide violence, or loss of a significant other or family member impacted reading assessments. It emphasized the intense focus required to perform well in reading and read aloud tests, so disengagement from students as a trauma-response was apparent, significantly hindering performance. A study by Borofsky et al. (2013) found that high exposure to community violence was inversely correlated with school performance when looking at effects of community violence on overall academic performance. The study found more frequent exposure to violence at an elementary age predicted lower GPA and school engagement in middle and high school students. Furthermore, research explained early exposure to ongoing traumatic life events are correlated with detrimental social, behavioral, and economic outcomes affecting long-term success and overall survival (Guevara et al., 2021). In summation, there is significant evidence demonstrating experienced traumatic events may hinder a substantial portion of students' school day and affect scholarly outcomes.

Trauma Informed Definitions and Explanations

In order to fully discuss the topic of trauma-informed schools, it is important to first highlight what "trauma-informed" implies, although a consistent definition of what it means for an organization to claim this title that stretches to all relevant avenues does not currently exist. In addition, it is appropriate to bring attention to how service areas may train employees in trauma-informed approaches, claim the title of trauma-informed, and at times fall short in

ensuring those services are being practiced faithfully and/or consistently by everyone without exception (Guevara et al., 2021). To proceed, Trauma-Informed Care (TIC) works to understand a patient's life experiences in order to provide effective services (SAMHSA, 2016). According to SAMHSA (2016), TIC includes both organizational (such as creating a safe environment and preventing secondary traumatization in staff) and clinical (includes utilizing trauma screenings and training staff in trauma-specific models) approaches.

Utilizing research from federal leaders within the public and mental health field such as those in, The National Association of State Mental Health Program Directors, The Attorney General's National Task Force on Children Exposed to Violence, Substance Abuse and Mental Health Services Administration (SAMHSA), The Trauma Center at the Justice Resource Institute, The National Center for Trauma-Informed Care, The National Institute for Mental Health Services, the National Child Traumatic Stress Network (NCTSN), and previous scholarly work, Hanson and Lang (2014) has comprised TIC into three domains. The goal was to create a greater consistency to operationalize TIAs, and therefore see better consistency in overall ability to train, evaluate, and intervene when addressing childhood trauma. According to the article by Guevara et al. (2021), the first domain is workforce development, focusing on staff training, staff wellness, and internal trauma experts. The second domain is trauma-focused services which included appropriate screenings and access to trauma-focused interventions. Lastly, the third domain is organizational environment and practices, which pertains to policy change, collaboration, and consumer engagement (Guevara et al., 2021).

An article by Sweeney and Taggart (2018) conceptualized data on the development of TIAs, understanding and misunderstanding these approaches, as well as potential snags. Some key elements listed by Sweeney and Taggart (2018) to better conceptualize trauma-informed approaches are to see through a trauma lens, this insinuates the recognition between trauma and mental health. To adopt a broader definition of trauma, especially one extending beyond PTSD including but not limited to, social and racial trauma or potential for the presence of

multiple traumas. It is important to inquire about past trauma sensitively, and to utilize evidence-based approaches that are trauma-specific. Another key element is to address vicarious trauma and any traumatization, while also prioritizing a trustworthy and transparent therapeutic relationship. Sweeney and Taggart (2018) went on to explain how utilizing a collaborative approach is helpful while also adopting strengths-based approaches. Prioritizing the emotional and physical safety of all persons involved throughout the duration of trauma-informed care is also of utmost importance. Lastly, what makes a trauma-informed approach different than merely a conceptual practice as some believe it to be is the change at a whole systems level to commit to a transformational change to the organization (Sweeney & Taggart, 2018).

To best conceptualize TIC, TIA, as well as Trauma Specific Services (TSS), the common denominator is all are rooted in a strengths-based philosophy that, according to SAMHSA (2011), is focused on: (a) recognizing and acknowledging the prevalence and effect trauma has on individuals, (b) detecting the signs of trauma, and (c) responding to trauma utilizing best practices that aim to (d) avoid retraumatizing children, families and communities (SAMHSA, 2011).

Effects on Student Learning

ACES: Experienced Trauma on Academic Success

One way to measure trauma exposure in students is through the questionnaire ACEs, which touches on adversities within the family environment, conflict in the home, abuse of several kinds, maltreatment, and exposure to violence (Guevara et al., 2021). In general, a learner with a score of 4 or higher is considered “high risk” for many of the adversities discussed throughout this section (ACES Aware, 2020). Research by Duplechain et al. (2008) also suggested reflecting upon Maslow’s Hierarchy of Needs to consider how trauma effects learners in that if students do not have basic safety needs met, it would prove very difficult to move up to

successful cognitive functioning, building self-esteem, reaching self-actualization and other important factors required to sustain a flourishing learning environment.

Crouch et al. (2019) conducted a study on how adverse childhood experiences affected school performance specifically in the areas of school absenteeism, school engagement, and repetition of grade levels. Results indicated over half the students involved in the study (51.2%) experienced at least one ACE, and 8% experienced 4 or more. The study demonstrated correlation of 4 or more ACEs with negative school performance in all 3 measured categories. Students living in a disrupted household had higher odds of absenteeism and/or nonengagement and/or repeating grade levels than children not living in disrupted homes. Students facing economic hardship demonstrated lower school engagement and/or absences than those in financially stable homes. Children exposed to violence also showed higher rates of disengagement than non-exposed peers.

To assess ACEs and school success in elementary learners, a study was conducted which included a random sample of 2,101 student participants and found 44% reported at least one ACE exposure while 13% reported 3 or more (Blodgett & Lanigan, 2018). The study demonstrated that as ACE scores increased, the likelihood of failing to meet grade level expectations in the subjects of mathematics, reading and writing increased as did behavioral issues while school attendance decreased. Hispanic and Black communities were at an even greater risk, as higher poverty rates increased the prevalence of low academic achievement (Blodgett & Lanigan, 2018). This study demonstrated how responding to a student's ACE score is not only imperative to improving their academic journey but catching and improving the trajectory of at-risk students early enough to make a difference could prove beneficial. It was noted that ACE exposures do not inevitably mean developmental or academic problems *will* occur in students since other protective factors may exist such as positive individual characteristics, the existence of at least one safe nurturing relationship, or strong family support (Blodgett & Lanigan, 2018).

Slade and Wissow (2007) conducted a study on the effects of trauma due to maltreatment in the home on behavioral and emotional problems in adolescents, thus impairing academic performance utilizing data between siblings. Findings supported more intense levels of abuse were associated with a higher probability of obtaining a low GPA (C or lower) and problems completing homework assignments on time (Slade and Wissow, 2007). Further, this study concluded trauma within the home impacted students on many academic platforms. Such as failing to complete a grade level successfully without repeating or obtaining passing grades, receiving lower scores on cognitive and standardized tests, and more frequent suspensions. Socially, students experienced more difficulties adapting to social situations and were less likely to form as many positive peer or teacher relationships compared to peers not experiencing trauma in the home. The study discussed how dysregulated emotional and behavioral problems in school may also develop as a result of interpersonal differences.

In a study by Rumsey and Milsom (2019), they concluded experienced childhood trauma was linked to learning deficits, poorer social-emotional health and overall behavior issues in students. One of their findings was the inversely correlated relationship between student engagement and dropout rates at the high school level. Approximately 17% of Americans ages 18-24 graduated late or not at all (U.S. Bureau of the Census, 2017). Furthermore, 19.8% of adolescents who experienced trauma dropped out at a higher rate compared to 12.9% of students who dropped out, not reporting experienced trauma (Rumsey & Milsom, 2019). Their research demonstrated trauma may be the cause for behavioral issues and disengagement in school, however, it is a factor that may be overlooked when seeking solutions for students. In their study, complex traumas are observed as repeated events in the adolescent's life that are threatening and pervasive such as poverty, homelessness, experienced acts of violence in the home or community, or witnessing violence (Rumsey & Milsom, 2019). These are all adverse experiences that can negatively impact learning capabilities such as sustained attention, organizing information, distort cause and effect relationships, hinder creative play, decrease

memory retention of new information and more according to the National Child Traumatic Stress Network (2014). Each student may respond to stress and trauma differently, but obtaining knowledge on the prevalence and affects it has on learning abilities and overall mental health is imperative for educators and faculty members to provide best-practice supports to all students.

Multicultural Implications

Recognizing racial trauma as an inclusive form of trauma is imperative. A study by Blitz et al. (2016) was conducted in an elementary school where nearly 50% of black students lived below the poverty line, located in the highest area of crime in the city. Of the 425 students in attendance, 90% qualified for free lunch, and 50% were black. The study described the disproportionate representation students of color faced in the number of referrals, suspensions, and low-test scores when compared to peers living above the poverty line (Blitz et al., 2016). The study explained their findings were conducive to patterns seen nationwide, in that students of color or who were economically disadvantaged experienced, overall, more disciplinary action (Civil Rights Data Collection, 2012). Differences in consequences were also described when looking at national averages, such as white students receiving more referrals for infractions such as vandalism, smoking, or truancy where black students faced consequences for more subjective infractions such as demonstrating threatening behavior, being disrespectful or even being excessively loud (Skiba et al., 2002).

A study by Borofsky et al. (2013) found exposure to violence negatively corresponded to adolescent learning. Blitz et al. (2016) additionally stated 60% of children of color living in poverty witnessed or experienced violence of some form often on multiple occasions, and 15% experienced six or more exposures. This significantly impacted students in the learning environment. The article recognizes the importance of educating teachers on social oppressions in their communities to best help students understand how to recognize disparities rather than internalize injustices. Unfortunately, racial trauma is still unrecognized in the DSM5.

A study by Maguire-Jack et al., (2019) studied the differences between overall ACE exposures as well as specific ACEs experienced amongst different racial groups. Research indicated the poverty rate for white newborns from 2000-2008 was around 10%, while 31% for black newborns and 25% for Latinx babies, with Latinx and Black children reporting more exposure to community violence than white children (Maguire-Jack et al., 2019). Additionally, findings suggested Black individuals scored significantly higher in the ACE categories of experiencing domestic violence in the home and having a parent who is incarcerated. White students scored higher in the areas of living with a mentally ill parent or someone with addiction, while Black students reported more experiences worrying about food scarcity. Maguire-Jack et al. (2019) explains the importance of recognizing not only the number of ACEs adolescent's experience, but associations between type and race/ethnicity within them to fully understand the prevalence.

Learning Through a Trauma Brain

Most educators are familiar with the stress responses, "fight", "flight", or "freeze", triggered when the body's stress hormone is heightened while causing other physical symptoms such as rapid breathing or increased heart rate (Kozlowska et al., 2015). It is not as well-known that repeated stressful exposures triggering this neuronic response causes the body to take longer and longer to return to baseline the more prevalent the stress. After consistent repeated exposures to traumatic events, an individual may be left in a highly reactive state in hopes to keep themselves safe, even in areas where the threat is no longer apparent (Rumsey & Milsom, 2019). This is the condition under which some students attend school with the expectation to learn and thrive.

According to research by Vogel and Schwabe, (2016) they explained the physiological effects stress had on the release of cortisol to areas of the brain that control memory and

emotion. It was explained that release of cortisol from the adrenal glands binds to two main receptors in the brain ultimately effecting cognition, the mineralocorticoid receptor (MR) binds to areas of the brain such as the hippocampus, amygdala, and PFC reaching peak concentration 20-30 minutes after stressor onset and is responsible for triggering a quick response, while the glucocorticoid receptor (GR) gets expressed ubiquitously throughout the brain, and is responsible for essentially returning the brain back to baseline roughly 90 minutes after a stress response (Vogel & Schwabe, 2016). The study demonstrated participants who learned a memory task, then experienced even a mild stress-induced situation the following day before being asked to recall items from the memory task, performed significantly worse than participants in the control group who did not experience stress prior to the task. Further, Vogel and Schwabe (2016) go on explaining how stress can shift our brain from a flexible, cognitive memory system that depends on the hippocampus, to a more rigid, habitual-like memory system based on the dorsal striatum. This is due to the MR receptor discussed earlier being blocked by an MR-antagonist, thus shifting the way our brain recalls a task. This finding was significant in that not only is reupdating memory impaired when learning takes place through the striatum, but this habitual form of learning affects behavior aimed at obtaining rewards or avoiding punishments as well (Vogel & Schwabe, 2016). Moreover, behavior of stressed individuals was shown to be more resistant to extinction, more habitual, and stimulus-response based, noting another study where stressed infants continued to utilize habit actions even though their behavior was no longer being reinforced as opposed to babies not under stress who stopped demonstrating the behavior when reinforcement ended (Vogel & Schwabe, 2016). This research demonstrates how stress significantly affects memory retention even stretching to which areas of the brain are triggered during learning effecting the *type* of learning taking place (habitual vs. flexible).

Trama Response VS ADHD

A child responding to or coping with experienced trauma does not always manifest in ways someone with the untrained eye would imagine. For example, it is not always showing

excessive sadness or crying. Children may develop behavioral issues as a way of controlling their environment making them feel safe (Van der Kolk, 2015). Although internalizing factors of trauma response (withdrawing, numbness, or depression) may be apparent to teachers, it is the externalizing factors such as acting out, that often get students in trouble (Rumsey & Milsom, 2019). As noted in a study on associations between adverse childhood experiences (ACEs) and ADHD diagnosis by Brown et al. (2017), when assessing for ADHD, evaluation for trauma is not currently a part of that process despite the overlapping symptoms such as impulsivity and demonstration of disruptive behaviors. Currently, one-third of practitioners reported not assessing adolescents on ACEs, with 4% reporting to ask about all the ACEs measured (Brown et al., 2017). This study pointed out that most formal ADHD diagnosis rely on parent and teacher rating scales, but rarely consider outside environmental or psychosocial factors. The study by Brown et al. (2017) included 76, 227 adolescents, while 9 ACEs were examined and compared to parent-reported ADHD prevalence and severity. Findings were conducted via telephone interview and only the parents were questioned. Findings on the relationship between ACE type and ADHD severity were positively correlated with two ACEs, children who had faced economic hardship and parental mental illness were the only associations with severe ADHD as opposed to mild ADHD. Other significant findings demonstrated children with an ACE score of at least 1 were more likely to have parent-reported ADHD (Brown et al., 2017).

According to the American Psychiatric Association (2013), trauma responses in children can manifest in behavioral difficulties such as demonstrating hypervigilance or avoidance behaviors, may encompass negative or intrusive thoughts such as nightmares, or may be recognized by difficulties regulating emotions (Guevara et al., 2021). Research by the Child Development Clinic (2019) looked at symptoms of trauma, ADHD, and where they overlap. Trauma might look like increased arousal and agitation, unusual reckless or self-destructive behavior, disassociation, feelings of shame or guilt, being quick to anger, avoiding trauma reminders, continued alertness for threats and danger, and feelings of helplessness. ADHD may

look like interrupting others, losing things necessary to complete tasks, excessive talking, fidgeting, difficulty staying organized, struggles sustaining attention, or difficulty following instructions. Both symptoms may portray difficulty concentrating and learning in school, difficulty sleeping, restlessness, hyperactivity, easily distracted, disorganized, and often appears to not listen (Staniland, 2019). It is imperative to recognize the overlap of symptoms related to traumatic exposure and ADHD in an ongoing effort to appropriately diagnose and manage the mental health of adolescents who may be too young to advocate for themselves. Research aligns with current practice guidelines for diagnosing ADHD according to the DSM5 identifying the need for trauma history to be a part of the conversation when discussing a possible ADHD diagnosis, comorbidity may also be true therefore requiring a more specific intervention type.

Current Evidence-Based Practices and Interventions

As previously mentioned, there is no current baseline intervention to implement trauma-informed services into schools in a universal manor, however, research by Hanson and Lang (2014) condensed existing research into three main domains for the purpose of training, evaluating and intervening within the school system. The first of these domains is workforce development, which includes training staff on appropriate levels of intervention within their scope of practice and to refer students to advanced internal trauma support when needed (counselor, psychologist, SRO, special interventionists, etc.). This domain also includes staff wellness and the importance of self-care as taking on the needs of students who struggle is incredibly difficult if you are feeling burnt out. Hanson and Lang (2014) also mention the possibility of countertransference or secondhand depression/anxiety and the importance of self-awareness.

The second domain explained by Hanson and Lang (2014) is trauma-informed services, which include access to trauma screenings and trauma-focused interventions. There are a number of trauma screeners available through numerous educational platforms, it is important

the school counselor's select one that best meets the needs of their students and is within the ASCA standards and regulations to distribute within the school system. Educators and faculty should recognize their access to trauma focused interventions, and that they are not being asked nor are they trained in performing trauma focused interventions with students. They would refer learners to school counselors, who also proceed to refer to clinical specialists when necessary (Hanson & Lang, 2019).

The third domain is organizational environment and practices, encompassing policy change, collaboration and consumer engagement (Hanson & Lang, 2019). Authors described the need to recognize policy change at an all systems level, meaning all faculty members need to collaborate and work together to truly become trauma-informed. Everyone plays a pivotal role in recognizing signs of trauma in students, so engagement from all titles within their appropriate scope of practice is necessary for successfully implementing trauma-informed services.

The most common evidence-based intervention for schools is implementing a multitiered system of support (MTSS), which provides direct services to all students in the building on tiered, 3-level system as explained in an article by Reinbergs and Fefer (2017). The first tier could include a screener in questionnaire form, given to all students on the state of current overall mental health and chosen selectively for the school according to their specific needs. Based on those screeners, tier two support would provide appropriate interventions to those students at the level of the school counselor, while tier three support would be outside referrals to clinical agencies at the request of the student, parent, or school counselor (Reinbergs & Fefer, 2017). Although many variations of MTSS programs within schools exist, they are important to ensure all students receive, at minimum, a tier one level of support.

Conclusion

Every faculty member in the school plays an important role in adapting trauma-informed interventions at an all systems level. Recognizing the signs of trauma in adolescents and intervening in some way, if even simply referring them to school counseling services, could mean a significantly different outcome for that student. All school personnel who have eyes on students at any time of day can participate in referring to counselors. Educators are especially encouraged to collaborate with counselors as they have the benefit of time spent with learners over other faculty members. ACEs show prevalences in a multitude of ways, which is why trusted adults are encouraged to view students as developing, vulnerable people who, no matter how resilient they may seem, could be desperate for just one person to notice.

Training

Through this training, teachers, administrators, and other school personnel attending will have knowledge on what it means to be a trauma-informed school and how this practice benefits students. Faculty will be versed in the importance of implementing a trauma-informed approach school-wide, what appropriate trauma-informed approaches they are able to practice at their given level of education, and gain awareness covering what current evidence-based practices should be utilized. Staff will hopefully see students through a new lens, one that understands and recognizes the significant impact traumatic stress has on students cognitively, emotionally, and in the learning environment. Teachers will be able to better recognize signs of trauma demonstrated by students, perform appropriate intervention skills based on their expertise and level of education, and refer students to deeper trauma-informed care when necessary. Finally, faculty members will become familiar with adverse childhood experiences (ACEs) and the implications the assessment has on the learning environment. Educators will in addition, gain awareness on similarities between the diagnosis of trauma and ADHD.

The target population for this training is educators, however any individual the student comes into contact with throughout the day such as administrative workers, the school nurse, paraprofessionals, etc. would be welcome to join to emphasize the idea of trauma-informed care at the all-systems level. The allocated time for the training is approximately 2 hours and 45 minutes, depending on the level of participation as far as discussions and questions from trainees.

Facilitators

The training should be performed by an individual with at minimum, a Master's degree in a mental health related field and someone versed in the language of trauma-informed approaches, such as a School Counselor, School Psychologist or the Social Worker depending on their level of education. It is recommended the training take place at the beginning of the school year to have consistency and commitment from staff before students are present for the year.

The training will take place on site at the high school during one allocated professional development workshop day for contracted staff and will be zoom recorded for non-contract staff to access if they desire.

Materials

To assess the effectiveness of the training, a pre and post test will be utilized. Knowledge on ACEs and what they imply for students will be measured, as well as how trauma is defined recognizing this varies based on the individual. Overall recognition on the importance of self-care to provide adequate services to students will also be assessed. A post training satisfaction survey will be utilized to measure the effectiveness of the training, how beneficial the information learned was for educators, and how knowledgeable staff believe the trainer was on the content while open feedback on training improvement is also requested. Materials for this training include a space with a projector screen for the facilitator and tables/surfaces adequate for writing for trainees. A packet containing required documents needed for training such as pre- and post-tests, training activities, and the exit survey should be distributed. The survey page should be torn off and collected following the training from all participants if possible. A timer may be helpful to stay on track during group discussions and breaks.

ASCA Standards

Today's training will *mainly* fulfill the following ASCA professional standards and competencies:

M 5. Effective school counseling is a collaborative process involving school counselors, students, families, teachers, administrators, other school staff and education stakeholders.

B-PF 6. Demonstrate understanding of the impact of cultural, social, and environmental influences on student success and opportunities.

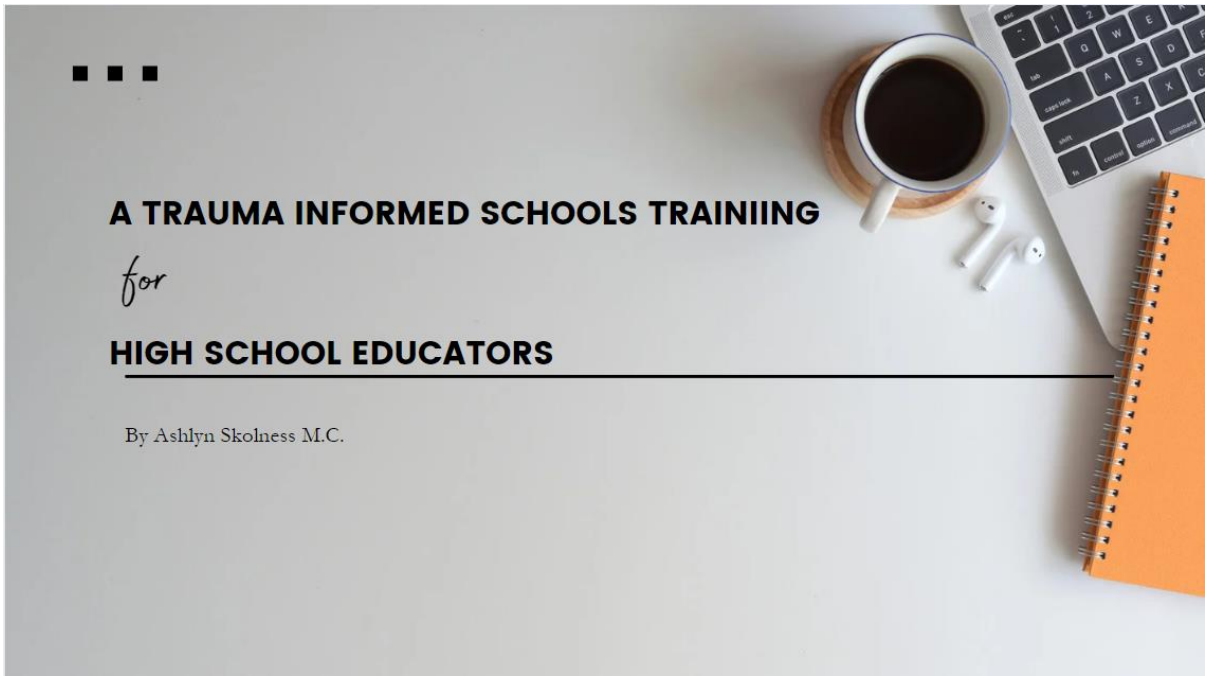
B-SS 4. Make referrals to appropriate school and community resources.

B-SS 5. Consult to support student achievement and success.

(American School Counselor Association, 2019)

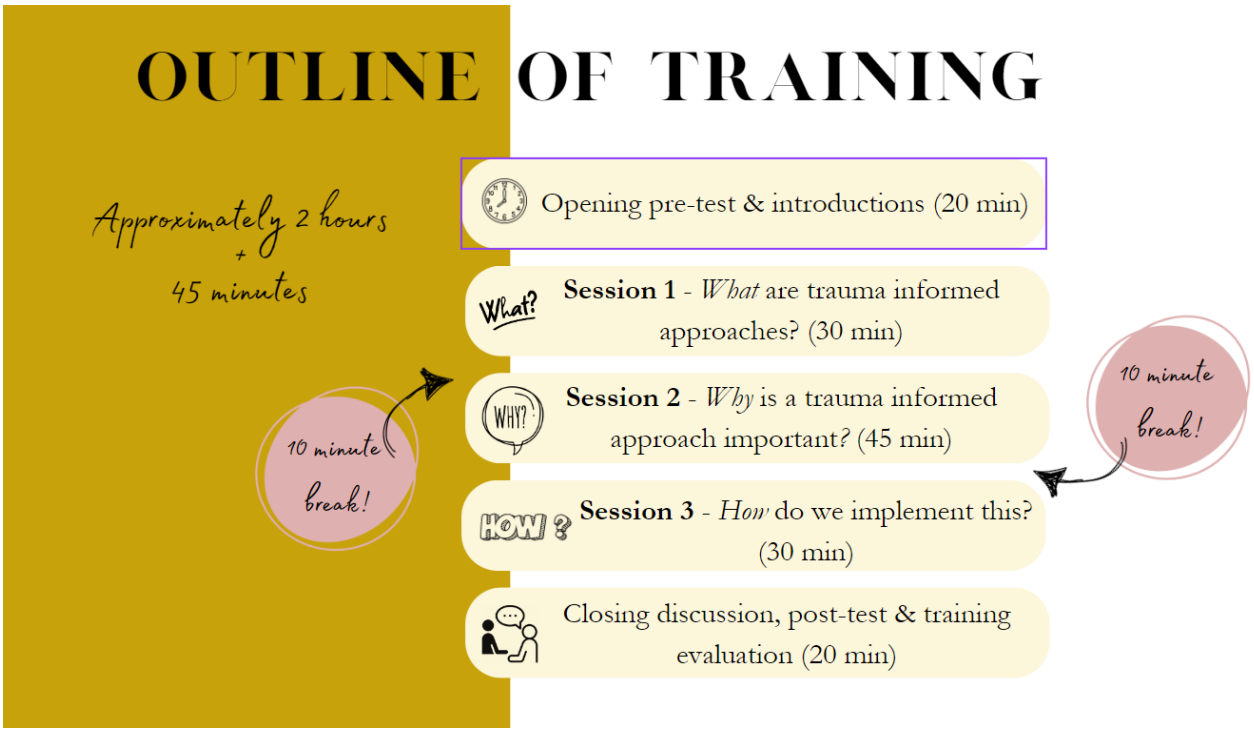
Presentation Slides

Slide 1:



- Hello everyone! Thank you for attending. My name is _____, I am a (*state what you do at the school*) here and appreciate you attending this training on trauma-informed schools.

Slide 2:



- Our training today should take around 2 hours and 45 minutes depending on how much time we take for discussions. You will first take a pre-test to gage how much you know about trauma and trauma-informed schools, followed by a post-test after the training. I also ask that you take the survey at the very end as your time is valuable, therefore should be used sparingly and intentionally!
- There will be 3 sessions, what, why and how trauma informed schools are important, with a 10 minute break between each one.

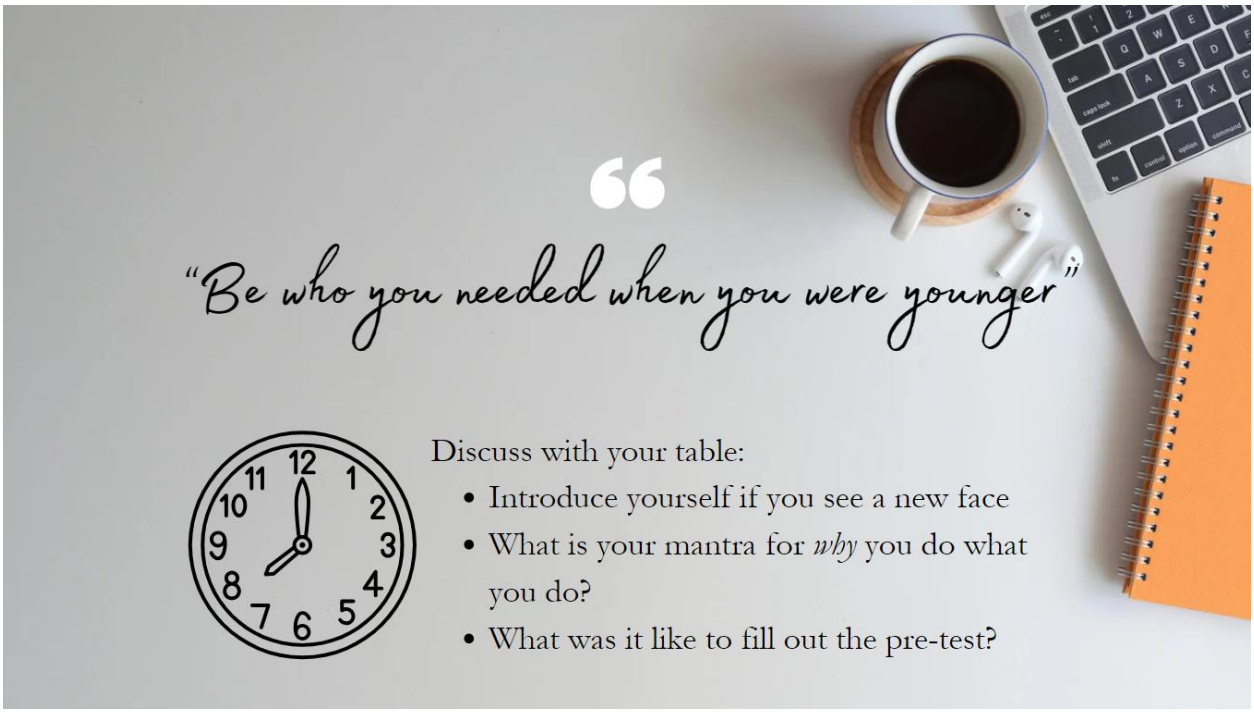
Slide 3:

- For this training, you will be given a pre- and post-test, scratch paper for any thoughts and reflections, and of course any beverages or snacks you need to get through the next few hours.

Slide 4:

- As you are all aware, this is a training that discusses the topic of trauma and all that entails. I want to remind everyone it is okay to step out and take a break if you need to, self-care is important and sometimes that includes giving yourself space. All names should be avoided if you chose to share. While I appreciate everyone coming with an open mind today, recognizing what is appropriate to share today is important for your own benefit, as I do not want anyone to walk away today feeling like they shared too much with colleagues. While people are sharing, side conversations are not only distracting, but especially in this scenario, disrespectful to the individual brave enough to talk. Lastly, although there is no guarantee of confidentiality today, stories and thoughts shared today should remain only with those present in this room.
- I appreciate everyone creating an environment where we can feel safe to share and have good discussions on sometimes hard topics.

Slide 5:



- I would like to start today with a table discussion. First, if you see a new face, everyone introduce yourselves! I then want you to think about your personal mantra on why you do what you do. For example, mine is, "Be who you needed when you were younger."

(5-minute discussion)

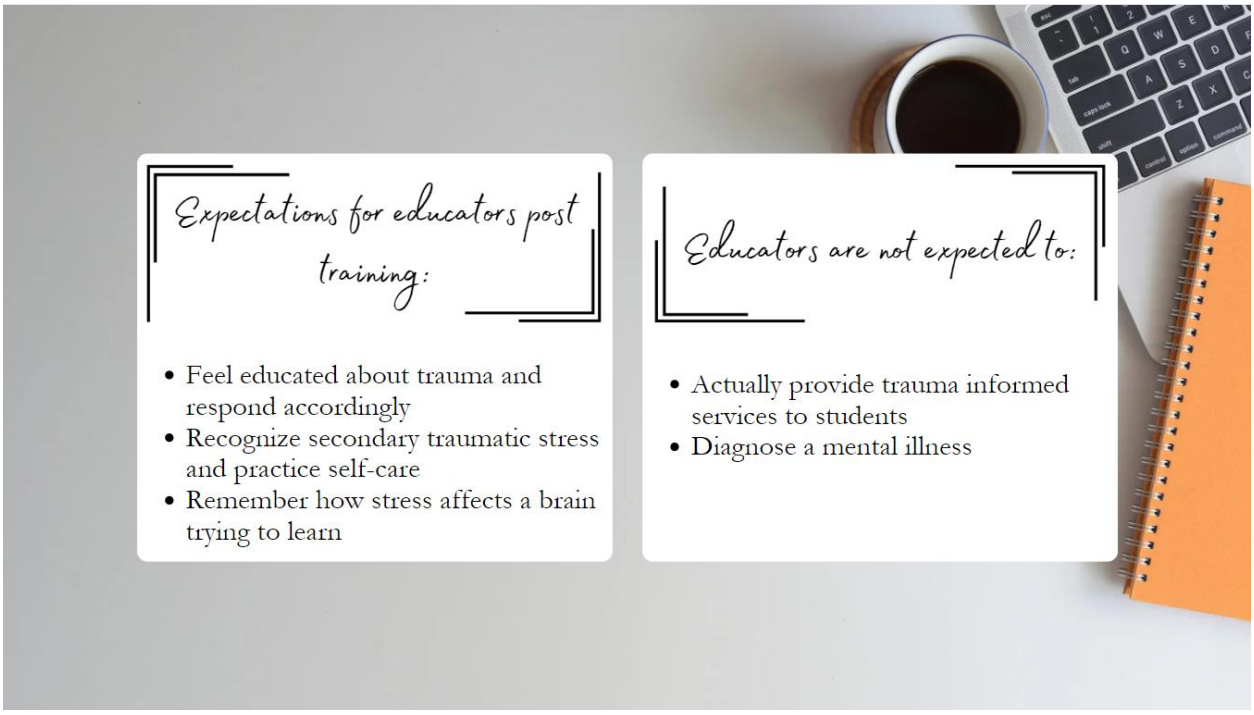
- Does anyone want to share their mantra?
- At this time, grab a pre-test off your table and take a few minute to fill it out. Go ahead and flip it over when you are finished.

(allow 5ish minutes for pre-test)

- What was it like to fill out the pre-test?

(2–3-minute discussion)

Slide 6:

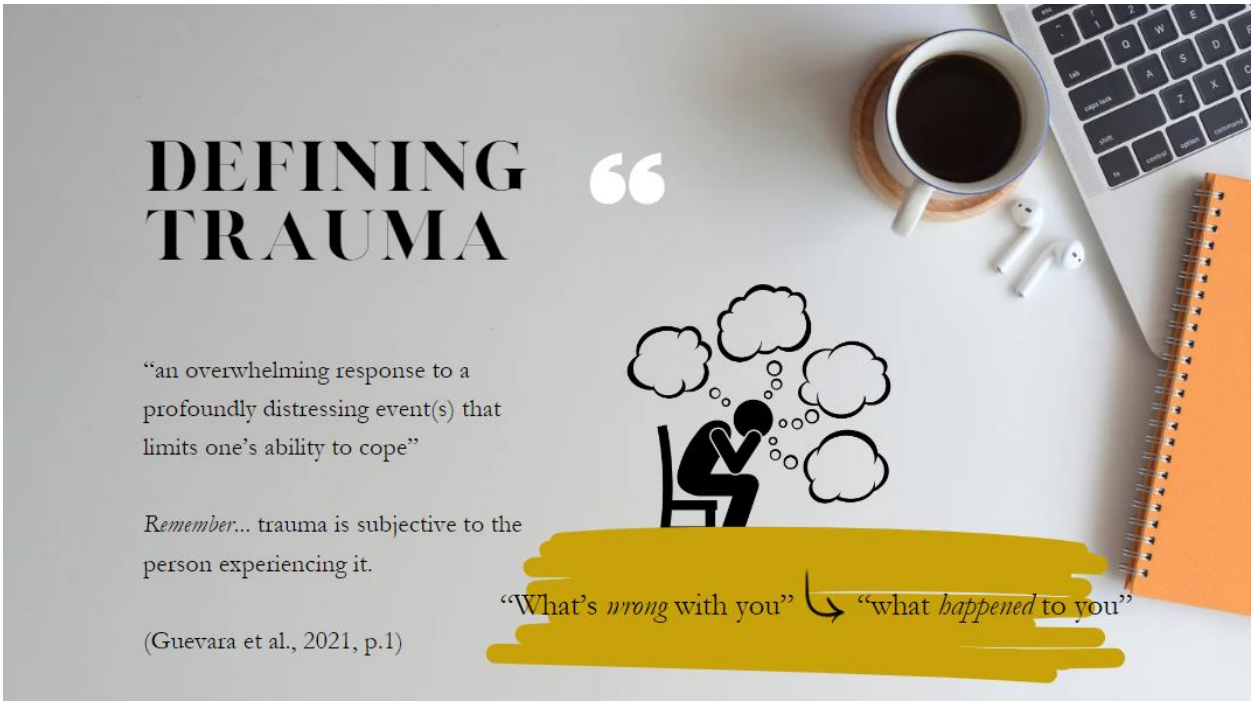


- Expectations for educators and staff following the training are to feel educated about trauma and feel comfortable responding within their scope of practice, recognize secondary traumatic stress and practice self-care, and to remember how stress impacts brain function and what that implies for learning students.
- Educators are not expected to provide any trauma services to students or do any diagnosing of mental illnesses.
- Questions?

Slide 7:

- Session 1, we will discuss a definition of trauma, learn about different types of trauma and what it means to be trauma informed.
- This sessions should take about 30 minutes.

Slide 8:



- For the purpose of this training, defining trauma in some form was important. Here, we define it as, "An overwhelming response to a profoundly distressing event(s) that limits one's ability to cope" (Guevara et al., 2021, p.1).
- It is important to keep in mind that trauma is subjective to the individual experiencing it, meaning an event that may severely trouble one person may not have any impact on another. It is not up to us to decide how someone is supposed to respond.
- Understanding someone with a trauma background means shifting your thought process from, "What's wrong with you?" to "What happened to you?"

Slide 9:

- We will now review the different types of trauma with some embedded discussions.

Slide 10:

- Acute trauma is a single, isolated event such as an accident, natural disaster, single act of violence or terrorism, or sudden unexpected loss .
- Discuss with your table some examples of acute trauma you have seen at your school, please remember to leave out names.

(2–3-minute discussion)

- Who wants to share some examples?
- *Examples*: losing home to a house fire, sudden loss of a parent/relative, getting in a car wreck, etc.

Slide 11:

- Chronic traumatic experiences are repeated and prolonged, such as prolonged family or community violence, long-term illnesses, chronic bullying, chronic poverty/related stressors, exposure to war, torture or forced displacement (National Center on Safe Supportive Learning Environments, 2024).
- What are some examples you can think of from students at your school?

(2-3-minute discussion)

- Anyone want to share?
- *Examples*: Living in a violent neighborhood, feeling afraid to be outside without a weapon, getting diagnosed with a chronic illness, excessive bullying, getting kicked out of your home, etc.

Slide 12:

- Complex trauma can be described as exposure to multiple traumatic events from an early age, often within a caregiving system or without adequate adult support. Examples are physical, emotional and sexual abuse, ongoing neglect by caregivers, witnessing domestic violence, and other forms of chronic violence without support (National Center on Safe Supportive Learning Environments, 2024).
- Discuss some examples you can think of with your table.

(2-3-minute discussion)

- Who would like to share?
- *Examples*: A 7th grade student who faces physical and emotional abuse by his father for being autistic and having severe ADHD because in his culture those diagnosis do not exist, so he is just “annoying and talks too much”.

Slide 13:

- Lastly, we have historical and racial trauma, which can be described as systematic oppression of particular groups across generations, racism, discrimination, and harassment (National Center on Safe Supportive Learning Environments, 2024).
- Discuss examples from students you can think of with your table.

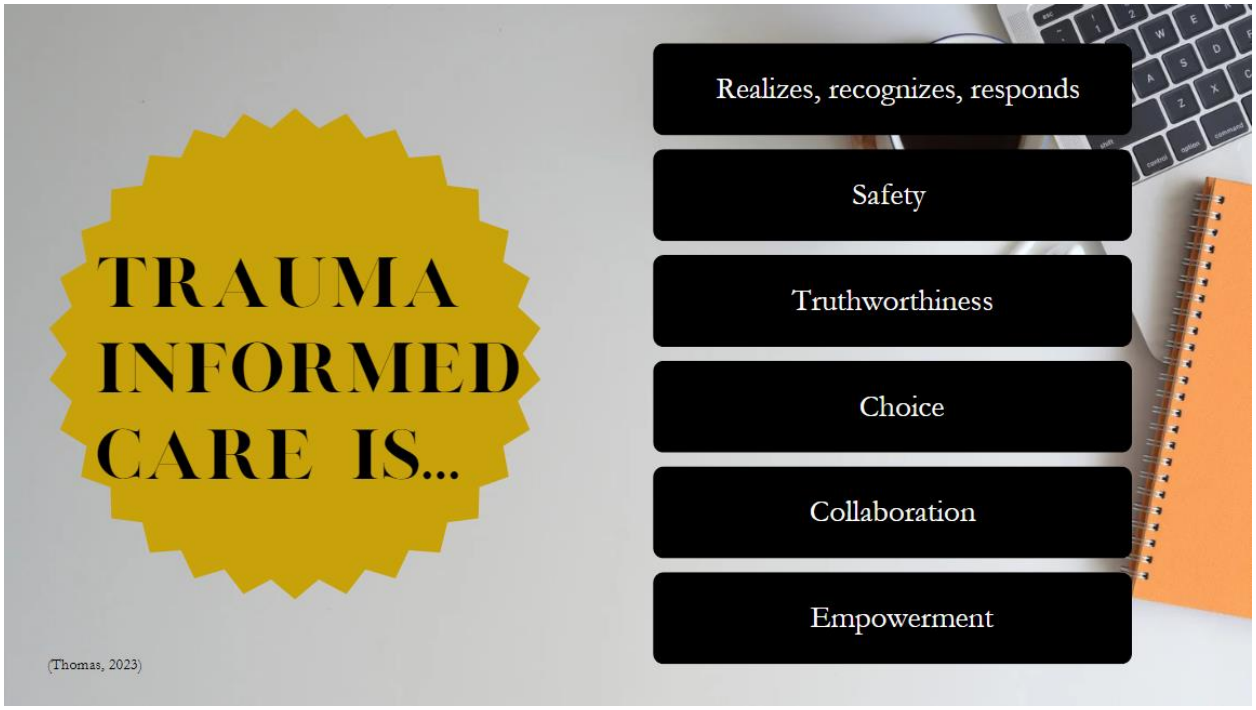
(2-3-minute discussion)

- Anyone care to share an example?
- *Example*: A student who got searched at a convenient store for looking “suspicious”, he was a black male, while his white peers walked free.

Slide 14:

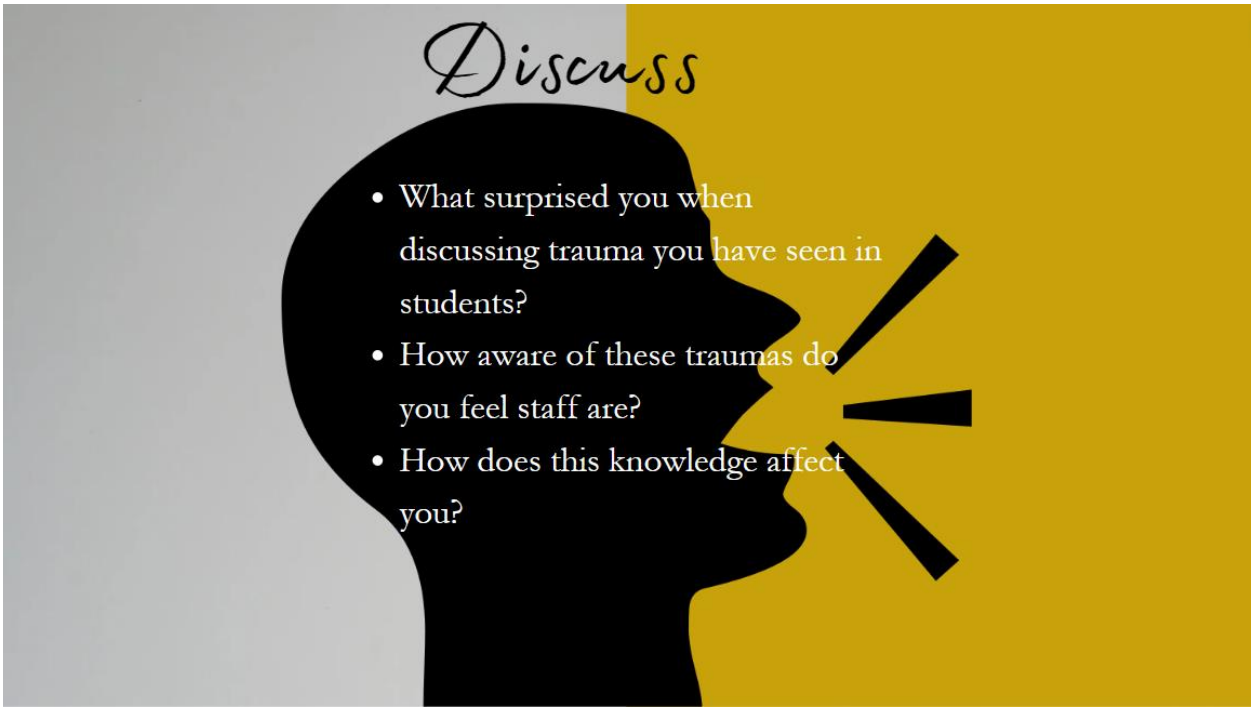
- To, in a sense, summarize what trauma informed care is, it is assuming more people than not have been through traumatic experiences, and that trauma stems beyond the diagnosis of PTSD. It Realizes how prevalent trauma is, recognizes how people are affected by it, and responds accordingly (Thomas, 2023).

Slide 14:



- There are 5 principles to trauma informed care (Thomas, 2023).
- Safety, which encompasses things such as respecting space around individuals, not standing too close, and acting when you see someone's safety being jeopardized.
- Trustworthiness, which is imperative for ensuring students are taken care of. Building trust takes time but is a building block of TIC.
- Choice, individuals have the autonomy over their care, as it is very much a joint effort.
- Collaboration, as counselors do a lot of explaining throughout care as we work *with* individuals rather than simply tell them what to do.
- Empowerment, this is their story, and we want people to feel good about where they are right now, working on current skills and building off those.

Slide 15:



- Let's recap with our table members.
- What surprised you when discussing trauma you have seen in students?
- How aware of these traumas do you think staff are?
- How does knowing this affect you or how to work with students?

(5-minute discussion)

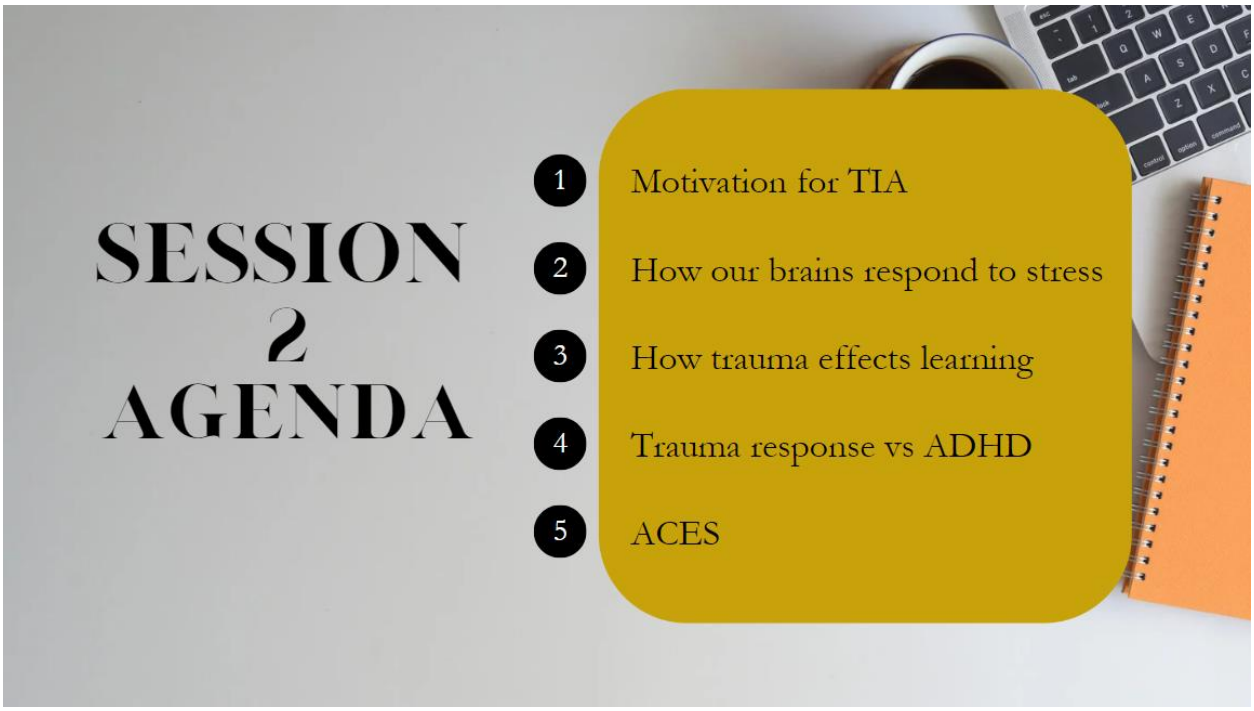
Slide 16:

- At this time, we will take a 15-minute break!

Slide 17:

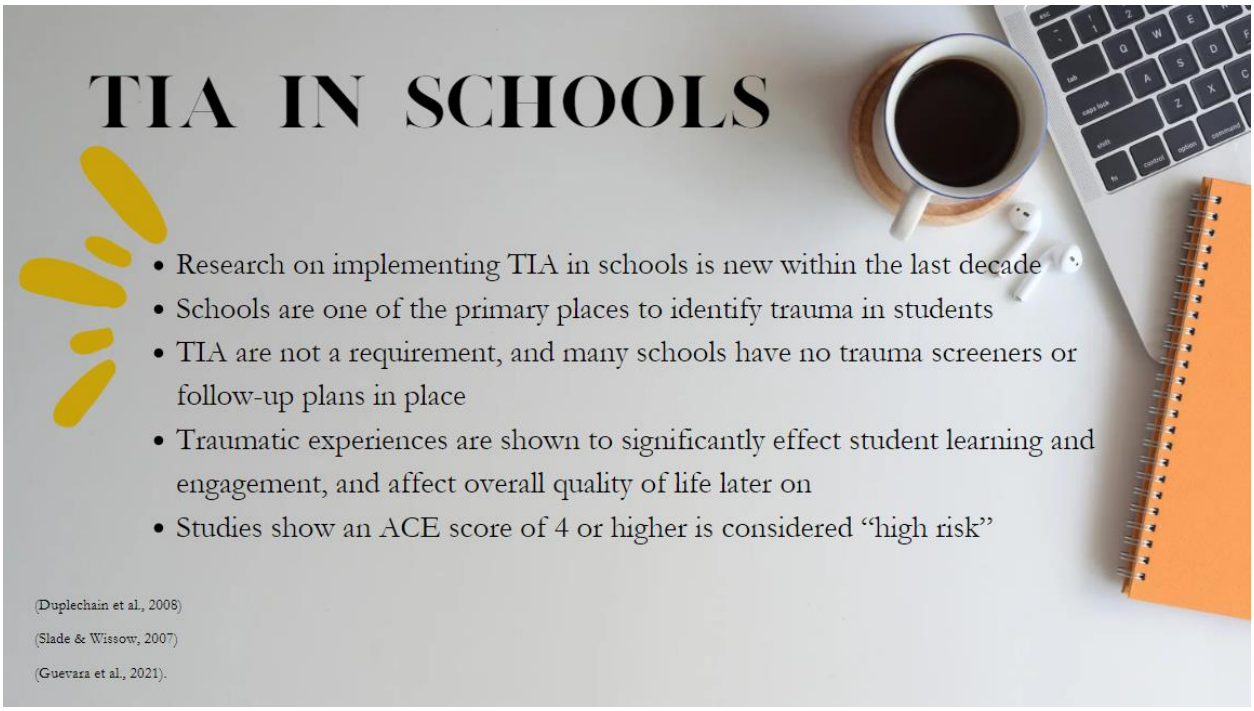
- Welcome back! We will now get started on session two.
- This session will cover the “why” on why a trauma-informed approach in schools is important.
- This is the longest session and should take around 45 minutes. We will have another 15-minute break after this!

Slide 18:



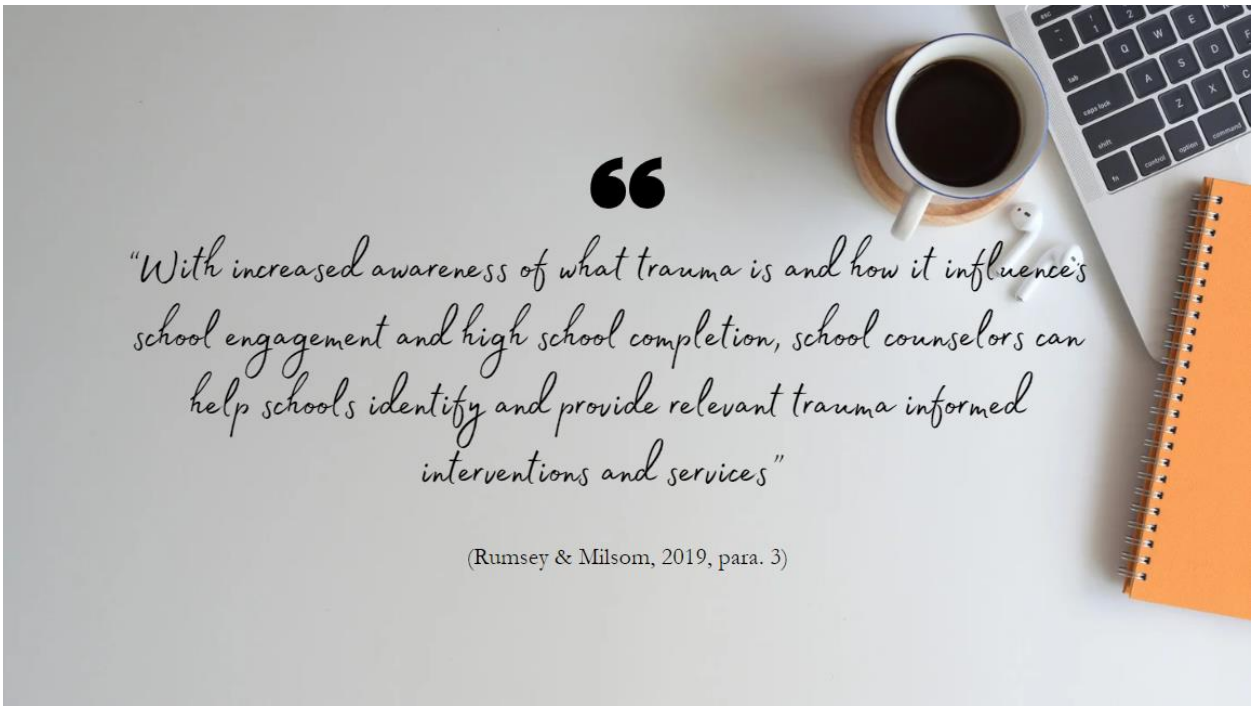
- Session two will cover some motivation for TIA, how our brains respond to stress, how trauma effects learning, the similarities between trauma and ADHD, and lastly, we will become familiar with adverse childhood experiences and what they mean for students.

Slide 19:



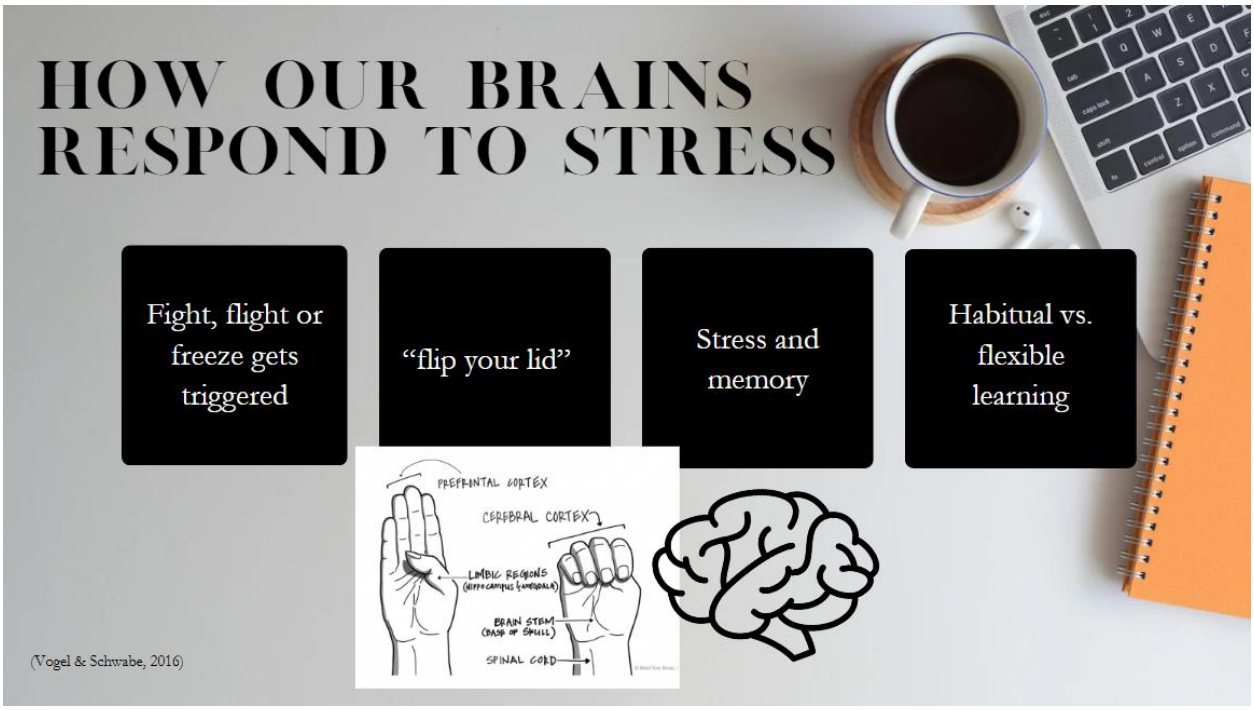
- There has been more research on TIA in schools within the last decade than ever before, however, it is still a somewhat evolving topic. How to seamlessly train schools to become "trauma-informed" is not a universal task (Guevara et al., 2021).
- We do know, schools are one of the primary places to identify students of trauma, however, schools are not required to become trauma-informed and many have yet to formulate any screeners or follow-up plans for students (Guevara et al., 2021).
- Traumatic experiences are shown to significantly affect student learning and engagement in many facets, while also affecting overall quality of life later on (Slade & Wissow, 2007).
- Studies demonstrate adolescents with an ACE score of 4 or greater is considered "high risk", which we will discuss more later on (Crouch et al., 2019).

Slide 20:



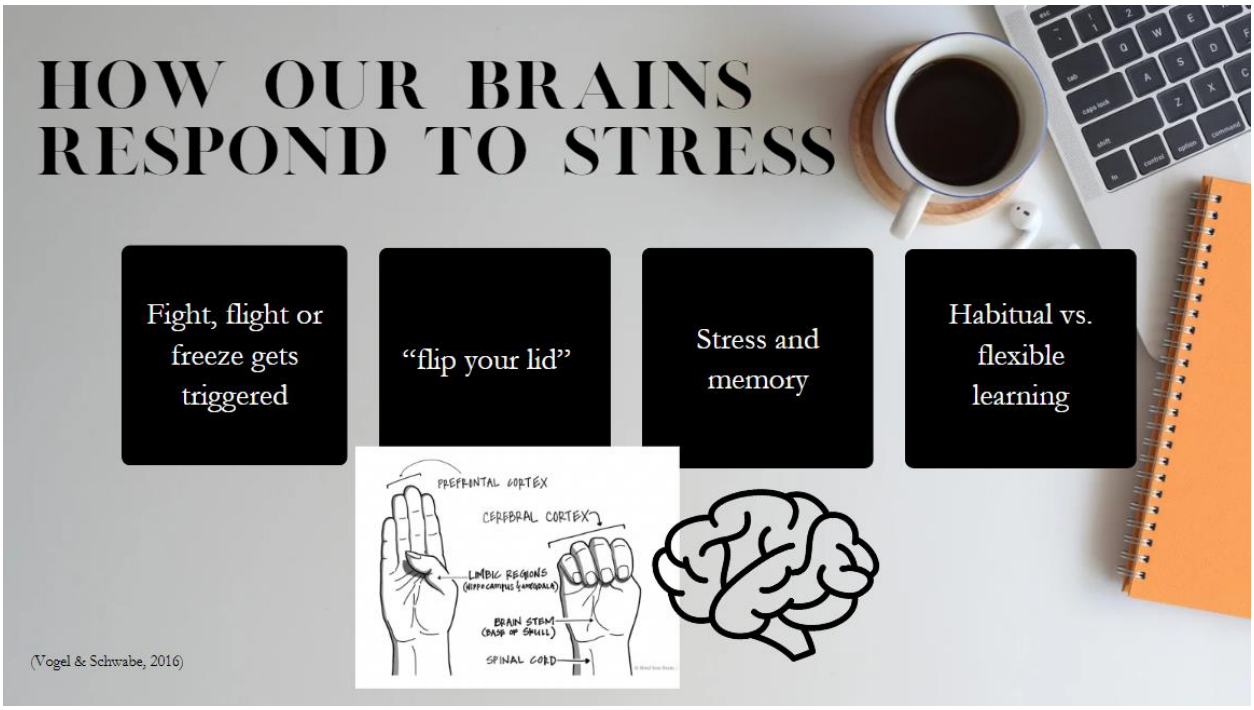
- A short pause, and a great reminder from an article by Rumsey and Milsom, as to why we have all carved out the time to be here today. We are a team, all faculty members. It takes everyone to be on board and understand how to work through tough days together.
- The counselor-teacher alliance is so important, and recognizing the need to sometimes put mental health before schoolwork is a fine line, yet an important one to be on the right side of.
- You have seen and will continue to see that a healthy mind produces an overall better learning experience for everyone involved.
- Thanks for being here today.

Slide 21:



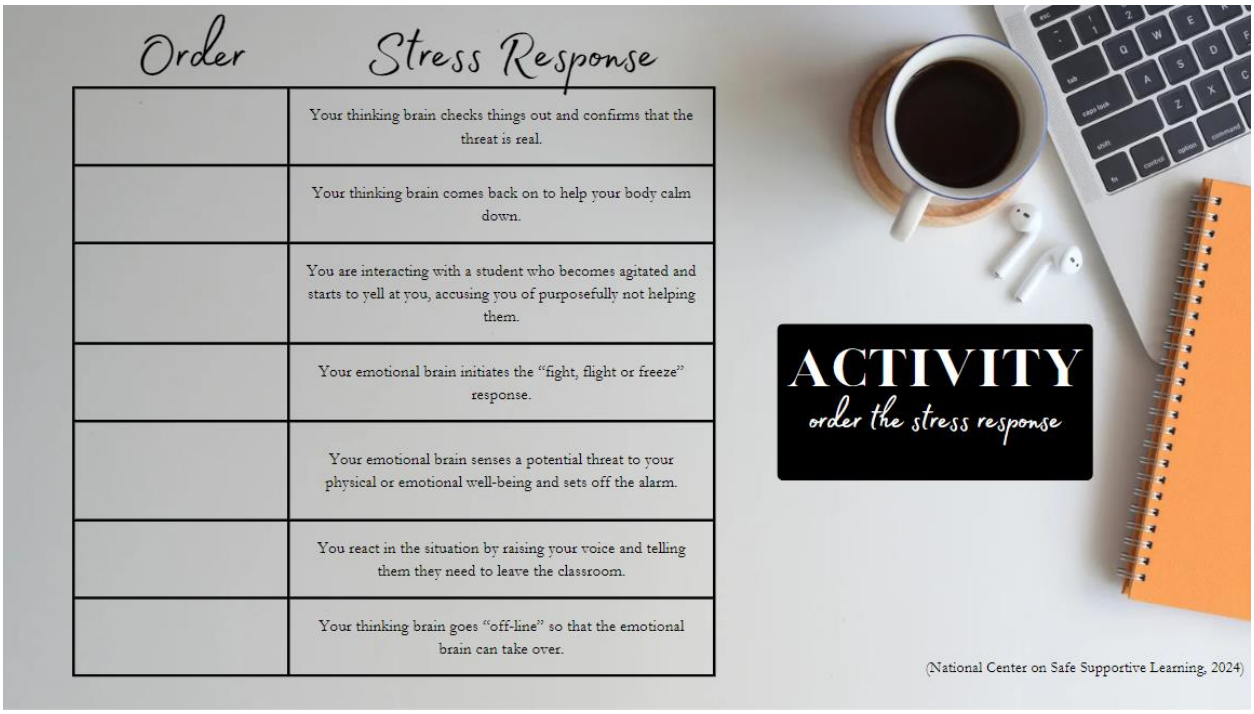
- Most of us have heard of the neurological responses, "fight, flight, or freeze", but did you know the more time you spend in a heightened state, the longer it takes your body takes to return to baseline? Our bodies sometimes even stay in the reactive state to keep us safe, even when the threat is no longer present (Rumsey & Milsom, 2019). It is in this state, some students show up to school.
- "Flipping your lid" is a nice visual way of describing what happens in our brain when cortisol levels spike and these reactions take place. Our upstairs brain (prefrontal cortex) which is in charge of logic and reasoning, flips up and is no longer communicating to your downstairs brain (cerebellum/limbic regions), where the hippocampus and amygdala are located. Thus, when your body feels threatened, the reasoning part of your brain is no longer able to talk sense into the region feeling threatened (Vogel & Schwabe, 2016).

Slide 21:



- Being the amygdala is what controls memory and emotion, when it is disrupted, it is extremely difficult for learning and retention to take place (Vogel & Schwabe, 2016).
- Pervasive stress can even shift your brain from a flexible learning system that depends on the hippocampus, to a more rigid, habitual-like memory system that depends on the dorsal striatum (Vogel & Schwabe, 2016). Habitual learning has shown less memory retention, more resistant to extinction, and geared towards obtaining rewards and avoiding punishments. I consider that a more robotic version of, "doing what you need to do to survive."

Slide 22:



- Now for an activity!
- Given what we went over about how our brains respond to stress, give your best guess at ordering the stress responses 1-7.
- You can do this together at your table or on your own!

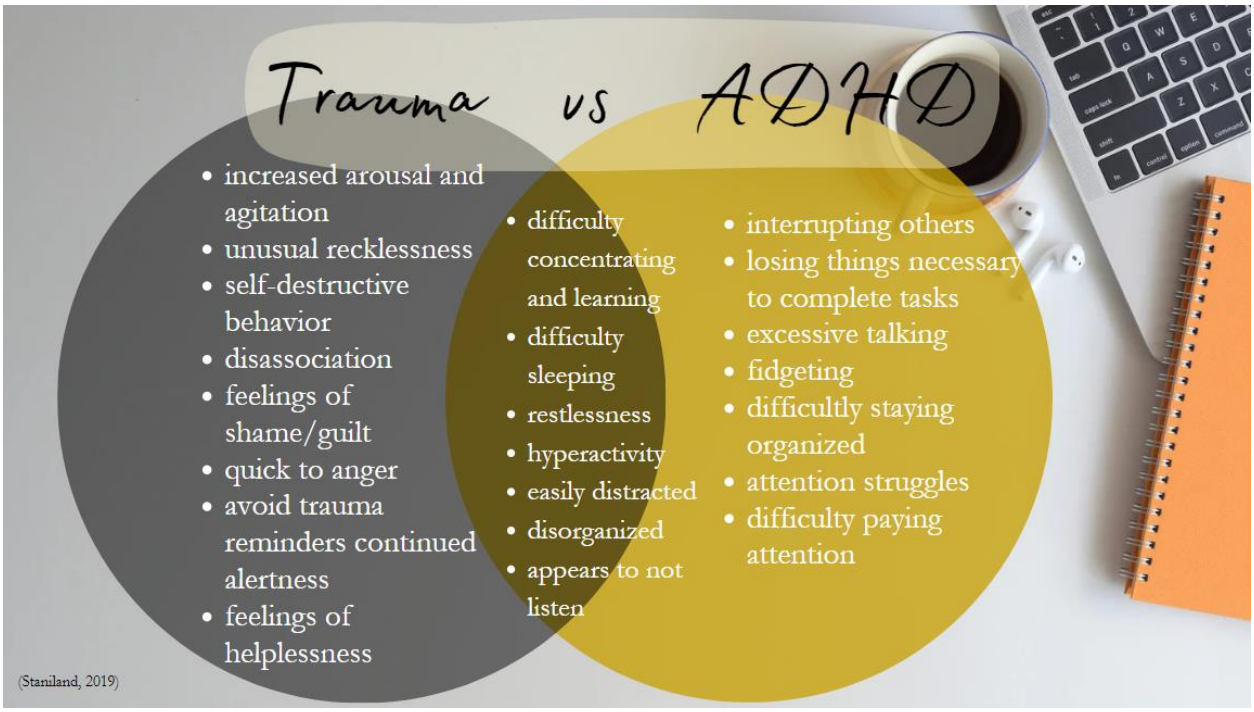
(5-7-minutes)

Slide 23:

- Check your answers and see how you did.
- Have you experienced a situation like this before as an educator?

(2-3-minute group discussion)

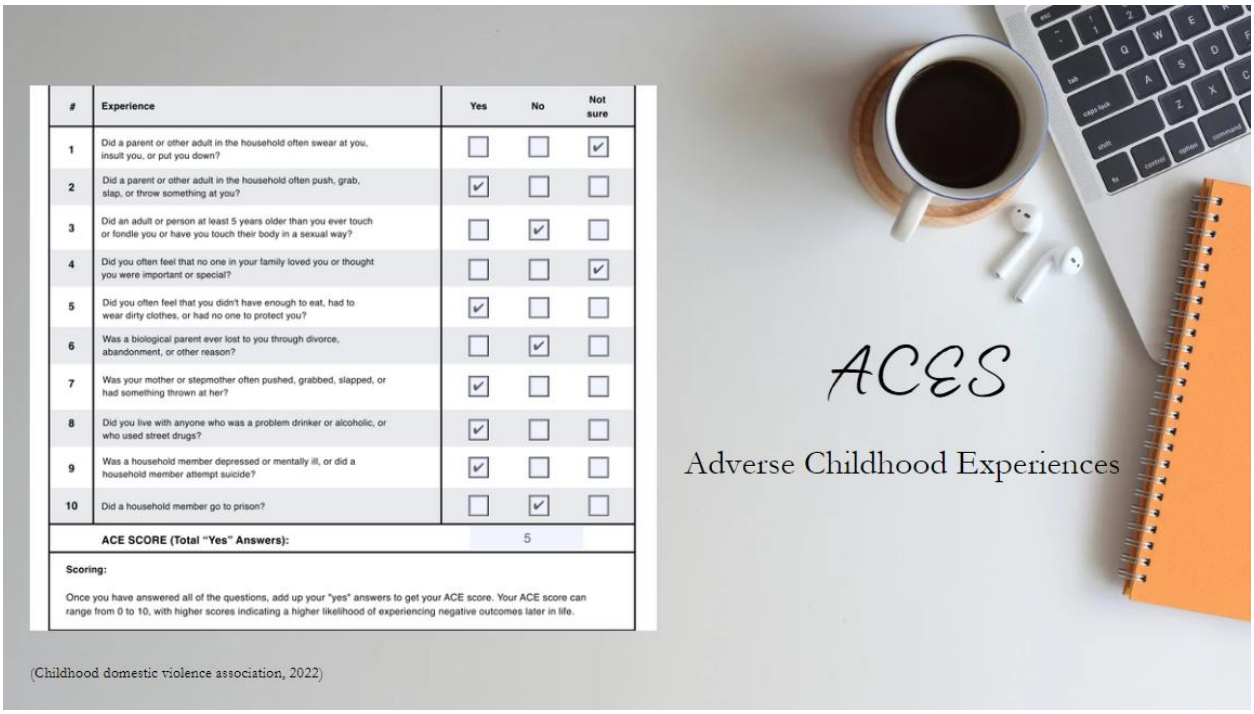
Slide 24:



- As we continue to recognize signs of trauma in students, it is important to realize some of the symptoms may overlap with ADHD.
- I bring this to your attention today as teachers play a pivotal role in diagnosing for ADHD, as doctors rely heavily on the referrals from school and parents.
- You have the ability to ask, “what if?”
- Comorbid diagnosis are also possible, but trauma can otherwise go untreated if no one speaks up for students to receive treatment for *all* necessary services.
- Take a minute and think to yourself if any particular student comes to mind.

(1-2-minute pause)

Slide 25:



#	Experience	Yes	No	Not sure
1	Did a parent or other adult in the household often swear at you, insult you, or put you down?	☐	☐	☑
2	Did a parent or other adult in the household often push, grab, slap, or throw something at you?	☑	☐	☐
3	Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way?	☐	☑	☐
4	Did you often feel that no one in your family loved you or thought you were important or special?	☐	☐	☑
5	Did you often feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect you?	☑	☐	☐
6	Was a biological parent ever lost to you through divorce, abandonment, or other reason?	☐	☑	☐
7	Was your mother or stepmother often pushed, grabbed, slapped, or had something thrown at her?	☑	☐	☐
8	Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?	☑	☐	☐
9	Was a household member depressed or mentally ill, or did a household member attempt suicide?	☑	☐	☐
10	Did a household member go to prison?	☐	☑	☐
	ACE SCORE (Total "Yes" Answers):	5		

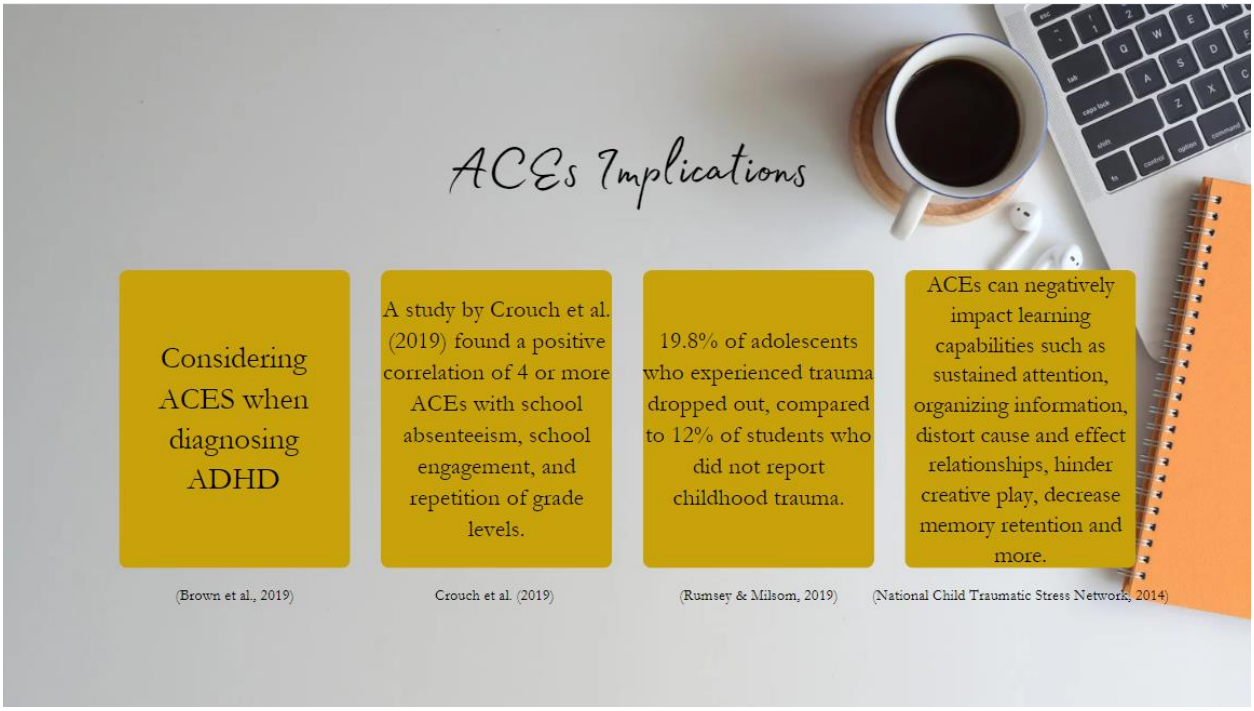
Scoring:

Once you have answered all of the questions, add up your "yes" answers to get your ACE score. Your ACE score can range from 0 to 10, with higher scores indicating a higher likelihood of experiencing negative outcomes later in life.

(Childhood domestic violence association, 2022)

- We cannot discuss trauma-informed services without mentioning ACEs.
- The 10 Adverse childhood experiences are:
- physical abuse, emotional abuse, sexual abuse, physical neglect, emotional neglect, alcohol or drug abused by a parent, mentally ill parent, divorce, incarceration of a parent, and childhood domestic violence.
- 64% of the population have at least 1 ACE.
- 12% of the population reported having an ACE score of 4 or greater, nearly doubling the risk of heart disease and cancer.
- ACEs also increase the likelihood of becoming an alcoholic by 700% and increase the risk of attempting suicide by 1200% (Childhood domestic violence association, 2022).

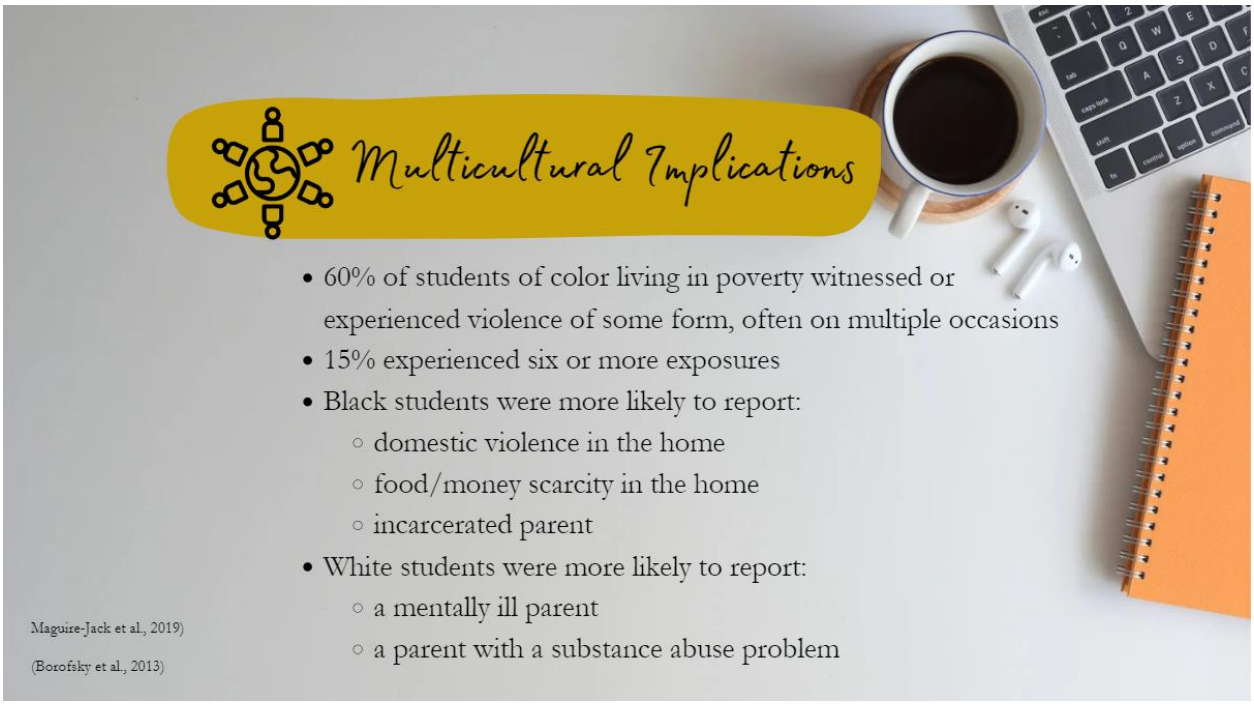
Slide 26:



- Mentioned above are just a few of many studies on how ACEs affect students in the learning environment.
- Assessing for trauma is not currently a part of the process when diagnosing for ADHD, despite the overlapping symptoms such as impulsivity and distractedness. Most formal diagnoses rely on parent and teacher referrals, and do not consider outside environmental or psychosocial factors (Brown et al., 2017).
- Again, 4 or more ACEs are linked to poorer school absenteeism, less school engagement, and repetition of grade levels.
- Students who experience trauma also drop out of school at higher rates (19.8% compared to 12%).
- ACEs also negatively impact learning capabilities including sustained attention, organization of information, distort cause and effect relationships, hinder creative play, and decrease memory retention.

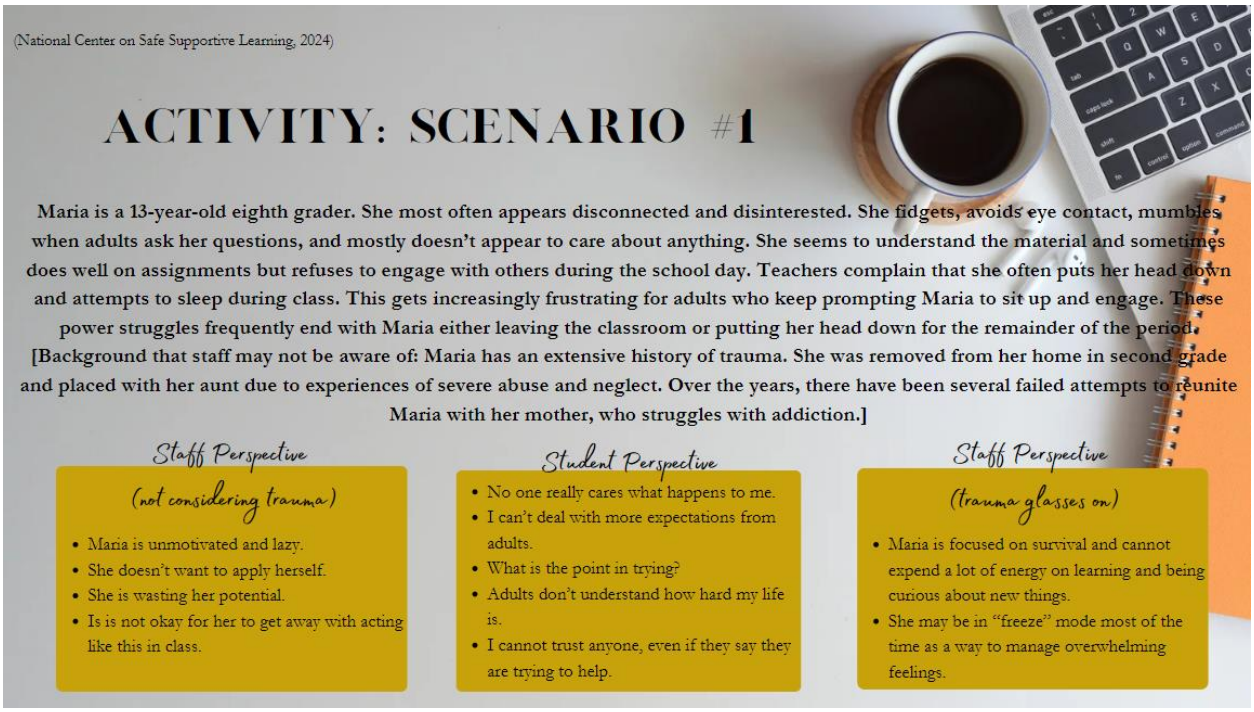
- This checks out when we think back to the slides on how a brain learns in a heightened state.

Slide 27:



- Recognizing racial disparities when discussing the topic of trauma is imperative.
- Historically, Black students report higher rates of witnessing acts of violence on multiple occasions, with 15% reporting 6 or more exposures.
- A study by Maguire-Jack et al. (2019) recognized the importance of not only considering the number of ACEs, but the associations between type and race/ethnicity of the person. This approach is geared towards understanding on a deeper level, the historical repetition of disadvantage students of color face.

Slide 28:

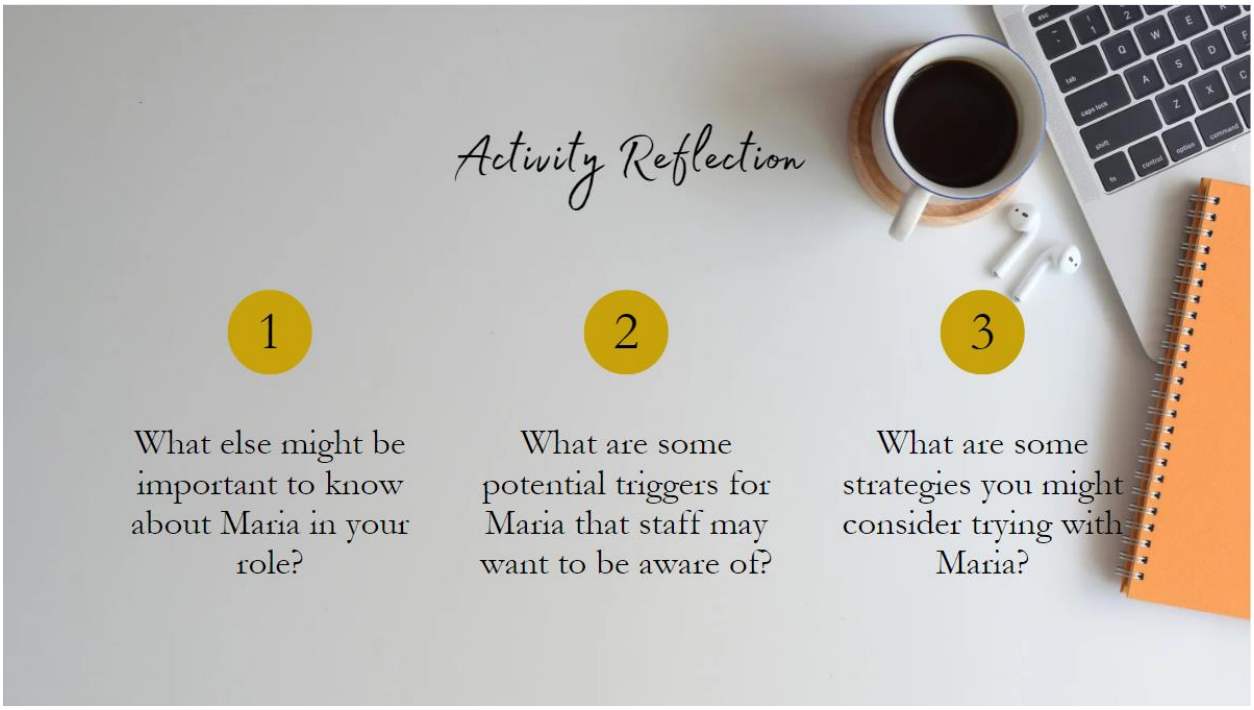


- For this activity, we will read the vignette, and you will be asked to consider it from three different perspectives and discuss with your table:
    - A staff perspective who does not consider a student has underlying trauma
    - The student perspective
    - Lastly, a staff perspective who does consider a trauma background
- We will share our thoughts after about 7-10 minutes.

(7-10-minute discussion)

- Who would like to share what your table talked about?

Slide 29:



- What are some questions you would still have for Maria?
- What are some triggers you would want to avoid when working/or talking to Maria?
- Lastly, after learning more about Maria, what would you do differently as educators when working with Maria?

(5-7-minute open discussion)

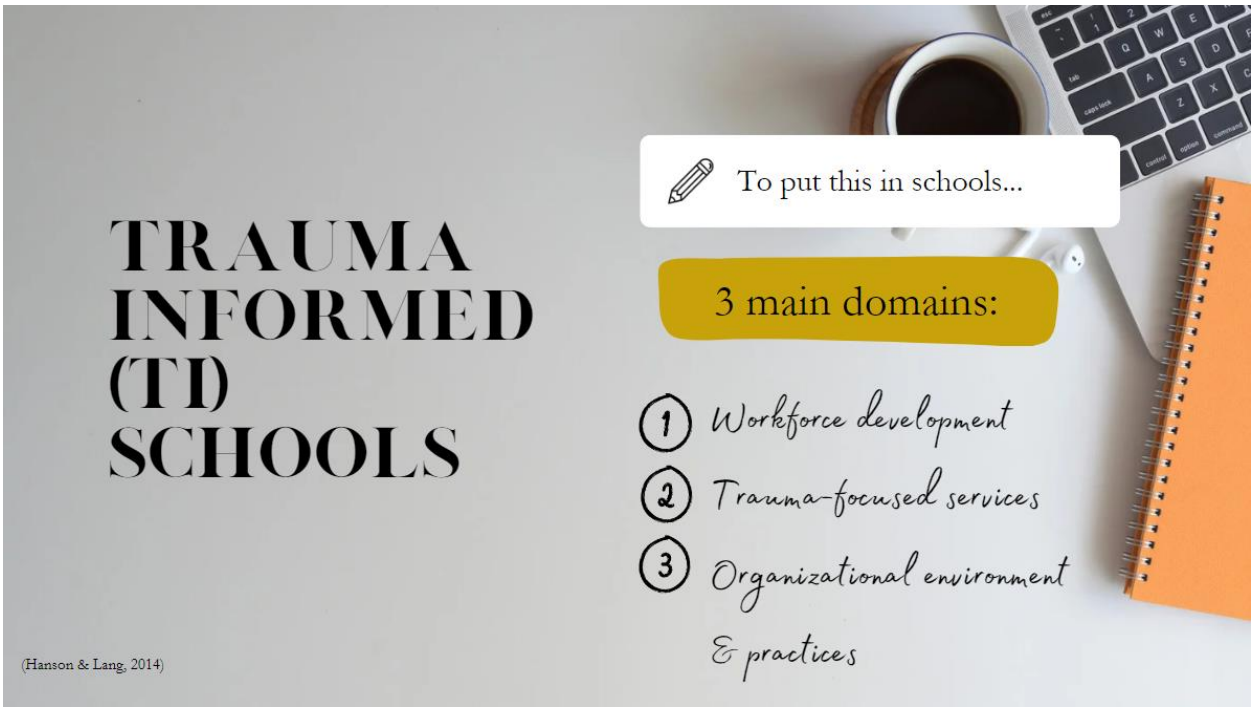
Slide 30:

- We have our next 15-minute break, I will see you all back soon!

Slide 31:

- This is our last session; it will take about 30 minutes.
- We have so far discussed what trauma is and why it is important to incorporate trauma-informed approaches in schools, we will now spend session 3 learning how we do this.

Slide 32:

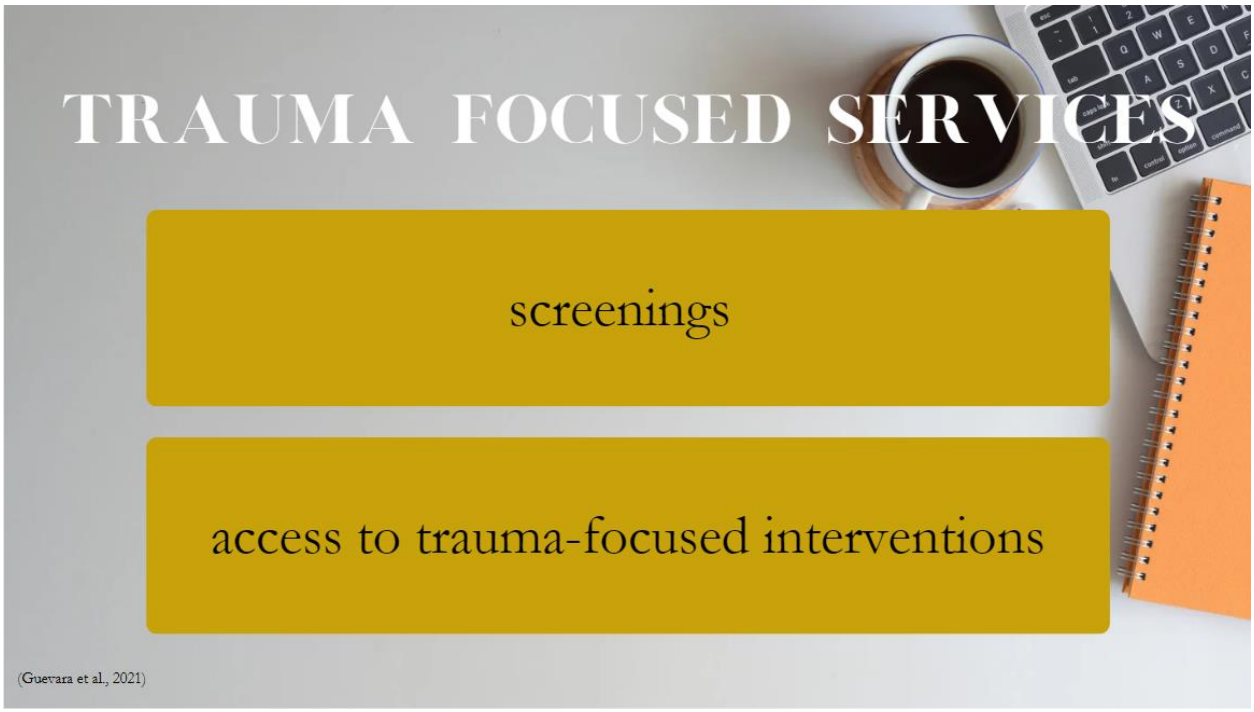


- It is important to mention, a universal training to provide to all educators for trauma-informed schools does not currently exist.
- For this training, an article by Hanson and Lang (2014) which condensed research into 3 main domains to best operationalize and teach TIA was utilized.
- The three main domains are workforce development, trauma-focused services, organizational environment and practices.

Slide 33:

- Trauma-informed environments start with training staff at their appropriate scope of practice, including when to refer students to the internal trauma expert in the building, such as the counselor, or when appropriate, school psychologist or social worker. A big portion of training at the educator level is simply developing an awareness for recognizing the signs of trauma in their students.
- Staff wellness is always included in TI interventions, as it becomes incredibly difficult to take on the needs of students if you are struggling yourself. Self-awareness is also key to trauma-informed interventions, as countertransference and secondhand depression/anxiety are a real possibility. Practicing self-care is important.

Slide 34:

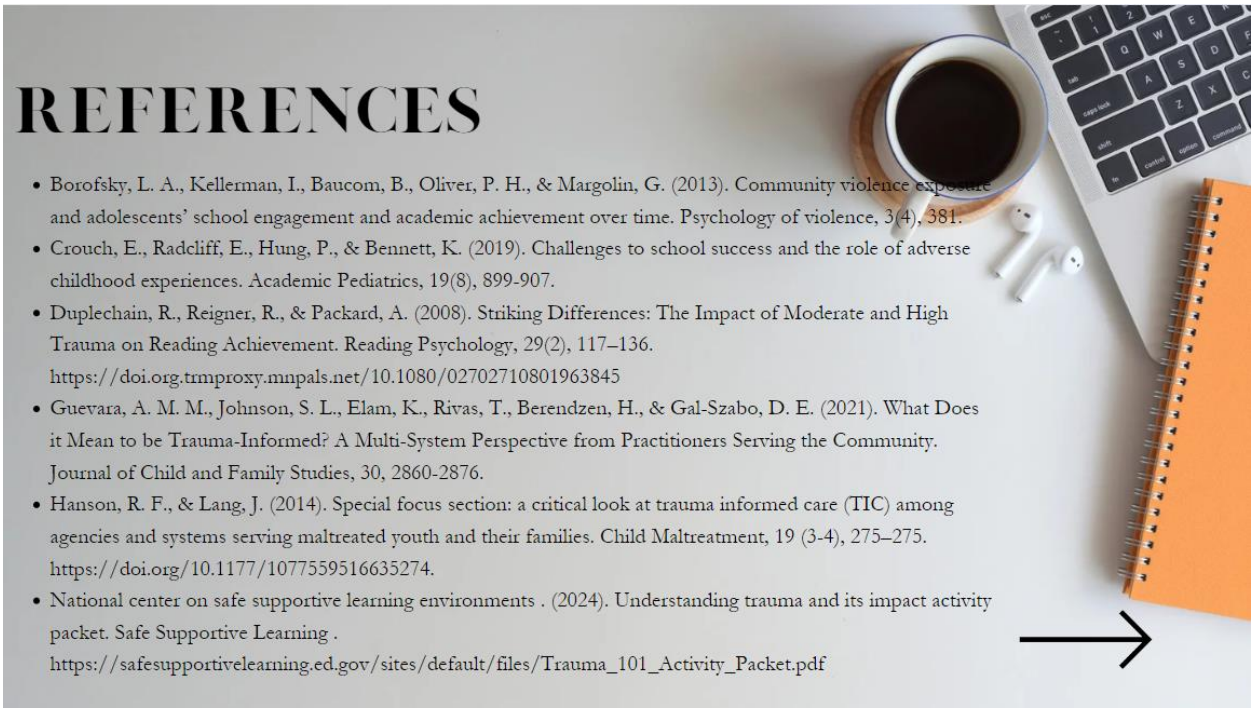


- The second domain explained by Hanson and Lang (2014) is trauma focused services, which include access to trauma screenings and trauma-focused interventions. There are a number of trauma screeners available through numerous educational platforms, it is important the school counselor's select one that best meets the needs of their students and is within the ASCA standards and regulations to distribute within the school system.
- Educators and faculty should recognize their access to trauma focused interventions, and that they are not being asked nor are they trained in performing trauma focused interventions with students. They would refer learners to school counselors, who also proceed to refer to clinical specialists when necessary (Hanson & Lang, 2019).

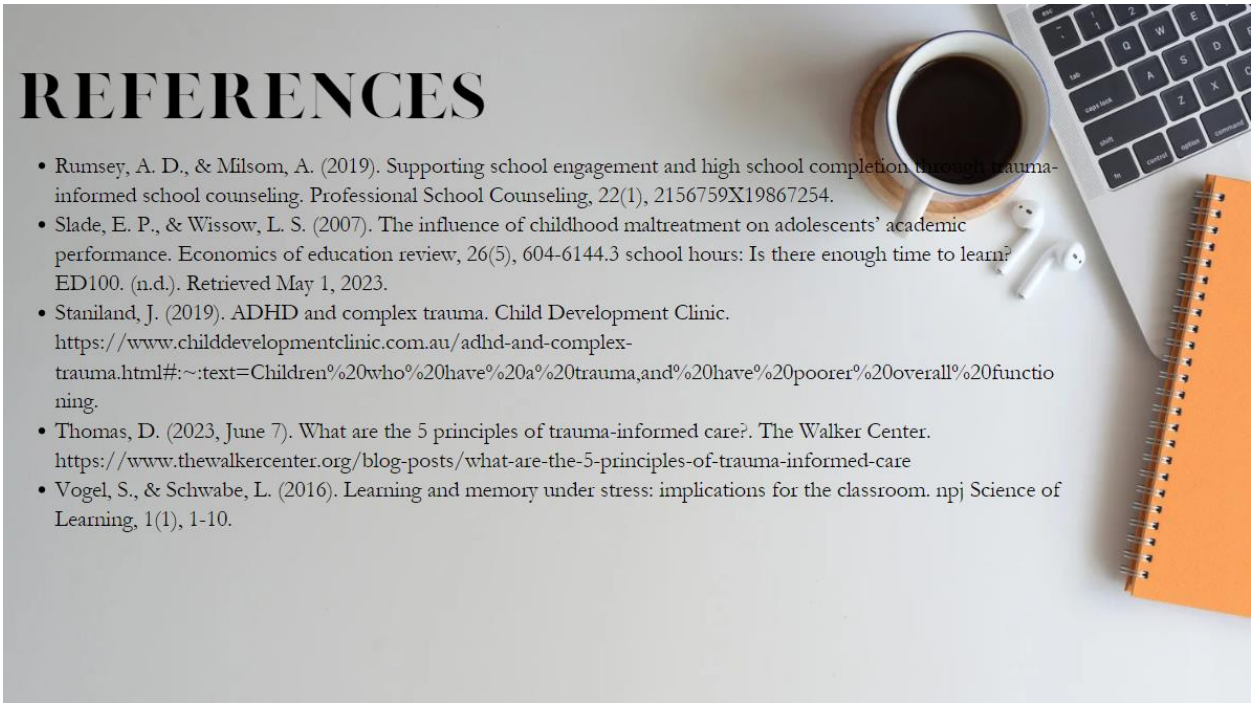
Slide 35:

- Essentially, the third domain recognizes the need for policy change at an all systems level, meaning all faculty members need to collaborate and work together to truly become trauma-informed.
- Everyone plays a pivotal role in recognizing signs of trauma in students, so engagement from all titles within their appropriate scope of practice is necessary for successfully implementing trauma-informed services.

Slide 36:


REFERENCES
• Borofsky, L. A., Kellerman, I., Baucom, B., Oliver, P. H., & Margolin, G. (2013). Community violence exposure and adolescents' school engagement and academic achievement over time. Psychology of violence, 3(4), 381.
• Crouch, E., Radcliff, E., Hung, P., & Bennett, K. (2019). Challenges to school success and the role of adverse childhood experiences. Academic Pediatrics, 19(8), 899-907.
• Duplechain, R., Reigner, R., & Packard, A. (2008). Striking Differences: The Impact of Moderate and High Trauma on Reading Achievement. Reading Psychology, 29(2), 117–136. https://doi.org.trmproxy.mnpals.net/10.1080/02702710801963845
• Guevara, A. M. M., Johnson, S. L., Elam, K., Rivas, T., Berendzen, H., & Gal-Szabo, D. E. (2021). What Does it Mean to be Trauma-Informed? A Multi-System Perspective from Practitioners Serving the Community. Journal of Child and Family Studies, 30, 2860-2876.
• Hanson, R. F., & Lang, J. (2014). Special focus section: a critical look at trauma informed care (TIC) among agencies and systems serving maltreated youth and their families. Child Maltreatment, 19 (3-4), 275–275. https://doi.org/10.1177/1077559516635274.
• National center on safe supportive learning environments . (2024). Understanding trauma and its impact activity packet. Safe Supportive Learning . https://safesupportivelearning.ed.gov/sites/default/files/Trauma_101_Activity_Packet.pdf

Slide 37:


REFERENCES
• Rumsey, A. D., & Milsom, A. (2019). Supporting school engagement and high school completion through trauma-informed school counseling. Professional School Counseling, 22(1), 2156759X19867254.
• Slade, E. P., & Wissow, L. S. (2007). The influence of childhood maltreatment on adolescents' academic performance. Economics of education review, 26(5), 604-6144.3 school hours: Is there enough time to learn? ED100. (n.d.). Retrieved May 1, 2023.
• Staniland, J. (2019). ADHD and complex trauma. Child Development Clinic. https://www.childdevelopmentclinic.com.au/adhd-and-complex-trauma.html#:~:text=Children%20who%20have%20a%20trauma,and%20have%20poorer%20overall%20functioning.
• Thomas, D. (2023, June 7). What are the 5 principles of trauma-informed care?. The Walker Center. https://www.thewalkercenter.org/blog-posts/what-are-the-5-principles-of-trauma-informed-care
• Vogel, S., & Schwabe, L. (2016). Learning and memory under stress: implications for the classroom. npj Science of Learning, 1(1), 1-10.

References

American School Counselor Association (2019). ASCA School Counselor Professional Standards & Competencies. Alexandria, VA: Author.

ACE screening clinical workflows, aces and toxic stress ... aces aware . (2020). https://www.acesaware.org/wp-content/uploads/2019/12/ACE-Clinical-Workflows-Algorithms-and-ACE-Associated-Health-Conditions.pdf

Alvarez, J. M., Saunders, R., Neubauer, E., & Brown, C. H. (2022). School counselors implementing a trauma-informed approach through evidence-based practices. *Professional School Counseling*, *26*(1a), 2156759X221086742.

Blitz, L. V., Anderson, E. M., & Saastamoinen, M. (2016). Assessing perceptions of culture and trauma in an elementary school: Informing a model for culturally responsive trauma-informed schools. *The Urban Review*, *48*(4), 520–542. https://doi.org/10.1007/s11256-016-0366-9

Blodgett, C., & Lanigan, J. D. (2018). The association between adverse childhood experience (ACE) and school success in elementary school children. *School Psychology Quarterly*, *33*(1), 137.

Borofsky, L. A., Kellerman, I., Baucom, B., Oliver, P. H., & Margolin, G. (2013). Community violence exposure and adolescents' school engagement and academic achievement over time. *Psychology of violence*, *3*(4), 381.

Center for Disease Control and Prevention (2019). About adverse childhood experience. https://www.cdc.gov/violenceprevention/ childabuseandneglect/acestudy.

Chafouleas, S. M., Koriakin, T. A., Roundfield, K. D., & Overstreet, S. (2019). Addressing childhood trauma in school settings: A framework for evidence-based practice. *School mental health*, *11*, 40-53.

Civil Rights Data Collection. (2012). Revealing new truths about our nation's schools. U.S. Department of Education, Office for Civil Rights. Retrieved from: http://www2.ed.gov/about/offices/list/ocr/ docs/crdc-2012-data-summary.pdf.

Crouch, E., Radcliff, E., Hung, P., & Bennett, K. (2019). Challenges to school success and the role of adverse childhood experiences. *Academic Pediatrics*, *19*(8), 899-907.

Duplechain, R., Reigner, R., & Packard, A. (2008). Striking Differences: The Impact of Moderate and High Trauma on Reading Achievement. *Reading Psychology*, *29*(2), 117–136. https://doi-org.trmproxy.mnpals.net/10.1080/02702710801963845

Goodkind, J. R., LaNoue, M. D., & Milford, J. (2010). Adaptation and implementation of cognitive behavioral intervention for trauma in schools with American Indian youth. *Journal of Clinical Child & Adolescent Psychology*, *39*(6), 858-872.

Guevara, A. M. M., Johnson, S. L., Elam, K., Rivas, T., Berendzen, H., & Gal-Szabo, D. E. (2021). What Does it Mean to be Trauma-Informed? A Multi-System Perspective from Practitioners Serving the Community. *Journal of Child and Family Studies*, *30*, 2860-2876.

Hanson, R. F., & Lang, J. (2014). Special focus section: a critical look at trauma informed care (TIC) among agencies and systems serving maltreated youth and their families. Child Maltreatment, 19 (3-4), 275–275. https://doi.org/10.1177/1077559516635274.

Hanson, R. F., & Lang, J. (2016). A critical look at trauma-informed care among agencies and systems serving maltreated youth and their families. Child Maltreatment, 21(2), 95–100. https://doi.org/ 10.1177/1077559516635274.

Husky, M. M., Salamon, R., Bitfoi, A., Carta, M. G., Chan Chee, C., Goelitz, D., Koç, C., Lesinskiene, S., Mihova, Z., Otten, R., Pez, O., Shojaei, T., & Kovess-Masfety, V. (2020). Self-reported mental health problems and performance in mathematics and reading in children across Europe. *European Journal of Developmental Psychology*, *17*(5), 704–726. https://doi.org.trmproxy.mnpals.net/10.1080/17405629.2020.1728247

Jaycox, L. H., Kataoka, S. H., Stein, B. D., Langley, A. K., & Wong, M. (2012). Cognitive behavioral intervention for trauma in schools. *Journal of Applied School Psychology*, *28*(3), 239-255.

Kozlowska, K., Walker, P., Mclean, L., & Carrive, P. (2015). Fear and the defense cascade. Harvard Review of Psychiatry, 23, 263–287. doi:10.1097/hrp.0000000000000065

Maguire-Jack, K., Lanier, P., & Lombardi, B. (2019). Investigating Racial Differences in Clusters of Adverse Childhood Experiences. *American Journal of Orthopsychiatry*, *90*(1), 106–114. https://doi.org/10.1037/ort0000405

Menschner, C., & Maul, A. (2016, April). *Key ingredients for successful trauma-informed care* ... samhsa. https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

National center on safe supportive learning environments. (2024). Understanding trauma and its impact activity packet. Safe Supportive Learning. https://safesupportivelearning.ed.gov/sites/default/files/Trauma_101_Activity_Packet.pdf

Nelson, V. (2022, August 5). *Student Study Time Matters*. CollegiateParent. https://www.collegiateparent.com/academics/student-study-time-matters/#:~:text=In%20a%20180%20day%20school,4%E2%80%935%20hours%2Fweek

Ngo, V., Langley, A., Kataoka, S. H., Nadeem, E., Escudero, P. I. A., & Stein, B. D. (2008). Providing evidence based practice to ethnically diverse youth: Examples from the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program. *Journal of the American Academy of Child and Adolescent Psychiatry*, *47*(8), 858.

Reinbergs, E. J., & Fefer, S. A. (2017). Addressing trauma in schools: Multitiered service delivery options for practitioners. *Psychology in the Schools, 55*(3), 250–263. https://doi.org/10.1002/pits.22105

Rumsey, A. D., & Milsom, A. (2019). Supporting school engagement and high school completion through trauma-informed school counseling. *Professional School Counseling*, *22*(1), 2156759X19867254.

Skiba, R. J., Michael, R. S., Nardo, A. C., & Peterson, R. L. (2002). The color of discipline: Sources of racial and gender disproportionality in school punishment. The Urban Review, 34(4), 317–342.

Slade, E. P., & Wissow, L. S. (2007). The influence of childhood maltreatment on adolescents' academic performance. *Economics of education review*, *26*(5), 604-614 *4.3 school hours: Is there enough time to learn?* ED100. (n.d.). Retrieved May 1, 2023.

Staniland, J. (2019, December). *ADHD and complex trauma*. Child Development Clinic. https://www.childdevelopmentclinic.com.au/adhd-and-complex-trauma.html

Sweeney, A., & Taggart, D. (2018). (Mis) understanding trauma-informed approaches in mental health. *Journal of Mental Health*, *27*(5), 383-387

Team, C. (2024b, March 13). *What are adverse childhood experiences (aces)?*. CDV. https://cdv.org/2022/12/what-are-adverse-childhood-experiences-aces/#:~:text=Most%20people%20(64%25)%20have,attempted%20suicide%20by%201200%20percent

Thomas, D. (2023, June 7). What are the 5 principles of trauma-informed care?. The Walker Center. https://www.thewalkercenter.org/blog-posts/what-are-the-5-principles-of-trauma-informed-care

U.S. Bureau of the Census. (2017). Educational attainment in the United States: 2016. Retrieved from https://www.census.gov/ data/tables/2016/demo/education-attainment/cps-detailed-tables. Html

Van der Kolk, B. A. (2015). The body keeps the score: Brain, mind, and body in the healing of trauma. New York, NY: Penguin Books.

Vogel, S., & Schwabe, L. (2016). Learning and memory under stress: implications for the classroom. *npj Science of Learning*, *1*(1), 1-10.

Walkley, M., & Cox, T. L. (2013). Building trauma-informed schools and communities. Children & Schools, 35(2), 123–126. https:// doi.org/10.1093/cs/cdt007.

Wiest-Stevenson, C., & Lee, C. (2016). Trauma-informed schools. Journal of Evidence-informed Social Work, 13(5), 498–503. https://doi.org/10.1080/23761407.2016.11668

Appendix A

Trauma-Informed Schools Pre-test

Circle the best answer based on your current level of knowledge

1) The ACE study is the study of
    a. Adverse cognitive effects
    b. Actual childhood experiences
    c. Adverse childhood experiences
    d. Amplified chronic exposure

2) Trauma informed care involves a shift in paradigm from "what's wrong with you?" to
    a. "Why are you behaving like this?"
    b. "How do we fix this?"
    c. "What are you doing wrong?"
    d. "What happened to you?"

3) A high ACE score can predict: Select all that apply
    a. High risk behavior
    b. Early death
    c. Chronic illness
    d. All of the above

4) Over half the population has experiences at least __ ACE(s).
    a. 3
    b. 4
    c. 1
    d. 6

5) Overlapping signs of trauma and ADHD include:
    a. Being easily distracted
    b. Difficulty sleeping
    c. Disorganization
    d. Hyperactivity
    e. All of the above

6) Traumatic experiences include:
    a. Returning from war
    b. Getting in a small car accident
    c. Running out of gas on the interstate
    d. Traumatic experiences are not measured by anyone other than the individual experiencing them

7) Taking care of myself is part of trauma informed care:
    a. True
    b. False

Appendix B

Trauma-Informed Schools Post-test and Answer Sheet

Circle the best answer based on your current level of knowledge

1) The ACE study is the study of
    a. Adverse cognitive effects
    b. Actual childhood experiences
    c. Adverse childhood experiences
    d. Amplified chronic exposure

2) Trauma informed care involves a shift in paradigm from "what's wrong with you?" to
    a. "Why are you behaving like this?"
    b. "How do we fix this?"
    c. "What are you doing wrong?"
    d. "What happened to you?"

3) A high ACE score can predict: Select all that apply
    a. High risk behavior
    b. Early death
    c. Chronic illness
    d. All of the above

4) Over half the population has experiences at least __ ACE(s).
    a. 3
    b. 4
    c. 1
    d. 6

5) Overlapping signs of trauma and ADHD include:
    a. Being easily distracted
    b. Difficulty sleeping
    c. Disorganization
    d. Hyperactivity
    e. All of the above

6) Traumatic experiences include:
    a. Returning from war
    b. Getting in a small car accident
    c. Running out of gas on the interstate
    d. Traumatic experiences are not measured by anyone other than the individual experiencing them

7) Taking care of myself is part of trauma informed care:
    a. True
    b. False

Appendix C

The stress-response participant handout - training activity

Order	Stress response
	Your thinking brain checks things out and confirms that the threat is real.
	Your thinking brain comes back on to help your body calm down.
	You are interacting with a student who becomes agitated and starts to yell at you, accusing you of purposefully not helping them.
	Your emotional brain initiates the “fight, flight, or freeze” response.
	Your emotional brain senses a potential threat to your physical or emotional well-being and sets off the alarm.
	You react in the situation by raising your voice and telling them they need to leave the classroom.
	Your thinking brain goes “off-line” so that the emotional brain can take over.

(National Center on Safe Supportive Learning, 2024)

Appendix D

The stress-response facilitator handout - training activity

Order—Leader answer key	Stress response
3	Your thinking brain checks things out and confirms that the threat is real.
7	Your thinking brain comes back on to help your body calm down.
1	You are interacting with a student who becomes agitated and starts to yell at you, accusing you of purposefully not helping them.
5	Your emotional brain initiates the “fight, flight, or freeze” response.
2	Your emotional brain senses a potential threat to your physical or emotional well-being and sets off the alarm.
6	You react in the situation by raising your voice and telling them they need to leave the classroom.
4	Your thinking brain goes “off-line” so that the emotional brain can take over.

(National Center on Safe Supportive Learning, 2024)

Appendix E

Trauma response vignette participant handout – training activity

Scenario #1: Maria is a 13-year-old eighth grader. She most often appears disconnected and disinterested. She fidgets, avoids eye-contact, mumbles when adults ask her questions, and mostly doesn't appear to care about anything. She seems to understand the material and sometimes does well on assignments but refuses to engage with others during the school day. Teachers complain that she often puts her head down and attempts to sleep during class. This gets increasingly frustrating for adults who keep prompting Maria to sit up and engage. These power struggles frequently end with Maria either leaving the classroom or putting her head down for the remainder of the period.

[Background that staff may not be aware of: Maria has an extensive history of trauma. She was removed from her home in second grade and placed with her aunt due to experiences of severe abuse and neglect. Over the years, there have been several failed attempts to reunite Maria with her mother, who struggles with addiction.]

Staff perspective (without considering trauma)	Student perspective	Staff perspective (with trauma glasses on)
1. What else might be important to know about Maria in your role? 2. What are some potential triggers for Maria that staff may want to be aware of? 3. What are some strategies that you might consider trying with Maria?		

(National Center on Safe Supportive Learning, 2024)

Appendix F

Trauma response vignette facilitator handout – training activity

Scenario #1: Maria is a 13-year-old eighth grader. She most often appears disconnected and disinterested. She fidgets, avoids eye contact, mumbles when adults ask her questions, and mostly doesn't appear to care about anything. She seems to understand the material and sometimes does well on assignments but refuses to engage with others during the school day. Teachers complain that she often puts her head down and attempts to sleep during class. This gets increasingly frustrating for adults who keep prompting Maria to sit up and engage. These power struggles frequently end with Maria either leaving the classroom or putting her head down for the remainder of the period.

[Background that staff may not be aware of: Maria has an extensive history of trauma. She was removed from her home in second grade and placed with her aunt due to experiences of severe abuse and neglect. Over the years, there have been several failed attempts to reunite Maria with her mother, who struggles with addiction.]

Staff perspective (without considering trauma)	Student perspective	Staff perspective (with trauma glasses on)
■ *Maria is lazy and unmotivated.* ■ *She doesn't want to apply herself.* ■ *She is wasting her potential.* ■ *It's not okay for her to get away with acting like this in class, even if she does well on an assignment or test.*	■ *No one really cares what happens to me.* ■ *I can't deal with more expectations from adults.* ■ *What is the point in trying?* ■ *Adults don't understand how hard my life is.* ■ *I cannot trust anyone even if they say they are trying to help.*	■ *Maria is focused on survival and cannot expend a lot of energy on learning and being curious about new things.* ■ *She may be in "freeze" mode most of the time as a way to manage overwhelming feelings.*

1. What else might be important to know about Maria in your role?
   Cultural background, strengths, staff she connects with, peer interactions
2. What are some potential triggers for Maria that staff may want to be aware of?
   Loss, change, disappointment, negative or shaming interactions with adults
3. What are some strategies that you might consider trying with Maria?
   Tracking moments when she is more engaged and energized, giving her a role, avoiding public criticism and confrontation

(National Center on Safe Supportive Learning, 2024)

Appendix G

Training Satisfaction Survey

Please circle the number indicating the extent to which you agree with the following statements:

Please rate how much you agree or disagree with the following statements, which comprise the learning objectives for this training.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1. This training enhanced my understanding of the prevalence and types of trauma my students may experience.	5	4	3	2	1
2. I learned how the brain and body respond to stress and trauma.	5	4	3	2	1
3. I am better equipped to recognize the effects of trauma on students, staff, and parents.	5	4	3	2	1
4. The content of the training was relevant and can be easily applied to my work.	5	4	3	2	1
Please rate how much you agree or disagree with the following statements about the training experience.					
5. The material was presented in a clear and logical manner.	5	4	3	2	1
6. The workshop kept my interest overall.	5	4	3	2	1
7. The presenter was well prepared and knowledgeable.	5	4	3	2	1
8. There was ample time for interaction and questions.	5	4	3	2	1
9. I would recommend this training to others.	5	4	3	2	1

Please respond as specifically as possible to the following:

1. I learned . . .
2. I most appreciated . . .
3. I was surprised . . .
4. The first thing I want to try is . . .
5. I would like additional education on . . .
6. We can improve this training by . . .

Please use other side for additional comments.

Thank You!

(National Center on Safe Supportive Learning, 2024)