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A Curriculum Project for Itinerant Teacher's Guidebook for Best Trauma
Informed Practices

Mark Ripper, M.Ed

Otterbein University

March, 2019

Submitted in partial fulfillment of the requirements for a Master of Arts in Education
degree.

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Copyright
By
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2019

Dedication

To all the teachers who work tirelessly to teach the next generation of citizens of the world.

ACKNOWLEDGEMENTS

Thank you to my parents, Russ and Jan, for being great role models and guiding me into the field of special education.

Thank you to my sister, Lisa, who was able to provide valuable resources and time to help make this research a success.

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Attached- Guidebook for Social Emotional Learning Strategies for Children With
Traumatic Experiences

SECTION ONE

Introduction

Trauma can have a lasting impact on childhood experiences. Merriam-Webster defines trauma as “a disordered psychic or behavioral state resulting from severe mental or emotional stress or physical injury”(Merriam-Webster, “n.d”). At a young age a brain affected by trauma develops differently, impairing the child’s full potential in the classroom. Research has been conducted showing the importance of brain development in young children. A study looking at abuse and related adverse experiences in childhood stated “childhood maltreatment has been linked to a variety of changes in brain structure and function and stress responsive neurobiological systems” (Anda, et al., 2006). Researchers Carrion and Wong (2012) considered the stress of trauma and how it alters the brain. In healthy individuals, the hippocampus region of the brain is engaged during the encoding process and the retrieval of information. In those who suffer from traumatic stress, the hippocampus makes memories abnormally. Certain memories may be over represented, like intrusive thoughts or nightmares. There is also under-representation, or suppression, which is inability to recall events and memories (Carrion & Wong, 2012).

The prefrontal cortex (PFC) in traumatic brains show difficulties with suppression of intrusive memories from trauma, creating a fear response (Carrion & Wong, 2012). The PFC in healthy individuals are able to support cognitive control, which is “The ability to filter and suppress information and actions in favor of shifting attention to relevant information and responses” (Casey, Tottenham & Fosella, 2002, p. 237). Those with traumatic experience can have difficulty with attention and become easily distracted.

Children who are exposed to trauma, by witnessing the abuse or being abused themselves, have adverse effects of “increased risk of truancy, health problems, suicide

attempts, emotional distress, criminal behavior, drug and alcohol problems, and intergenerational violence” (United States Department of Justice 2011 a, b). Webb (2015) states that out of 30,000 adults in the Kaiser Health Plan in California, 12.5 % witnessed childhood exposure to intimate partner violence. As a teacher, I find this data is disturbing.

The data presented reinforced my interest on the topic of childhood trauma. During these past few months, I reflected on my teaching and asked, “why trauma?” and “What is the purpose of putting time and energy into this topic?” For one, I have experience teaching students of various backgrounds and disabilities. One of the hardest things about my job as an intervention specialist was working with students with trauma, not because of the hard work that went into it, but because the lack of curriculum that is designed for it. Schools have a method and a theory, but just one specific intervention is not going to work for every classroom. For a 3-5 year old to experience something so traumatizing in their lives, such as physical, sexual, and prenatal abuse, really bothered me. I am supposed to provide a safe environment for my students, and these students were scared and in a fight or flight mode most of the time. Students struggled in my classroom, and I struggled at times to provide them an environment with tools for success.

About three years ago, I had a student who experienced severe trauma (physical and emotional abuse) at a young age and now in the classroom with no social skills, needing a lot of self-help skills, and struggling with pre-academic development. Anytime a teacher talked loudly, a student banged his blocks, or the fire alarm went off, he went into flight/fight/freeze mode. I remember not knowing really what to do at that split

moment due to the thought that a child was so traumatized in his short life he could not regulate his body. I remember the constant one on one that was needed to make sure that this child was progressing step by step. I cannot tell you what theory I used, or which intervention was displayed in my classroom, but I can tell you that time, commitment, and love for that particular student played a major role.

In undergraduate classes, we were taught about educational theories, but learned little to nothing when it came to traumatic experiences in children. Then I remembered going to professional development training as a teacher. We learned lots of valuable information on trauma, but nothing really happened after those meetings. No resources or guidance were given to us. I remembered that feeling of not knowing what to do in that split moment with my one student, and I remembered the look on that particular student's face showed fear of the unknown. Fear as to what might happen next. I remembered getting eye level with this student and giving him a hug. No words, just deep pressure from the hug. I could hear him release a sigh of air and he just wanted that hug for several minutes. Those feelings confirmed that trauma is real in early childhood classrooms, and gave me a passion to pursue the topic further.

In my opinion, childhood is a time where a child should be free of worry and to grow up and have fun and to be a child. They should have experiences of playing sports, engaging in the arts, creating meaningful friendships. It is a critical crisis in education when we see a significant population of children witnessing abuse or being abused themselves. Each case of trauma is unique, and most of the teachers I know do not have extensive knowledge of psychology and trauma intervention. This is my motivation to

help change the classroom knowledge on trauma intervention, and provide a consistent resource for teachers and schools.

Significance of the Problem

In my 4.5 years working as an Early Childhood Intervention Specialist in two districts, I attended professional development sessions regarding trauma. We learned useful information to use with our students, but were never given the resources or tools to take our training and apply it in our schools. Through the Curriculum Design capstone project, I plan to create a guidebook for my department. This guidebook will investigate best practices and interventions that could be implemented to offset the effects of young children's trauma. The guidebook will include resources such as numbers for psychology services, hotlines for suspected abuse, and many more. My plan is for this guidebook to continue to change and evolve throughout the years as a tool for our teachers. Therefore, the research question that guides this project is: How can the research on trauma-informed teaching and practices translate into the classrooms of early childhood intervention?

Section Two

Literature Review

Classifications of Trauma in Educational Settings.

When we hear the word trauma, we tend to think about head injuries in professional sports, Post Traumatic Stress Disorder (PTSD) of veterans, or the Traumatic Brain Injuries (TBI) of those who encounter serious accidents. Trauma is an experience that is considered dangerous and disturbing for the receiving party, which can result in psychological harm, and/or injury through physical, sexual, emotional, and prenatal abuse. People do not often associate trauma with children. Young children are the most vulnerable of traumatic events due to the constant development of their brain. Children are unable to understand what is going on and why the abuse is happening to them. Trauma can cause damage that can last a lifetime.

Statistics on the population that experiences trauma varies and is considered inconsistent. Webb (2016) stated that the number of children exposed to partner violence were between 3.3-10 million a year, and varies depending on what is classified as trauma. In a study of 30,000 adults on the Kaiser Health Plan, 12.5 percent had some form of exposure to intimate partner violence, while 10.8% experienced childhood abuse within the category of physical, sexual, or emotional abuse (Webb, 2016). Briggs-Gowan, Ford, Fraleigh, McCarthy, and Cooper (2010) stated in their research that parental violence exposure in the United States was between 12-24%, which is similar to a study done by Knickerbocker, Heyman, Slep, Jouriles, and McDonald (2012) that showed 15-24% of children were exposed to domestic violence at some point in their lives. Mongillo, Briggs-Gowan, Ford, and Carter's (2009) research showed that 23.4% of children will have experienced at least one traumatic event between the ages of 6 months and 36

months. Of the 23.4%, 19.5% of parents will report dramatic changes with their children. Robers, Ferguson and Crusto (2012) did research showing that 26% of children will experience or witness a traumatic event in their lifetime.

The problem with these data collections are the inconsistencies. While the data ranges from 10.8% up to 26% of children, the issue is the complexity of trauma. The research listed above are traumas that have been documented. Each child who experiences trauma will react differently. How many children experience trauma and no one knows? At such a young age, we do not know the full impact of how trauma affects the child. Trauma is a very complex topic that includes different kinds of abuse and experiences along with different outcomes.

Sexual trauma.

Sexual trauma is an event no child should ever experience. Büyükbayraktar, Er, and Kesici (2017) stated that children do not understand what is happening to them when they are sexually abused. Children lack the maturity to understand consent. A meta-analysis study conducted by Stoltenborgh, van IJzendoorn, Euser, and Bakermans-Kranenburg (2011) looked into 217 publications of child sexual abuse (CSA) from 1982-2008. They noticed the global prevalence of CSA was around 11.8%.

With sexual abuse comes the risk of an impaired sense of self. Briere and Elliott (1994) stated how children are treated/ maltreated in the early stages of life will influence their self-awareness abilities. As a result, children who experience severe child maltreatment, either early abuse as a child, or continuous sexual abuse, might interfere with the development of the child's sense of self. (as cited in Cole and Putnam, 1994) Lastly, a meta-analysis conducted by Devries et al. (2013) looked at CSA and suicidal behavior. Their findings suggested if the relationship between CSA and suicide is casual,

then the calculations that 20.1% to 22.3% of suicides in women could be connected to CSA. For men, this number is between 9.6% to 10.8%. These results are similar to a study conducted by Brenner et al. (2011) with veterans. The study concluded that those with a history of PTSD are associated with a risk for attempting suicide. Sexual abuse is a serious trauma for young children to experience, and can impact the child's entire life.

Physical trauma.

Physical trauma occurs when people experience physical harm to their bodies caused by others, or witnessing physical harm to another. Wolfe (1998) states that physical abuse takes the forms of scalding, object beatings, punching, kicking, and slapping that could be avoidable behaviors and considered non accidental. Domestic violence is one of the categories of physical trauma children endure. Afolabi (2015) talks about domestic violence and how many scholars, academics, and professionals in human development around the world view domestic violence as a social and human rights violation. The issue Afolabi stresses is that domestic violence plays a significant role in the mental health of our children. Davies and Cummings (1994) state that the responses of the child during martial conflict are for the children's emotional security. Physical trauma is easier for teachers in schools to identify compared to other forms of trauma, due to trainings on recognizing marks, bruises, and other indicators on a child if we suspect abuse.

Prenatal trauma.

Prenatal abuse is considered child abuse due to the child's exposure to drugs, alcohol, excessive stress from the mother, or physical violence against mother and child. This impacts the child's life before they are even born. Many studies consider prenatal trauma to have lasting consequences as discussed in this paper.

Dodich (2015) looked at the unborn fetus and how different drugs affect the newborn child. Dodich explains that it is important to screen all pregnant women for substance abuse during the initial obstetrical visit, then once every trimester. A late start in prenatal care, inconsistent prenatal care, an unstable home environment, and issues with work and school can potentially be a signal that the mother is experiencing abuse.

Dodich (2015) discussed a few different substances women should avoid while they are pregnant. The first is alcohol. Alcohol is considered one of the leading preventable causes of birth defects. There is no safe alcohol use when pregnant. When consumed, alcohol will cross the placenta and can damage the fetus. This can result in short term withdraw lasting up to 72 hours, to the child developing long term chronic disorders like Fetal Alcohol Syndrome (FAS). FAS can cause poor growth in the fetus and in childhood. There is a risk of behavioral and cognitive impairment, poor memory skills, and low IQ. One study even showed that when a mother consumed 2 drinks per day while pregnant, the child's IQ at the age of 8 decreased by 7 points. (Streissguth, Barr, Sampson 1990, as cited in Dodich 2015 pg 196)

Opioids are a class of natural, endogenous and synthetic compounds that activate receptors in the central nervous system (Dodich 2015). Pregnant women who are addicted to opioids are more likely to take heroin and methadone. Prenatal opioid exposure is associated with low birth weight and length, along with a low head circumference and SIDS. A baby who was prenatally exposed to heroin will experience withdrawal after 24 hours of birth, and methadone withdrawal around 24-72 hours after birth.

Cocaine is a central nervous system stimulant that can affect prenatal development in babies (Dodich 2015). Prenatal exposure to cocaine can increase the risk of placental abruption, premature rupture of membrane, and premature deliveries. There is also a risk of spontaneous abortion. Other side effects of cocaine are genitourinary malfunction, fetal menace, bleeding, and low birth weight and length.

There are findings from other studies that support the work of Dodich. Richardson, Goldschmidt, and Willford (2008) noticed that infants who were exposed to cocaine in prenatal development were more fussy and unable to adapt to their surroundings than infants with no cocaine exposure. This observation was also significant for alcohol, tobacco, and marijuana. Richardson, Larkby, Goldschmidt, and Day (2009) noticed that children who were exposed to cocaine prenatally also had some of the highest behavior problem scores. The researchers stressed that adolescents who were prenatally exposed to cocaine were two times likely to do marijuana and alcohol by age 15 when compared to their non exposed peers. Studies conducted by Hulvershorn, Schroeder, Wink, Erickson, and McDougale (2015) looked at children who were prenatally exposed to abusive drugs by the birth mother and psychotropic medicine. They concluded that children who were prenatally exposed to the abusive drugs were prescribed more psychotropic medicine over their lifetime as opposed to non-exposed peers. Prenatal drug abuse has long term consequences in young children. All different types of trauma affect one major part of the child's body, the brain and its development.

Implications of Trauma on Brain Development.

Trauma plays a serious role when it comes to early childhood experiences on the brain. Carrington and Wong (2012) state that trauma is a threat to a child's well-being. Stress responds causally in survival modes, and could potentially alter brain

development, causing children to potentially develop Post Traumatic Stress Disorder (PTSD). PTSD is critical because this can call children to minimize the emotional part of the memory by recalling that particular abuse from the outside in (observer perspective).

What are memories?

There are two kinds of memory, explicit and implicit (Nelson and Carver, 1998). Explicit memory is declarative, meaning that memories are brought to mind as an image, and we are consciously aware of that memory. Explicit memory is the type of memory that includes being able to recall events, places, objects, and items associated with the events. It is a rapid memory, and involves at least one trial to remember. Explicit memory allows one to remember exactly what they were doing when a major event happened in their lives. Implicit memories are memories that are considered to be unconscious memories. Implicit needs multiple exposures to acquire, and might not involve ourselves. Traumatic events can change the way memories are processed.

Traumatic memories.

Research conducted by Dawson and Bryant (2016) looked into a child's vantage point in recalling traumatic events. The researchers used the recollections from child survivors in the tsunami that hit Asia in 2004. The study was conducted five years after the tsunami with children that were between the ages of 7-13 at the time of the tsunami. The method comprised of 110 children (45 boys, 65 girls) and a questionnaire was translated and verified for accuracy/ comprehension. The questionnaire used a 4 point Likert scale on how frequently the children experienced various symptoms. The participants were also asked if they remembered the tsunami. Results show that 48% indicated a high probability of a diagnosis of PTSD. Two had no recollection of the tsunami, no personal memories or understanding of that particular day. 33 children had

an indirect memory of that particular day (understanding what happened that day without personally recalling it). 67 children were able to directly recall the event. One third of the participants stated their stories were compiled from hearing stories from others. While not well documented, it is possible that children who experience trauma at an early age may reconstruct the traumatic experience because they do not have the resources cognitively, or they are influenced to other retrospective reports due to limited knowledge.

Hippocampus and prefrontal cortex.

Carrion and Wong (2012) looked into the effects of trauma in the hippocampus. Researchers saw that hyperarousal could potentially make memories difficult to regulate, which causes memories to become processed abnormally. This can lead to two things, overrepresentation, such as having intrusive thoughts and nightmares, or suppression, which is selective thoughts and the inability to recall particular memories (2012). Those with trauma will experience flashbacks, or will respond as if they cannot remember a single thing that occurred during their traumatic event.

The study produced interesting results about the size of the hippocampus volume secondary to the cortisol neurotoxicity after severe trauma and chronic PTSD. People with severe trauma experiences could have smaller volume of hippocampus compared to healthy individuals. Youth who experience trauma and PTSD could have some deficits in the structure of the hippocampus. This can affect its functioning, including impairments in memory processing. This may also show in learning difficulties and difficulty processing and understanding traumatic events (Carrion and Wong, 2012).

Additional studies by Whittle et al. (2013) predicted that childhood maltreatment is associated with a decrease in hippocampus volume in adolescent years of early to the

mid years. Their findings indirectly showed that childhood trauma was associated with larger hippocampal volumes on the left side during the early stages of adolescence, where there would be a decrease in the growth, from the early to the mid adolescent years. This proves that childhood trauma is visible in the development of the hippocampus during adolescence.

De Brito et al. (2013) has a different approach on hippocampus volume in the brain. They looked into samples of children living in the community with experienced maltreatment to see if there was a connection between maltreatment and future psychiatric vulnerability. A study conducted by McCrory, De Brito, and Viding (2011) showed that out of 10 studies with children and adolescents with PTSD from trauma and maltreatment, all have failed to show lower hippocampal volumes than adults. Carrion, Weems, and Reiss (2007) noted that the volume of the hippocampus was not to be considered a risk factor when it came to the development of the brain and PTSD symptoms. They did state that participants who were classified as highest severity with PTSD and hyperarousal symptoms showed a reduction in the hippocampus volume. While the hippocampus is critical, there are other areas of the brain that are impacted by traumatic events.

Prefrontal cortex.

When we look at the anatomy of the brain, the PFC is located at the front of the brain covering the frontal lobe. The science of psychotherapy states that this particular region of the brain is involved in cognitive behavior, decision making, moderating social behavior, and personality expression. This makes the PFC a crucial part of the brain that can be severely impaired when dealing with trauma.

Carrion and Wong (2012) state that the PFC is a frontal lobe structure that has a critical role regarding attention shifting, along with forming stimuli response associations. In healthy individuals, (Casey, Tottenham, & Fossella, 2002) the brain is able to suppress irrelevant information that is presented for processing. This means that those who have trauma could have difficulties keeping their attention and become distracted easily (Carrion & Wong, 2012). Ishikawa, Nishimura, and Ishikawa (2015) looked into how early stress can induce anxiety-like behaviors in the prefrontal cortex using rats. They looked at the influence that stress has on peri weaning and preadolescent stages on the display of emotional behaviors. Stress was measured using six methods. Forced swimming in cold water for 10 minutes, or warm water for 15, 5 foot shocks every 3 minutes, being restrained for 30 minutes while enduring tail pinches every 5 minutes, cold stress where rats were randomly selected for 12 days, and lastly immobilization for 15 minutes. The results showed that stressed rats had an increase in anxiety like behaviors in the PFC. The rats suffered from altered monoamine functions to the medial prefrontal cortex (mPFC), which led to the increase in anxiety behaviors. This study showed that the stresses the rats endured caused emotional dysregulation, and potential for disorders such as PTSD, depression, anxiety and schizophrenia.

Implications of Trauma on School Success.

Traumatic events during childhood experiences have life consequences. There are lasting effects when it comes to mental health and academic rates. Porche, Fortuna, Lin, and Algeria (2011) looked at childhood trauma and psychiatric disorders and how it is correlated to the school dropout rate nationwide. This study estimated prevalence rates of students dropping out of school and tested the connection of childhood traumatic stress

and childhood psychiatric disorders and mental health services. The results were shocking. Thirty-eight percent of participants in this study reported experiencing a major childhood trauma that occurred in their life at age 16 or younger, and 19.79% out of the 38% eventually dropped out of school, which is higher than the participants that did not experience any childhood traumatic events (12.97%).

The statistics of traumatic experiences correlating to drop out rates is alarming. Of the 19.79% that dropped out, 31.13% experienced physical abuse, 26.01% witnessed domestic violence, 25.34% experienced rape, 24.82% were beaten, and 22.43% experienced a natural disaster. A major finding was that 32.05% of those dropping out reported symptoms indicating an onset of one or more DSM IV diagnosis. Children who are exposed to trauma are 2.5 times more likely to drop out of school.

Adverse childhood experiences (ACE) are used to look at epidemiological and neurobiological evidences of trauma and its effects on children (Anda et al., 2005). Blodgett and Lanigan (2018) looked at ACE and school success in elementary children. While ACE is used interchangeably with trauma, the resources and information are valuable. Researchers stated that The National Child Traumatic Stress Network treated 1,699 children, with an average child reporting having experienced 2.9 traumas. This included emotional abuse, domestic violence, having an impaired caregiver, or experiencing a loss. Having a higher ACE and more exposures to trauma means the child will have a higher risk of repeating a grade, being absent more, or having lower school engagement. This relates to three areas of performance concerns: academic failure, attendance problems, and school behavior. Blodgett and Lanigan (2018) saw that twenty-seven percent of children observed had one area of concern, 17% had two areas of

concern, and 5% had all three areas of concern and 51% had no areas of concern.

Traumatic experiences can have a negative impact on school performance and has lasting impacts on the students' mental health.

Mental health is critical and needs to be addressed in the school system. Trauma experiences during childhood affect students' mental health and dropout rates. Research conducted by Fergusson, Boden and Horwood (2008) looked at how exposure to childhood sexual and physical abuse impacted early adulthood. The study was a 25 year longitudinal study looking at the effect of Child Sexual Abuse (CSA) and Child Physical Abuse (CPA), and the long term mental health issues that arise such as anxiety, depression, anti-social disorders, suicide and behavior issues.

Students age 16-18 who were classified as having depression and anxiety disorders using the DSM IV was 22.5%. Using the Self-Reporting Delinquency Inventory, 4.8% of 16-18 year old's had conduct disorder. Substance dependence, including alcohol, cannabis, and illicit drugs accounted for 8.6% of the 16-18 year old's. 14.7% of 16-18 year old's in this study reported suicide ideation, and 3.6% reported attempting suicide. Evidence from the study showed that CSA is stronger and more consistent than CPA. CSA is related to increase in mental health, while CPA is correlated more to social, family and child context. Overall, 38.9% of students had mental health disorders and experience with trauma. (Fergusson, Boden and Horwood, 2008)

Dutro and Bien (2014) conducted a trauma case study perspective on student positioning in schools. One student's name was Carlton. He was a second grade student who was brought to school by his foster parents. He was diagnosed with Hodgkin's

Lymphoma. Both of Carlton's biological parents were meth addicts, and Carlton was a victim of abuse and neglect. Leaving his parents and being placed in foster care resulted in being separated from his older siblings. As a result, he lost the chance to see his siblings on a regular basis. Based on the knowledge base and literature, Carlton would be seen as having challenges in his life. What is unique about this experience was the teacher response. She understood Carlton had faced challenges in his life, and viewed him as someone who survived. This thought process is what needs to change in our education settings, specifically in the classrooms.

Trauma and the Classroom Environment.

Teacher perspectives and beliefs.

Martin, Cromer and Freyd (2010) showed that teachers are in a position to be able to identify possible cases of child abuse and neglect due to the amount of time spent with children. Teachers are different from other mandatory reporters because they interact with their students daily and are more likely to witness behavior changes when the abuse occurs.

Martin, Cromer and Freyd (2010) looked at evaluating teacher perceptions of the effects of physical, emotional, and sexual abuse on student learning, along with classroom behaviors. Teachers in this study were from the United States and Canada, and the grades taught ranged from preschool through secondary education. Teachers in this study averaged 13 years of teaching experience. The results showed that teacher beliefs on the effects of physical, sexual, and emotional neglect on student performance in academics, along with behaviors displayed in the classroom, fit the criteria for academic difficulties, internalizing behaviors, disruptive behaviors and attention deficit.

Teachers believed that physical and sexual abuse on learning were more noticeable on academic difficulties. Emotional neglect trauma was seen as having both academic difficulties, along with showing internalizing behaviors. Teachers' beliefs reported that maltreatment would result in problems with attention along with disrupting behaviors. Classroom teachers showed confusion regarding understanding the problem, such as if it is ADHD, ODD, or an internal such as anxiety and depression. Uncertainty of teacher knowledge reduces the accurate detection of abuse in the classroom setting. (Martin, Cromer, and Freyd 2010)

Child perspective and beliefs.

O'Neill, Guenette, and Kitchenham's (2010) research looked into the understanding of children who experience complex trauma and the attachment disruption in the classroom. Teachers should understand that children who experience trauma have a hard time with arousal regulation. This can create an unregulated response of flight, fight, or freeze responses from students. Teachers in the classroom who are unaware of childhood trauma might view the child's behavior as being defiant, thus giving out inappropriate punishments due to child responses to triggers.

Children who have experienced trauma and its consequences from surviving in abusive relationships to living with disorganized attachment relationships are at risk for academic and behavioral changes in the elementary classroom setting. Children in the classroom who have experienced complex trauma are living in the present. The past is difficult to remember, and the future is threatening and unknown for these children. Students need the classroom to become a safe space which will help them build relationships, along with activities that are appropriate to stimulate their young brains. These students need a classroom that will allow them to succeed. Teachers having

knowledge on student triggers and abilities will help their students escape the fight flight, and freeze responses (O'Neill et al., 2010).

West, Day, Somers, and Baron (2014) conducted a study to look at description of internal and external behaviors that are directly experienced or witnessed by court ordered youth in the schools. Researchers listened to the voices of these youth who experienced trauma to develop trauma informed intervention training. The age range of these youth were 14-18 years old. The researchers conducted six focus groups to better understand the students' experiences, along with how these behaviors interfered with classroom learning.

Researchers broke the data up into themes. Youth exposed to trauma and stress showed externalizing behaviors caused by triggers. Students reported that triggers impacted interactions with school staff and peers, creating strong aggression. Students who identified these external behaviors reported having anger emotions in the classroom. Some triggers include stress, pressure, irritability and pressure. Another theme with behaviors include verbal fights, aggressive body language, and invitation to violence. Environmental influence outside the classroom was also looked into. Students listed influences to be their peers, community members, even relatives who portray negative attitudes regarding school and education. Constantly being exposed to negative attitudes and traits everyday creates a negative impact on classroom and school success (West, Day, Somers, & Baron, 2014).

From listening to the voices of these youth, West, Day, Somers, and Baron (2014) identified two themes that are beneficial for teachers to listen to and understand. First is that the students felt that teachers need to demand and encourage respect in the school

setting. Upholding the values the school displays can help students to feel respected by both peers and staff of the school. Another theme was that students valued the MR, which was a trauma informed location in the school where students can go for support. When students were feeling overwhelmed and stressed, the teachers could send the students to the MR, or students could go on their own. As long as the teachers were sending the students for the right reasons instead of getting tough behaviors out of the classroom, then the MR can be a vital resource for students and the school in regards to trauma. Listening to the students can pave the way for research for best practices regarding trauma intervention (West, Day, Somers, & Baron 2014).

Trauma Intervention and Best Informed Practices.

One of the best things we can do for students who suffer traumatic events in their lives is to show positive support and engagement with students. This can be achieved through training teachers to recognize and understand serious effects of trauma on students along with outcomes that occur when no intervention is provided.

Cunningham (2004) created guidelines to reduce the risk of vicarious trauma for students going to school to become social workers. Vicarious trauma is when practitioners become at risk for negative effects from the exposure to survivors of trauma. While this looked at through the education of social workers these strategies can be applied in teacher educator programs across higher institutes of learning. Reinbergs and Fefer (2017) mention the work of today's teachers is challenging and as they work in under resourced environments. These staff members can be susceptible to receiving secondary traumatic stress.

Cunningham (2004) mentions while being exposed to trauma stories can help prepare social work students, there are risks. Social work students potentially have little to no

exposure to trauma professionally, which can overwhelm students through course readings, presentations, and discussions related to client traumatic events. However, the benefits could outweigh the risks. Exposing students to traumatic events can reduce the shock of traumatic experiences experienced when working in the field professionally, allowing the workers to succeed at their jobs (Cunningham, 2004).

Instructors are introduced to a framework to help students understand and process what is being discussed in class. Instructors need to be trained in these courses to help students understand how to safely process emotions they might be experiencing. The instructors need to promote honest discussion to help acknowledge student difficulties with traumatic topics and help students with healthy processing information techniques. This helps to create a safe learning environment and reduce the risk of vicarious trauma (Cunningham, 2004).

A study conducted by Cummings, Addante, Swindell, and Meadan (2017) about creating supportive environments for students who have exposure to traumatic events included individual interviews with 14 community service based providers throughout the Midwest. The providers worked with children ages 0-5 who experienced or were exposed to traumatic events. The providers' responsibilities included the prevention of child maltreatment along with the enhancement of child-parent relationships. Participants in the study completed a questionnaire and semi structured interview.

The results of this study showed good processes that teachers can utilize in the classroom regarding trauma intervention. With adaptive behaviors, Linda, a participant in the study, shared "they will strike out first. So they are aggressive as well, like 'I'm going to hurt you before you hurt me' kind of 'I'm going to be on guard all the time.'"

“This is a first reaction to push people away by acting out”, John, another participant, stated. “ Teachers need to understand that children who were exposed and experienced traumatic events can potentially show behavioral and emotional patterns in childcare/ preschool settings. These patterns appear to be different across individuals based upon the child’s characteristics and the events they experience”. These two statements by the participants explain the reality our students face when experiencing a traumatic experience. No child is going to act the same way and trust in other people becomes nonexistent in some cases (Cummings, Addante, Swindell, & Meadan 2017).

This study is critical because it builds a foundation for us to consider best practices. Participants were asked to help with identification of classroom strategies for students who experienced traumatic events. Participants identified that being attuned to the child and the family needs was necessary in order to understand those with trauma experiences. This can be done by staying open and curious about what is going on. Teaching staff need to respond to traumatic events with sensitivity. For example, instead of father/ mother day, switch the name to family day. This shows unconditional support for families (Cummings, Addante, Swindell, & Meadan 2017).

Positive regard was also discussed in this study. One of the participants, Marla, stated “children will have challenging days”. How the teacher responds to a challenging day is critical. Teachers can be stern and strict, which will prevent the formation of trusting relationships, or the teachers can be positive. Telling parents positive things about their child and showing each child that they are the most important person in the world creates a foundation of trust and relationship building between teacher and student. By creating positive relationships, teachers will be reminded to display proper reactions

towards children. This prevents teachers from being quick to anger, or showing judging traits that punishes students for behaviors that are out of their control (Cummings, Addante, Swindell, & Meadan 2017).

Lastly, teachers need to have collaboration skills with others to support children. Keeping respectful relationships with parents ensures that teachers have knowledge of what is going on with their students in their daily lives and the mindset they are displaying. By opening lines of communication, teachers and parents/family can communicate student progress and ensure that proper strategies and intervention are occurring (Cummings, Addante, Swindell, & Meadan 2017).

Teachers need to support and have knowledge about environmental changes when dealing with trauma experiences in children. The social environment revolves around interactions. Participants in the study discussed social related triggers and certain considerations. Some triggers mentioned included gender of the teacher, demeanor of the teacher, and potential physical contact. Children are good at reading adults. If an adult raises their voice or puts their hands on a child (such as hugs or a touch on shoulder), that could become a social trigger for that particular child, causing traumatic flashbacks and behaviors children cannot control (Cummings, Addante, Swindell, & Meadan 2017).

Teachers should also be aware of is temporal environments. For example, Terry in the study mentioned how fall was a trigger for her son, Because he went into foster care in the fall and was adopted in the fall, he would think why his mother gave him up and why she didn't love him anymore. Temporal environment is vital for teachers to understand and aware of so they can understand the situation of the child's behavior and

become nurturing towards the child that is experiencing those emotions (Cummings, Addante, Swindell, & Meadan 2017).

Teachers should consider the physical and sensory environment of the classroom. Participants in the study referred to darkness and loud noises as triggers, fire alarms and door slamming can become a chaotic environment for students. Unwanted touches and physical proximity can trigger children to act aggressively or cower. Teachers need to be aware of the physical setting of their classroom, from the play areas, the seating charts and carpet area, and make sure every student is comfortable with the physical space and the noise production that is being produced in the room (Cummings, Addante, Swindell, & Meadan 2017).

Trainings are essential to help teachers in the classroom. The study discusses how teachers are dependent on their ability to anticipate and respond to the needs of the students. This is based on curiosity and not assumptions. While potentially there might not be any way teachers can avoid certain triggers that students have, there is the potential to prevent trauma by creatively thinking about the class layout and making proper accommodations to minimize triggers (Cummings, Addante, Swindell, & Meadan 2017).

The research conducted by Wright (2017) supports the ideas of Cummings, Addante, Swindell, and Meadan (2017) Wright looked at is fostering positive relationships. Having positive and supportive relationships are necessary for students with trauma experiences who have early behavior and academic problems. When children with trauma experiences are surrounded by positivity and good energy, they are likely to become trusting of others, less temperamental, and start to display positive

emotions. Teachers might see the positive changes in students, and generate energy and passion for those students in return. Because students with trauma backgrounds lack in some social skill developments with peers, the teachers in the classroom can be mindful to create opportunities for positive interactions with others. Strategies include providing opportunities for both group and individual play, quiet areas for children to take a break, modeling strategies for engaging into play and how to solve conflicts, and identification of positive interactions.

Another idea that Wright (2017) brought up is creating a supportive learning environment. Many believe that those who have trauma experiences can control the behaviors and make better choices than what they are currently making. This is considered a huge mistake. Teachers need to understand that behaviors such as aggression, inattention, difficulty following directions, and tantrums are symptoms of traumatic stress, and those behaviors are sometimes out of the control of the child. Children with traumatic experiences sometimes come from homes where behaviors are forced and power and violence will take the reign over rules. Teaching students differences between rules and discipline is essential to developing predictability. Some things that teachers can do is to discuss and revisit the rules and expectations, discuss the rational for the rules, avoid any sort of threats or battles with students, and make sure to retell students that school is a safe environment for students emotionally and physically.

The research done by Loomis (2018) looked at the role of preschool as a point of intervention in trauma exposed children. The researcher believed that one way of making trauma informed care accessible is to incorporate it into the early childhood education and early care systems that are currently in place. These systems include schools,

medical systems, and social services. Therapeutic preschools go above and beyond the traditional preschool setting and curriculum regarding social and behavior needs of students. Therapeutic preschools focus on safety, relationship building, group and individual therapy and routines throughout the school environment, and the importance of play.

Loomis (2018) talked about a few models of trauma informed education aimed to work and meet the child's needs regarding behavior and social/emotional challenges that might be potentially linked to trauma. While most research of trauma informed education involves older students, there are some models that could also work for preschool. The first is the Head Start Trauma Smart (HSTS), which is the only known trauma informed preschool program. Developed in 2008, the goals of HSTS are to “decrease the negative impact of chronic, toxic stress, support children's social and cognitive development, and to create trauma informed network and culture for participating children, families, and school staff” (Holmes, Levy, Smith, Pinne, & Neese, 2015). This program is currently being implemented in numerous states across many Head Start programs.

Another model being used is HEARTS, which is a school wide intervention program in San Francisco. There are three tiers to this program. Tier one is supporting changes in the schools and the school's culture and learning environment. Tier two relates to training the staff in resources and discipline. Tier three addresses the resources and interventions for students with traumatic experiences. The HEARTS program reported that after five years, out of school suspensions, office referrals, incidents regarding physical aggression decreased by 87% (Loomis 2018). This program shows

the potential that a schoolwide model of trauma in the preschool setting could potentially be valuable.

The next model for consideration in implementation is CBITS, which is used around the fourth grade and is a structured curriculum that combines group therapy, individual treatment, parent outreach, and teacher education. Students are screened for trauma exposure to determine their eligibility to participate in the CBITS program. While this intervention is not designed to work with preschool age children, there are a few things that might be applicable to a younger student group. Individual treatment, parent engagement, and teacher education from or similar to this program can be implemented in the preschool culture and environment (Loomis 2018).

Another intervention teachers can implement is the Multitier Trauma Intervention. Reinbergs and Fefer (2017) explained their work in analyzing research on assessments and interventions to create a model of trauma practices which could be used in schools. They created a three tier system set in place with three objectives: assessment, intervention, and practitioner support. Each of the tiers has different screenings to identify students who might need intensive supports, potential interventions, and what practitioner support is needed.

Tier one has different assessments such as the Systematic Screening for Behavior Disorders (SSBD), the Behavioral and Emotional Screening System (BESS), and the Stress and Difficulties Questionnaire. Tier one has two approaches to intervention: universal social emotional learning (SEL) and Positive Behavior Intervention and Supports (PBIS). These approaches include the explicated instruction that is revolved around the social, behavior, and emotional expectation. This intervention is commonly

used in schools. Practitioner support is needed because teachers are successful when they have the support of administration, the program is accepted school wide by staff, and the intervention is flexible and adaptable. Teachers play a role in learning about trauma and its preventions and interventions. (Reinbergs and Fefer, 2017)

Reinbergs and Fefer (2017) mentioned that Tier two is designed for students who had screened positive for any social, emotional, or behavioral concerns. These concerns might require a specific assessment in order to help understand the concern. In this tier, if past trauma is documented, the difficulties that the student displays might not even be from the traumatic event. The assessments used in this tier would be the Behavioral Rating Scale for Children, Third Edition, and the Achenbach System of Empirically Based Assessment (ASEBA). The assessments have a protocol which allows for multiple informants and includes subscales to identify a variety of social, emotional, and behavioral development. The rating scales provide targets for interventions due to the wide range of symptoms that go beyond traumatic stress. There are three options for intervention at this stage. First is Cognitive Behavioral Intervention for Trauma in Schools (CBITS). As mentioned earlier in Loomis (2018), CBITS is a cognitive-behavior therapy program designed to be implemented in the school setting. The manual for CBITS is low cost, and the program materials and training are conducted for free on the website. There are two group sessions which work to reduce symptoms such as depression, PTSD, and anxiety among trauma affected youth. The age for this intervention is at 11 years old, similar to Loomis (2018) age of fourth grade. Bounce Back is a program of CBITS that is designed for younger children in grades K-5. Last is the Support for Students Exposed to Trauma. This follows the format similar to CBITS.

The intervention shows promise because it is implemented by teachers, and can potentially reach a larger number of students. Practitioner support is critical because there needs to be a system where teachers can ask and receive a clinical consultation, which is important in preventing secondary traumatic stress in staff (Reinbergs & Fefer, 2018).

Tier three is used for severe cases. One assessments would include the University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index (UCLA PTSD RI) . There needs to be great care and caution with a Tier three clinical assessment of trauma. We need to make sure we never operate outside of our areas of training and to seek supervision. Any child with Tier three status usually needs to be referred to a clinician with expertise in the area of concern. Trauma Focused Cognitive Behavior Therapy is an intervention option. It is flexible to work with various groups, traumas, and disabilities. Tier three intervention is possible in the school setting with an outside therapist. Practitioner support would vary based on school district, resources and personnel. This might include trauma caseload distribution, clinical supervision, and self-care strategies for teachers (Reinbergs & Fefer, 2018)

In order to be effective, the services we provide have to be organized, focused on prevention, based on data collection from evidence based practices, and has to involve the entire community of the school. This is critical for the success of tiered programs to help students with trauma experiences (Reinbergs & Fefer, 2018).

Another research article by RB-Banks and Myer (2017) looked at childhood trauma in today's urban classroom and how to move beyond the therapist office. This is a program that is taught in teacher prep classes but can be used with veteran teachers. A

therapist who is trained in childhood trauma intervention collaborates with teachers and shows teachers how interventions can work in the classroom. Classroom teachers should not rely on the child's verbal skills to self-express. Early trauma is successful if it is through physical means like movement, dramatic play, draw and art work. Understanding that "movement helps in the face of trauma experiences" (RB-Banks and Myer, 2017) can go a long way in ensuring that interventions are working.

The research provided allows us to look at trauma, how it affects the brain, and how it affects the school system. Young children need the intervention early in order to make positive changes. Teachers and staff members need to be trained and aware of potential traumatic events students are going through. RB-Banks and Meyer said it best that movement helps students in the face of their trauma. Movement is critical in the implementation of our curriculum which is going to rely heavily on the trauma team to make sure consistency and goals are being met on all levels needed for the success of the child.

Chapter Three: Theoretical Perspective

Research has shown many themes about working with students who have traumatic experiences. First, trauma statistics are fluid. We see 10.8% to 26% of children experience trauma. We know that there are various kinds of trauma from prenatal, sexual, physical, emotional, life experiences and many more. Trauma, in some way, shape, or form, alters the brain where the prefrontal cortex and the hippocampus are potentially affected based on the severity of trauma where parts of the brain can control the emotion and the actions. We know school performance becomes affected to the point where dropout rates and mental health are major concerns. Lastly, we learned that students have an uncontrollable flight or fight response. This research points to the necessity that that best practice interventions is needed in order for our students to be successful.

One of the major things that I notice was consistency. Cunningham (2014) and Loomis (2014) both mentioned that those who work with trauma cases often experience vicarious trauma. It is critical for teachers to understand details related to vicarious trauma through existing literature, some of which can be found in this paper's literature review. How can we work with children with trauma experiences, provide interventions, and make sure that they are making progress when we are not taking care of ourselves? A burned out teacher does no good in the classroom. The research suggests that we need to invest in better protocols in helping teachers deal work with the students who have experienced trauma. Teacher consistency is vital for the success of our students. While vicarious trauma is a topic that is being discussed in teacher education programs across

colleges and universities, this type of training also needs to be conducted for veteran teachers.

Teachers need to be in an environment that supports the work they are doing with young children, and teachers need to show positivity and passion for their students. Collaboration is essential when it comes to research on trauma intervention. The only way that classrooms will be successful is when teachers have open line of communication with co-teachers, parents, therapist, and administrators.

The research has shown us that there is a major gap in who these interventions are designed for. A good bit of interventions are designed for the school age students at the kindergarten to grade 12 levels, but very few resources are present at the preschool level. The curriculum design is going to focus on two different interventions for preschool teachers and students. First is the Head Start Trauma Smart (HSTS). This program is one of the first researched intervention programs that was designed for preschool age children. My experience with HSTS comes from my classroom experience working in collaboration with Head Start for four years. Teaching in an urban setting has shown me the importance of Head Start in low income communities and the critical work they do to ensure student success. While researching different interventions for the curriculum based on the research, I learned that the school district I currently work in uses the Positive Behavior Intervention and Supports (PBIS) program. PBIS works because it focuses on positive behavior, it is a multi-tiered system, and it involves staff buy in and training so that they can be well versed in this intervention. While there is not a lot of information regarding PBIS in the preschool level, I propose that schools and their teachers incorporate a hybrid program using HSTS and PBIS. This will make sure

students with traumatic experiences are getting consistent interventions that are developmentally appropriate. This model will make the most sense because when students are moving up to kindergarten they will have consistency with interventions and how the model works.

Trauma Informed Care

Before we get started with the two interventions, teachers need to have a clear understanding of Trauma Informed Care (TIC). Having this knowledge provides the foundation for any curriculum dealing with trauma intervention. Trainings will need to be conducted by certified organizations in order to understand students' traumatic history and the best ways we can reach those students. Dorlee (2018), provides a brief overview of TIC.

A **trauma-informed approach** incorporates:

- **Realizing the prevalence** of trauma
- **Recognizing** how it affects all individuals involved with the program, organization or system, including its own workforce
- **Resisting re-traumatization**
- **Responding** by putting this knowledge into practice (Dorlee, 2018)

Core Principles of a Trauma-Informed System of Care:

- **Safety** – ensuring physical and emotional safety
- **Trustworthiness** – maintaining appropriate boundaries and making tasks clear
- **Choice** – prioritizing (staff) consumer choice and control (people want choices and options; for people who have had control taken away, having small choices makes a big difference)
- **Collaboration** – maximizing collaboration
- **Empowerment** – prioritizing (staff) consumer empowerment and skill-building (Dorlee, 2018)

7 Domains of Trauma-Informed Care:

1. **Early screening and comprehensive assessment** – *If the client isn't talking, ask: "What's happened?" (Don't ask: "What's wrong with you?") Not everyone is ready to talk but we give them permission to talk when they are ready.*

2. **Consumer driven care and services** – *Listen to the people who are coming to us for services. Ask them if you can improve your services. Ask what can we do to help you better?*
3. **Trauma-informed, responsive and educated workforce** – *Everyone in the system from the receptionist through the doctor matters. Disrespect can be triggering.*
4. **Emerging and evidence-informed best practices** – *We need to use universal precautions. We need to expect either childhood experience or a current trauma but once we ask what happened, we need to provide EBP assistance.*
5. **Safe and secure environments** – *It is important for the clinician to make it safe for the client. The organization also needs to make the client feel safe and comfortable (or is the waiting room dingy and dark?).*
6. **Create trauma-informed community partnerships** – *This is very important to include in our work. Reach out to other organizations such as schools, the juvenile justice system etc. We need to spread this information to our partners in the community.*
7. **Develop a performance monitoring system** – *Develop a data collection system to demonstrate what are the outcomes that you are seeing. (Dorlee, 2018)*

While these guidelines are used by social workers, it can also be applied to the teaching model. Several of these strategies, such as the core principles, are embedded into PBIS and HSTS. Awareness of trauma, and the child's behaviors that are potentially related to trauma will help with our model of intervention. These tips become the key to the intervention.

Head Start Trauma Smart.

Head Start is a government funded program which provided quality learning to low income areas across the country. Head Start bridges the learning gap and prepares students for school aged (K-12) education. One of the first researched based interventions for students with trauma experiences came from Head Start in Trauma Start Head Start. The experts at Crittenton Children's Center, located at Saint Luke's Hospital in Kansas City, developed the Trauma Smart intervention (Trauma Smart Works, n.d). They created an administrators guidebook which was renovated in 02/22/2018, which

- Supports agencies as they create trauma informed environments that reduces the staff turnover and improve family outcomes
- Provides skills that teachers need to address the most challenging behaviors among students not addressed by social/emotional programs.
- Trauma informed classrooms which support children as they are building attachment and pro-social skills that show school success and life
- Supports families on the impacts of trauma and how to address it and improve engagement in school settings
- Reduces suspensions and expulsions to help students stay at school to learn.
- Integrates best practice regarding mental health for the students, teachers, and caregivers to prevent staff burnout and increase the success of the student.
- Reduces the impact of adverse childhood experiences (ACEs) such as aggression or withdrawn behavior, tantrums and phobias relating to school. (“Trauma Smart Administrator Guide”, 2018)

This guide provides the reader with an in-depth look at the phases of implementation that goes into Trauma Smart. Planning, implementing, and sustaining are the key factors for this curriculum to become successful in the classroom. The planning phase is the first step in the success of this program, where the goal is for the agency to become more trauma informed. This means the agency understands the importance of teaching students resiliency skills, the impact parent and teachers have by modeling those skills, awareness of the issue of trauma in the population they are serving, and sensitivity to the potential impact in which human interactions are affected by trauma and traumatic experiences. Once the team is aware of the planning, implementation is next.

Implementation goals are to “create a more trauma informed agency in order for staff and families to heal and build resiliency for children and their caregivers” (“Trauma Smart Administrator Guide”, 2018, pg. 3). The development of a strong team is necessary for the success of this program. The team includes an administrator who can make decisions with authority, trauma smart coaches, and others who want to be a part of the team.

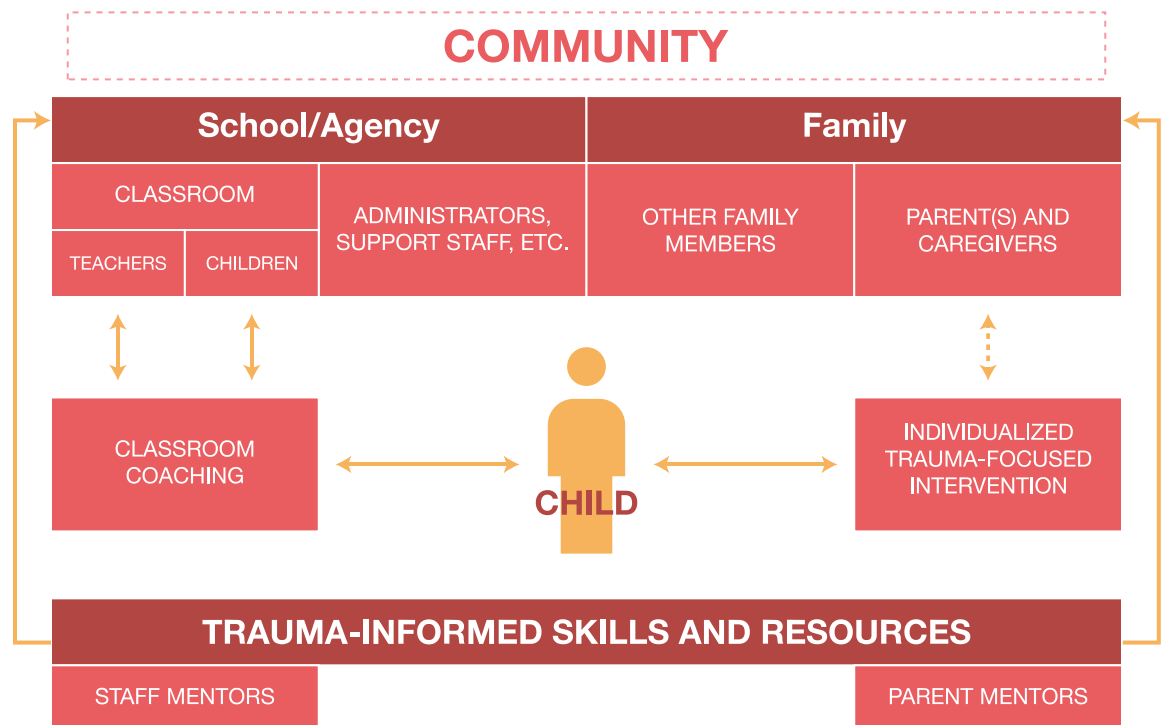
These members accept the challenge to have a trauma informed team where they would become the experts for the rest of the school. The last is the sustaining phase. This phase

is completed when the agency meets the goals and activities set out in the planning phase. When we are in this stage, we have to make sure the trauma team is continuously re-evaluating and making the program better every time. After the goals are met, we go right back into planning to set new goals or evaluate how things went.

Once we have an understanding of the three phases of implementation, we can look at the model of Trauma Smart to understand the basis of the curriculum. There are four components that make up HSTS:

1. Trauma informed care teams
2. Trauma focused staff and caregiver training
3. Classroom Coaching/skill building
4. And trauma focused therapeutic intervention for children and families affected by trauma (“Trauma Smart Administrator Guide”, 2018).

This picture is used in Head Start to give us a visual understanding and model of how the intervention works.



(Trauma Smart works, n.d)

The child is at the center of the model. This child is surrounded by the staff and parents, who received education regarding trauma, the effects of trauma, and how it impacts early childhood development and growth. When we look at the child, the arrow going to the left is classroom consultation. This part of the picture will include the coaching, skill building activities, and the teacher support regarding the classroom design to create supportive environments to help children. This is a critical part of the intervention as it helps the children form genuine relationships, regulate emotions and meet age appropriate developmental milestones. On the right side of the picture, this is the focus on therapeutic interventions that are provided to the families who might need the additional support regarding trauma intervention. (“Trauma Smart Administrator Guide”, 2018)

The administrator guide talks more in-depth regarding classroom interventions and training. Using the coaching model, Trauma Smart coaches would be in the classroom regularly to provide support focusing on teacher development regarding trauma and implementing trauma informed practices and skills learned during the trainings. This allows for accountability and consistency with interventions and a support system in place so teachers do not fail.

Positive Behavior Intervention Supports (PBIS)

The school district that I currently teach in uses Positive Behavior Intervention Support (PBIS). Using PBIS means there is no specific curriculum or intervention that is the magic pill, but rather, it utilizes a multi-tiered system to help understand and implement interventions. There are three tiers. Tier one is school wide intervention used for every student. Tier two is the next step, which provides more structure and support

interventions, usually in small group or one on one. Tier three is the last step, which provides direct intervention for around the 5 percent of the population that needs intense interventions.. A tiered system allows for PBIS to be used across the school setting. This means that the district, the staff, and the students all participate in the process of implementation. The school environment that PBIS thrives in will include the classroom and non-classroom locations (the hallway, fieldtrips, lunch rooms, gym, school functioned events) (OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports, 2015)

Terminology is essential in understanding PBIS. Four terms to understand when using PBIS:

- Positive Behavioral Interventions and Supports (PBIS) Referenced in IDEA to refer to a frame work for delivering practices and systems to enhance academic and behavior outcomes for students with disabilities and their families
- Response to Intervention (RtI) initially developed and used in special education to refer to a framework for improving identification and delivery of educational supports for students with significant learning disabilities, and later became a framework for supporting academic needs of all students.
- Multi-tiered Systems of Support 2013 (MTSS) Used in general and special education to refer to a framework for delivering practices and systems for enhancing academic and behavior outcomes for all students.
- Multi-Tiered Behavioral Frameworks 2014 (MTBF)- Used in elementary and secondary education to refer to a framework for delivering practices and systems enhancing the behavior outcomes for all students (OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports, 2015, pg. 2)

These terms are a must know for those who are interested in implementing PBIS into their schools and the district. PBIS also looks at four categories of overall effectiveness that is needed for the program to succeed. For this to happen, teachers need to consider the Common Vision/Values of the schools we teach in. We need to consider the goal or the purpose that can be loved and embraced by the school staff that can be the

cornerstone for the actions and decision making throughout this process. Common Language is also needed as the terminology, concepts and phrases help explain the vision the school has. This helps the vision to be clear, understood, effective and relative for the staff in the organization. Next we have Common Experiences, which looks at the actions and procedures used by all staff members. The last thing needed for an effective organization is Quality Leadership. This includes the policies and processes that are distributed in order to continue the vision, the common language, and the experience with continuity. (OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports, 2015). The four categories for effective organization creates the foundation for PBIS to be successful. Without these features, the interventions will fail.

There are various core features regarding the implementation of the PBIS model. Implementation fidelity is where there is a system in place to ensure that there is an accurate implementation of the evidence base practices and systems in place for student responsiveness. Using fidelity, we can examine the continuum of evidence based interventions, where the curriculum is available for all the students, where modifications are arranged if needed, and if intensive curriculum is designed as needed in a modified way. The continuum needs empirical evidence showing the intervention being connected to the outcome, being achievable and able to be replicated, shows validity and durability. Content expertise and fluency looks at the local personnel who have a deep understanding of knowledge and experience to support the implementation of evidence based interventions and practices. Leadership implementation and coordination looks into evidence based practices, and administration are responsible to making sure the program is being implemented, there is good management of resources, and the decision

making revolves around being data based practices. Continuous progress monitoring is critical since the performance is reviewed consistently on a schedule to look into rates of improvement, or growth, and trends of student responsiveness, and how to adapt the curriculum and modify if needed. PBIS examines universal and comprehensive screenings, where the performance of students are reviewed regularly on schedule to look at process, support implementation, how effective the supports are, and if any changes needs to occur. Last is cultural and contextual relevance. This assesses the implementation of everything listed above and how it was adapted to the local culture and the influences of the individuals, bias, and beliefs that are highlighted (OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports, 2015, pg. 12). All of these technical systems become vital as we learn about the tiered system that PBIS uses to initiate the interventions school wide.

Tier one is designed to be taught to all children. It is considered primary or universal prevention (OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports, 2015). Tier one settings means that we are working to “prevent the development of new cases (incidence) of problem behaviors by implementing high quality learning environments for all students and staff across all settings” (OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports, 2015 pg. 6). The idea is that the PBIS model is founded on the belief that children can display appropriate behaviors. (“Positive Behavioral Interventions & Supports “n.d”).

The tier one intervention includes:

- School wide positive expectations are defined and taught

- Classroom expectations and routines consistent with school wide positive expectations
- Procedures in place for continuum of encouraging expected behaviors/ discouraging problem behaviors
- Procedures to encourage family/school collaboration. (OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports, 2015)
- Adults in classroom model caring behavior and emotional regulation(Evers, “n.d”, pg. 4)
- Classroom instruction on social emotional learning, building skills, and inclusion, along with mental health.(Evers, “n.d” pg. 4)
- Behavior strategies are clear, consistent, and predictable across the entire school letting.(Evers, “n.d”, pg.4)

The systems in place in tier one explain the importance of a successful implementation. Leadership teams are needed with active administrator performance, routines, structure and schedules need to be efficient for team meetings. A commitment statement is needed for the positive culture school wide culture, and training is needed for new staff. Tier one sets the foundation needed for the next two tiers to be implemented.

Tier Two interventions are considered to be supplemental support, or secondary/targeted. It is designed to address challenges of behaviors in a group of students who all show similar problems of behaviors for the same reasons, such as attention, or avoidance (Evers, “n.d”). Tier two systems utilize all of tier one strategies, along with an intervention team with a coordinator, behavioral expertise, increased precision in data collection, formal process for screening and identifying students in need of more than tier one, and access to training and technical assistances on tier two practices and supports (OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports, 2015, pg. 14).

Tier Two practices include:

- All Tier one practices
- Increased instruction and practice with self-regulation and social skills
- Increased adult supervision
- Increased opportunity for positive reinforcement
- Increased antecedent manipulations
- Increased precisions to minimize rewards for problem behavior
- Increased access to academic support (OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports, 2015, pg 14)
- Referrals to community services and programs, classroom supports to help teachers implement differentiated instruction and behavior management. Small group interventions to teach students emotional regulation,
- Brief functional Behavioral Assessments (Evers, “n.d”, pg. 5)

Tier three is the last tier in the PBIS model. This tier is also called intensive, as it is geared for the individual student. The system includes both tier one and two systems and also involves the multidisciplinary team based on individual student needs. Behavior support expertise is needed, along with formal data collections plans related to implementation fidelity of individualized behavior intervention plans. Lastly, the formal collections and use of the data is used in the impact of the support plan needed for student outcome (OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports, 2015, pg. 15).

Tier three practices include:

- Tier one and two practices
- Comprehensive function based assessment, along with functional behavioral assessment,
- Individual plan of support
  - Prevention
  - Teaching
  - Positive reinforcement
  - Safety
  - Reduction of natural rewards regarding problem behaviors
- Support and culturally responsive person with centered planning involving family and community supports (OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports, 2015, 15)

- Teacher interventions identifying triggers and developing strategies to reduce/ address issues
- Parent/caregiver training and support to help adults in the child's life understand how to effectively parent the child.
- Wrap around services and interventions(Early,“n.d, pg. 5)

The three tiers show the complexity of PBIS and how much implementation needs to be successful in order for effectiveness at the later stages. For implementation to be successful, we need approval from administration, staff buy in, initiative and program integration, local data to help with decision making, district information, and team coaching and leadership teaming.

Guidebook Creation

As I typed all of these models out, the one question I asked myself was: “How do Trauma Informed Care, Head Start Trauma Smart, and Positive Behavior Intervention & Support all fit together?” The idea of the guidebook is to utilize all the models to get the conversation started on trauma intervention that involves positive intervention and support, empathy, and adult collaboration. PBIS looks at the overall behavior of the students, and creating a positive culture in the schools. For students with traumatic experiences, we need to be aware of their experiences and behaviors that are considered “hidden” in order to provide the best interventions. The guidebook’s function is going to be used to help get the conversation started regarding utilizing the three models to ensure success and smooth transition for our trauma students as they transition from preschool to the school age programs. We know that students with trauma need love and time in order to help them with coping. This understanding will supplement the positive behaviors learned in PBIS. With planning and utilizing all three of the models mentioned, preschool classrooms will have a roadmap when it comes to consistency in planning for

interventions for students. The guide book will feature steps and guidance on how to get the intervention rolling by creating the guidelines in which the school will operate, and the steps needed to bring TIC, HSTS, and PBIS into one model.

A secondary guidebook will be designed with the intent on helping teachers in the classroom with tier one interventions. As we look at intervention plans, teachers need to have a strong course of action when it comes to classroom preparation in preschool classrooms. As we saw in Porche, Fortuna, Lin, and Algeria (2011) and in Blodgett and Lanigan (2018), trauma has a negative effect in school performance. Reinbergs and Fefer (2017) mention PBIS and SEL. While PBIS is used in the district, SEL is needed to work on various skills. O’Conner, De Feyter, Carr, Luo, and Romm (2017) conducted a meta-analysis to compile a review about SEL. The goal of their research was to show that early childhood programs are designed to help students to work on social and emotional development as well as creating an environment which students are becoming school ready. The researchers looked at five areas that define social and emotional learning, as defined by the Collaborative for Academic, Social, and Emotional Learning (CASEL):

- Self-Awareness- Knowing what one feels, accurately assessing one’s interest and strengths, and maintaining a well-grounded sense of self-confidence
- Self-Management- Regulating one’s emotions to handle stress, control impulses, and motivate oneself to persevere in overcoming obstacles, setting and monitoring progress toward the achievement of personal and academic goals, and expressing emotions appropriately
- Social awareness- Being able to take the perspective of and empathize with others, recognizing and appreciating individual and group similarities and differences.
- Relationship skills- Establishing and maintaining healthy and rewarding relationships on the basis of cooperation and resistance to inappropriate

social pressure; preventing, managing, and constructively resolving interpersonal conflict; and seeking help when needed

- Responsible Decision-making- making decisions based on a consideration of all relevant factors, including applicable ethical standards, safety concerns, and social norms; the likely consequence of taking alternative courses of action; and respect for others
(O’Conner, De Feyter, Carr, Luo, & Room 2017, pg.2 as cited in CASEL, 2012)

The research by O’Conner, De Feyter, Carr, Luo, and Romm (2017) looked at what works between the teacher and the students when it comes to strategies related to social emotional development. With physical space and materials, having adequate space for students to engage in social play can help decrease aggression. The more cramped the space is, the more likely for aggressive behaviors. Having developmentally appropriate materials available, and providing a wide variety of materials that will foster collaboration in play settings. To create social interactions, thirty minutes or more is needed to foster complex ideas in play situations. Next the researchers looked into classroom management. Having adequate planning and preparation allows the teacher to create a roadmap for how the day is going to go. Also, having routines in place help the teachers stay on track, and not get caught off guard. It is easier to manage chaos and get the classroom back on track when the teacher and class follows a schedule. Having a high quality trusting relationship between the teacher and student is needed to have warmth and positive discipline in the classroom. Teachers and students will be better prepared to respond to any challenges that might arise when the classroom environment is set up to create opportunities for positive interactions, respond to the needs of students, create and sustain boundaries, and provide consistency when dealing with behaviors (using PBIS strategies) O’Conner et al. (2017).

Creating an emotionally supportive climate is needed for positivity in the classroom. Teachers can be a role model by displaying various skills every day, such as saying hi to each student walking in, giving praise and encouragement, showing the students praise and value in their work by displaying it across the room in their eyes, and sending home positive reports about their day. O'Conner et al. (2017)

Teachers can teach their students social emotional learning skills in preschool by modeling emotions, reacting to student emotions and interactions, and teaching about emotions and relationships (O'Conner et al., 2017, pg. 5). The idea was to create a tool kit to use in the classroom. Tool kits ranges from group affection activities by modeling to students different strategies, such as emotional language and ways to communicate, techniques on how to socially interact with others through listening, and problem solving and behavioral self-regulation. Another tool kit would be how to react to students emotions. This includes encouraging positive and negative emotions when they come up in the classroom, mirroring the students emotions, describing the situation the student is in, showing empathy to the students who are struggling in class, and creating social problem solving dialogue. O'Conner et al. (2017)

Strategies that could be considered in classroom interactions would be singing songs and games based on feeling and emotions, reading stories that talk about emotions and a range of feelings, role play situations, organize games which promote cooperative play, create transition routines, and teaching difference between aggressions on purpose and accidents (O'Conner et al, 2017, pg. 8).

Section Four

Curriculum Design

Introduction

Working as an itinerant teacher is very challenging. In our district, preschool itinerant teachers serve students across the entire district making sure they get the intervention they are entitled to and deserve. Teachers drive to homes, daycares, various private preschools, Head Starts, and district schools. Itinerant teachers work with a wide variety of teams to ensure our students are receiving the best education available to them. Positive collaboration is a must when it comes to the education of our children. This is even more critical when working with students who have traumatic experiences. Traumatic experiences vary depending on the child and the severity of the trauma. Interventions need to be fluid, and be able to be modified on a case by case basis.

Curriculum Design

The guidebook is designed for itinerant teachers in my district that deal with different schools that are not affiliated with their district of employment. The eventual goal would be distribution of the guidebook for all teachers. For example, in our area, we work with students who are in Head Start, daycares, and private preschools. When we are working with students in schools that are not affiliated with our district, intervention can become very tricky. Teachers might have their own way of providing trauma interventions, creating department inconsistencies for the child. Our district is a PBIS district, and we want to make sure our students have consistent exposure to similar

intervention practices. Listed below are guidelines and strategies to help get the process started.

Trauma Team- The first thing to establish is a Trauma Team. This team should consist of the go to staff members when it comes to resources for Itinerant Trauma Intervention. These members will be the staff that people will go to for help and resources regarding the guidebook. When creating a Trauma Team, it is very important to secure administrator buy in. Without the administration's approval, the curriculum implementation would not be an option. Once the administration approves the curriculum, recruitment of the Trauma Team can begin. Recommended staff members to participate would be:

- Administrators
- Coordinators
- Teaching team
  - Intervention Specialist (2-3 good recommendation)
  - Therapist
    - Speech and Language Pathologist
    - Occupational Therapist
    - Physical Therapist
- Social worker
- School Psychologist
- Community member

These members of the team would be dedicated to becoming experts in the field of trauma and trauma intervention. This means attending professional developments in the following categories. Trauma Informed Care, where the team will learn about best practices on how to interact with a child who is going through traumatic experiences. Positive Behavior Intervention Support (PBIS) is district wide intervention that we use.

It is necessary that we become experts in PBIS in order to successfully implement this intervention at the preschool level. Last is Head Start Trauma Smart. This is a courtesy training that is highly recommended. Students we service come from Head Start, which has their own trauma program called Head Start Trauma Smart. It would be recommended to attend trainings and have conversations with Head Start staff in order to have a better understanding of their policy. Additional trainings would be beneficial based on the needs of the team and student. (Due to the confidentiality of this project and the district/ schools,) Advised to look at the State Department of Education website to gather information regarding local and state professional development.

Goals and Expectations- goals need to be put in place to ensure continuity of this intervention program. The team should come up with one year and five year goals, with various checkpoints along the way.

One year goals are realistic goals that need to be achievable in order to keep the momentum going with the Trauma Team. Examples of goals would be:

- Creating the Trauma Intervention team
- Creating the trauma intervention calendar for the year
  - Dates trauma trainings are going to occur
    - Talking to the experts at the local and state level
      - PBIS, Trauma Informed Care, Head Start Trauma Smart, etc.
  - Dates to report a recap on the training
  - Dates to inform the itinerant department to go over the information learned
  - Creating dates for new hire training.
- Collaborating with other schools in the area
  - Head Start

- As two major early childhood programs as we both learn and interact with each other.
- Daycares with had a high number of district students in the past five years.

Check in Points (Between 1-5 years)

Every year the Trauma Team should look at the following:

- Making sure new hires are trained in interventions
- Having refresher trainings with local and state experts on trauma intervention to ensure information is up to date with all staff.
- Looking at the data from intervention on individual teams to ensure that progress is being made (accountability)

5 year goals- what we want to see in the long term

- Rates of improvement- Did the student, who received interventions, behavior ultimately get better throughout the course of the year/ years?
- How did students with traumatic experiences fair with early intervention than those who might not have had intervention? What did the numbers look like?
- If students advanced to elementary school, what are the suspension rates? Are they lower or higher than the average before the program started?
- What is the success of our partnerships across the city like? What are our hopes to maintain this success?

Trauma Intervention

When does trauma intervention start? This occurs when the teaching staff, social workers, parents, or other staff member brings the student's situation to the teaching staff.

As a teacher, talking to our team is going to be the first step. Listed below is a checklist of recommended people that the Trauma Team would like to attend.

In district schools

- Administrator
- Teaching team

- Intervention Specialist
- General Education Teacher (if there is one)
- Therapist (if there are any)
  - Speech and Language Pathologist
  - Occupational Therapist
  - Physical Therapist
- Social worker
- School Psychologist
- Families

In Head Start Programs

District

- Administrator
- Teaching team
  - Intervention Specialist
  - Therapist (if there are any)
    - Speech and Language Pathologist
    - Occupational Therapist
    - Physical Therapist
- Social worker
- School Psychologist

Head Start

- Administrator
- Teaching team
- Disability Coordinator
- Social Worker
- Psychologist
- Family Member

Daycares/Preschools

District

- Administrator
- Teaching team
  - Intervention Specialist
  - General Education Teacher (if there is one)
  - Therapist (if there are any)
    - Speech and Language Pathologist
    - Occupational Therapist
    - Physical Therapist
- Social worker
- School Psychologist
- Family members

Daycares/other preschools

- Administrator
- Teacher
- Other- Any employee that would be considered to provide knowledge
- Family members

Once we have the Trauma Team checklist, it is important to understand that this checklist can be changed. This is just a guide for a list of recommended people to consider when having meetings regarding trauma interventions for the student.

In order for this guidebook to continue- we need to have 80% buy in from the recommended Trauma Team checklist in order for our program to continue.

% of participation_____

Implementation of our curriculum.

We get our implementation with buy in from people committed to making a change! The Trauma Informed Care, PBIS, and HSTS curriculums can be modified as needed, because, as it was mentioned earlier, the child interventions need to be case by

case. A student who attends a Head Start program will get all three interventions combined, but someone who attends a daycare only might only get the TIC and the PBIS curriculums.

Once the team has gotten together and gone to district approved local and state trainings as well as trainings in other areas (HSTS) it is time for the Trauma Team to come up with statements

- What is our purpose?
- What is our Mission?

As a Trauma Team, we need to have a clear and consistent expectation on what our purpose and mission are. Having this outlined needs to be a priority so teachers, staff, partnerships, and community know what our idea and beliefs are.

Understanding Trauma Informed Care (TIC) & Positive Behavior Intervention and Supports (PBIS)

Trauma Informed Care

A **trauma-informed approach** incorporates:

- **Realizing the prevalence** of trauma
- **Recognizing** how it affects all individuals involved with the program, organization or system, including its own workforce
- **Resisting re-traumatization**
- **Responding** by putting this knowledge into practice (Dorlee, 2018)

Core Principles of a Trauma-Informed System of Care:

- **Safety** – ensuring physical and emotional safety
- **Trustworthiness** – maintaining appropriate boundaries and making tasks clear
- **Choice** – prioritizing (staff) consumer choice and control (people want choices and options; for people who have had control taken away, having small choices makes a big difference)
- **Collaboration** – maximizing collaboration
- **Empowerment** – prioritizing (staff) consumer empowerment and skill-building (Dorlee, 2018).

7 Domains of Trauma-Informed Care:

8. **Early screening and comprehensive assessment** – *If the client isn't talking, ask: "What's happened?" (Don't ask: "What's wrong with you?") Not everyone is ready to talk but we give them permission to talk when they are ready.*

9. **Consumer driven care and services** – *Listen to the people who are coming to us for services. Ask them if you can improve your services. Ask what can we do to help you better?*
10. **Trauma-informed, responsive and educated workforce** – *Everyone in the system from the receptionist through the doctor matters. Disrespect can be triggering.*
11. **Emerging and evidence-informed best practices** – *We need to use universal precautions. We need to expect either childhood experience or a current trauma but once we ask what happened, we need to provide EBP assistance.*
12. **Safe and secure environments** – *It is important for the clinician to make it safe for the client. The organization also needs to make the client feel safe and comfortable (or is the waiting room dingy and dark?).*
13. **Create trauma-informed community partnerships** – *This is very important to include in our work. Reach out to other organizations such as schools, the juvenile justice system etc. We need to spread this information to our partners in the community.*
14. **Develop a performance monitoring system** – *Develop a data collection system to demonstrate what are the outcomes that you are seeing. (Dorlee, 2018)*

Childhood trauma is common and is a result of the child's early life experiences.

Schools need to raise staff awareness that many students might need the additional support and safety. Having a physically and emotionally safe environment is crucial for student engagement in the curriculum. It is important to remember that the trauma children endure impacts many aspects of their lives, including developing risky or problematic coping strategies. This could lead to behaviors such as "interpersonal violence, avoidance of academic activities, and substance abuse" (Evers, "n.d", pg 3).

Head Start Trauma Smart

Head Start is a government funded program that aims to provide quality learning to at risk, low income areas. The aim of Head Start is to bridge the learning gap among students. Some of the beliefs of the administrator's guide of the Crittenton Children's Center are:

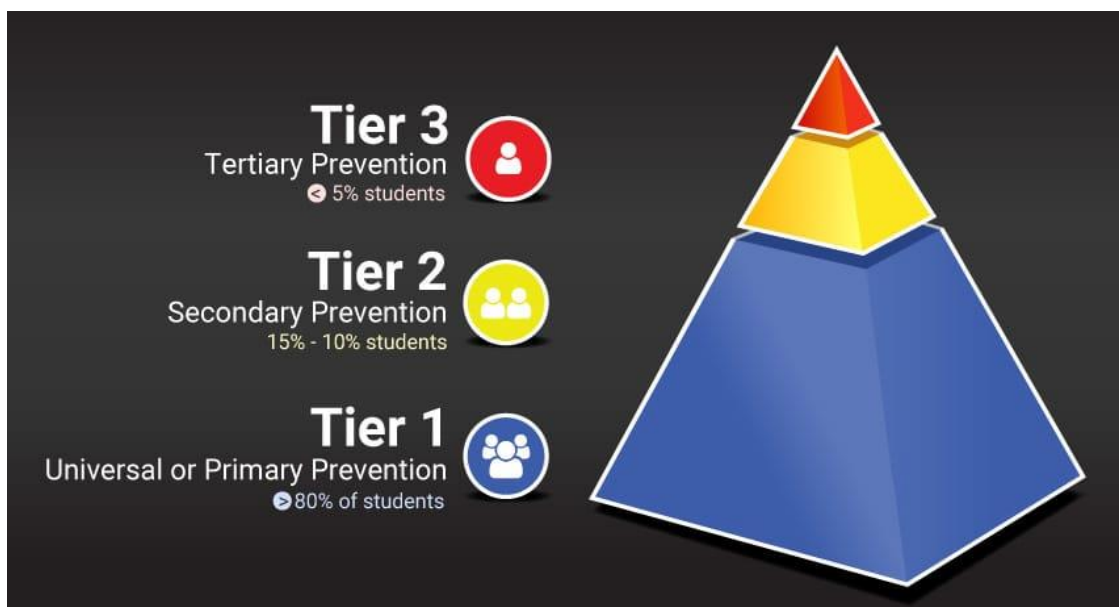
- Supporting agencies as they create trauma informed environments that reduce the staff turnover and improve family outcomes
- Providing skills that teachers need to address the most challenging behaviors among students not addressed by social/emotional programs.

- Trauma informed classrooms which support children as they are building attachment and pro-social skills that show school success and life
- Supporting families on the impacts of trauma and how to address it and improve engagement in school settings
- Reducing suspensions and expulsions to help students stay at school to learn.
- Integrating best practice regarding mental health for the students, teachers, and caregivers to prevent staff burnout and increase the success of the student.
- Reducing the impact of adverse childhood experiences (ACEs) such as aggression or withdrawn behavior, tantrums and phobias relating to school. (“Trauma Smart Administrator Guide”, 2018)

We will see that the Head Start beliefs are similar to the PBIS model, which makes it compatible.

PBIS-

PBIS is what our district implements in classroom settings. PBIS uses a Three Tier system to provide levels of intervention and support as needed based on the needs of the child. Below is a visual of the Tier System. (What is PBIS, 2018)



PBIS uses a three tier system. Tier 1 is considered Universal or Primary Prevention. This is considered to be school wide, as the target population is around 80%. Tier 2 is call secondary prevention, as this will be additional interventions that are for 10-15% of

the school population that need a little bit more one on one intervention to supplement the Tier 1 intervention already in place. Tier 3 intervention is usually called Tertiary Prevention. This is used for less than 5% of the school population. The end result of this intervention has an individual, extensive plan for the child in order to work on improving their behaviors in the classroom. (What is PBIS, 2018)

This manuscript will help provide your department with the tools needed to create a Trauma Team. A consistent approach is necessary to teach our children in all of the partnerships to develop skills needed for their school careers and life. Attached is a starting guide that Pre-School teachers can use in the classroom to help students that have experienced trauma, “Social Emotional Learning Strategies for Children with Traumatic Experiences.”

Implementation.

How do we implement the curriculum? This starts with the Trauma Team briefing the itinerant staff members about the guidebook. How the curriculum is used, what the different categories mean, and ways to implement it in the classroom. This would be a training so that we can work to make sure that there are consistencies with all the teachers in the itinerant department when it comes to teaching the interventions the same way. When the Trauma Team is notified of a child who is suspected of having childhood trauma experiences, the itinerant teacher will go out and conduct an observation in the classroom environment. Based on the observations that the teacher observed in the classroom, the itinerant will use the guidebook to start implementing interventions in the school setting. They will collaborate with the school staff in regards to consistent interventions listed. There should also be opportunities for “check-in’s” for both the teacher and the trauma team to ensure that the intervention is working. If not, the itinerant should look at the data with regards to making the appropriate changes necessary to meet the needs of the child.

Conclusion-

As my research has been completed, I need to reflect upon the strengths and weaknesses that were addressed in the research that helped create the guidebook and manuscript. This research was completed in order to create a guidebook for teachers to use in the field of early childhood education. The concept was to identify beginning intervention strategies for our (Pre-K) population of students experiencing traumatic experiences. One strength is the idea of the Trauma Team. This is a hybrid program that used a few different strategies when it came to implementation. This holds schools and teachers accountable for providing a learning environment for traumatic students. Another strength of the guidebook was designing intervention strategies that can be used in the classroom. Itinerant teachers travel to different classrooms on a daily basis. We work with teachers who are not as experienced, or are “blind” to their teaching methods in that they stick to their old ways of theory and practice. The guidebook provides an effective way to make changes to provide a warm, safe, and consistent environment in the classroom for students with traumatic experiences. The guidebook focuses on SEL, which the research considered to be essential when it comes to success in schools. Focusing on different strategies at such a young age like trust, relationship building, emotions, and self-regulation, are needed to help trauma students. These frameworks set the foundation when it comes to the foundation of having meaningful interactions with the world, and how the child can regulate those feelings of stress and emotion from flashbacks. This document has strengths when it comes to flexibility. Research changes over time, and we will continue to learn new, improved, and effective ways to deal with intervention and trauma at the early childhood education level.

One of the weaknesses of this curriculum is that it just provides a snapshot of interventions that classroom teachers can implement in the classroom. For a novice teacher dealing with students with traumatic experiences, this document could be a blessing or a curse. Each child responds to intervention in a different way, and not every child is going to respond to the interventions that were listed. A future project would be to implement different curriculums for different traumas experienced, and try to pin point more effective interventions based on needs of the child. Another weakness is having premade materials. When itinerant teachers are working in different school settings, we are working with different teachers and families that want resources to help their child. The guidebook was designed to be a quick reference to help teachers out with strategies and interventions, but for example, there are no templates for emotion cards, or cutouts for daily routines. This is a burden for the intervention specialist to make all the materials for the staff, but would also create inconsistencies within the department when it comes to having one curriculum and one set of materials for general interventions for trauma students.

As the curriculum development comes to a close, next steps are already circling in my mind. One of the first things I would want to do is explore and expand Section Two. I want to look into more types of trauma categories such as homelessness, witnessing trauma, natural disasters, war and conflicts, or even discrimination trauma of sorts. Having information about various trauma experiences that students could be facing can help with future intervention research. I would then want to look into more therapist based interventions. How can we incorporate strategies that therapist use into the classroom with the right kinds of training? What might that look like, and how can we

take the steps to get started? Different types of trauma and therapist interventions require different curriculums to be created. This will allow more accurate interventions to be put in place, and more effective strategies to consider.

For future researchers, I think theory to practice is going to be the next step when it comes to research. Taking all of the different curriculums, and reviewing data that is going to be collected in order to see how the interventions are working in the classrooms. Also, is a longitude study possible, where we can track students through their school careers to see if there is any changes in school success, academically, socially, and behaviorally? Trauma Intervention needs to become a priority in order to protect students in the future from falling into habits of failure. With successful interventions comes successful students.

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**GUIDEBOOK
FOR SOCIAL
EMOTIONAL
LEARNING
STRATEGIES
FOR CHILDREN
WITH
TRAUMATIC
EXPERIENCES**



This guidebook will
examine the following
areas critical for Social
Emotional Development
in students with
traumatic experiences

1. CLASSROOM RULES
AND EXPECTATIONS
2. DAILY ROUTINES
3. EMOTION
4. SELF REGULATION
5. TRUST
6. RELATIONSHIP
BUILDING
7. CLASSROOM
LAYOUT

**The world needs a
sense of worth, and
it will achieve it
only by its people
feeling that they are
worthwhile**

- Mr. Rogers -

Classroom Rules and Expectations

Classroom rules and expectations are critical in the early years of a child's education. Rules and expectations sets the tone when it comes to how the children act. If no rules were in place, the classroom would be chaotic. Children who experience traumatic experiences need structure and order.

- Have calm neutral tone
- Constant modeling to reinforce the positive behaviors
- Use as regular redirection "how do we walk in the classroom?"

AREA SPECIFIC RULES

Area specific rules apply to different areas in the classroom. The dramatic play area is generally going to have different rules than the art area. Make sure you are consistent with the classroom expectations. When teachers are reinforcing the rules and expectations in the classroom areas, we are reinforcing the positive way to interact within the environment.

Example

Block area

1. 4 friends at a time (have 4 Velcro s for pictures)
2. No knocking down blocks
3. Two feet on floor
4. Hands to yourself.

5 FINGER STRATEGY

Pick 5 rules and expectations you would want the class to know. These would be the overall classroom rules that apply during the course of the day. These rules need to be quick and easy to remember for the children.

Example

1. Quiet voices
2. Walking feet
3. Hands to self
4. Kind words
5. Help others

These rules are rules that students can help create during the first day of school, or be teacher directed based on teaching preference. It needs to be clear, and tell the class how to act and behave throughout the day. (Visuals are always good to have)

(Sprick et,al 2009 pg. 34-39)

(M.H. Ripper, personal communication, 2018)

Examples of Rules and Expectations

<https://i.pinimg.com/originals/c1/a4/b0/c1a4b0950ed34c6435d9899b2929e22b.gif>

<https://i.pinimg.com/originals/7a/4a/c5/7a4ac5a86feb76a2078b8fe43593743d.jpg>

CHAMP - Rug Rules:		
C Conversation		Voice level zero... OR Use an inside voice.
H Help		Raise your hand.
A Activity		Sit on your dot. Be ready to learn.
M Movement		Sit criss-cross applesauce, hands in your lap.
P Participation		Look and listen... OR Talk to a partner.



Daily Routines

When working with students who have traumatic experiences, we want them to feel safe in school. This means preparing them for the expected, and preparing them for the unexpected. Students who experience trauma need the security of understanding when they transition and why they transition.

List are strategies that we can use in the classroom to help those who struggle with the unknown of what is going to happen next.

Allow for more time than needed, especially at beginning of the year to help with transitions.

Posted Daily Schedule that is consistent every day.

- *Same routine day in and day out.*
- *Talk about each activity to prepare the students for changes*

Classroom Timers and reminders before transitions.

- *5 more minutes song*
- *Class countdown 10-0 before clean up*
- *Singing the cleanup song*
- *Allow additional time to clean up.*

Individual schedules

1. *Now/Then*
2. *First/Then/Next*

Each step is progression. Start with step one, and work your way down to individual schedules based on needs of the child. Picture cards the same as the daily schedule.

Social Stores regarding the daily routine.

- *Using pictures of the child*
  - *Pictures of the child*
  - *Third person.*
- *Each page should be step by step about what is going to happen throughout the day.*
- *Talk about transitions and what to do (clean up, line up etc.)*

EMOTIONS

Emotions

Understanding Emotions and how to regulate our bodies is critical to learn at the preschool age. Students with trauma usually have no real understanding on how to regulate their bodies especially in flight, fight, or freeze. We need to provide practice and opportunities to teach these students healthy ways of dealing with their emotions.

One of the first things we need to do is to help the student be able to identify emotions. This is critical for the student to understand themselves and their own emotions.

Listed are a few strategies to help with emotion identification of self and others.

Modeling Emotions to the Child

Have student imitate teacher facial expressions using a mirror.

If You're Happy and You Know It

Each part you sing another emotion

Do gross motor movement to display the emotion

Act out the emotions

("Testy yet trying", 2011)

Emotion Sorting

Have different adults, students, and school make various emotion faces.

Cut out and laminate.

Have students match emotions.

Feelings Matching Game

Have two of each emotion

Cut out and Laminate

10 activities (2016)

Emotion Book

Create an emotion book in the classroom by having students draw facial expressions.

Students can read book at carpet and identify emotions.

Adapted from 10 emotions (2016)

10 Activities to Help Students Explore Emotions. (2016, June 11). Retrieved from <https://www.apperson.com/teach-talk/10-activities-to-help-students-explore-emotions>

SELF REGULATION STRATEGIES

Self-Regulation

Self-Regulation is critical when it comes to the success of the student with body control and regulation. Those with trauma have no control on their feelings when they are triggered. These interventions are to help the student in the moment of flight, fight, and freeze.

Practice, Practice, Practice. Every Day take time to model self-regulation strategies. Stick to the intervention for minimum 21 days then reevaluate. Document behaviors and success/failures each day

Deep Breathing

Take deep breaths (as many as needed)

"Breathe in your favorite food, blow out the birthday candle"

Use palm for food, index finger for candle

Unique way to teach students how to take deep breaths

Dinosaur School

Always talk to students at eye level

- *Always look in their eyes when talking*
- *Be invested in what students are saying.*

Quiet Area (Safe Space)

Pillows for deep pressure

Relaxing music or silence based on student preference (using headphones)

Fidgets to manipulate.

- *Playdoh*
- *Magnets*
- *Wiggle seats*
- *Pressure vest*
- *Thera-band on chair*
- *Weighted garments*

Yoga

Otis the Monkey

Teaching Basic poses

- *Table*
- *Downward Dog*
- *Tree*
- *Flutter Fly*

Yogarilla

Deep Pressure

Pushing hands together

Giving yourself hug with pillow

Squeeze arms

Stomp feet

Lentini, 2005

Physical Activity

Movement breaks

- *Walking*
- *Bikes*
- *Therapy swings*
- *Trampoline*
- *Heavy work*
  - *Jug walking*
- *Running*
- *Marching*
- *Stomping*
- *Jumping*

TRUST

Trust

Every teacher should know that building the trust of your students is one of the most important things we can do as teachers. When students show their trust in us, it becomes easier to implement interventions. With traumatic students, trust might be something that is hard to gain due to potential experiences. Listed are a few strategies we need to remember and strategies to implement trust building.

Never touch a child without permission

- 5 choice contact option
- Child gets to choose how to engage with adult/peers
  - High Five
  - Fist Bump
  - Handshake
  - Hug
  - No contact
  - Wave if they choose

Being honest and communicate

- Remind students that you believe in them to do a good job.
- Invent in what the child is saying and give them full attention
  - No side conversations
  - No cell phone

Make sure body language and voice is not intimidating for the student

- No overlooking the child (standing over)
- No yelling
  - Could potentially trigger child

Arts

Coloring

Painting

Playdoh

Clay

Relationship Building

Relationship building is one of the key elements when it comes to student success in the classroom. Social emotional development rest on the idea of social interaction. Positive social interaction is the key for creating self-esteem.

RELATIONSHIP BUILDING

Daily Jobs

- *Have students engage in jobs involving working with another peer*
- *Reward students for good completion*
  - *Communication*
  - *Teamwork*

Modeling

- *Show the students how to interact with their peers*
  - *Model asking to play*
  - *Model how to take turns*
  - *Model conversations*

RELATIONSHIP BUILDING GAMES

Cats and Dogs

Half the class is cats, other half are dogs.

They have to make the animal sounds and form two groups at opposite ends of classroom

Group Puzzle

Everyone gets a few large pieces of floor puzzle

Have to communicate and respect other classmates when completing

(Mulvahill, 2019) adapted from Idea

Scavenger Hunt

Each student has different objects to find

Students have to trust and communicate to finish the scavenger hunt

Drawing

Have each student draw a picture of their partner

Have to say one nice thing about them

Classroom Layout

The Classroom Layout is one of the first things we need to consider when we interact with a child who has traumatic experiences. We want to make sure that we have space that is considered developmentally appropriate, safe, and inviting to the child. Each with traumatic experiences experience their trauma in different ways. We have to remember what works one year for a child might not work another year for another child. This is why we always have to adapt our classrooms to reflect the space.

Clear Designed Space

- Space designed for specific purpose
  - Helps with confusion
  - Knowing the expectation of space
    - Blocks
    - Art
    - Carpet

(Sprick et. al, 2009)

Child Friendly-What The child Sees in their eyes?

- Materials
- Child size class items (chairs, desk)
- Play materials
- Daily Schedule
- Carpet area
- Room inviting/safe

Organization

- Structure in the classroom allows student to have clear expectation of what is expected
  - Clean room vs. messy room = order vs. chaotic

(Sprick et. al, 2009)
(M.H. Ripper, personal communication, 2018)

Rules and Expectations

- Posted throughout the classroom
  - Along with visual schedules to remind students of upcoming transitions/ expectations

(M.H. Ripper, personal communication, 2018)

Safe Space

- Quiet area students can go to escape during flight, fight, freeze
  - Not distract other students
  - Warm and inviting