

“Trauma Informed Care for Educators”
A Summary Presentation by Meghan Hurley, LCSW
Written by Lindsay Gould

1 out of every 4 children attending school has been exposed to a traumatic event within the past year that can affect learning and/or behavior.

There are many developmental events that can affect the trajectory of a child’s life. Research shows that social emotional skills in Kindergarten can predict outcomes for levels of mental health, substance abuse, criminal involvement, and even public assistance. It has long been proven IQ can predict positive life outcomes like education, but more recent studies have found non-cognitive skills like self-discipline, self-control, and empathy may be even more important for life outcomes.¹ A large analysis shows an 11% gain in academic achievement for students who participate in social emotional learning programs, while another study shows for every dollar spent on social emotional learning there is return of \$11 by way of academic achievement, reduced substance abuse, mental health, and social services costs.² Sadly, school suspension rates have nearly tripled in the last 30 years. However, a recent study found that teachers in middle school who adopted an empathetic mindset cut suspensions in half.³

You may be able to think of a student who exhibits behavioral problems and struggles with social emotional skills. These struggles may be a result of *TRAUMA* which is “the unique individual experience of an event or enduring condition in which the individual’s ability to integrate his/her emotional experience is overwhelmed and the individual experiences (either objectively or subjectively) a threat to his/her life, bodily integrity, or that of a caregiver or family member.” (Saakvitne, K. et al, 2000). Traumatic experiences rewire how the brain organizes and reacts. Trauma causes the brain to constantly operate in “fight or flight,” it decreases the development of the prefrontal cortex where impulse control, complex behavior, personality, and problem solving are developed. The child begins to see the world as a scary place where people can’t be trusted. Maslow’s hierarchy of needs illustrates how when basic needs, such as safety and physiological needs are not met, there is no way to reach the self-actualization stage where academics lie. The bottom line, **trauma changes the brain.**

How as an educator can you help identify and redirect a student suffering from trauma?

There is a need to develop a plan of care incorporating a child’s trauma history and addressing the relationship between the trauma and the current symptoms and behaviors. The Adverse Childhood Experiences study (ACEs) is an ongoing body of research between the CDC and Kaiser Permanente. The study evaluates adverse childhood experiences with a scoring system. The system can predict adult negative outcomes based on the number of ACEs a child is/has experienced. ACEs that have been identified are physical abuse, sexual abuse, emotional abuse, mental illness of a household member, problematic drinking or alcoholism of a household member, illegal street or prescription drug use by a household member, divorce or separation of a parent (including the incarceration of a parent), and witness to domestic violence towards a parent. This research is helping to fill the gap where scientific data measures the impact of the ACEs on social, emotional, and cognitive impairment.

How does trauma present in a student?

Students can show a variety of internalizing behaviors such as disruptive behavior, poor frustration tolerance, anxiety, depression, poor concentration, low motivation, relationship problems, dissociation, and medical problems. These internal behaviors can lead to the student displaying external behaviors such as school/work problems, stress related disorders, anger/aggression, impulsivity, substance use/abuse, criminal behaviors, oppositionality, self-mutilation, suicidal thoughts/behaviors. Therefore, academic skills can be impacted by childhood adversity, causing potential language, communication, problem solving, and executive function.

Mental Illness	Overlapping Symptoms	Trauma Type
Attention Deficit/ Hyperactivity Disorder	Restless, hyperactive, disorganized, and/or agitated activity; difficulty sleeping, poor concentration, and hypervigilant motor activity	Child trauma
Oppositional Defiant Disorder	A predominance of angry outbursts and irritability	Child trauma
Anxiety Disorder (incl. Social Anxiety, Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, or Phobia)	Avoidance of feared stimuli, physiologic and psychological hyperarousal upon exposure to feared stimuli, sleep problems, hypervigilance, and increased startle reaction	Child trauma
Major Depressive Disorder	Self-injurious behaviors as avoidant coping with trauma reminders, social withdrawal, affective numbing, and/or sleeping difficulties	Child trauma

Griffin, McClelland, Holzberg, Stolbach, Maj, & Kisiel , 2012); courtesy of the Southwest Michigan Children’s Trauma Assessment Center

Trauma informed care as well as brain-based approaches are found to be the best approaches to dealing with trauma. Trauma informed care approaches involve purposeful, supportive approaches to individuals exposed to trauma by prioritizing physical and emotional safety, building trust, maximizing consumer choice and control. Children concerned about their survival cannot broaden their focus, engage in self-reflection, or allow themselves to be emotionally vulnerable. We also want to incorporate brain-based approaches to treating trauma, which involves understanding the brain’s neuroplasticity.

“The brain is most “plastic” or change-able during infancy and childhood, but it remains plastic throughout life. Thoughts and behaviors are regulated by patterns of connectivity in the brain, or neural networks. It takes a lot of repetition to build new neural networks. The goal of brain-based approaches is to weaken trauma-based neural networks and build/strengthen neural networks that will facilitate growth and promotion.” Megan Hurley


What is trauma informed care, and how can you implement practices to help a child in your class suffering?

We want to consider “triggers” for a child. A trigger is anything that sets off a memory or flashback of their trauma causing the painful, emotional response, for example, a situation that make a child feel “I’m not important” and “No one cares about me.” The child enters into a zone where they feel unsafe, the situation is beyond their control, and they feel trapped. This is probably when teachers or staff notice behaviors that they have to address. There are three timelines for dealing with emotional and behavioral crises.

- Universal/all the time – before an emotional/behavioral crisis
- In the moment – when a child is dysregulated
- After an emotional/behavioral crisis – circling back

Before a crisis, the goal is to create a safe environment where a student can build their capacity to regulate their emotions. This is achieved by building and developing relationships, establishing routines, support for transitions during the day so there are no surprises, regulating activities to increase a child’s window of tolerance, mindfulness and mediation practices, regular rhythmic movement, supporting a child through their developmental deficits, both physical and social/emotional, creating a “family” culture, adding physical activity for 30-60 mins a day, and tripled recess time. Outdoor time in green spaces has been proven to improve ADHD symptoms severity, as well as outdoor exercise has been shown to reduce depression.⁴

Some ineffective strategies to be avoided would be excessive questioning, lecturing, appealing to logic, making comparisons, offering rewards, ignoring, threatening, minimizing, and time-outs. Getting angry is the least desirable strategy. Threats and attempts to control only increase the alarm activity in the amygdala, escalating a situation. Strategies like using logic or rewards rely on frontal lobe functioning which doesn't work because a child who has experienced trauma has difficulty accessing this area of the brain (Adapted from: Forbes, H. (2012). *Help for Billy*. Beyond Consequences Institute). The goal overall is to “de-escalate” the situation, help a child regulate and get back to a calm zone before a child enters flight or fight. The chart below to learn how you can watch the state of the child.



Adaptive Response	REST	VIGILANCE	FREEZE	FLIGHT	FIGHT
Predictable De-escalating Behaviors <i>(behaviors of the teacher or caregiver when a child is in various states of arousal)</i>	Presence Quiet Rocking	Quiet voice Eye contact Confidence Clear simple directives	Slow sure physical touch “Invited” touch Quiet melodic words Singing, humming music	Presence Quiet Confidence Disengage	Appropriate physical restraint Withdraw from class TIME!
Predictable Escalating Behaviors <i>(behaviors of the teacher or caregiver when a child is in various states of arousal)</i>	Talking Poking Noise Television	Frustration, anxiety Communicate from distance without eye contact Complex, compound directives Ultimatums	Raised voice Raised hand Shaking finger Tone of voice, yelling, threats Chaos in class	Increased or continued frustration More yelling Chaos Sense of fear	Inappropriate physical restraint Grabbing Shaking Screaming
Regulating Brain Region	NEOCORTEX Cortex	CORTEX Limbic	LIMBIC Midbrain	MIDBRAIN Brainstem	BRAINSTEM Autonomic
Cognition	ABSTRACT	CONCRETE	EMOTIONAL	REACTIVE	REFLEXIVE
STATE	CALM	ALERT	ALARM	FEAR	TERROR

All rights reserved © 2012 Bruce D. Perry

We can aide a child to getting regulated using empathy and understanding, validating, and reflective listening, in a non-judgmental, non-threatening way.

After a crisis, we can use the crisis to teach a social emotional lesson by reviewing what happened in the child’s perspective, then from others’ perspectives. Continue rebuilding the relationship, re-regulating, and teaching coping skills, reinforcing the “family” culture, and adjusting our expectations if need be.

TIER 1 Universal supports:

- Maintain usual routines after a traumatic event. A return to “normalcy” will communicate the message that the child is safe and life will go on.
- Give children choices. Often traumatic events involve a loss of control or chaos, so you can help children feel safe by providing them with choices.
- Increase the level of support and encouragement.

- Recognize that behavioral problems may be transient and related to trauma. Provide a safe place for the child to talk about what happened
- Give simple and realistic, age-appropriate answers to children's questions about traumatic events.
- Be sensitive to cues in the environment that may cause a reaction.
- Warn children if you will be doing something out of the ordinary, such as turning off the lights or making a loud noise.
- Be aware of other children's reactions to the traumatized child. Protect the traumatized child from peers' curiosity and protect classmates from the details of a child's trauma.
- Although not all children have religious beliefs, be attentive if the child experiences severe feelings of anger, guilt, shame, or punishment attributed to a higher power. Do not engage in theological discussion. Refer the child to appropriate support.

TIER 2 Targeted Supports:

- Use trauma history and symptom screening tools to identify children who made need targeted and intensive supports.
- Set clear, firm limits for inappropriate behavior. IF you must use consequences, develop logical - rather than punitive - consequences.
- Anticipate difficult times and provide additional support. Many kinds of situations may be reminders, or triggers, to the child.
- Understand that children cope by re-enacting trauma through play or through their interactions with others. Resist efforts to draw you in to a negative repetition of the trauma. For instance, some children will provoke teachers in order to replay abusive situations at home.
- Consider putting a 504 plan in place to make accommodations:
- Shorten assignments
- Allow additional time to complete assignments
- Give permission to leave class to go to a designated adult (such as a counselor or school nurse) if feelings become overwhelming
- Provide additional support for organizing and remembering assignments
- Allow sensory breaks

TIER 3 Intensive Supports:

- Incorporate the trauma-based needs into the student's IEP, and focus the student's behavior plan on regulation.
- Seek resources from a mental health provider for individual students. Consider evidence-based trauma focused treatment such as the Neurosequential Model, Trauma-Focused Parent Child Interaction Therapy, Trauma-Focused Cognitive Behavioral Therapy, experiential play therapy, Trauma Systems Therapy, or other treatments.
- If possible, refer the student to a mental health provider to complete a trauma assessment. Ask the mental health provider to help you form hypotheses about the student's needs that can drive the interventions in the behavior plan.
- Consider using Cognitive Behavioral Interventions for Trauma in Schools (CBITS). <https://cbitsprogram.org/>
- Group and individual interventions for 5th – 12th grade
- Designed to be implemented by mental health clinicians in schools
- Support for Students Exposed to Trauma (SSET) modification can be implemented by non-clinicians
- Uses psychoeducation, relaxation, social problem solving, cognitive restructuring, and exposure

- Bounce Back similar program for elementary schools
http://www.rand.org/pubs/external_publications/EP50854.html

To learn more about Trauma Informed Care, or to have Meghan present on this topic, please visit our website, <https://www.riverbridgerc.org>.

***All information in this article taken from Meghan Hurley, LCSW**

Sources

¹Jones, D. E., Greenberg, M., & Crowley, M. (2015). Early social-emotional functioning and public health: The relationship between kindergarten social competence and future wellness. *The American Journal of Public Health*, 105(11), 2283-2289.

²Collaborative for Academic, Social, and Emotional Learning. <http://www.casel.org/impact/>)

³Okonofua, J. A., Paunesku, D., & Walton, G. M. (2016).

⁴(ADHD study: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448497/>)