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Perceptions of Diagnosing and Treating Attention Deficit Hyperactivity Disorder and Complex Trauma in Schools

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Perceptions of Diagnosing and Treating Attention Deficit Hyperactivity Disorder
and Complex Trauma in Schools

by

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MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
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Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Attention Deficit Hyperactivity Disorder affects up to nine percent of children in the United States (DuPaul et. al, 2014; Ralph et. al, 2001; Spencer, 2007; Wedge, 2016). Furthermore, 25% of children will also be exposed to Adverse Childhood Experiences (ACEs). Exposure to ACEs is strongly correlated with negative short-term and long-term effects on a child's cognitive, physical and mental health, and social-emotional development. Oftentimes these experiences create a neurological shift in children and result in symptoms that align with the criteria for ADHD. As well as. Complex Trauma. (PTSD- Type II). Many children are first identified with these symptoms and needs when they enter school. Schools are a significant entry point for bridging students and families with referral to services. Previous research suggests that schools approach the diagnosing and treatment of ADHD and Complex Trauma through effective multidisciplinary teams, positive school climate, resources to families, and social-emotional small group and individual interventions. This study sought to identify the perceptions of school social workers and teachers in metropolitan elementary schools regarding the diagnosis and treatment of both Attention Deficit Hyperactivity Disorder and Complex Trauma. Data was gathered by means of a recorded qualitative interview of five elementary school teachers and five elementary school social workers. The recorded interviews were then transcribed and coded through content analysis for top themes. The following themes were derived from the participant interviews: the importance and helpfulness of training, accommodating children with ADHD and Complex Trauma. (PTSD--Type II), roles and responsibilities, and the importance of a positive school climate.

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Table of Contents

Abstract.....	2
Acknowledgements.....	3
Introduction and Purpose Statement.....	5
Literature Review and Research Question.....	6
Conceptual Framework.....	15
Methods	16
Research Design	16
Sample	16
Protection of Human Subjects	17
Data Collection.....	17
Data Analysis.....	18
Findings	18
Discussion.....	41
Implications for Social Work Practice.....	45
Implications for Policy.....	45
Implications for Research.....	46
Strengths and Limitations	46
References.....	48
Appendices.....	56
Appendix A.....	56
Appendix B.....	59

Introduction

This research focused on perceptions of diagnosing and treating elementary aged children exhibiting symptoms of Attention Deficit and Hyperactivity Disorder (ADHD) and Complex Trauma (PTSD- Type II). The prevalence of children diagnosed with ADHD ranges between five to nine percent in the United States (Ralph et. al, 2001; Spencer, 2007). Significant research notes that children with ADHD are more likely to have exposure to adversity and traumatic experiences (Gleason & Humphreys, 2016; Koyoncu et. al, 2016). The percentage of children in the United States who have had an adverse childhood experience is strikingly high at 25% (Anda, 2007; Crosby et. al, 2015; MSSA, 2016). An adverse or traumatic experience is one that threatens someone's life, safety or well-being and results in intense feelings of fear, terror, helplessness, or hopelessness (Christian et. al, 2015).

Both ADHD and Complex Trauma (PTSD-Type II) can negatively affect the trajectory of a child's academic, social, behavioral, and future occupational success (Anda, 2007; Guzman et. al, 2011; Mainwaring, 2015; McElroy & Hevey, 2013; McKelvey et al., 2016; Monañez, 2015; O'Malley et al., 2016). Attention to the differential diagnoses of ADHD and Complex Trauma (PTSD-Type II) in children requires a focus on the etiology of the overlapping symptoms of impulsivity, inattentiveness, and hyper vigilance (Crosby et. al, 2015; Ralph et. al, 2001; Van der Kolk, 2015).

Approximately 80% of the time, schools serve as the connection to resources and services for the diagnosing and treatment of mental health and cognitive conditions of students (MSSWA, 2016). According to research, teachers feel confident in identifying symptoms of ADHD, understanding of the diagnosis as something out of the student's control, and accommodating this disorder in their classrooms (Blotnicky-Gallant et. al, 2015; Walter et. al, 2006). Alternately,

teachers feel less prepared to deal with mental health conditions or symptoms of Complex Trauma (PTSD-II) in their classrooms. Traumatized children have schools facing a dilemma of balancing high academic standards while still having the resources available to provide support for a student's basic needs and mental health (Alisic, 2012).

Literature Review

The literature will provide a brief review of the prevalence, symptoms, and practices for the diagnosing and treatment for both ADHD and Complex Trauma (PTSD- Type II) in elementary aged children. The literature will also review teacher and school social worker perceptions of knowledge and roles relevant to assisting students with ADHD and Complex Trauma.

Definitions of ADHD and Prevalence

History of ADHD

Historically, the etiology of Attention Deficit Hyperactivity Disorder (ADHD) has been widely debated. In 1902, individuals presenting with the symptoms of what we now know as ADHD were described as having an “unmoral” disorder (Spencer, 2007). Early in the course of the disease, psychologists and medical professionals questioned whether this was a mental disorder or strictly behavioral. Today, the research is continually expanding regarding causes of ADHD (Cuffe et. al, 1994). Research is now considering genetic predispositions as well as other from environmental and psychosocial factors. These factors might include Adverse Childhood Experiences (ACEs) such as: abuse, exposure to poverty, violence, toxins, and prenatal substance exposure to cigarettes and alcohol (American Psychiatric Association, 2013; Branscome et. al, 2014; Children's Defense, 2016; DuPaul et. al, 2014; Spencer, 2007). From 2003 and 2011 the prevalence of ADHD diagnoses in children increased by 42% in the United States. In 2014,

ADHD became the most prevalent emotional behavioral disorder affecting children (Branscome et. al, 2014). While the prevalence of children diagnosed with ADHD continues to grow and ranges between five to nine percent in the United States, the rate in Norway maintains at two percent (Ralph et. al, 2001; Spencer, 2007; Suren et. al, 2013). The diagnosing of ADHD is highly debated as to whether more knowledge allows for earlier detection of ADHD or if there is an over diagnosing of ADHD in present society.

Symptoms of ADHD

Symptoms of ADHD consist of impulsivity, low frustration tolerance, lack of executive functioning skills of organization, and also in-attention that is prolonged and developmentally abnormal (American Psychiatric Association, 2013; DuPaul et. al, 2014; Gleason & Humphreys, 2016; Ralph et. al, 2001; Spencer, 2007). These symptoms often cause children with ADHD to function below their peers in academic and social settings. Consequently, children with ADHD are more likely to be suspended from school, be referred to special education, and have a higher prevalence of dropping out of school prematurely (DuPaul et. al, 2014; Humphreys et. al, 2012). While the symptoms of ADHD can fade with time, 80% of children will still have significant symptoms as an adolescent and 50% will continue to be treated for ADHD into adulthood (Ralph et. al, 2001). As adults, 70-80% of individuals with untreated ADHD are reported to be underperforming at work (Humphreys et. al, 2012).

Definitions of Complex Trauma and Prevalence

In the 1970's when the inclusion of PTSD was first considered a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, Third edition, (DSM-III) there was limited research to guide the diagnosis (Courtois, 2008; Luxenberg et. al, 2001). Researchers have explored the different categorizations and effects of acute, chronic, and complex traumas.

While acute trauma is an isolated incident of trauma and chronic trauma is repeated exposure, complex trauma is repeated exposure to stressors that affect a child's responses to stress and ultimately their development (Anda, 2007; Crosby et. al, 2015; Christian et. al., 2015; Courtois, 2008; Ghosh Ippen et al., 2014; 2015; Luxenberg et. al, 2001; McKelvey et al., 2016; O'Malley et al., 2016). Research indicates that while not everyone who experiences trauma will face extreme physical and/or psychological symptoms, children and adolescents are most at risk of developing a condition such as PTSD (Type-II) or referred to in this research, Complex Trauma (Luxenberg et. al, 2001). Trauma occurs when one's sense of safety is threatened. This could occur through an actual, attempted, or threatened event of: sexual abuse, assault, exploitation, physical abuse or assault, emotional abuse, psychological mistreatment, neglect of basic needs, a serious accident or illness, witnessing or experiencing of domestic violence, traumatic grief or separation; witnessing community, school, or interpersonal violence, natural or manmade disasters, war, terrorism or political bombing, forced displacement, historical trauma, racism, and system induced trauma (American Psychiatric Association, 2013; Christian et. al, 2015; Ghosh Ippen et al., 2014). The diagnostic criteria for PTSD (Type-II) includes symptoms of the person reliving the experience through flashbacks, avoiding reminders of the event, and a persistent state of hyper arousal (Luxenberg et. al, 2001). Complex Trauma (PTSD- Type II) can be further defined in terms of Adverse Childhood Experiences (ACEs). Research studies on ACEs reveal that they are common, they are likely to co-exist, and predictably have devastating effects on individuals, families, and communities (Christian et. al., 2015; MDH, 2011; Runyon et. al, 2015). Statistically, 25 percent of all children have had at least one adverse childhood experience (Christian et. al., 2015).

Complex Trauma (PTSD- Type II) manifests in symptoms such as: inability to effectively regulate affect and impulses, inattention, a lack of self-perception, difficulty in relationships, and somatization of symptoms (Courtois, 2008; Luxenberg et. al, 2001). In children, Complex Trauma (PTSD- Type II) can also look like: late language acquisition, in-attention, impulsivity, poor emotional management, lower executive functioning, and poor memory (American Psychiatric Association, 2013; Branscome et. al, 2014; Children’s Defense, 2016; Clarkson Freeman, 2014; Cuffe et. al, 1994; Lipschitz, 2002; Willis & Nagel, 2016). Children who experience significant traumas are found to be less likely to pass social-emotional screenings for school readiness and may present with depressive, anxious, or antisocial behavior (American Psychiatric Association, 2013; Clarkson Freeman, 2014; D’Andrea et. al, 2012, McKelvey et al., 2016). Children may also externalize their experiences through outbursts that involve yelling, running away, and both physical and verbal aggression (Clarkson Freeman, 2014; Cuffe et. al, 2014; Crosby et. al, 2015). They may have difficulty interacting with peers and authority figures and feel a sense of safety through physical isolation and emotional distance (Clarkson Freeman, 2014; D’Andrea et. al, 2012). Children may also struggle with internalizing behaviors, such as shutting down and may have diminished capacity and confidence causing them to disengage from working. Both of these expressions of coping have an incredible impact on a student’s acquisition of a formal education.

The effects of Complex Trauma also affect short and long-term physical, neurological, mental health, social emotional development, academic and occupational outcomes, and can predict repeated cycles of trauma (Christian et. al, 2015; McKelvey et al., 2016; MDH, 2013; Thompson et. al, 2015). Data from the original ACEs study revealed the more ACEs one has, the higher the likelihood there is for devastating health outcomes later on in life (Anda, 2007; Harris,

2014; Thompson et. al, 2015). When toxic stress such as an ACE is experienced without the support of a trusted caregiver, individuals will often engage in coping behaviors such as overeating, stealing, and substance for relief from the emotional distress created by trauma. (Anda, 2007; Fox et al., 2015; Miller-Graff et al., 2015; Larkin, 2012; McElroy & Hevey, 2013). Risk behaviors and symptoms of dysregulation can prevent successful acquisition of an education and predict repeated patterns of re-traumatization. Research shows that individuals with many ACEs are more likely to plan to work a job right after high school while students with fewer ACEs were more likely to go on to be college graduates (Christian et. al., 2015).

Co-morbidity of ADHD and Complex Trauma Conditions

Of an urban population surveyed, each child had experienced an average of 4.9 traumatic events. 42.9 percent of caregivers for these children sought help due to concerns with their child's social emotional needs and 14.3 percent of caregivers had developmental concerns for their children (Hale et al., 2010). Dr. Nadine Burke Harris of The Center for Youth Wellness in San Francisco began recognizing that the children she began treating for ADD and ADHD had more than the diagnosis in common, they were victims of adverse experiences (Harris, 2014). ADHD and childhood traumas are both prevalent diagnoses in society. Researchers are continuing to question if the co-morbidity of these two diagnoses can be better sufficiently explained (Cuffe et. al, 2014). Research suggests that children who meet diagnostic criteria for ADHD do not always have adverse experiences, yet symptoms of those diagnosed with Complex Trauma often resembled ADHD (Clarkson Freeman, 2014; Cuffe et. al, 2014; D'Andrea et. al, 2012; Gleason & Humphreys, 2016; Koyocu et. al, 2016; Lipschitz, 2002; Malarbi et. al, 2016).

Assessment and Criteria for the Diagnosis of ADHD and Complex Trauma

School setting do not diagnose neither ADHD or Complex Trauma (PTSD- Type II).

School districts caution conversations regarding diagnosing in school settings. School social workers and staff can encourage the family to seek more information. Presented referral options from the school social worker might include: seeking a medical professional, school-based therapy, an in home skills worker, mental health case manager. Research indicates that best practice for diagnosing significant impairment in children involves multiple respondents and multiple measures (DuPaul et. al, 2014). Multiple respondents might include teachers, daycare providers, and primary care givers. Multiple measures assess the developmental, social, and trauma history, along with the neurobiological, emotional, and behavioral factors. Diagnosing ADHD at the elementary school age often requires feedback through rating scales from primary guardians as well as teachers and school social workers (DuPaul et al., 2014; Spencer, 2007). The function of gathering these two perspectives relies heavily on similar behaviors of the children being observed in two settings such as home and school (Gleason & Humphreys, 2016). A thorough reflection on the child's trauma history and emotional status can be retrieved using the Pediatric Symptoms Screen for Children (Jellink et. al, 1988) as well as scales for Complex Trauma symptoms (Foa et. al, 2001), however neither are a required screening for ADHD.

Treatment of ADHD and Complex Trauma

Structure, boundaries, secure independence, positive communication, and coping and problem solving skills are necessary for the successful development of children (Waxmonsky et. al, 2015). Research informs of significant considerations in teaching, parenting, and extra instruction for children with ADHD. Eighty percent of students with mental health needs are serviced through school, though only 11% of those students receive help (MSSA, 2016; O'Brien et. al, 2011). It is important to note that people of color specifically have low rates of accessing mental health resources, yet discrepantly experience more ACEs and receive a diagnosis of

ADHD more frequently (McKelvey et al., 2016). While many students with ADHD and/or Complex Trauma might receive an Individualized Education Plan (IEP) through Special Education Services, others function well with other treatments such as school-based therapy (DuPaul et al., 2014).

Treatments suggested for children with ADHD consist of medication, parent skills training, and group or individual therapy (Gleason & Humphreys, 2016; Ralph et. al, 2001). While medications can allow for better functioning for student's impulses, research shows that medication alone may not be successful in reducing negative behaviors (Ralph et. al, 2001). Early treatment of trauma may work to provide safety and skills for self-regulation (Courtois, 2008). While medication may decrease the anxiety and depressive symptoms of children who have experienced trauma, it may not fully diminish the need for children to dissociate to avoid the emotional distress of their trauma (Courtois, 2008). Behavioral interventions and play therapy have been found highly successful for students diagnosed with ADHD and/or Complex Trauma (PTSD- Type II) (Blotnicky-Gallant et. al, 2015; Cuffe et. al, 2014). Trauma research focuses on the efficacy of Exposure, Cognitive-Behavior, and Psychoanalytic therapy interventions. Psychoanalytic therapy focuses less on changing the behavior and focuses on the root of why those symptoms and behaviors exist (Van der Kolk, 2015). Best practice utilizes multiple treatment approaches (Courtois, 2008). When considering the treatment for children with Complex Trauma (PTSD Type-II) it may be important to consider the guardian. Guardians themselves may be living with their own trauma effects and have barriers to accessing opportunities to support their children experiencing trauma. A parent-child approach through Cognitive-Behavior Therapy can oftentimes help the child and guardian to co-regulate and cope (Santiago et. al, 2013).

Perception and roles of teachers and school social workers

Traditionally, teachers have been responsible for the academic needs of their students (Alisic, 2012). Today teachers find themselves working to address students behavioral and emotional needs as well. According to the research, teachers feel the biggest barrier has been a lack of training pertaining to trauma, mental health, and neurological disorders (Blotnicky-Gallant et. al, 2015; Walter et. al, 2006). From self-reports, teachers were found to lack knowledge on mental health conditions as well as access to resources (Alisic, 2012; Walter et. al, 2006). Teachers reported that they did not have experience consulting with outside mental health professionals about the concerns of their students (Walter et. al, 2006). Teachers were also found to believe that symptoms of diagnosed ADHD are out of the student's control, while symptoms of Complex Trauma were viewed as oppositional and defiantly deliberate choices being made by the student (Blocknicky & Gallant; Crosby et. al, 2015; Walter et. al, 2006). Teachers also felt a sense of doubt in responding to the trauma in wanting to both affirm the students experiences, all the while helping them focus on positive elements outside of the trauma (Alisic, 2012). The Surgeon General advocates that teachers should be trained to enhance the social and emotional development of their students, use evidenced based classroom management, and connect students to referrals for clinical assessment and treatment if necessary (Walter et. al, 2006). Teachers who had received training on mental health and medical conditions were more likely to use differential instruction and accommodations rather than behavioral contracts or plans (Blotnicky-Gallant, 2015). Teachers felt their students fared better when they cultivated positive relationships with their students were able to assist them in gaining competency in coping skills and providing a safe and positive environment (Alisic, 2012; Crosby et. al, 2015; Willis & Nagel, 2015). Teachers who assisted their students in reframing their experiences, helped them

build capacity for learning (Willis & Nagel, 2015).

With the rise of mental health and different abilities rising to 20% of students in their classrooms (higher if an underserved demographic), schools have reported needing more assistance from mental health professionals such as school social workers, psychologists, and school counselors (Branscome et. al, 2014; Lynn et. al, 2003; Monañez, 2015; O'Brien et. al, 2011). The recommended ratio of school counselor and school social workers is 1:250 students (ASCA, 2016; SSWA, 2016). School social workers are often responsible for helping train teachers in evidenced based techniques to assist with student behavior (Branscome et. al, 2014; Walter et. al, 2006). School social workers and counseling teams serve as a support network for school administrators and teachers in gaining competency to identify concerns and treat ADHD or Complex Trauma (PTSD Type-II) symptoms in the classroom (O'Brien et. al, 2011; Monañez et. al, 2015). School social workers also serve as a bridge from a student's home to school. While many families might be open to discussing concerns of inattention or impulsivity, they may not want to consider their child as having ADHD. If a child has experienced trauma, this information may be kept private or the perpetrator may be the guardian. Strong partnerships with community resources for students and families are an important component of prevention of trauma and the treatment of ADHD and Complex Trauma (PTSD Type-II) symptoms (Monañez et. al, 2015).

School Climate

Research reveals that when students feel connected to school, they succeed to a greater degree socially, behaviorally, and academically (Monañez et. al, 2015; O'Brien et. al, 2011; Woolley, 2016). Staff who work in schools that are focused on cultivating a positive climate report feeling more supported and feel they do better in their jobs (Oyersman, 2006). Leading a positive school climate may be the responsibility of a team of staff, administrators, or school

social worker depending on the school building (Berzin et. al, 2011; O'Brien et. al, 2011).

Helping students connect to school might be as simple as being acknowledged by school staff or greeted when walking into the building, school wide celebrations, being supported by a mentor, an in class positive behavior chart, seeing a school-based therapist, or participating in a social skills group with the school social worker.

Conceptual Framework

The Empowerment Theory suggests that individuals have innate strengths that promote resiliency, problem solving, and capacity for change (Wise, 2005). For this research, the Empowerment Theory is directed toward the school social worker and teachers in their work with students presenting with symptoms of ADHD and Complex Trauma. As licensed professionals, school social workers and teachers are required and expected to seek out continuing education credits and build upon competencies and best practices. While the training for teachers on mental health and diagnoses is limited, teachers are able to seek out their own resources and information to build their competencies to effectively support students with these needs. The Empowerment Theory supports that the school social workers and teachers will also keep the mindset that children with ADHD and/or Complex Trauma symptoms have resiliency to improve and thrive (Broom, 2015). Teachers and school staff can positively alter the quality of a student's life through supporting their own self-empowerment and social cohesion (Murphey et al., 2014). A foundational approach to trauma suggests that when those who have had adverse experiences have received support from trusted individuals in their lives, the effects are less detrimental (Anda, 2007; Wise, 2005).

Methods

Research Design

This research required knowledge of the previous and recent literature that outlines the approaches to diagnosing and treatment ADHD and Complex Trauma (Type-II). The research design used qualitative research methods and content analysis. Qualitative interviews were determined to be the most effective means of gaining thorough insight into the experiences that arise working with students with ADHD and/or Complex Trauma (PTSD Type-II). The interviews provided subjective experiences to determine how ADHD and/or Complex Trauma (PTSD Type-II) are diagnosed and treated. The participants, elementary teachers and school social workers, were selected by a snowball sample in the metropolitan Minnesota area. Participants were informed of the research through a public Facebook post and e-mails sent to their public e-mail addresses. Snowball sampling allowed for participants to refer another individual who fit the research criteria.

Sample

The sample for this research consisted of five elementary school teachers and five elementary school social workers that have experience working with students with ADHD and/or Complex Trauma (PTSD Type-II) symptoms or diagnoses. Participants were required to hold either bachelor or master level degrees. The teachers and school social workers worked and lived in the metro area of MN including St. Paul, Minneapolis, and the surrounding suburbs. All of the participants held a Master's degree in either education or social work. Of the teachers who participated, two were male and three were female. All five school social workers were female. All the participants were actively practicing their profession within a public, private, charter, magnet, or immersion elementary school. Four of the school social workers had five years or less

experience, while one of the school social workers had more than 10 years of experience as a school social worker. Two of the teachers had over 20 years experience while three of the participants had 5 years or less of experience.

Protection of Human Subjects

The Informed Consent document was approved by the Institutional Review Board of St. Catherine's University and outlined preventative measures to ensure the safety of the participant was upheld. The Informed Consent Form (see Appendix A) was read to the participant after introductions and prior to the interview questions. A paper copy of the form was given to each participant. The Consent Form specifically described the use of the recording instrument during the interview. The subject was assured that the recording and transcription of the interview would be destroyed by June 30th, 2017. It was discussed with the participant that the topic of trauma can be sensitive and that precautions were taken in this research study to reduce the risk of emotional distress or harm to the participant. The research questions were framed to inquire regarding professional experiences with ADHD and/or Complex Trauma (PTSD Type-II). The participant was notified that if at any time he or she felt uncomfortable with the research questions or process there was no obligation to provide an answer or to continue the interview. The participant was also informed that there was no direct compensation offered for this research study. The participant was then asked if they were comfortable signing the Consent Form. Once the form was signed, the researcher began conducting the interview. All participants consented and completed the full interview.

Data Collection and Instrument Process

Data were collected by means of a semi-structured in-depth interview with open-ended questions. Questions for the research were formulated based on the literature review, as well as

the knowledge of the participant's frame of reference for ADHD and/or Complex Trauma (PTSD Type-II) diagnosing and treatment. This research included 10- 90 minute in-person semi-structured qualitative interviews conducted in private settings chosen by participants. The participants were told the purpose of the study, why the participants were selected, the procedure of the study, risks or benefits associated with the study, issues of confidentiality, and the voluntary nature of participation. Participants were then asked to sign the Informed Consent Form and provided their own copy of the form. The interview was recorded via a password protected phone and was later transcribed in a document. Both the researcher and the participant had the document of research questions in front of them. Follow-up questions were asked intermittently to gather or clarify information from the participant. After completing the interview questions, the researcher thanked the participant, referred to the voluntary nature of the Informed Consent, and encouraged follow up should the participant have any questions or concerns.

Data Analysis Plan

The voice-recording device allowed for the researcher to pause and rewind and ensured validity of "Speech-to-Text" and eased the transcription process. The transcriptions were de-identified and coded using content analysis (Padgett, 2008). Transcriptions were read line by line to identify important concepts and codes in the narratives. Quotes were then compared across interviews in an Excel spreadsheet for frequency that were the developed themes. Themes from the research data were compared to the empirical research and reflected upon in the following.

Findings

This study sought to identify teacher and school social worker perspectives and roles in diagnosing and treating ADHD and/or Complex Trauma (PTSD-Type II) in the elementary

school setting. Five elementary school social workers and five elementary school teachers responded to and agreed to participate in qualitative interviews for the purpose of this study. The following themes were derived from the participant interviews: the importance and helpfulness of training, strategies for accommodating children with ADHD and/or Complex Trauma (PTSD Type-II), the co-morbidity of ADHD and Complex Trauma, roles and responsibilities, staff stress, and the importance of a positive school climate.

The Importance and Helpfulness of Training

The importance and helpfulness of training arose from teachers and school social workers in response to meeting the oftentimes complex needs of students with ADHD and/or Complex Trauma (PTSD Type-II). Teachers and school social workers identified that training could be helpful to better understand the needs of their students and how to provide the best accommodations for them. Seventy-five percent of social workers in this research study credited their graduate programs in assisting in their competency of ADHD and/or Complex Trauma (PTSD Type-II), while teachers reported relying heavily on school resources, their own pursuit of information, and school provided trainings. One teacher participant described his experience in his undergraduate education program:

“General Ed teaching makes you aware of it, but doesn't teach you how to handle them all the time or give you ideas. Sometimes I think it makes you aware of the practices and everything, but going out and actually teaching is totally different than what they actually put in.”

Another teacher reported that in learning to accommodate ADHD in her classroom:

“What I've read and researched has probably been the best.”

One-hundred percent of teachers were likely to reach out to another school staff whether that is a

teaching colleague, administrator, or student support staff when needed. A teacher added that he reaches out to his network and beyond to understand best practices with his students:

“My grad school friends and colleagues and reading online of how to handle things, symptoms of things, reactions to things and how things can be handled.”

Social work respondents in this study reported that if they are the only social worker in their building, they contact support from individuals in the field outside of their school. One respondent reported seeking help from other graduates from her Master’s program, as well as her sister in law who is a school based therapist. Another social worker reported she will seek:

“Old colleagues, I read books, I go online, different referrals and brainstorming. I have so many resources.”

One-hundred percent of all respondents alluded that training is much needed and can be helpful.

One teacher reflected on his training experiences in relation to trauma:

“Trauma based. I've had lots of training on that. It has helped me be more empathetic.”

One teacher recounted that she feels a lack of training and therefore cannot effectively respond to her students:

“But I haven't gotten training on how to help them or support them, which is pretty frustrating...”

One school social worker reported a pro-active approach to training staff in regard to trauma and its impacts:

“We do trauma informed school training at the beginning of the year and I think since we've been doing that it seems like people are doing a better job of identifying early mental health symptoms or they say, ‘I notice this and I'm curious.’ Whereas before they might have not talked to me about it or they may have noticed something and brought it

up as a behavior concern.”

Another school social worker discussed the importance of training for school staff and the significant impact it has on relating empathetically to the students:

“And unless you have the training you don't understand how hard it can be for a kid to overcome, especially if they don't have the tools that you need and it [trauma] changes your brain. So it can shut off parts of your brain and alters the way you think about things.”

Eighty percent of teachers and school social workers reported that it would be important to have more training on ADHD and trauma. One teacher stated that she needed more training and that it was contingent on whether those needs were presented in her classroom that year:

“I almost feel like if you don't have students with that specific diagnosis you don't learn it and you aren't taught how to deal with it.”

Another teacher stated her thoughts:

“I just think there needs to be more awareness in schools and more trainings on how to support these things, cuz it is a big deal and students need our help in order to be successful.”

Strategies to Accommodate students with ADHD

Teachers and school social workers were able to identify the students they worked with who had ADHD symptoms, the varying needs the students have, as well as the ways in which they accommodate the student's needs. The teachers surveyed reported on average 11.4% of students in their classroom exhibiting ADHD symptoms. 60 percent of teachers reported that their comfort level in working with students with ADHD has increased with time. One teacher reported this sort of transition of his comfort level working with students with ADHD over time:

“Coming out of school I was a three or a four out of ten. It was kind of overwhelming...But now after a couple years it’s probably a seven.”

Participants in this research identified a variety of accommodations for students with symptoms of ADHD in the school system such as: fidgets, movement, organizational strategies and social skills. Staff noted that the impulsive nature of ADHD has a significant impact on the student’s sense of belonging and self esteem. One teacher recounted:

“We do have one student who told me, ‘I didn’t take my medicine so I’m going to act bad.’ So that tells me at home that someone must be telling him that. I told him, ‘You aren’t going to act bad.’ But you could tell he was a different person and it made me sad that the medicine made him to be someone he really isn’t.”

The reality for many students with symptoms of ADHD is that they may become aware that they are different from their peers or that they are not able to attune easily to instructions and even social cues. A school social worker recounted her experience talking to parents about the relational impact of possible ADHD. She told parents:

“...She feels like she’s playing tennis and there are 15 balls coming at her and she doesn’t know which one to grab and so her self esteem is being impaired, her social relationships. With girls it’s so social and she misses like 15 social cues and when she finally tunes in she has hurt feelings or gets mad because she missed something and feels a threat because they’ll be laughing and she thinks they are laughing at her and doesn’t realize there was joke told, she missed the engagement, they are laughing and looking at her, and they are sad that she missed the joke.”

One-hundred percent of respondents commented on movement being a significant accommodation with students with ADHD. One teacher reported of students with ADHD like

symptoms or trauma:

“Kids need fidgets, some kids need wiggles, some kids just need to be able to walk around. So we have all those options for them.”

A school social worker reported that at her school:

“We let kids have breaks. We let kids go run with one of our staff, or go play basketball, and have free bathroom uses.”

Another teacher greatly resonated with kids needing more movement throughout the day. He reported that he has created an after school outlet for underserved students to learn to ride bikes.

The following are his observations on the impact of movement for students with attention needs:

“I ride bike with kids and some of the kids who can't focus when we are sitting, when I'm riding along with them we can have a conversation and I can point and say, ‘Hey did you see that over there?’ They seem to be able to focus more when they are moving.”

Other accommodations as noted by teachers and school social workers included: task lists, communication with home, alternate work spaces, clear boundaries, and social skills training.

This school social worker helps educate teachers on how to differentiate the instruction to be inclusive of the different learning style for a particular student:

“I talk to teachers about having a ton of work spaces. Even if you have a standing desk, a bookshelf where she could work. We have ball chairs for that physical movement. I have some kids I sneak into movement breaks and kind of vet them in because they just need to exercise. I try to help teach them tasks lists, use of privacy folders, headphones. There's a lot of scaffolding in the classroom.”

While many of the interventions are taught to students as an independent skill, others require additional time, support, and staffing. A teacher described her experience accommodating a

student with movement needs in her classroom:

“I’d say, ‘Ok, let’s go do some jumping jacks in the hallway!’ and I’d just stand by the door or I would text a couple of the support staff and ask if they could take him on a body break, or can you support my class while I help him? I just feel like they need an option for a break and to move. They can’t help it, so there’s a no point in getting upset at them or it’s just he needs to go somewhere else right now. This isn’t the place for him. It’s silent reading and he can’t control it.”

One-hundred percent of respondents reported that they connect with guardians with concerns about behavioral symptoms of ADHD. Reception to the communication and support varies due to a family’s circumstances as well as sometimes an unclear understanding of how to best support their student. One reflection from a teacher about a previous student suggested that parents have come to her for help for next steps in helping their student:

“I don’t know if they don’t know about ADHD. A lot of our parents have completed 6th grade maybe, so I don’t know if they actually know what that means, but they do say, ‘They are out of control at home don’t know what to do.’”

While a school system may have access to professionals from different disciplines, there are some guidelines and procedures that can make conversations of this nature challenging with families. A social worker reflected on her school’s process for supporting parents with ADHD:

“I had one or two that have asked. I believe that we don’t have a lot of resources for ADHD, we kind of like tell them, ‘You can have your pediatrician check them out’ or the Special Ed coordinator or school social worker talks with them, but we can never say, ‘We think your student has ADHD,’ We aren’t allowed to say that.”

One teacher reported that he doesn’t feel comfortable providing outside resources:

“I didn't provide resources. I know there are people who know a lot and they would be the ones who would do that. our school nurse is pretty active in stuff like that along with the school social worker and Special Ed teacher the three of them take care of that.”

Strategies to Accommodate Complex Trauma (PTSD Type-II)

While teachers and school social workers were able to identify symptoms of a student's ADHD, symptoms of Complex Trauma (PTSD Type-II) were oftentimes indistinguishable unless information was provided in regard to a student's life experiences. While teachers and school social workers may not have been aware of the details regarding a student's trauma, all were aware of helpful practices to meet the needs of a child who has experienced Complex Trauma (PTSD Type-II). One-hundred percent of teachers and social workers identified that consistency, a sense of safety, and belonging are significant needs for students with trauma histories. One school social worker reported of students with trauma:

“They need their world to be smaller. I tell teachers, ‘You need to close the door because a child is going to be more vigilant about the hallway than the classroom. So if you want them to see you teaching, you need to close the door, or they won't see you but they could tell you 15 different people who walked by and the ratio of how many of those people were wearing tennis shoes or boots. They couldn't tell you anything about your lesson.’”

A teacher reflected on the need of his students for a sense of belonging:

“Kids with trauma need to have as many adults as possible who care about them, so I try to be one of them.”

Another teacher reported this feeling of safety and understanding as significant:

“Their number one need is to feel safe. And they also need someone to communicate with

about their struggles to be able to let things go long enough to learn.”

While teachers and school social workers do their best to accommodate a student’s need to cope and empathize with the difficulty of their situation, they report it can be challenging to maintain high expectations. Reflecting on one of his current 4th grade students, a teacher stated that he strives to:

“Try to listen to them and tell them, ‘I understand you are having a hard time with these things, but there are still things you have to do.’”

A school social worker described collaborating with a student’s grandmother to help support the student and that together they hold him accountable and keep expectations high:

“We ride the kid really hard to make sure he is working really hard in school and tell him that he's gonna be somebody.”

Flexibility is a noted theme throughout accommodations for trauma. One teacher who had a student with many health concerns recounted that he’s told both the student and parent:

“I don't care, I'd rather you were healthy than be here today... so I tell him get healthy, we'll figure it out as we go.”

Another teacher reported that sometimes academics has to come second to the student’s physical and psychological well being.

“They might need extra love, even more than me, other adults. If they are tired, they might actually need to go sleep in the office for a little bit. When they have a need, it needs to be met.”

This teacher reflected that sometimes students need to be given meaning and purpose or something they can be successful in. He told a story about how he proactively enlisted two students who he knew could not be successful in a school assembly:

“There were two kids in my class that couldn't handle it and have trauma backgrounds. I had them help me move 15 bikes from my room to the parking lot. I just wanted to do something with them that made them feel special.”

According to both teacher and school social worker responses, supporting students in ways that help them cope is significant. One teacher reports that she provides students:

“A lot of comfort and support, a lot of reassurance, a lot of checking through the day like I just go thumbs up, thumbs down. A lot of praise, a lot of movement, body breaks, and they need to know what's coming next, schedules, like if something is off they make sure I know.”

A school social worker reported that students benefit from knowing how trauma impacts their minds and bodies and provides them an outlet to express those feelings:

“I think they need a lot of sensory type of breaks to get out some of that energy. They also need education of knowing when these symptoms are coming on so that they can have a way to excuse themselves or ask to leave the room for a little bit and recollect and get that out because that trauma is building inside of them and unless there is an escape route, it's going to come out in the classroom.”

This teacher helps students cope by giving them a positive distraction to get back on track:

“I see them when they are out in the hall because they are mad about something. I see them when they run away and they are hiding in the bathroom and I'll let them push my science cart in the hall to try to get them back and out of full of rage and back to being more measured. I think I'm good at that actually. And I don't take it personally.”

One-hundred percent of teachers reported using other resources in the school to support families and student. Supports consulted with include: administrators, school social workers,

special education teachers, the nurse, a school psychologist, and school based therapists.

A teacher reflected on asking for support from the school social worker:

“As far as complex trauma, our social worker is pretty good at having initial meeting and connecting with the parents and hopefully connecting them with community support.”

A school social worker reported that shame can be a hindrance to open communication with families:

“When I see parents come in and say, ‘Yep, this huge thing happened’ and you know, I think there’s a shame piece to some traumatic events. So I think it stays a secret until somebody bring it out and gets it diagnosed.”

A teacher reported that students also internalize this shame narrative about their trauma experiences:

“Some kids will open up to the school social worker and then (gasp) will stop. She was talking to one of my students and she blurted it one day and now has shut down when she asked her a little bit more to help her. So we only know bits and pieces, which is understandable for the students, but it’s hard because we don’t know exactly what they need and I don’t know exactly how to support certain traumas kids have experienced.”

Co-morbidity of ADHD and Complex Trauma

As noted by the research, ADHD and Complex Trauma (PTSD Type-II) have many overlapping symptoms in children. While the co-morbidity of ADHD and a trauma history are very possible, one teacher reported that this important differentiation may not be addressed in training teachers receive:

“I will say I think teachers in general tend to just want to lump it all together under

ADHD and tend to address families that way. I hope that there's a shift in finding out, 'Is there something this child could be struggling with outside of ADHD and that could be causing them to be inattentive?'"

One school social worker reported that most of her students were living in poverty and with family immigration concerns. For her, understanding the root cause of the behavior is essential:

"I would say I am more likely to identify hypervigilance or symptoms that seem to be related to trauma more than just pure ADHD because the nature of my caseload...So it's hard for me to identify a time when I've been observing a child and I'm thinking it's organic ADHD I would say that is pretty rare..."

Another school social worker reflected on the importance of differential diagnosis in terms of the impact and symptoms of both trauma and ADHD:

"I think of trauma in terms of the ACE scores, so trauma would be like a 3-4 or higher...See I think that ADHD is an umbrella diagnosis and I think that when kids have anxiety either organic or from a situation or they are depressed. So I don't think that all kids diagnosed with ADHD have ADHD, because hyper vigilance would be anxiety."

Roles and Responsibilities

Roles and responsibilities is a realm of elementary school culture that is oftentimes of greatest stress for teachers and school social workers. All participants alluded to the hard demands and workload of their positions. Specifically in terms of assisting with students with symptoms of ADHD and Complex Trauma (PTSD Type-II), 100 percent of teachers expressed that it was their responsibility to help accommodate students with needs in their classroom. One teacher reported that:

"I think a teacher's role is to access the support they feel is necessary for the student and

so even accessing the Gen. Ed. social worker or the therapist or consulting and collaborating. I think that we, our school, has a student support team which is the principal and the Behavior EA [Educational Assistant] and the Gen. Ed. social worker.”

Teachers interviewed from a variety of schools reported different individuals that are student supports in their buildings, but not always being aware of their role or if they can access them.

This teacher noted a support, but was unaware the significance of his role:

“We have outside people come in and observe. I don't exactly know what his role is. I think he's a psychologist, maybe? He comes and observes and provides notes to parents that might show some of these things. But a lot of times we don't see exactly what he writes.”

One respondent expressed his experience moving teaching positions and schools every year as a barrier to understanding roles and school functioning:

“I think you have to be long enough at a school to know everything. I've only been at a school one year and it's not enough to know how everything is working.”

Teachers reported that the school social worker's main roles were to connect with students individually, in groups, and with families. One teacher responded that:

“Currently right now our social worker has weekly meetings for small groups that is how we are currently addressing it. I do believe she does morning checking with certain kids.”

School social workers see their role involving resource brokering, supporting students, families, and helping to support the teacher. One teacher spoke on his understanding of the school social worker's role:

“There's communication at home. Helping to find, especially the lower income schools

helping to find a home, a next meal, details, and clothing.”

School social workers also note assisting in bridging communication from school to home and responding to crises.

“The most prominent are maintaining a caseload of individual and groups. There are a lot of different reasons why they are seeing me. Some there is more traditional counseling, others are for friendship groups, social skills instruction groups. Sometimes it's like a life circumstance that they are getting support with. Ideally, we tried to prioritize kid-facing time. I'm in charge of the child study team. That's another big portion of my day and then working with the special education team and then some of the other things that fall under the social work umbrella like resource brokering, crisis management, communicating with families, case managing the kids who have other providers whether it's like a therapist or if they have skills worker or other people in the building.”

School social workers support teachers in accommodating students with mental health or behavioral needs. One school social worker described her efforts in supporting teachers with strategies and accommodations:

“They really need to be onboard with interventions as well in order to get them to work. So working with that teacher is a very big part of my job. Helping them understand it and coming up with things they feel is going to be beneficial.”

Another school social worker outlined that some days her role is to help buffer the child and teacher relationships:

“I think it's my role that if the teacher is done socially, emotionally with this child to anticipate that and throw myself under the bus and say, ‘Why don't I support this child,

so it's a Friday, it's been a long week, we've touched another kid I think you should do some work in my office today so send me some work and send me the kid and give everyone a little break.' We all need a break from each other. Because I need that relationship to not totally bust. My clients just shift from child to grown up to caregiver."

Many school social workers also find themselves in leadership roles. One school social worker reported:

"I'm on the intervention team so that's where the teachers come together and they're have either academic or behavior concerns and giving suggestions on how to proceed and how to move forward. I'm the lead for that. I'm also a part of PBIS [Positive Behavior Interventions and Support] and the attendance team so we are looking at the kids who are lacking in their attendance and not showing up and then communicating with parents about how we are going to improve this so that we don't have to go towards a child protection issue and academic neglect."

Impact of Stress on Teachers and School Social Workers

The school environment is incredibly demanding of staff emotionally, mentally, and sometimes physically. Particularly with the needs of students with ADHD and Complex Trauma (PTSD Type-II). One hundred percent of teachers and school social workers reported that this work has an impact on them. One teacher elaborated about how emotionally draining it can be to support the students in their situations:

"I cry because I think about them. They're upset. You wish everything was easy for them, you know? That's part of it, but also how to handle people in general. Always being a little more patient, you don't know what the background is for somebody, where they are coming from and those experiences. I think that's some of the biggest thing."

A school social worker described how this work is emotionally demanding of her:

“...It’s incredibly stressful job. It’s a job that’s really hard to do within like a typical 40 hour work week. You have to be so relationally and emotionally present, your tool is essentially yourself and when you use that all day long it’s really, really hard.”

As noted in the literature review, the recommended ratio of school social workers and counselors to students is 1:250. According to information provided by the ten participants in this research, only one school has met that ratio. 90 percent of total respondents reported feeling like having more adults to support students at school would be beneficial. One teacher stated:

“But our primary social worker is .5 in our school and they are not there all the time, so a lot of these things are occurring I think that more mental health support would be helpful.”

Another teacher reported on the lack of staffing at his school building and how this impacts the students and school as a whole:

“We have one full time intern school psychologist. I think sometimes she gets overwhelmed. There’s a lot of issues that kids are handling where I am, but that’s all the district could afford.”

One teacher reported that sometimes it feels like there are so many different professionals who do different things and that,

“I almost wish there was just one person you could sit down with as a teacher and with a parent who has a concern and have a meeting. I think you have to refer to get access to other things and teachers are spread so thin over five subjects, 25 kids. I really wish I could have all the answers for you, but I have to focus on how can I bring things to the classroom to make it engaging, be aware of and how to handle it. I’m not always the best

at giving resources.”

A school social worker affirmed that to support students with higher needs, more staff must be involved:

“I just need more people in the building is what it comes down to. More adults to provide this for kids because it can work and they can get better. They can develop those skills...we know what works with kids is so relational and it needs to be with the younger kids really repetitive and responsive so you have to be there for them, when they need you in their moments of distress again and again and again and again. In a school building that's really hard when everyone is stretched so thin and you can get to them in the moment despite that that's what is likely that healing moment.”

Another school social worker expressed that the demands are too great:

“One social worker can't do it all!”

She also went on to say that a balanced work and lifestyle is difficult:

“I don't typically even sit and eat my lunch without working I a lot of times will have kids with me while I eat my lunch or will be responding to emails or calling parents so I need to do a better job of that. You only have six and a half hours to get everything done that it's hard for me to justify taking a half hour out just to sit and do nothing. I usually am one of the first people there and one of the last people to leave because there is so much to do behind the scenes. As a social worker your job is not just to work with the kids, it's a systems perspective. I need to be talking with kids. I need to be talking with parents and therapist, and other outside professionals and their teachers too. So you need to figure out how you are going to mix in that as well.”

One teacher expressed that he felt he couldn't reach all his students, especially those struggling:

“I spread myself so thin sometimes. You always notice those high ones first but sometimes when someone is suffering in silence on the side you can't get to them and it makes it very hard.”

Another teacher who expressed needing help in his classroom reported:

“I was a classroom teacher and when I needed help with a kid my experience was that I was given more work to do and very little help.”

With trauma experience requiring individual attention, a school social worker expressed that with the high stress of the school environment, teachers hope for a quick solution to the problems:

“Then teachers come to me and say, ‘Ok fix this kid.’ It doesn't work that way and I don't want to say working with me for a year isn't going to do anything but I don't say that because I don't want to make it sound like what I do isn't valuable, but if it is trauma, working with me for a year and seeing me once a week for 20 minutes is not going to do much. We might be able to help some of the symptoms at school but it's going to be a very small amount of those symptoms and that amount of progress.”

One hundred percent of respondents, both teachers and school social workers were able to identify a way they chose to cope with the stress of the school environment. They reported exercise, sleep, having good work boundaries, therapy, mindfulness, and faith. One teacher offered:

“After school I go for a run on the treadmill. Even after a really bad day with that student I just have to say it's a new day, a fresh start, it's not his fault and you can't hold things against them and they don't know any better.”

Another teacher responded that self-care was of absolutely necessity for her well-being:

“Yes, yes, definitely. Exercise, faith, and change. I've had to change job locations, I've had to move around enough just to get breaks.”

A school social worker brought up boundaries being an important factor in successful self-care practices:

“I have good boundaries or I wouldn't be able to do this work as long as I have. But there are definitely days when I just, whew I need to call a friend, I need to cry or go for a workout or something like that. I just need to trust that there are caregivers in these children's lives, like I have to just replay in my head a narrative these kids are going to be ok, I'll see them tomorrow and I have to trust that there are monitors to keep them safe while they are there and just keep showing up.... I do meet with my principal. I'll close the door and unload a little bit if he needs to know something what's going on with kids. The nurse and I are really tight and the counselor and I meet weekly to talk about kids and we'll close the door and have good conversations.”

The Importance of a Positive School Climate

Teachers and school social workers also identified that students with trauma may exhibit behavior in two ways, externalizing or internalizing. Both have an impact on student achievement, engagement, and connectedness at school. A teacher with a student having experienced trauma reflected on her student's difficulty in socializing appropriately with her peers:

“Last year I had a student who was sexually assaulted in kindergarten and really having a hard time in her in the classroom and having conversations with her peers, things that are normal because of things she's been exposed to, but really teaching her social skills and teaching what is right to share, what is not ok, what is appropriate, to who should

you talk to.”

One school social worker reflected on the variety of reactions to trauma that are seen in students behavior and why attending to all is important:

“I think it's so hard because trauma is different for everyone even in the same family, one traumatic event happened with all the siblings and we have the one sibling who is running out of the building screaming, the one sibling who is sexually active and promiscuous, risk taking behaviors, and we have one who is withdrawn and a perfectionist so it's so hard to know what's going. You just assume right away, ‘Oh that's just a behavior problem. Look at her sister. She's quiet and she writes and nothing affected her.’ So I really think we really need to be looking out for the quiet kids.”

The extremeness of students externalizing behaviors as described by a school social worker reveals the larger impact on a school community and the damage that can compromise the school building, equipment, and overall sense of safety:

“Some kids when they are really dysregulated tear things off the walls, hide in closets, or throw things, or self harm.”

A teacher expressed that while he can be empathetic towards a student’s experience, this cannot justify the behavior as well as preoccupy the roles of administrators at his school:

“So on a bad day we have six kids running around the school and they just follow them around. It drives me nuts. I work in too much chaos for me. Because people pushed out the trauma piece for people who are too empathetic it's an excuse to not to anything. It keeps two social workers, a principal, assistant principal, behavior team, Special Ed all traveling through the hall as people run through the media center, the bathrooms, in and out, and the rest of the kids have to hear it and see it. “

Teacher stress was addressed as having a large impact on the school climate. One school social worker explained that:

“I think there's definitely a domino effect, the teachers get stressed out and then the kids get stressed out. When we can focus on de-stressing the whole unit, the adult and the kids, I think the class feels the best.”

One teacher responded directly that the behaviors and symptoms of trauma affects other students and their learning:

“Kids who do have trauma sometimes have like raging fits in the hallway and administrators are like carrying them or removing them so that they don't get hurt and other students don't get hurt, but it's distracting like you can hear it all the way down the hall, you can hear because we keep our classrooms open. All of my kids like it totally sets them off and they are looking out the door. I have one student that has really high needs level three if he starts having a tantrum or a fit in our class then the whole class is off. I'm trying to teach them to ignore, but it's hard on the rest of the student and staff and you are wondering, ‘Is that student ok or are the teacher ok?’”

A school social worker responded that sometimes it can be so easy to acknowledge the behaviors, but so challenging to take ownership of the impact it can have on a person:

“It absolutely affects the school climate and it think we don't talk about it. I don't think we talk about it enough and it can be kind of crazy making for teachers because a lot of the feedback they get is improving their classroom management and what sort of engagement strategies they should be using and bigger level like teacher stuff and so then I think that can result in the teacher internalizing a lot of guilt and blame and thinking that if they had only done what this classroom strategy technique.”

This teacher felt like that because her school was fairly new on their fourth year of operation that,

“The school climate could use some help.”

Teachers and school social workers reported school climate was addressed by implementing Tier-1 school wide interventions such as Positive Behavior Interventions and Supports (PBIS), D.A.R.E. (Drug Abuse Resistance Education), behavior social mapping, and the Zones of Regulation. One school social worker reported on behalf of a more proactive approach for the school climate:

“So you need to be doing Tier-1 interventions in all those areas, and we sometimes think academics as a Tier-1 and then social as a Tier-2 and behavior as a Tier-3. But we should be doing interventions school wide so there is fewer needs to those interventions up there.”

The same school social worker reported the social skills school wide approach and its impact:

“We do social behavior mapping school wide, those are the two main things that we do. So at any given time if a kid is running, ‘That’s really unexpected, what good looks like is, blah blah blah.’ It’s a very concrete way of teaching skills and it’s not an assumption that you know, but I’m going to tell you what good looks like, and I’m going to tell you how it makes me feel and when you are acting right I’m going to have good thoughts about you, and if you are acting unexpectedly I’m going to have weird thoughts about you. The goal is that we all have good thoughts about each other. Breaking down a lot of the social secrets into more concrete ways so that kids know what the expectations are so kids know and I feel like that addresses culture and race and gender and religion, breaks everything down. Because if you are coming from a camp you might not know what good looks like, so it’s a non-shaming way. I teach parents that too so that if it feels comfortable for them

to weave some of that language in their home. What are the expectations at church, in the pew, ok, similar, in social studies.”

Along with the mentioning of common language to use as a school and connect to behavior, communication was a common concern that arose from teachers. For many teachers, not having the details of a child’s trauma history can be challenging to accommodate for. One teacher expressed:

“My principal actually when all of this came out was very private, the information wasn't even shared with me even though I am her teacher, so I actually had to make my best judgment and differentiate and work with her and I felt like my principal didn't want me to be a part of that. And after that it was very private and I didn't learn anything else. I wouldn't know if she was seeing a therapist. Even in our normal day she was never pulled out let's have a walk, a talk. Nothing.”

In a separate interview with a school social worker the need-to-know sharing was also noted as a barrier in collaboration across multi-disciplinary teams in the school:

“Her teacher is getting really frustrated and upset about it which is tough because I have to respect the parents privacy and her privacy and I'm not going to share that information with the teacher, but them finding a way to help that teacher understand what is going on.”

Yet another social worker recounts trying to carefully navigate confidentiality with colleagues suggests that:

“Always informing teachers and being an open book too. Keeping it on a need to know basis and sharing as much as possible because teachers want to know what's going on.”

Another social worker expressed concern about how important confidential information was and

it not being kept private in the school building by staff:

“I intentionally don't eat lunch in the staff room because they are constantly talking about the kids in theirs do that's not as our training as social workers that is not ethical it's violating confidentiality and I don't want to sit in their and hear them say things about kids who a lot of the time can't control their behavior.”

Another barrier for effective communication is that teachers have inflexible schedules determined by the classroom prep and lunchtime in which makes it difficult to schedule a meeting with other professionals in the building or families to communicate altogether.

Therefore, one respondent reported that she felt:

“Classroom teachers miss out on a lot because you can't be present at every meeting because who is going to cover your class? But in all actuality, we should be the ones that are at them because we are the ones with them all the time. So it's kind of difficult.”

Discussion

This study sought to identify perceptions of elementary school teachers and school social workers in the diagnosing and treatment of ADHD and Complex Trauma (PTSD Type-II) symptoms in school settings. This research was also intended to add to current literature and inform on procedures and interventions provided by school districts in the diagnosing and treatment of ADHD and Complex Trauma (PTSD Type-II). The following discussion has been organized to reflect the Micro-, Mezzo-, and Macro- systems involved in the findings.

Micro- System

Within the Micro- system of the school setting, teachers and school social workers in this study identified that it was their role as school staff to be understanding and flexible to what the student needs, while still trying to hold them to high academic expectations. All five teachers

reported a sense of responsibility to help students acquire their education and use a variety of interventions and techniques to assist them.

Data gathered from this research from five classroom teachers affirmed the continued prevalence of ADHD symptoms in elementary aged children. While data from 10 years ago estimated that five to nine percent of children would be diagnosed with ADHD, findings from this study revealed that among five elementary school teacher's classrooms there was an average report of 11.4% of students who have diagnosed ADHD or who exhibited ADHD like symptoms (Ralph et. al, 2001; Spencer, 2007). One-hundred percent of teachers and social workers reported movement being the most significant need of ADHD in school. This need was identified due to the sedentary nature of schooling and the student's impulsivity. Many of the interventions revealed in this research noted that students with ADHD needed multiple opportunities to engage in movement. Examples provided by respondents of this type of accommodation included: an extra pass to get a drink, a movement break, and fidgets.

Of the teachers and school social workers interviewed for this study, all reported being aware of many students who have had Adverse Childhood Experiences (ACEs). All of the school social workers interviewed reported getting referrals to work with students who have experienced trauma. Teachers and school social workers identified that the most significant needs of students with trauma symptoms include someone to talk to and coping skills. This coincides with research conducted by Courtois (2008) that early trauma work requires safety and skills for regulation.

Mezzo- System

All of the teachers and school social workers in this study recognized their work within the Mezzo- systems by communicating with family members, outside professionals, and creating

a safe and positive school environment for the students and staff.

All five of the teachers surveyed reported comfortably accessing extra supports in their building to assist with the student whether that was the behavior staff, school social worker, school based therapist, psychologist, or nurse. The teachers reported to rely heavily on the school social worker or other staff to bridge resources from school to home for the students. Two teachers reported that many families feel safer meeting with just the school social worker and will be more open to discuss the sensitive nature of their child's concerns or experiences.

The five school social workers all felt a sense of responsibility to partner with the teachers, students, and families. Information provided included that they felt their role as a support for the teacher in providing ideas for interventions to meet the child's emotional and behavioral needs. All of the school social workers reported using agencies to help families and students such as community social workers, therapists, and even mentors in a church community.

The school climate is noted by the literature to be of utmost importance because when student feels connected to school they have better chances of succeeding socially, behaviorally, and academically (O'Brien et. al, 2011; Woolley, 2016). While three of the school social workers reported being highly involved in school climate initiatives such as problem solving meetings, PBIS, behavior mapping, no teachers reported in this interview direct involvement or concrete awareness of school climate initiatives. All teachers and school social workers reported efforts in helping students connect to school whether through positive interactions, attending to their needs, social skills and friendship groups, or community building in the classroom. While the research notes that students and staff feel more supported when there is attention on a cultivating positive school climate (Oyersman, 2006). A teacher reported that in her building she felt staff didn't want to address school climate because the environment was so stressful and staff didn't

want to acknowledge that. One school social worker reported on the detriment of this mindset in that there is a trickle down effect and that there is a domino effect that when staff are stressed, students feel that stress as well. In school, stressors impact staff relationships with each other, students, quality of teaching, and the ability for students to acquire an education. According to the responses from this study, school climate is a behind the scenes effort by a few staff members and the interventions are not well known or observed by school staff. It would be curious to know how students perceive the school climate of these buildings as well.

Macro- System

The importance Macro- system within this research identified a call for policy for more support staffing in school buildings due to the intensity of the needs of students. Ongoing training and time for school staff to consult with one another in regard to the topics of ADHD and Complex Trauma (PTSD Type-II) was also addressed as a significant need. The recommended ratio of school counselor and school social workers are 1:250 students (ASCA, 2016; SSWA, 2016). Only one school in this study is meeting the recommended ratio for school social workers. Ninety percent of the teachers and school social workers note that more staff is needed to meet the needs of students. All respondents reported that their jobs were stressful and working with students with ADHD and Complex Trauma (PTSD Type-II) had an impact on them. The information gathered from this research was consistent with previous studies that reported teachers felt the need for more training in regard to ADHD and mental health conditions (Alisic, 2012; Blotnicky-Gallant et. al, 2015; Walter et. al, 2006). It was identified in this research that school social workers and teachers report feeling a lack of access to effective trainings through their school or school district. The Surgeon General advocates that teachers should continue to receive training on the social and emotional development of children, using

evidence based classroom management, and understand how to connect students to referrals for clinical assessment and treatment (Walter et. al, 2006). Eighty-percent of teachers and school social workers reported having pursued their own training for trauma or ADHD or have learned through experience.

Implications for Social Work Practice

This research implies an explicit role that school social workers have within the school environment. School social workers are both at the forefront of crises and behind the scenes coordinating resource efforts for students and their families. School social workers have an obligation to ensure that the children and families they are working with are provided accurate information and appropriate resources. This requires special attention to the collection of social histories on behalf of students who are exhibiting symptoms of ADHD and/or Complex Trauma (PTSD Type-II). Many school social workers find themselves in a position of leadership in helping schools develop positive school culture and climate as well as problem solving committees. School social workers can assist in school-wide social emotional learning and modeling. With understanding of person in environment and systems theory, school social workers offer a powerful perspective to help teach and empower educators to understand the complexities and successful interventions for students with ADHD and/or who have experienced trauma. Through the empowerment theory, school social workers seek to empower students, staff, and families to work toward stabilization.

Implications for Policy

As noted in this research, the recommended ratio of school social workers is 1:250 students. According to the research participants, most schools are far below this suggestion. Many schools share a school social worker in the district or have one school social worker for

500+ students. With 90 percent of school staff noting that they needed more staff to help support the needs of students, there is a necessity of advocating for funding for more student support staff. Along with this implication, a theme in the findings concluded the desire for more training for staff in the school to better understand and accommodate the needs of the students. Further attention should be given to the differential diagnosis between young children exhibiting symptoms of ADHD who have trauma histories. Lobbying efforts could seek a change in curriculum for teacher's higher education programs to include a focus on ADHD and trauma. Educational policies should seek the incorporating of social-emotional learning, culturally competent, and trauma-informed practices as a part of the school day as well as time for teachers to consult with one another.

Implications for Research

This study looked at both teacher and school social work perceptions of ADHD and Complex Trauma (PTSD Type-II) in the school setting. Future research should consider gathering more information regarding the resources and ongoing training available to teachers and school social workers to inform them of best practices. Other research might seek out perceptions of administrators on the roles of the school social worker and teacher on behalf of students with ADHD and Complex Trauma (PTSD Type-II). Further research could explore the demographics of students and school staff, as well as the prevalence of diagnoses across varying student groups (i.e. age, race, religion, etc.). Research could also continue identifying best practices in the differential diagnosis of ADHD and Complex Trauma (PTSD Type-II).

Strengths and Limitations

This research does not look directly at self-perceived competency, but can assist in informing school systems of competencies and support needed for teachers and school social

workers engaging with students with ADHD or Complex Trauma (PTSD Type-II) and their families. No demographics were collected on behalf of this study from the teachers or in regard to their school buildings, nor was the discrepancy of children of color being diagnosed with ADHD and more prone to ACEs addressed in this research. This research was limited to the experiences of teachers and social workers in an elementary school setting. Further limitations in this study included the sole reliance of self-reporting by the teachers and school social workers in regard to their perceived competency and understanding of roles in working with students who present symptoms of ADHD and/or Complex Trauma (PTSD Type-II).

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Appendix A.

ST CATHERINE UNIVERSITY
Informed Consent for a Research Study

Study Title: Perceptions of Diagnosing and Treating Attention Deficit Hyperactivity Disorder and Complex Trauma in Schools

Researcher(s): Megan Gauer-Kloos, LSW

You are invited to participate in a research study. The study is being conducted by Megan Gauer-Kloos, a Masters' student at St. Catherine University in St. Paul, MN. The faculty advisor for this study is Rajean Moone, Ph.D, Department of Social Work at St. Catherine University. The purpose of this study is to collect qualitative experiences from elementary school social workers and teachers on the knowledge of and practice behaviors in assisting with the diagnosing and treatment of ADHD and Complex Trauma for students in the Metropolitan area of Minnesota. This study is important because often schools are the access point to mental health resources for children. Approximately 10 people are expected to participate in this research. Below, you will find answers to the most commonly asked questions about participating in a research study. Please read this entire document and ask questions you have before you agree to be in the study.

Why have I been asked to be in this study?

Your invitation to this study was determined based on your experience as a teacher or school social worker with elementary aged students in Minnesota.

If I decide to participate, what will I be asked to do?

If you meet the criteria and agree to be in this study, you will be asked to do these things:

- Sign this consent form.
- Participate in a 60 minute interview.
- Agree to be recorded by a password-protected device.
- Agree to have the interview transcribed and coded for themes and for use in a final clinical research paper and presentation.

In total, this study will take approximately 60 minutes for a total of one session.

What if I decide I don't want to be in this study?

Participation in this study is completely voluntary. If you decide you do not want to participate in this study, please feel free to say so, and do not sign this form. If you decide to participate in this study, but later change your mind and want to withdraw, simply notify me and you will be removed immediately. Your decision of whether or not to participate will have no negative or positive impact on your relationship with St. Catherine University, nor with any of the students or faculty involved in the research.

What are the risks (dangers or harms) to me if I am in this study?

Due to the nature of this research involving ADHD and Complex Trauma in students, participants may experience discomfort in recalling various experiences with students and families.

What are the benefits (good things) that may happen if I am in this study?

There are no direct benefits to you for participating in this research.

Will I receive any compensation for participating in this study?

You will not be compensated for participating in this study.

What will you do with the information you get from me and how will you protect my privacy?

The information that you provide in this study will be recorded by password protected electronic devices, transcribed to eliminate any identifying data, and coded for themes. I will keep the research results on password protected electronic devices that only myself and the research advisor will have access to. I will finish analyzing the data by June 30th, 2017. I will then destroy all original reports and identifying information that can be linked back to you. The video recording of the interview will be erased by June 30th, 2017.

Any information that you provide will be kept confidential, which means that you will not be identified or identifiable in the any written reports or publications. If it becomes useful to disclose any of your information, I will seek your permission and tell you the persons or agencies to whom the information will be furnished, the nature of the information to be furnished, and the purpose of the disclosure; you will have the right to grant or deny permission for this to happen. If you do not grant permission, the information will remain confidential and will not be released.

Are there possible changes to the study once it gets started?

If during course of this research study I learn about new findings that might influence your willingness to continue participating in the study, I will inform you of these findings.

How can I get more information?

If you have any questions, you can ask them before you sign this form. You can also feel free to contact Megan Gauer-Kloos at gauel073@stthomas.edu. If you have any additional questions later and would like to talk to the faculty advisor, please contact Rajeane Moone at 651-235-0346. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

You may keep a copy of this form for your records.

Statement of Consent:

I consent to participate in the study and agree to be audiotaped.

My signature indicates that I have read this information and my questions have been answered. I also know that even after signing this form, I may withdraw from the study by informing the researcher(s).

Signature of Participant

Date

Signature of Researcher

Date

Appendix B.

Interview Questions

Teacher:

1. What led you to this profession?
2. What kind of degree do you hold?
3. How long have you been teaching?
4. What grade do you teach?
5. Can you tell me about the students that you work with everyday?
6. How many mental health workers does your school have on staff, including social workers, school counselors, therapists?
7. What has been your experience and training in identifying and accommodating ADHD?
8. Can you describe your comfort level in working with children who have symptoms of ADHD?
9. Based on any of your experiences or training, what do you believe are the causes of ADHD?
10. How many students in your classroom are diagnosed with or have symptoms of ADHD?
11. When you have a student you have concerns about ADHD, to whom do you turn to in your network to help you?
12. Can you tell me about a time where you had a conversation regarding ADHD symptom concerns with guardians?
13. Do you feel able to provide resources to guardians in regard to ADHD concerns, if so, what resources are aware of?
14. What has been your experience with trainings about mental health, trauma, or ADHD? How has this impacted your teaching?
15. Can you describe your comfort level in working with children who have experienced

trauma?

16. Based on experiences or training, what do you believe the causes of Trauma are?
17. How would you describe the needs of students you know have experienced trauma?
18. When you have a student you have concerns about trauma, to whom do you turn to in your network to help you?
19. Can you tell me about a time where you had a conversation with a family that was about a student's trauma and symptoms?
20. Has supporting students who have significant trauma needs had an effect on you? In what ways do you cope?
21. How does the trauma of children affect the school climate? In what ways is this addressed?
22. What do you believe the teacher's role is in identifying and treating symptoms of ADHD and Complex Trauma?
23. What are the roles of your student support staff (i.e. school counselors, school social workers, school based therapists) in helping with the process of identifying and helping treat ADHD and Complex Trauma in the school setting?
24. What would be your ideal approach to supporting students struggling with symptoms of ADHD and/or Complex Trauma at school?

School social worker:

1. How did you come to this profession and career in the school setting?
2. Can you tell me about the students on your caseload?
3. How many mental health workers (school counselors, social workers, therapists) does your school have on staff?
4. Can you describe to me your most prominent roles and responsibilities as the school social worker.
5. Can you tell me about a time that you had a conversation with a guardian about concerns of a their student's ADHD symptoms? What resources were provided?

6. When you have a student you have concerns regarding a possibility of ADHD, who do you turn to in your network to help you?
7. How many students with diagnosed ADHD on your caseload do you believe also have experienced trauma?
8. What trainings have you received on trauma in children?
9. What are some of the needs children have who have been exposed to trauma?
10. When you have a student you have concerns about trauma, to whom do you turn to in your network to help you?
11. Can you tell me about a time that you had a conversation with guardians in regard to concerns about a student's trauma? What resources were provided?
12. Has supporting students who have significant trauma needs had an effect on you? In what ways do you cope?
13. How does the trauma of children affect the school climate? In what ways is this addressed?
14. What do you believe is the teacher's role in helping identifying symptoms, diagnosing, and supporting students with ADHD or Complex Trauma?
15. What do you believe the social worker's role in identifying symptoms, diagnosing, and supporting students?
16. What would be your ideal approach to get students the diagnoses they might need?
17. What would be your ideal approach to supporting students struggling with symptoms of ADHD and/or Complex Trauma at school?