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Trauma in schools: Identifying and working with students who have experienced trauma

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Trauma in schools: Identifying and working with students who have experienced
trauma

By

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MSW Clinical Research Paper

Presented to the Faculty of the School of Social Work St. Catherine University and the
University of St. Thomas St. Paul, Minnesota
in Partial Fulfillment of the Requirements for the Degree of

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

Schools have academic and behavioral expectations that can be extremely challenging if not impossible for children who have experienced trauma. With approximately 25%-50% of children nationwide having experienced trauma, this is a widespread issue and major concern. Challenges in school for these children include learning difficulties, attention difficulties, struggle to regulate emotions, difficulty with peer relationships, and reactivity. This qualitative study investigates the question; how do social workers identify and work with students in a school setting who have experienced trauma? The researcher interviewed six licensed clinical social workers in the Twin Cities metro area who are working in schools. Findings showed that five categories emerged from the data, each encompassing several important sub-themes. The categories included identification, trauma interventions, trauma trends, barriers, and additional work. These categories and sub-themes provided insight into how social workers in a school setting identify children who have experienced trauma, interventions that they find useful, trends that they see regarding trauma, barriers to working with children in schools who have experienced trauma, and additional work that is needed was identified, which is not necessarily work that needs to be done by the social worker. The findings provide valuable information for school staff and social workers for effectively identifying and working with children who have experienced trauma, particularly the practice of trauma-informed care.

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Introduction

Schools have academic and behavioral expectations that can be very difficult, even impossible to meet for a child who has experienced trauma. Schools do not typically promote trauma-informed teaching and most public schools are not trauma-informed. One teacher might see a “bad kid” willfully disobeying rules who requires punishment or suspension. A trauma-informed teacher might see that same child as an activated child struggling to self-regulate and manage his emotions who requires support. There are many complicated layers to the issue of childhood trauma. There are various manifestations of trauma which lead to misdiagnoses and inappropriate, ineffective interventions.

My interest in trauma informed care began while interning as a social worker at an elementary school. This school was in a Twin Cities suburb. The students were ethnically diverse for the area, though primarily Caucasian. They were also diverse in socioeconomic status from very wealthy to very poor. Very few of the families were homeless. One of the students I worked with was a 9 year-old who had experienced severe trauma. His biological father was physically, verbally, and emotionally abusive to him and his mother. As a child, the child was regularly tied to a chair and forced to watch his father physically and sexually assault his mother. His diagnoses were Attention Deficit and Hyperactivity Disorder (ADHD) and Disruptive Mood Dysregulation Disorder, neither of which addressed his history of trauma. He was on medication for mood stabilization and a stimulant for ADHD. He was treated in a partial hospitalization program four times but it was not effective, possibly because it did not address the trauma he had experienced. His challenges in the classroom included inability to focus on one task, inability to sit for prolonged periods of time, refusal to participate in activities, and class disruption. He did not identify any other students as friends. He was behind a grade level

in most of his subjects and was unable to do homework outside of class. He was getting easily frustrated and explosive when he didn't understand. The teacher reported she found him unlikeable and exhausting. The lead social worker described him as highly intelligent, observant, persistent, and stubborn.

Research shows students of color, particularly those with low socioeconomic status, are more likely to have experienced trauma (Crosby, 2015). Trauma also affects brain chemistry and causes learning difficulties (Delima & Vimpani, 2011; Fox, Perex, Cass, Baglivio, & Epps, 2015). As a social work intern at a charter high school, I observed additional issues I now know were related to trauma. The school served as an alternative school for individuals who were unable to be successful in a typical public school setting. The majority of the students identified as African-American and some as Hispanic. They came from primarily low-income homes. Many of the students qualified for and received special education services and had an Individualized Education Plan. Public school teachers are only required to have two to five hours of mental health training every five years (Lahey, 2016). This often does not include trauma education and schools rarely require training to become trauma-informed. This is especially ineffective when considering 25-50% of children in the United States experience a potentially traumatic event by age 16 (National Child Traumatic Stress Network, 2017).

Experts believe there are two types of trauma: simple trauma, which is the occurrence of a one-time traumatic event and complex trauma, which refers to a child's exposure to multiple or prolonged traumatic events, particularly abuse (National Child Traumatic Stress Network, 2016). My interest is primarily in the effects of complex trauma, therefore, going forward the trauma I describe will be complex trauma unless stated otherwise. The high school where I interned had many issues with students "acting out" and had to deal frequently with disciplinary issues. Some

of these disciplinary issues included truancy, avoidance, and verbal and physical aggression.

One student appeared to be paying more attention to his peers than the teacher. When the teacher put him on the spot and asked him to answer a question, he became verbally aggressive and was asked to leave class and go to the dean's office.

Teachers and school staff are quick to discipline misbehavior but can misinterpret trauma-related stress and survival reactions as misbehavior. Symptoms of trauma look similar to various other mental health diagnoses, which adds a complicated layer to treatment. This is evidenced in the research which explores comorbidity and differential diagnosis with trauma and Attention Deficit and Hyperactivity Disorder, Oppositional Defiant Disorder, Mood disorders and more (Becker & Freyd, 2008). The neurological effects resulting from trauma block higher cognitive learning processes (Van der Kolk, 2014). These effects also lead to a state of hyper-arousal which can appear like ADHD. Children who have experienced trauma are more likely to be stressed or upset due to emotional dysregulation. Due to their brain chemistry, when someone who has experienced trauma becomes stressed or upset, they are unable to de-escalate at a typical rate, which then causes more problems (Van der Kolk, 2014).

While we know children who have experienced trauma are more likely to struggle in school academically, behaviorally, and socially (Merritt & Klein, 2014); evidence based practice supports paying particular attention to the therapeutic relationship when working with survivors of childhood trauma (Foltz, 2008; Gill, 2010; Gurwitch, Messer, Masse, Olafson, Boat, & Putnam, 2016; Knight, 2015; Scales & Scales, 2016; Zulueta, 2006). Forming this relationship can be especially challenging because children with histories of trauma can have difficulty forming trusting relationships as well as difficulty/ inability regulating their emotions. They risk being re-traumatized by well-meaning, but uninformed practitioners and the practitioner risks

experiencing secondary trauma (de Zulueta, 2006; Van der Kolk, 2014). Unfortunately, research on serving children with trauma histories in a school setting is lacking in specific information about both the unique challenges and how to best overcome these challenges.

Social workers in school settings have the unique position to be able to see how a child functions in class, with both teachers and their peers. They are able to assess the student's functioning, and dig deeper to work toward understanding. While a social worker in a school setting would not likely be able to do in-depth trauma treatment or therapy, they could identify symptoms of possible trauma, refer the child to appropriate resources, and work within the school system to advocate for mandatory trauma education for all staff. This research project will highlight the challenges social workers face when working with children who have experienced trauma and show the need for additional support of these students and the professionals caring for them. This leads to the research question: How do social workers identify and work with students who have experienced trauma?

Literature Review

There is a continuously growing body of research related to childhood trauma. The prevalence of traumatic childhood experiences is greater than anyone would have imagined twenty years ago. As the research and information increases, more questions arise. There has not been much research done specifically on the school functioning of children who have experienced trauma. In addition, I wondered how students who have experienced trauma are identified and how their challenges are addressed. This led me to my research question. How do social workers identify and work with students who have experienced trauma?

Trauma Symptoms

Trauma symptoms manifest in various ways, particularly complex trauma, which refers to a child's exposure to multiple or prolonged traumatic events, particularly abuse (National Child Traumatic Stress Network, 2016). Traumatic events affect different children in different ways. They cause the child to feel intense fear or panic. When a child has experienced multiple traumatic events, his brain learns to automatically go into survival mode (Van der Kolk, McFarlane & Weisaeth, 1996). When the brain is in survival mode, stress hormones flood the sympathetic nervous system which leads to the fight, flight, or freeze response (Delima & Vimpani, 2011; Gill, 2010.) The amygdala becomes overactive and triggers these emergency responses even when there is not an emergency. Continued exposure to high levels of stress hormones causes damage that manifests as excessive stress hormones at baseline and inability to calm or de-escalate once escalated (Cicchetti & Toth, 2005). Children who have experienced trauma may appear hypervigilant, highly aroused, and hyperactive (Brendtro, 2015; Fecser, 2015). This could cause problems in the classroom due to the typically strict school requirements of remaining seated and maintaining focus on the teacher or on particular tasks for extended periods of time. A teacher might see a student's behavior as "acting out" and oppositional while he might be unable to concentrate due to feelings of fear for his safety (Fecser, 2015).

Children who have experienced trauma struggle to regulate their emotions. They learn to cope with stressors through fight, flight, or freeze/ hyperarousal or dissociation (Zulueta, 2006). When they are hyper-aroused, they are very impulsive and reactive. It takes longer for a child who has experienced complex trauma to de-escalate because his parasympathetic nervous system has suffered damage, causing him be overloaded with stress hormones that cannot be processed

(Cicchetti & Toth, 2005). Trauma also affects the development of skills, emotions, and values (Amendola & Oliver, 2013.)

Trauma and Learning

Early childhood maltreatment and trauma hinder healthy development and are connected to impairment in academic and social functioning (Merritt & Klein, 2014). Children who have experienced trauma experience neurobiological effects hindering their abilities to learn (Delima & Vimpani, 2011; Fox et al., 2015). Children who have experienced trauma are more likely to have language delays, particularly in expressive language. Language is an important part of school and education. Children who are in foster care or adopted have a higher likelihood of having experienced trauma than children who are not (Phillips, 2007). In a 2006 study by Selwyn, more than half of the 130 children between ages 3 and 11 who were in foster care or adopted required school support due to emotional and behavioral problems. A study conducted on high school students showed that as levels of traumatic stress increased, the ability to problem-solve decreased (Coker, Ikpe, Brooks, Page & Sobell, 2014). Clearly, this indicates a deficit in ability to learn. Trauma damages the hippocampus which can impede memory and learning (Brendtro, 2015). The more trauma and stress a child experiences, the less likely he or she can cognitively process information and learn.

Differential Diagnosis

Another concern when treating traumatized children is misdiagnosis. There is a lack of research on the misdiagnosis of children who have experienced trauma. Many of the effects of childhood trauma imitate other childhood mental health diagnoses. In addition, children who have experienced trauma are more likely to have comorbid mental health issues (Becker-Blease & Freyd, 2008; Cuffe, McCullough, & Pumariega, 1994; Murrell, 2015). Attention Deficit and

Hyperactivity Disorder (ADHD) and learning and behavior issues are identified in schools by teachers who then refer the child for testing. ADHD has become a common diagnosis and one of the most frequently accessed interventions is medication (Cornel-Swanson, Irwin, Johnson, Bowman, & Frankenberger, 2005). In addition, school social workers report that after a child is placed on medication, the social worker is generally uninvolved in follow-up despite recommendations by the social worker. Like children who have experienced trauma, children with ADHD have trouble regulating emotions, sitting still, concentrating, organizing, and have problems with their peers (Murrell, Steinberg, Connally, Hulse, & Hogan, 2015). ADHD is also often comorbid with learning disorders and disruptive behavior disorders.

Cuffe et al. (1994) examined four cases of comorbid ADHD and PTSD and hypothesized PTSD may create related attention deficit symptoms. The clear evidence of hyperarousal in PTSD patients can appear to be hyperactivity. The child may appear inattentive due to inability to differentiate between routine, trivial stimuli and important, dangerous stimuli. Another study of ADHD symptoms in abused children in comparison to non-abused children found children who experienced abuse had higher scores of impulsivity and inattention than non-abused children but not higher scores of hyperactivity (Becker-Blease & Freyd, 2008). A study by Ford, Racusin, Ellis, Daviss, Reiser, Fleischer, & Thomas (2000) investigated the comorbidity and relationship between ADHD, oppositional defiant disorder (ODD,) maltreatment, PTSD symptoms, and other trauma exposure. The Ford study determined the relationship between these symptomologies is unclear. Oppositional behavior is more likely to be punished harshly which could lead to trauma. Children who have experienced trauma exhibit oppositional behavior as means of self-protection or due to inability to regulate their emotions. School staff members often see this as purposeful, oppositional behavior.

Trauma and the Importance of Relationship

One theory about the origin of trauma is that it stems from a disrupted attachment in early childhood (Zulueta, 2006). Children who have experienced trauma have a very difficult time forming healthy attachments, though these attachments are imperative for effective treatment. Relationships and the therapeutic alliance are extremely important (Foltz, 2008; Gill, 2010; Gurwitch, et al., 2016; Knight, 2015; Scales & Scales, 2016; Zulueta, 2006). Many medications, apart from stimulants, interfere with oxytocinergic levels in the brain, which in turn interferes with the individual's ability to form relationships (Foltz, 2008). In a school setting, the child will be more likely to learn if he forms a positive relationship or alliance with the teacher. This can be particularly difficult for a child who has experienced complex trauma because adult caretakers have not been reliable and predictable. Children with these histories often do not know how to use adults in positive ways. A child who has experienced trauma may present as stubborn, argumentative, and oppositional, but they truthfully may be yearning to feel some sort of control in a world that feels unpredictable (Fecser, 2015).

Trauma-Informed Schools

According to the manual created by the Massachusetts Advocates for Children (Cole, O'Brien, Gadd, Ristuccia, Wallace, & Gregory, 2005) there are several key components for developing trauma-sensitive schools. The components include school-wide infrastructure and culture, staff training, linking with mental health professionals, academic instruction for traumatized children, nonacademic strategies, and school policies, procedures, and protocol (Anderson-Ketchmark & Alvarez, 2009). Trauma-informed school policies strive to maintain expectations while holding students accountable (Crosby, 2015). Policies promote positive behavior without sacrificing classroom seat time. Utilization of these evidence-based practices

decrease the number of detentions, suspensions, and expulsions. In school-based treatment, some elements of PTSD treatment models exacerbate trauma symptoms (McCrea, Guthrie, & Bulanda, 2015). This can happen when children endure concurrent, complex trauma, particularly if the child lives in a community of violence and poverty.

Racism and Trauma

The experience of racism is a contributing factor to trauma. A study showed that participants who were inner city African-American youth experienced moral disengagement and traumatic stress based on their life and experiences (Coker, et al., 2014). African-American children are more likely to be assigned to special education than white children (Linton, 2015). Another study showed that community violence is higher in low socioeconomic, African-American areas (Crouch, Hanson, Saunders, Kilpatrick, & Resnick, 2000). In addition, chronic community violence has been shown to cause traumatic stress in children (Dulmus & Wodarski, 2000).

Long-term Effects of Trauma

Childhood trauma has been shown to have long-term effects. Smith, Chamberlain, & Deblinger (2012) identified that females involved in the juvenile justice system experienced childhood trauma at a disproportionately higher rate than juvenile non-offenders. Delinquency and trauma are co-morbid, although research has not shown exactly how they impact one another. A study by Fox et al. (2015) examines the relationship between aversive childhood experiences including trauma and serious, violent, and chronic juvenile offenders. They found 90% of juvenile offenders in the United States had experienced a traumatic childhood event, defined as anytime a child does not feel safe and protected, “which can be the result of intentional violence—such as child physical or sexual abuse, domestic violence—or the result of

natural disaster, accidents, or war,” (National Child Traumatic Stress Network, 2017). Another study investigating the relationship between childhood trauma and adult maladaptive personality traits (de Carvalho et al. 2015) found dysfunctional personality traits were highly prevalent in adults who had experienced childhood trauma. Adults diagnosed with borderline personality disorder were also found to have a high correlation to a history of childhood trauma (Van der Kolk, 2014).

Conclusion

Children who have experienced trauma have a difficult struggle. They face a litany of possible challenges which could include learning problems, emotional regulation problems, interpersonal problems with teachers, other staff, and peers. This research study will investigate what social workers see as challenges in the school setting for children who have experienced trauma as well as how they identify and work with students who have experienced trauma.

Conceptual Framework

In addressing the issue of trauma in schools, I am using an ecological framework along with some elements of trauma-informed practice. Urie Bronfenbrenner created the ecological systems framework, which emphasizes the interaction between the individual, context, and timing (Rosa & Tudge, 2013). The term “ecology” in the framework signifies the interplay between individuals and the environments with which they interact. The systems Bronfenbrenner (year) identifies in the interactions include microsystems, mesosystems, exosystems, macrosystems, and chronosystems. Children who have experienced trauma are likely to show very different ecologies than those who have not experienced trauma. Microsystems in this study refers to the individual, his or her family, his or her close friends, and other small, direct individual contact groups. A mesosystem includes the interaction of two or

more systems. The main mesosystem focus for this study will be the school system. Exosystems are systems which affect the child but with which they are not directly in contact, such as the child's parent's workplace. Macrosystems include institutions, culture, subculture, and even belief systems. Chronosystems refer to time or timing. This is particularly important when researching children with trauma history. For example, the time of their parents' divorce, perhaps age two, will alter the existing relationship between the child and their environment and may lead to developmental change. If a child felt particularly connected to his father who moved away after a divorce, this will change the way the child interacts at home, at daycare, and other environments.

The ecological framework is particularly relevant to this research because there is so much focus on development. Children grow and develop, learning from everyone and everything around them, while they are also affected by their genetics and biology (Rosa & Tudge, 2013). A child who has experienced trauma may feel unsafe at home due to abuse and, having internalized the belief that the world is scary and adults are unpredictable, he may also feel unsafe at school. The mesosystem of school may connect with his family who may report that he has behavior problems at home that they struggle with. In the macrosystem, cultural norms, stereotypes, and racism may influence the school staff's perception of the issue. The systems are all constantly interacting and forming the child's development. If a child who has experienced trauma can get positive support and have positive school experiences, he may be able to learn some adaptive coping skills and learn to be more successful within other contexts as well (Crosby, 2015).

I am also including trauma-informed care as part of my conceptual framework. There are several frameworks which comprise trauma-informed care (Crosby, 2015). Rather than focusing

on those individual frameworks, I want to address the broader concept of trauma-informed care. One model for trauma-informed educational practices, Multiplying Connections, uses the acronym CAPPD which charges the staff to remain Calm, be Attuned, stay Present, be Predictable, and Don't let a student's behavior escalate one's own emotional response. School staff who are untrained in trauma or trauma-informed care are unlikely to understand the benefits of models such as these. The typical dynamic in school is to have a teacher or staff member to exercise authority and control over the class. This would be counter-productive for children who have experienced trauma and may be defiant toward authority, already feeling oppressed. Professionals are more likely to suffer from secondary trauma or vicarious trauma if they have less training and information about trauma (Carello & Butler, 2015). The trauma-informed care framework is utilized throughout this research project.

Methods

This research was designed to answer the question: How do social workers identify and work with students who have experienced trauma? This section identifies and explains the research design and the ways in which the design appropriately addresses the issue. The process for sample selection is described along with the steps taken for protection of human subjects, data collection tool, and methods of collection. Lastly, the steps of data analysis are illustrated and defended. I will also discuss the strengths and limitations of this research design.

Research Design

The research design was a qualitative study using semi-structured interviews with social work professionals who work in schools with clients who have experienced childhood trauma. This appropriately answers the research question, which asks for school social workers' professional opinions about the challenges they see in school settings for children who have

experienced trauma, how they identify children who have experienced trauma, and how they work with them. The interviews were transcribed and I used content analysis to identify and describe the themes which emerged from the data.

Sample

The sample consisted of six social work professionals who work in school or educational settings with children who have experienced trauma. In order to recruit subjects, I made a post on social media via the Facebook groups “SWAPS Twin Cities,” and “Twin Cities Human Services,” giving a brief introduction of myself and the project, then requested that anyone who might be interested contact me (see Appendix A.) My sample included four female social workers and two male social workers. All of the participants were licensed clinical social workers. Two were licensed graduate social workers (LGSWs) and four were licensed independent social workers (LICSWs.) Five of the participants had the title of school social worker and one had the role of a school therapist. Three of the participants worked with high school students and three participants worked with elementary students. Five of the participants were Caucasian and one participant was Hispanic. The participants worked at five different schools in the Twin Cities metro area and two participants worked at the same school. The school with two participants specializes in trauma and trauma-informed care. One elementary school was also working with the district to become trauma-informed. While the other three social workers all practiced trauma-informed care, their schools did not identify or practice trauma-informed care. I assigned random three-letter names to each participant after coding was completed in order to refer to each participant. The names assigned were Jon, Sam, Lyn, Ali, Pam, and Kat.

Protection of Human Subjects

In order to conduct research with human subjects as a Masters-level graduate student at University of St. Thomas, I was required to apply to the school's Institutional Review Board (IRB). This was a safeguard to ensure the protection of human subjects. Before applying to the IRB, I was required to complete CITI certification which reviews ethics in research and issues with researching human subjects. I provided all subjects with an informed consent form (see Appendix B) which described the data being collected, potential risks, and the steps I had taken and would be taking to ensure confidentiality and minimize risks. In order to protect confidentiality, I transferred the interview recording to my St. Thomas OneDrive. I immediately deleted the recording off of the recording device once the data had been transferred to the OneDrive. I personally transcribed the data. When the data was fully transcribed, the interview recording was deleted.

The consent form was reviewed with the respondent. The consent form was edited and pre-approved by the faculty chair and the research committee. The respondent was informed that the researcher would conduct an interview which would last approximately 60 minutes. The interview was audio recorded on two separate devices to ensure that it recorded. The transcription was then coded by the researcher. The interview was made anonymous and confidential by removing the respondent's name and school identification from all notes and transcription. The findings were presented at the final research presentation day. The audio of the interview was destroyed after transcription and coding were complete. Consent forms will be kept for three years and destroyed after that time.

Data Collection

The data collection tool was a qualitative semi-structured interview. The interview questions were developed based on a combination of the information in the literature review and my personal research interests based on experience. The interview schedule consisted of open-ended questions (see Appendix C). The questions were developed using a classroom example of a good interview schedule and adapting them to the topic of interest and based on the literature review. The questions were formulated to facilitate a natural flow of conversation. The first questions are about the respondent's job and duties. They become more specific to include questions about the respondent's education in recognizing trauma and ways in which trauma is addressed in a school setting. Once an individual contacted me about interest in being interviewed, we scheduled a time and location for the interview to take place. I worked with the respondent to coordinate the ideal location, typically the respondent's office, though in one case an interview took place in a private space in the St. Thomas library. Each interview took between 20 and 50 minutes. I recorded the interview on two recording devices, my cell phone and my computer, to ensure it recorded. At the end of the interview, I thanked the participant, offered to send them a copy of the completed paper, and invited them to attend my oral presentation in May.

Data Analysis

In order to analyze the data, I started by transcribing the interviews. To transcribe the interviews, I downloaded free software called Audacity in which I could adjust to slow the speed in order to transcribe more effectively. After transcription, I completed a content analysis by coding themes that arose in the interviews. Content analysis was done by reading the transcripts at least five times and coded by identifying common emerging themes throughout multiple

interviews in the responses to the questions. The themes were written next to the text on paper transcripts. Next, the themes were evaluated to see if they were redundant or could be merged and incorporated into larger themes or categories. After I identified the themes and categories, the transcript was reviewed three more times to confirm accuracy. I selected the best two or three quotations that best illustrated each theme for inclusion in the paper.

Strengths and Limitations

There are clear strengths and limitations of using this research design. One strength is I was able to hear the subject's story in their own words. I interviewed subjects face to face which provided subject's personal, valid experience. Qualitative research produces deeper and more insightful data (Monette, Sullivan, Dejong, & Hilton, 2014). As the researcher, I am more likely to personally connect to the data and information through the narrative. Qualitative data allows concepts and ideas to emerge rather than forcing data into preconceived concepts. I was able to draw conclusions during the process of collection and see how they changed.

One limitation was the short time period to conduct the study. Also, only six participants were interviewed, which may not have allowed all the pertinent themes to emerge. The data was challenging to code and qualify, as in qualitative research, the researcher's bias affects the data (Monette et al., 2014). Another limitation is I did not use triangulation, the process of approaching the problem from different directions/ methodologies to compare conclusions (Padgett, 2008). Triangulation would have increased the validity; however I did not have the capacity at that time to utilize this method. I also did not use computer-assisted qualitative data analysis (CAQDA) which means my data analysis was more subject to human error. I was also unable to use member-checking. Member-checking guards against bias but implies a single reality. The idea of saturation, fullness coming from depth rather than breadth, was also not a

feasible method for me either, because I interviewed a set number of six participants. Despite the limitations, this research was able to examine how social workers identify and work with children in a school setting who have experienced trauma.

Results

Within the data, I found several common themes which I categorized into five separate categories. I identified several sub-themes in each category. The identified themes and categories attempted to answer the research question, how do social workers identify and work with students who have experienced trauma? The categories included identification of children with trauma, social worker's work, trauma trends, barriers, and additional work.

Identification

Big reactions. An important part of the research question assessed how a school social worker might identify students who have experienced trauma. One of the most commonly identified sub-themes in identification was big reactions/ overreactions. One participant I identified as Jon stated:

We see lots of kids who have really, really quick reactions to perceived threat. They go from zero to sixty over the door slamming or someone looking at them wrong because they can't interpret it.

Lyn provided another example, "...We have the kids who are aggressive. You know, they get bumped into accidentally and they're automatically hitting. It's like, oh, I wonder if that's their stress response system." Similarly, Kat identified the example, "Let's think I'm walking behind the kid and he's startled or something, or somebody walks past him and bumps his shoulder or something. If he goes from zero to sixty, that's a big indicator."

Difficulty with peer relationships. Another common sub-theme in identification was relationship difficulties with peers. Many participants identified lack of social skills as a barrier that negatively impacts a child's ability to build relationships and friendships, which often leads to a lack of connection with peers.

Jon explained it this way,

...the youth is reaching out to someone to try and be a friend, but what it is, they're being disrespectful, or they're punching them, or they're making a sexual comment, or they're looking at someone weird kind of thing, so other kid is like what is going on? And they're trying, they just don't know how to do it because of impact in their life. They never learned how to do it, or to them this is norm... they wanna make friends, and it doesn't go very well, or they don't know how to have a healthy relationship.

Lyn provided a good example of lagging social skills, stating, "... there's often times a lot of difficulty reading social cues. Or they're hyper-vigilant to very subtle body language and things that other kids are giving off and so they get kind of over-reactive to things."

Pam spoke of how children who've experienced trauma and have lagging social skills are often perceived by peers as different. She said,

They're mean, or else they just don't know how to interact in the right way where it's like, kids just think they're really odd, which is too bad... I see a lot of them though, who don't know how to interact. Even those ones who are resilient. It's kind of like they don't know how to invite themselves to play or how to ask people to play with them.

Developmental disruption. An additional sub-theme in identification was developmental disruption. Developmental disruption occurs when a child experiences trauma

while their brain is still developing, therefore they may not have what appear to be age-appropriate reactions or functioning. Jon reported,

there's a very famous slide of a three year old's brain, a normal healthy brain, and a child that's experienced neglect. The child that's experienced neglect's brain is significantly smaller, and so, there's that whole piece of effect that if you don't have a lot of enriching experiences early on, it does have deficits. And we know that they have a hard time making cause and effect thinking. They have a hard time with, you know, delaying gratification.

Sam also articulated his experience with developmental disruption,

...to see how trauma, how it changes brain development and, you know, derails normal development, so, when I meet students and I'm getting to know their story, I'm looking for, that's the first thing I look for is, you know, have they had trauma experiences that might explain why, for instance, a fifteen-year-old is doing some things that's more typical of a five year- old. That maybe something happened around that age that sort of they're stuck there, haven't learned some coping skills.

According to Kat,

...a lot of kids who were traumatized, they kind of get stuck at that age, you know if you were traumatized when you were a child, like I have a fifteen year-old who has gone through some pretty big traumas, and I've seen him act certain ways when he's upset that'll take him back to that age that he was.

Behavior referrals. Behavior referrals are often how the school social worker becomes involved with students who have experienced trauma, therefore another common sub-theme in identification is behavior referrals. According to Jon,

So, usually what ends up happening is that somebody gets identified that's having like a behavioral issue, and then the mental health team kinda looks into it, we start digging out and uncovering more, more stuff, and then figuring out what the appropriate interventions are.

Lyn identified her most common referrals as, "behavioral difficulties in their classroom setting, so kids having a lot of difficulty kind of regulating their behavior and their emotions and that kind of thing." Ali reported that their process includes ongoing reporting, "we just kind of keep a running list of different kids who've kind of popped up for behaviors or something we just kind of monitor over time to see if they're doing well or need more support."

Trauma interventions

Examining what's behind behavior. Another part of the research question asks how social workers work with students who have experienced trauma. Several sub-themes were identified with this category as well. The first and most prevalent theme was examining what is behind the behaviors. As Ali stated, "I can't say that there are many kids that we can identify that have behavior issues that you look and you don't find something behind it." Jon described it as well,

...a lot of it is trial and error and trying to figure it out, or you know, you think you have an idea, and then all of a sudden you turn the page and it's more information, then you're like, "Ha, that makes complete sense now." You know to find out that, you know, someone saw their mom being shot, or their dad was killed, or their, you know, kind of the experiences that unfortunately some of our kids have had.

Sam talked about the team approach in examining what is behind the behaviors,

I think our staff use discretion well, our understanding of the roots of behavior. But we have to team a lot and revisit students' backgrounds and look at things that aren't working, what are we doing that might be setting a student off.

Lyn described working to be aware of possible trauma,

...but when we are working with kids and trying to figure out what's kind of behind the behavior or something like that we're always trying to pick out those things that could indicate there's trauma and using trauma-sensitive approaches.

Relationship-building. Another important sub-theme in trauma interventions is relationship building. Jon stated,

...everything from sort of the concept of relationship building, in the sense like how do we go about making sure kids feel connected to their school, you know, and it may not be with the teacher. Maybe it's with like, if they have a good relationship with the person who serves lunch, or one of the janitors, and how do you facilitate that relationship, because you know relationships are buffers and resiliency factors, so how do we, as a school, encourage that.

According to Sam,

We form intense relationships, especially students who might have had early neglect or abuse, and so you might be seeing the reactive attachment, and it's a push. There's a lot of highs and lows and push and pull...

Pam described,

I focus on the rapport. I think that first step for me is very much letting the kid feel comfortable and safe with me before addressing anything else. I mean, I have a lot of toys like legos and play-doh and markers and coloring so I build a lot more on the

relationship before we have to dig a little deeper just because it's hard to get a kid to even want to talk to you.

Meetings students where they are at. The next sub-theme is meeting student needs/ meeting students where they are at. Jon said,

There's nothing in the IEP, there's nothing as far as mental health goes. What I always say, though, is to the effect of, if it looks like something a kid needs, give it to him... I think the school district really needs to look at things from what's helpful, not necessarily what's normal interventions. What's a normal school versus what our kids need."

Kat talked about meeting students where they are at as well.

So let's say there is trauma, if I really feel that there had been trauma and they're denying, then you kind of, look into, okay, I wonder why they're denying, and if right now they need to, if that's a coping, if that's what gets them through life at the moment, and you never, you never push for it. You know that they're acting this way, I'm gonna allow that, we may come back every once in a while, but you can't push, you cannot push, you have to wait til they're ready.

Empathy. Another sub-theme that emerged in trauma interventions was empathy. Jon stated,

If you look at it, I think from an empathetic, respectful, not blaming, you get parents and people to share a lot of information about what happened. Most of our teachers get it, in the sense of, they understand that our kids are gonna have good days and bad days, or you know, they didn't sleep well last night, so they're struggling today. So it's a different mindset here than at most public schools and honestly probably other programs

in our building even have. It's a fact of our kids are kind of some of the more, you know, for whatever the word you want to use, needy kids.

Pam described her approach,

Some steps I take, I use empathy, I use building rapport, I use just one on one time, giving them time to just talk. And I do do one on ones so if there is a kid who I think needs it, I mean I do 25 a week with just one on ones.

Individuality. Another sub-theme was individuality and recognition that every child is different. Pam explained:

I'm dealing with some kids who have a mother who is violent and two of them just want to talk and one just refuses to talk and I'm not pushing, I can't do that. So I guess, yeah, just been through trauma some want to talk some—it just depends who they are.

Ali described the individual approach by behavior staff,

...the behavior person also works with each individual kid to figure out what's best for when you contact parents, when don't you, how does that work with each kid and they're really taking into consideration what their trauma is and how it's impacting them.

Kat reminded the reader, "...know that all these kids are different and there's not a cookie cutter way to deal with them at all, you know, I think it's very individualistic..."

Teaching and supporting staff. One of the biggest and sometimes most complicated parts of social worker's work is to teach and support other staff.

Jon explained,

A lot of what my role is is helping staff who are not mental health specialists understand what the impact of mental health could be and what they're seeing with the kids. You know, in the sense of, if we have kids who are, you know, very quick to anger, or are

always fighting, or always disrespectful, or like pushing buttons, you know, sort of helping them understand it not necessarily from the behavior side, but also get a bigger picture from the mental health perspective of, this is why this is what's going on. You know, or maybe this is what they're trying to get out of it, like that functions of behavior, lots of that.

Pam talked about her approach,

...teachers always want me to do something right away, but before I do anything, I meet with the kid, I get a good history, I meet with the family, and I get a good history, and once I'm working from a place where I have some information, I work with the kids and the families to get them skills, and I work with school staff on ways to adapt for those kids.

Kat stated that,

...education-minded people think differently, so I know that if I have a student who has some serious trauma—because their teachers aren't gonna see the trauma, they're gonna see the behaviors, they're gonna see them not turning in the work or being flippant in school. You know, so then I have to go in and kind of explain this is what's going on in this child's life, this is why he's acting, you know, I have to give them the why, because they just see the actions.

Secondary trauma. The last sub-theme for trauma interventions is secondary trauma.

The social worker must acknowledge this as well as working to address it and prevent it. Sam described,

And we get burnt out too. But we have summers off. That's the secondary trauma, or vicarious trauma that we talk about here sometimes because it takes a lot out of you. But

it gets easier. You get kinda desensitized and so certain things get easier to handle with experience. I mean I've, I know that about myself already, that three years ago was harder than it is now, just being able to, to take all that in and carry it and then leave it here too when you leave.

Lyn discussed the way her school is addressing this,

...and then also we've been really trying to work hard at the secondary trauma issue and training staff about what secondary trauma is and what it looks like and recognizing it in themselves. And then really emphasizing the importance of self-care for staff and trying to model that and kind of provide some of that for them, too.

Trauma trends

Gender. The next category that emerged from the data is trauma trends. These are themes around trauma and trends within trauma discussion that emerged for the six participants. The first trend was about females internalizing and males externalizing. Sam stated,

I guess regardless of race or gender people act out or internalize, but the way it looks can be different depending on the culture or gender. Girls tend to be characterized as more emotionally manipulative and guys more quick to be physically aggressive...

Lyn also acknowledged this trend, saying,

I would say that maybe with gender that you know, tend to see boys kind of externalizing things more and girls kind of internalizing things more. And of course that's not always true, but if I had to kind of stereotype it a little bit I guess I would see that. I think that because of that I think that girls sometimes get lost. You know, 'cause teachers tend to bring kids to your attention that are acting out and some of those kids who are internalizing... You know we have kids and they tend to be girls, who have had trauma

who—how it looks is they're more perfectionist. They're extra courteous and helpful, overly to the point that it's negatively impacting them but teachers don't always recognize that and so I think that the boys tend to get more attention that way because of that.

Poverty. The next sub-theme that emerged in trauma trends was poverty/ low income.

Jon reported,

I think some of it might be socioeconomic. Like if you live in a bad neighborhood or a, if you, if you have poverty and live in a rough neighborhood where there's a lot of violence. I mean, kids experience trauma by seeing things, guns going off, police all the time, just not feeling safe. I don't think that matters, necessarily, if you're white, black, Hispanic, you know what I mean, that's like where you live, so it might be more to do with culture—you know, socioeconomic.

Pam describes her past experiences stating,

I worked at a title school last year and the discrepancy is sad but it's just completely different where it's calm here. So to find the trauma is almost more hard and they hide it more because the poverty's less compared to a title school. Last year I mean, I guess we would just tell right away. These kids would be standing on a table, they'd be hitting other kids, they're yelling at you as an adult.

Race. Another sub-theme was that the clients who have experienced trauma are disproportionately African-American. Sam stated, "well, unfortunately, my caseload is disproportionately and overwhelmingly one race, or you know, nonwhite, it's predominantly black and predominantly male, but we got some females." Lyn reported,

[My caseload] tends to be heavier on African-American students. And then you know, that kind of ties together with socioeconomic status as well. Just because we tend to have more kids in poverty who are African-American. You know. Have not had an equal shot in life.

Pam's view corroborated this, stating,

I believe in white privilege so I do see these students who are of color who have been through trauma. I think they just have it harder in general. Like especially at a school like this where we're predominantly white but if they've been through trauma not only are they a person of color but if they live in poverty and then they've been in trauma so all the cards are stacked against them. So I think just the difference of being a minority compared to not being a minority is just extremely hard in general because you're looked at differently.

Shift from traditional school setting. Another trend is a change or shift from a traditional school setting. Sam explained,

I think behavior staff and staff here put up with a lot more than people at a mainstream school would put up with because we know what our students have been through and that certain expectations are not realistic for them because trauma could, you know, maybe they have, it's not all trauma, but, you know there's students who have other chemical imbalances or genetic things that, ADHD, that don't necessarily have anything to do with trauma histories...

Ali described her district's work,

...our district is working on culturally-specific school something where we focus a lot on people of different backgrounds and the traumas and how that's impacting their learning.

So our school is really shifting from traditional behavior responses to understanding trauma and responding appropriately.

Ali also identified the barriers with a traditional school setting,

...the biggest challenge is, it's with all kids and that's being expected to focus for an extended period of time and to be doing a lot of auditory learning while, you know, they might be daydreaming or thinking about different things that have happened. They need some movement, they need to have some change in their day, and so, the traditional way school is set up is very hard for a lot of them.

Barriers

Discipline. There are barriers to working with children who have experienced trauma as well. Several sub-themes identify the barriers most frequently identified by the participants. The first barrier was behavior difficulties/ behavior correction/ discipline. Pam reported,

If the special ed kid has been through trauma, again, and I think they really forget that, so not only are they [special education] but now they've been through trauma. And so again, the cards are stacked against them and it's just constantly correcting the behavior, correcting the behavior but not just sit down and say, "Hey, what's going on? Let's just take out some coloring." And you can get a lot more out of a kid. But it's that constant like, "I've gotta correct them, they've gotta do better," but rather not like, "hey, where are you coming from?"

Kat stated, "I have other friends at other schools, other social workers, and, you know, they just see the behavior. That's all they see. You don't see the why, you know."

Difficulty building trust. Another barrier in identifying and working with children who have experienced trauma is difficulty building trust. According to Lyn,

Sometimes those relationships are slower to develop because kids with trauma are slower to trust adults, I have found. And it can be a frustrating kind of dance because most of the time teachers are really trying really hard to connect. And some of the students, particularly those who have like that more complex trauma, where their traumatic issues kind of occurred in the context of relationships or caregivers, you know, they might have some kind of attachment issues and so teachers can get frustrated. Like they're trying to connect and the kid has like got the wall up or something.

Kat described,

... with me it took them a while, I think to trust me, and I still think some are still, are still working on it. Like I have one who does trust me but at the same time he, aside from me, I don't know what positive female relationship he has. So, you know, if there's an issue, he gets mad at me or he doesn't trust me and that's okay, like with, that's okay, I can deal with that.

Struggle with school staff. A prevalent sub-theme that came up as a barrier for this work was difficulty/ struggle with school staff. Lyn described working on transitioning to a trauma-informed model, stating,

I think it's coming, they're getting better at it but it's kind of a slow process and we've had a little bit of resistance. There are staff who have difficulty kind of switching that lens and still kind of view all behavior through that behaviorist kind of way, so it's a challenge.

Pam cited her concerns as well, identifying,

But the teachers don't build rapport and I—that's the biggest piece is, oh hey, this student has witnessed domestic violence. I think of this third grader right now and he grew up

until last year being a part of it. And finally they're out of it, him and mom, and they came to our school and he has a diagnosis of PTSD. And he runs around and finally I built this relationship with him and I created him this calm-down backpack and a calm-down spot, but they're switch teachers. So one teacher's all about it and the other is just like, "no, he needs to be held accountable for his actions and when he doesn't do work he needs to be held accountable." And as a social worker you know I have to not overstep my boundaries either to the teacher but that's what I see a lot is where it's like, "I don't care what they've been through." They don't say it like that but rather, "they are here to be a student and I need to teach them and they need to do good and if they choose not to do it I'm not gonna care about that side of the piece of where they came from."

Kat described the struggle as well,

You know, that's, it's kind of a struggle so no, there are no trainings, and even like, when we ourselves try to hold the trainings for the school, for the teachers, you know, because they think very differently, and it's kind of a struggle. There's a lot of bashing of heads when there's education minds and mental health minds.

Maslow's issues. The next sub-theme or barrier is described as "Maslow's issues." This is based on Maslow's hierarchy which describes how an individual is unable to move up to the next highest level of needs and functioning if the previous level is not met. The very first level includes basic human needs including food, water, and shelter. The next level includes safety.

Jon reported,

I would say it's everything from some of those behavioral symptoms. You know, the things that look like ADHD or PTSD—or mood disorders, or a learning disability, or some of the cognitive-related concerns that kids have. Or the fact of just understanding

when kids come in sort of with the Maslow type thing, like they are not feeling safe, they haven't gotten food at home, because whatever it comes down to. It's more complex, I would say, the diagnosing of it, because it often looks like something else.

Ali also described this barrier, stating,

...I see a lot of kids coming from chaos, a lot of kids not knowing if they're going to have a place to live or food to eat and meet their basic needs, and yet they're here trying to learn.

Kat explained,

...when you're in an academic setting, when you're at school, you don't understand, I don't think they see all the other life things that are happening and how that affects everything because when you don't know where you're going to sleep at night, who the hell cares about this geometry homework, you know.

Policy. The last barrier that emerged was fear created by policy. Pam reports, "I fear, I mean daily after the election I always am fearing that our jobs will be taken and the funding will even go less..."

Ali also cited concerns for her students' fears regarding policy, "I have a lot of kids who are currently very nervous about whether or not their families are going to be kicked out of the country. I've had some kids have family members deported."

Additional Work

Universal approach. The last category identified is additional work. There is additional work to be done, though not necessarily only on the part of the social worker. The first sub-theme for additional work is a universal approach. Jon described:

...you can't pick kids out in the room who experience—you know it's not like there's a flashing sign above their head. And just helping them realize that it's not necessarily about individual interventions you can do in a school setting, it's about universal interventions. It's like what can you do that's beneficial for all students, but particularly beneficial for kids who've experienced trauma.

Lyn described a benefit to a universal approach,

Actually what we try to train people here is that we try to treat everyone as if they've had trauma. Like, using that universal precaution and if we just treat everyone in a trauma-sensitive way then it doesn't matter, we don't need to identify kids.

Lyn also added, “And that's partly why we've tried to kind of create trauma-sensitive schools because those staff like myself, there's not enough of us to go around and so we need everyone to kind of help.”

Trauma education in schools. The next sub-theme identified was trauma education in schools. While it is being implemented in some schools, it is also a great need in others. Lyn reported,

All the staff in the school have had training, at least an introduction to trauma and what the symptoms might look like. Particularly, you know, the fight, flight, or freeze stuff we've really worked hard on but we've also talked about, you know, just how when kids especially have trauma that occurs while they're still developing that it can impact their speech and language development, you know, their emotional development, their—all those different developmental areas.

Kat identified the need as well, stating, “Well, I would love it if we could have trainings with teachers. I think that, I think that should be done like twice a year, that should be a required thing.” Lyn described steps her district is taking,

And we’ve done a monthly newsletter for teachers as well—or you know all the staff—that just reminds them of different tips for trauma-sensitive schools or little video clips or article or those kind of things. So trying to really kind of—not overwhelm them but kind of constantly flood them with the information so it becomes more part of the culture of the school.

Additional resources. Another sub-theme under additional work is additional resources. Whether the resources include funding, staff, or mental health support, there are needs. Pam identified lack of resources as a major challenge, stating,

Major challenges? Well definitely not enough mental health support. I’m one social worker. We have 1,400 students here and any student can come to me at any time and they are mine. So I technically have 1,400 kids on my caseload but obviously they don’t all need me. So I would say the lack of mental health support. I can’t believe that there’s not more social workers.

Pam also described the need for resources,

I think more social workers, more school based therapists, something more with mental health help, there can’t just be one of me. Because if I’m dealing with a crisis then there could be 25 kids left behind that day. Funding. Not enough funding, it’s really sad.

Similarly, Ali made this statement,

I just think it’s really important and I hope we can keep funding for this, because when a school has a model that has the social work, that has the therapy, that has the school staff

understanding trauma, there's so much more success. You can see kids who used to be in trouble every day, now succeeding and learning and it's amazing.

Continuing education. Continuing education is the next sub-theme within additional work. While Lyn got her Master's degree in 1995, she reported, "I would say the vast majority of my learning has taken place more recently. The concentration of my professional development in the last five years has been on trauma for sure." According to Pam,

Once you get your Masters I think it really does open a door, where I don't know if they'll continue to hire people without their Masters, they were saying, in the district 'cause you do just have that. You almost, you know, you need to continue your education. I do feel prepared on the trauma piece definitely.

Practice. The final sub-theme identified in additional work is practice. It is important and necessary to have practice in this work and find ways to teach others beyond the books and information. Sam reported,

I tried to immerse myself in any training or education around what trauma does to the brain, how to treat it... the books don't prepare you to be in the situation where a student is having a crisis or having some kind of post-traumatic stress reaction to things...

He continued later by stating,

I think one thing that staff, and myself too, can be frustrated with is when you get training about recognizing symptoms and awareness of trauma and the effect and then as a school it's hard to figure out how to implement or what to implement to respond to that. 'Cause it's just always this back and forth of, you know, being aware of, and sensitive without enabling behaviors, or...it's tough, with this, with the students we have here, it's really tough...

Lyn described,

...we are trying very hard to kind of take, like I mentioned, the approach of training staff. We started with kind of more introduction and overview-type trainings and then we have been trying to go a little deeper with actual practical strategies that teachers can you know, take and utilize right away in their classrooms.

Kat emphasized the helpfulness of practice through her internship, “I think a lot of what prepared me was I think my internships. Last year I was at a school and I saw how trauma affected... but honestly being very new at this I’m still learning.”

Discussion

Interpretation of Findings

Identification. The first category, identification, encompassed four sub-themes. The first theme, big reactions emerged in every interview. Children who have experienced trauma typically are unable to regulate their emotions. Even if they appear relatively calm, their brain chemistry and bodies have adapted to respond more quickly and strongly to potential danger, which could in reality be a harmless stimulus. In the typical school setting, there is a lot of stimulation including other children, teachers, different environments, and more. A child who has experienced trauma is often hypervigilant and with the amount of stimulation present in the environment, they are more likely to be emotionally escalated, thus more reactive. These responses are detected by school staff because they may continue to escalate the student’s behavior and as noted in the literature, children who have experienced trauma tend to have damage in their hippocampus and are flooded with stress hormones which will not allow him to de-escalate in timely manner.

The second sub-theme, relationship difficulties, was also mentioned in every interview. Children who have experienced trauma struggle with peer relationships. One reason is their reactivity and inability to regulate their emotions. Most children learn emotional regulation at a young age from attuned caregivers. If their caregivers are the source of danger, they do not learn to regulate their emotions. When a child is reactive and volatile, other students may not feel safe or comfortable around them. Difficulties are caused by the tendency to misinterpret what others are saying. In addition, they may not have had any sort of stable relationship in their past, therefore may be unaware of what that would look like or how to have one. The three high school social workers expressed that their students tend to be strongly seeking relationships, though the relationships tend to be intense and fragile. This theme affects both a child's microsystem and his mesosystem.

The third sub-theme, developmental disruption was identified in several interviews. Students who have experienced trauma have frequently experienced some sort of disruption in their development. At times this manifests in regression, or behaviors which would appear in children younger than the child's biological age. A child who experiences trauma at a certain age experiences a disruption. His body functions and development are halted in order for the body and brain to focus on the immediate need, which is safety and survival. A child may never master the skills that he or she was meant to master at that age without trauma intervention.

Lastly, behavior referrals are often how children who have experienced trauma are brought to a social worker's attention in school. Because of the dysregulation these children experience, they struggle with the norms in a traditional school setting and exhibit behavior issues. Using an ecological model, one can see the effect these themes have on a child's microsystem. When a child has difficulties with peer relationships, their ecosystem is smaller

and is mostly comprised of adults. Developmental disruption also affects the microsystem because the child, not showing age-appropriate behaviors may not be accepted by the people around him because he would not fit in.

Trauma interventions. Another category that emerged was trauma interventions. This category identifies the work social workers do to help students who have experienced trauma. Seven sub-themes made up this category. A sub-theme that was pervasive throughout the interviews was examining what is behind the behaviors. As a social worker, it is important to see behavior as a message and attempt to figure out what that message is. By examining what is behind behavior, social workers are able to determine the student's needs then work with them to get those needs met. For students who have experienced trauma, their behaviors often function as self-protection.

Relationship building was an important sub-theme that emerged in all of the interviews. In order to work with a student who has experienced trauma, that student needs to feel some level of safety. This can be particularly difficult for children who have experienced trauma that was inflicted on them by other people such as emotional, physical, sexual, or psychological abuse or neglect. An important therapeutic tool used by social workers is the therapeutic relationship so relationship building is a skill that is used frequently. Having at least one positive relationship has been shown to be a resiliency factor. If the social worker is able to build a relationship with that student, the student is more likely to feel safe and be able to work with them. The social worker can also help facilitate positive relationships with other school staff by helping to make sure the student has time with that staff and communicating this need to other school staff.

Meeting a student where they are at was another sub-theme. Social workers need to have the flexibility to adapt to different people. Meeting a student where they are at is part of building a relationship and getting on the same page.

Empathy is a sub-theme of trauma interventions and also an important tool for social workers. Empathizing with others helps facilitate understanding. Children who have experienced trauma often don't feel understood. Using empathy is also a way of partnering with the student and showing that the social worker is on the student's side.

It is imperative to recognize student's individuality, knowing that every child is different. While there are many symptoms, struggles, and interventions that are similar in multiple children who have experienced trauma, they can be completely different based on the individual. This ties in with meeting a student where they are at because every individual is different. Once a relationship has been established, the social worker may be able to better determine how to work with the individual student.

The sub-theme of teaching and supporting other staff is an important and sometimes challenging part of social worker's interventions. Social workers have a different approach to working with students than other school staff, which sometimes makes it difficult to balance teaching and supporting other staff without overstepping boundaries, or making the other staff feel threatened. The social worker needs to be able to understand and empathize with the staff's struggles while helping them find effective ways to adapt to and work with the student. Social workers help the staff understand and empathize with the student as well.

The secondary trauma sub-theme is connected to the trauma-informed model. This model states that people who are less informed about trauma and the effects are more likely to suffer from secondary trauma. So, not only will uninformed staff suffer from secondary trauma,

but they will not be aware that is what is happening. The participants who brought up secondary trauma in the interviews were the participants from the trauma-informed school and the school that is working to become trauma-informed. Secondary trauma was not addressed by the three social workers who are working in non-trauma-informed schools.

Trauma trends. The next category was trauma trends. The first trend was females internalizing and males externalizing. This is seen more frequently because in this society it is more acceptable for males to externalize, i.e. fight or yell, whereas it is more acceptable for females to internalize their emotions, i.e. feel sad, cry. This could be considered part of the macrosystem of our culture and the entrenched gender roles being assumed by children. With females getting overlooked due to these trends, more males tend to be identified as having experienced trauma.

The next trend was poverty. It is more common to see trauma in children and families who live in poverty or low income communities. One reason for this is that living in poverty is, in itself, a significant stressor. If an individual is struggling to provide for his basic needs, he is more likely to feel stressed. In addition, research shows poverty/ low-income communities tend to be less safe and have more violence.

Another trauma trend was race, specifically the disproportionate number of African-American clients. This could be tied to poverty, as one participant reported that in her district they have more kids in poverty who are African-American. Another explanation for this is that the macrosystem of American culture and society have not afforded African-American individuals the same opportunities as non-minorities. White privilege and stereotypes likely play a role in this. African-Americans are more likely to be profiled as violent or troublemakers. This could lead to confrontation with authority figures which may be traumatic. The criminal

justice system disproportionately targets people of color. African-Americans are more likely to be arrested and more likely to be incarcerated than white people. Children who experience the incarceration of a parent tend to have more traumatic stress and this is more prevalent in the African-American community.

The final sub-theme in trauma trends is the shift from the traditional school setting. The data shows that there are significant reasons why it is difficult for children to be successful in the traditional setting, whether they have experienced trauma or not. Several schools are shifting from the traditional school setting in order to better meet student needs and cater to their success. This includes training staff members on trauma, smaller class sizes, and more interactive learning and movement rather than sitting in one place most of the day. In addition, while behaviors are acknowledged, there is not such a focus on discipline. Rather than detentions and suspensions, students are asked to take breaks.

Barriers. The next category describes barriers to identifying and working with children who have experienced trauma. The first sub-theme in barriers was a focus on behavior difficulties, behavior correction, and discipline. As mentioned in the trauma interventions category, social workers must examine what is behind the behaviors. Disciplining based solely on behaviors doesn't allow for empathy nor does it promote examination of the possible function of the behaviors. In the case of children who have experienced trauma, the function is typically self-protection.

The second barrier is difficulty building trust. As the participants identified, children who have experienced trauma struggle to build trust. This also has a self-protective function, as trusting could make them vulnerable which could allow them to get hurt as it has in the past.

The next barrier is struggle with school staff. Social work staff and other school staff sometimes have different mindsets, different priorities, and conflicting ideas. There was a significant difference reported between the interactions between the specialized trauma-informed school staff and social workers and the non-trauma-informed school staff and social workers. This is described more in the section describing trauma-informed care.

An additional barrier is identified as Maslow's issues. This barrier simply identifies the difficulty of functioning for a child when he does not have resources to meet his basic needs of food, water, shelter, and safety.

Finally, a barrier commonly mentioned was fear created by policy. In the current political climate, funding has been cut for special education and mental health services and crisis services are in danger. There have been executive orders banning those from several majority Muslim nations from entering the country, increased immigration enforcement and deportations, and proposed legislation to build a wall between the United States and Mexico. Students who are impacted by these policies have more barriers now than they did before these policies were enacted. This is part of children's macro and chronosystem as the widespread concern and worry as the policies are enacted.

Additional work. The last category is additional work. Sub-themes identified additional work that has been or should be done in order to be successful in the endeavor of identifying and working with children in schools who have experienced trauma. The first sub-theme was a universal approach. This is being implemented by two of the social workers who are working in a school which has a specialized trauma-focused program. A third social worker was working with her school district to implement a trauma-informed universal approach. When a universal,

trauma-informed approach is utilized, more students are likely to have successes in school and fewer children will be excluded.

The next sub-theme was trauma education in school. This was identified as being implemented in two schools and as being needed in the other schools. Trauma education for staff could make the difference between a student's success or failure in school.

Another sub-theme was the need for additional resources. The participants reported that they have a strong need for additional resources which include mental health resources, funding, and social workers. Social workers are a relatively recent addition to schools and their role can be unclear to other staff. The social worker may become a "catch-all" for any issues that might come up including discipline, skills work, referrals, and even simply student monitoring.

The next sub-theme was continuing education, which was identified as necessary and valuable by several respondents. This is particularly important as the research of trauma and trauma-informed care is expanding exponentially. As two of the participants identify, their social work education did not provide much information about trauma other than PTSD as most of the research in trauma has been done in the last fifteen years. Most of the participants reported that they felt they still have a lot to learn.

The last sub-theme in this category was practice. While knowledge about trauma and trauma-informed care is invaluable, the majority of the respondents felt they were best prepared to work with children who have experienced trauma after they had completed practicums or learned and engaged in practical strategies for working with these populations. Reading and learning about the trauma response and why a child might react or behave in a certain way helps with understanding but does not compare with the experience of seeing it and intervening.

Trauma-informed care. Trauma-informed care is being implemented intentionally and effectively in one out of the five schools in which the participants work. According to another participant, her district is working toward becoming more trauma informed, beginning with training all of the staff on the basics of trauma. The other three participants are informed about trauma and engage in trauma-informed care, however they experience barriers, particularly with other staff in the school when trauma-informed care is not the acknowledged standard. There was a clear difference between the way that the two participants in the trauma-informed school and all the other participants spoke about other school staff. One participant from the trauma-informed school described how the staff understand the roots of behavior and that they team to revisit the student's background and how it affects what is working and what is not. The other participant from the trauma-informed school discussed how relationships are buffers and resiliency factors, therefore they try to facilitate and encourage positive relationships between students and any staff with whom they appear to have a connection. People tend to forget that in a school someone who serves lunch or manages transportation could have daily interactions with a child, whether it be behavior correction and discipline, or smiling and greeting them. In a trauma-informed model, all of these staff people will be informed about trauma and able to interact with all of the children in a trauma-sensitive way in which they are less likely to cause additional stress. The participants at schools which are not currently operating utilizing a trauma-informed model talked about staff differently. They talked about the staff's resistance to change and difficulty switching lenses from focusing on behavior. They also identified the conflicts that arise between "education minds and mental health minds," and the staff's resistance to building rapport with students. One participant worried about overstepping her boundaries as a social worker when communicating with the teacher. There is not the same feel

of a cohesive and supportive system in the schools which are not yet practicing trauma-informed care.

Additionally, the trauma-informed care model can be beneficial for all children as well as school staff, who are in need of additional resources. There is typically only one social worker in each school. Trauma-informed school staff are able to help alleviate the pressure on the social worker by being able to be resources. The trauma-informed care model is an approach which can be universally applied, will not cause any harm, and will be beneficial to all students.

Practical Implications and Conclusion

Implications for social work practice. This research study shows the common themes that emerged regarding how social workers identify and work with students who have experienced trauma through the qualitative lens of the researcher and the participants. This research has shown the benefits of practicing trauma-informed care and continuing education on trauma-informed care. It is beneficial for social workers to get as much education as possible and apply it to practical situations. The practical implications also emphasized the important social work skills of building relationships, meeting students where they are at, and empathy. There is also a need to create a collaborative work environment between all staff, which will be easier if the trauma-informed care model becomes universal in schools.

Implications for policy. The more that is discovered about trauma, the more awareness we gain about the prevalence of childhood trauma. School boards may begin to enforce policy to use a trauma-informed care model which would be beneficial to students. In addition, staff will get added support to recognize and prevent secondary trauma. The findings show that implementing this model will be a challenge at first, but it can ultimately lead to a more collaborative team within the school and more successful students.

Implications for research. Findings show the challenges and barriers for school social workers and also show the need for intervention. There are several points which could be researched further for more information. For example, one could research efficacy of different models of trauma-informed care. Another area could be to research school satisfaction for children who have experienced trauma. A comparison between schools implementing a trauma-informed care model and schools who are not would likely have differing rates of disciplinary actions including detention and suspension, as well as graduation rates.

Strengths and limitations. One strength of this research study was that I was able to get comprehensive narratives from individual school social workers. I was also able to incorporate the views of social workers from schools that had different levels of trauma-sensitivity. The participants included social workers who worked with high school students as well as social workers who worked with elementary students. I interviewed both male and female social workers. The themes and categories identified were generally consistent with the literature.

Limitations of the study included the low number of participants and limited time. My sample did not include social workers of color aside from one Hispanic participant, which may have had an effect on the answers to the questions. Finally, as a human I have inherent biases and make assumptions, therefore the data is processed through my personal lens which may not be generalizable to the majority of social workers.

In conclusion, there is a lot of work to be done with students who have experienced trauma. This study gave insight into the challenges these students experience in school as well as ways in which social workers address them. Going forward, it will be important to educate school staff about trauma and trauma-informed care so that students who have experienced trauma are not overlooked or dismissed.

References

- Amendola, A. M., & Oliver, R. W. (2013). Aggression replacement training and childhood trauma. *Reclaiming Children & Youth*, 22(2), 56-61. Retrieved from <http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/ezproxy.stthomas.edu/login.aspx?direct=true&db=sih&AN=89922678&site=ehost-live>
- Anderson-Ketchmark, C. & Alvarez, M. E. (2009). Addressing trauma in schools: an online resource. *Children & Schools*, 31 (3,) 189-191.
- Bankston III, C.L. (2013). Charter schools. *Contexts: Understanding People In Their Social Worlds*, 12(3,) 16-18. *SocINDEX with Full Text*. Web. 16 Oct. 2016. <http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=95532653&site=ehost-live>
- Bartlett, J. D., Barto, B., Griffin, J.L., Fraser, J.G., Hodgdon, H., & Bodian, R. (2016). Trauma-informed care in the Massachusetts child trauma project. *Child Maltreatment*, 21(2,) 101-112. *SocINDEX with Full Text*. Web. 17 Oct. 2016. <http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=115181698&site=ehost-live>
- Becker-Blease, K.A., and Freyd, J.J. (2008). A preliminary study of ADHD symptoms and correlates: Do abused children differ from nonabused children? *Journal of Aggression, Maltreatment & Trauma*, 17(1), 133-140. *SocINDEX with Full Text*. Web. 16 Oct. 2016. <http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=34693136&site=ehost-live>

Brendtro, L.K. (2015). Our resilient brain: Nature's most complex creation. *Reclaiming Children and Youth, 24* (2,) 41-49

Brown, W. K. (2011). Growing past childhood trauma. *Reclaiming Children & Youth, 19*(4), 13-17. Retrieved from <http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/ezproxy.stthomas.edu/login.aspx?direct=true&db=sih&AN=58655246&site=ehost-live>

Carello, J. & Butler, D. (2015). Practicing what we teach: Trauma-informed educational practice. *Journal of Teaching in Social Work, 35*, 262-278

Coker, K.L., Ikpe, U.N., Brooks, J.S., Page, B., & Sobell, M.B. (2014). The effect of social problem solving skills in the relationship between traumatic stress and moral disengagement among inner-city African American high school students. *Journal of Child & Adolescent Trauma, 7*(2,) 87-95. *SocINDEX with Full Text*. Web. 16 Oct. 2016. <http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=96064512&site=ehost-live>

Cole, S.F., O'Brien, J.G., Gadd, M.G., Ristuccia, J., Wallace, D.L., & Gregory, M. (2005). *Helping Traumatized Children Learn: Supportive school environments for children traumatized by family violence*. Massachusetts Advocates for Children: Trauma and Learning Policy Initiative

Cooley-Strickland, M.R., Griffin, R.S., Darney, D., Otte, K., & Ko, J. (2011). Urban African American youth exposed to community violence: A school-based anxiety preventive intervention efficacy study. *Journal of Prevention & Intervention In The*

Community, 39(2,) 149-166. *Social Work Abstracts*. Web. 16 Oct. 2016.

[http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true
&db=swh&AN=82571&site=ehost-live](http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=swh&AN=82571&site=ehost-live)

Cornel-Swanson, L., Irwin, M., Johnson, K., Bowman, K., & Frankenberger, W. (2005). The use of stimulant medication for treatment of attention-deficit/ hyperactivity disorder: a survey of school social workers' knowledge, opinions/ attitudes and experience. *School Social Work Journal*, 29, (2,) 62-82.

Crosby, S.D. (2015). An ecological perspective on emerging trauma-informed teaching practices. *Children & Schools*, 37 (4,) 223-230

Cuffe, S.P., McCullough, E.L. & Pumariega, A.J. (1994). Comorbidity of attention deficit hyperactivity disorder and post-traumatic stress disorder. *Journal Of Child And Family Studies* 3 (3,) 327-336. *Social Work Abstracts*. Web. 16 Oct. 2016.
[http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true
&db=swh&AN=30935&site=ehost-live](http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=swh&AN=30935&site=ehost-live)

de Carvalho, H. W., Pereira, R., Frozi, J., Bisol, L. W., Ottoni, G. L., & Lara, D. R. (2015). Childhood trauma is associated with maladaptive personality traits. *Child Abuse & Neglect*, 44, 18-25. doi:10.1016/j.chiabu.2014.10.013

de Zulueta, F. (2006). The treatment of psychological trauma from the perspective of attachment research. *Journal of Family Therapy*, 28(4), 334-351. doi:10.1111/j.1467-6427.2006.00356.x

- Delima, J., & Vimpani, G. (2011). The neurobiological effects of childhood maltreatment: An often overlooked narrative related to the long-term effects of early childhood trauma? *Family Matters*, (89,) 42-52. Retrieved from <http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com.ezproxy.stthomas.edu/login.aspx?direct=true&db=sih&AN=69718740&site=ehost-live>
- Dulmus, C.N. & Wodarski, J.S. (2000). Trauma-related symptomatology among children of parents victimized by urban community violence. *American Journal of Orthopsychiatry*, 70 (2,) 272-277. *Social Work Abstracts*. Web. 16 Oct. 2016. <http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=swh&AN=68556&site=ehost-live>
- Fecser, M.E. (2015). Classroom strategies for traumatized, oppositional students. *Reclaiming Children and Youth*, 24 (1,) 21-24.
- Foltz, R. (2008). Medicating relational trauma in youth. *Reclaiming Children & Youth*, 17(3), 3-8. Retrieved from <http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com.ezproxy.stthomas.edu/login.aspx?direct=true&db=sih&AN=35442927&site=ehost-live>
- Ford, J.D., Racusin, R., Ellis, C.G., Daviss, W.B., Reiser, J., Fleischer, A., & Thomas, J. (2000). Child maltreatment, other trauma exposure, and posttraumatic symptomatology among children with oppositional defiant and attention deficit hyperactivity disorders. *Child Maltreatment*, 5(3) 205. *SocINDEX with Full Text*. Web. 16 Oct. 2016.

[http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true
&db=sih&AN=3391663&site=ehost-live](http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=3391663&site=ehost-live)

Ford, J.D. (2002). Traumatic victimization in childhood and persistent problems with oppositional-defiance. *Trauma & Juvenile Delinquency: Theory, Research, & Interventions*, P 25-58, 2002, Ricky Greenwald, Ed., -- See NCJ-198433) *SocINDEX with Full Text*. Web. 16 Oct. 2016.

[http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true
&db=sih&AN=SM198435&site=ehost-live](http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=SM198435&site=ehost-live)

Foster, H. & Brooks-Gunn, J. (2013). Neighborhood, family and individual influences on school physical victimization. *Journal of Youth & Adolescence*, 42 (10,) 1596-1610. *SocINDEX with Full Text*. Web. 16 Oct. 2016.

[http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true
&db=sih&AN=90169382&site=ehost-live](http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=90169382&site=ehost-live)

Fox, B. H., Perez, N., Cass, E., Baglivio, M. T., & Epps, N. (2015). Trauma changes everything: Examining the relationship between adverse childhood experiences and serious, violent and chronic juvenile offenders. *Child Abuse & Neglect*, 46, 163-173.

doi:10.1016/j.chiabu.2015.01.011

Fuller-Thomson, E., Mehta, R., & Valeo, A. (2014). Establishing a link between attention deficit disorder/attention deficit hyperactivity disorder and childhood physical abuse. *Journal of Aggression, Maltreatment & Trauma*, 23 (2,) 188-198. *SocINDEX with Full Text*. Web. 16 Oct. 2016.

[http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true
&db=sih&AN=94795598&site=ehost-live](http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=94795598&site=ehost-live)

Galster, G., Santiago, A.M., and Stack, L. (2016). Elementary school difficulties of low-income Latino and African American youth: The role of geographic context. *Journal of Urban Affairs*, 38 (4,) 477-502. *SocINDEX with Full Text*. Web. 16 Oct. 2016.

[http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true
&db=sih&AN=118513971&site=ehost-live](http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=118513971&site=ehost-live)

Gill, S. (2010). The therapist as psychobiological regulator: Dissociation, affect attunement and clinical process. *Clinical Social Work Journal*, 38(3), 260-268. doi:10.1007/s10615-009-0213-5

Gómez, J. M., Lewis, J. K., Noll, L. K., Smidt, A. M., & Birrell, P. J. (2016). Shifting the focus: Nonpathologizing approaches to healing from betrayal trauma through an emphasis on relational care. *Journal of Trauma & Dissociation*, 17 (2,) 165-185.
doi:10.1080/15299732.2016.1103104

Gray, C., Carter, R., & Silverman, W. (2011) Anxiety symptoms in African American children: relations with ethnic pride, anxiety sensitivity, and parenting. *Journal of Child & Family Studies*, 20 (2,) 205-213. *SocINDEX with Full Text*. Web. 16 Oct. 2016.

[http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true
&db=sih&AN=58785492&site=ehost-live](http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=58785492&site=ehost-live)

- Howell, K.H. & Miller-Graff, L.E. (2014). Protective factors associated with resilient functioning in young adulthood after childhood exposure to violence. *Child Abuse & Neglect*, 38, 1985-1994.
- Jenkins, E., Wang, E., & Turner, L. (2014). Beyond community violence: Loss and traumatic grief in African American elementary school children. *Journal of Child & Adolescent Trauma*, 7 (1,) 27-36. *SocINDEX with Full Text*. Web. 16 Oct. 2016.
<http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=94799806&site=ehost-live>
- Kawabata, Y. & Crick N.R. (2015). Direct and interactive links between cross-ethnic friendships and peer rejection, internalizing symptoms, and academic engagement among ethnically diverse children. *Cultural Diversity & Ethnic Minority Psychology*, 21.2, 191-200. *SocINDEX with Full Text*. Web. 16 Oct. 2016.
<http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=102063615&site=ehost-live>
- Kay, J. (2009). Toward a neurobiology of child psychotherapy. *Journal of Loss & Trauma*, 14(4,) 287-303. *SocINDEX with Full Text*. Web. 17 Oct. 2016.
<http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=42411055&site=ehost-live>
- Kira, I.A., et al. (2012). Attachment disruptions, IQ, and PTSD in African American adolescents: A traumatology perspective. *Journal of Aggression, Maltreatment & Trauma*, 21(6,) 665-690. *SocINDEX with Full Text*. Web. 16 Oct. 2016.

[http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true
&db=sih&AN=78448216&site=ehost-live](http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=78448216&site=ehost-live)

Knight, C. (2015). Trauma-informed social work practice: Practice considerations and challenges. *Clinical Social Work Journal*, 43(1), 25-37. doi:10.1007/s10615-014-0481-6

Lahey, J. (2016). The failing first line of defense. *The Atlantic*. Retrieved from <http://www.theatlantic.com/education/archive/2016/10/the-failing-first-line-of-defense/50448>

Linton, K. (2015). Differential ratings of specific behaviors of African American children in special education. *Child & Adolescent Social Work Journal* 32 (3,) 229-235. *SocINDEX with Full Text*. Web. 16 Oct. 2016.
[http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true
&db=sih&AN=102498681&site=ehost-live](http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=102498681&site=ehost-live)

Lipschitz, D.S., Morgan III, C.A., & Southwick, S.M. (2002). Neurobiological disturbances in youth with childhood trauma and in youth with conduct disorder. *Journal of Aggression, Maltreatment & Trauma*, 149-174. Web. 16 Oct. 2016.
[http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true
&db=swh&AN=72231&site=ehost-live](http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=swh&AN=72231&site=ehost-live)

Marsiglio, M., Chronister, K., Gibson, B., & Leve, L. (2014). Examining the link between traumatic events and delinquency among juvenile delinquent girls: A longitudinal study. *Journal of Child & Adolescent Trauma*, 217-225. *SocINDEX with Full Text*. Web. 17 Oct. 2016.

<http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=99007900&site=ehost-live>

McCrea, K., Guthrie, D., & Bulanda, J. (2016). When traumatic stressors are not past, but now: Psychosocial treatment to develop resilience with children and youth enduring concurrent, complex trauma. *Journal of Child & Adolescent Trauma*, 5-16. *SocINDEX with Full Text*. Web. 16 Oct. 2016.

<http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=113040958&site=ehost-live>

McLean, C., Morris, S., Conklin, P., Jayawickreme, N., & Foa, E. (2014). Trauma characteristics and posttraumatic stress disorder among adolescent survivors of childhood sexual abuse. *Journal of Family Violence*, 29(5), 559-566. doi:10.1007/s10896-014-9613-6

Merritt, D.H. & Klein, S. (2014). Do early care and education services improve language development for maltreated children? Evidence from a national child welfare sample. *Child Abuse & Neglect*, 39, 185-196

Monette, D.R., Sullivan, T.J., Dejong, C.R., & Hilton, T.P. (2014). *Applied social research: A tool for the human services* (9th ed.). Belmont, CA: Brooks/Cole Cengage Learning.

Murrell, A., Seteiner, D.S., Connally, M.L., Hulsey, T., & Hogan, E. (2015). Acting out to acting on: A preliminary investigation in youth with ADHD and co-morbid disorders. *Journal of Child & Family Studies*, 24(7,) 2174-2181. *SocINDEX with Full Text*. Web. 16 Oct. 2016.

<http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=103063248&site=ehost-live>

National Child Traumatic Stress Network. (2016, October 17). www.ncstn.org

Padgett, D.K. (2008). *Qualitative methods in social work research* (2nd ed.). Los Angeles, CA: Sage Publications.

Phillips, R. (2007). The need for information on how the attachment difficulties of adopted and looked after children affect their schooling. *Adoption & Fostering* 31 (3,) 28-38. *SocINDEX with Full Text*. Web. 17 Oct. 2016.

<http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=27199858&site=ehost-live>

Rauch, S. L., Van der Kolk, B. A., Fisler, R. E., Alpert, N. M., Orr, S. P., Savage, C.

R., Fischman, A. J., Jenike, M. A. & Pitman, R. K. (1996). A symptom provocation study of post traumatic stress disorder using positron emission tomography and script driven imagery. *Archives of General Psychiatry*, 53, 380–387.

Rosa, E.M., Tudge, J. (2013). Urie Bronfenbrenner’s theory of human development: Its evolution from ecology to bioecology. *Journal of Family Theory & Review*, 5, 243-258

Sawyer, C.B. & Merritt, D.F. (2006). Understanding the impact of prenatal and early childhood trauma: The story of Jonah. *Trauma & Loss: Research & Interventions* 6 (1,) 34-44. *SocINDEX with Full Text*. Web. 17 Oct. 2016.

<http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=20941576&site=ehost-live>

- Scales, T. L. & Scales, A. T. (2016). After trauma: Family relationships and the road to healing. *Social Work & Christianity*, 43(1), 26-39. Retrieved from <http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/ezproxy.stthomas.edu/login.aspx?direct=true&db=sih&AN=113172169&site=ehost-live>
- Smith, D.K, Chamberlain, P., Deblinger, E. (2012). Adapting Multidimensional treatment foster care for the treatment of co-occurring trauma and delinquency in adolescent girls. *Journal of Child & Adolescent Trauma*, 5, 224-238.
- Snyder, F. J., Roberts, Y. H., Crusto, C. A., Connell, C. M., Griffin, A., Finley, M. K., et al. (2012). Exposure to traumatic events and the behavioral health of children enrolled in an early childhood system of care. *Journal of Traumatic Stress*, 25(6), 700-704.
doi:10.1002/jts.21756
- Strand, V. C., Abramovitz, R., Layne, C. M., Robinson, H., Way, I. (2014). Meeting the critical need for trauma education in social work: A problem-based learning approach. *Journal of Social Work Education*, 50, 120-135
- Tishelman, A., Haney, P., O'Brien, J.G., Blaustein, M.E. (2010). A framework for school-based psychological evaluations: Utilizing a 'trauma lens'. *Journal of Child & Adolescent Trauma* 3 (4,) 279-302. *SocINDEX with Full Text*. Web. 17 Oct. 2016.
<http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=55310544&site=ehost-live>
- Van der Kolk, B. A. (2014.) *The body keeps the score: Brain, mind, and body in the healing of trauma*. New York, NY: Penguin Books

Van der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (1996). *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York: Guilford Press.

Van Voorhees, E. & Scarpa, A. (2004). The effects of child maltreatment on the hypothalamic-pituitary-adrenal axis. *Trauma, Violence, & Abuse, 5* (4,) 333-352

Zelechowski, A., Sharma, R., Beserra, K., Miguel, J., DeMarco, M., & Spinazzola, J. (2013).

Traumatized youth in residential treatment settings: Prevalence, clinical presentation, treatment, and policy implications. *Journal of Family Violence, 28* (7,) 639-

652. *SocINDEX with Full Text*. Web. 16 Oct. 2016.

<http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true>

<http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=90397321&site=ehost-live>

Appendix A

Facebook post:

School Social Workers,

I am a graduate student in the Masters in Social Work program at St. Catherine University/ University of St. Thomas. For my final research project, I am exploring the question, “: How do social workers identify and work with children in schools who have experienced trauma?In a school setting, what do social workers see as challenges for children who have experienced trauma?” I am excited about this topic and this research and I am looking for school social workers who would allow me to interview them about this topic!

The interview will be coordinated around your schedule and the location will be decided on based on your convenience. It will last approximately 30 minutes to one hour. If you are interested in participating in this research study, please message me on FB or email me at berg0369@stthomas.edu your earliest convenience! Thank you for your consideration!

Appendix B

Consent Form

[IRBNet Tracking Number] Trauma in Schools

You are invited to participate in a research study about how social workers identify and work with children in schools who have experienced trauma. I invite you to participate in this research. You were selected as a possible participant because you work in an educational setting with children who have experienced trauma. You are eligible to participate in this study because you are a graduate-level clinician and mental health professional, you are over age 18, you are a licensed social worker, and you serve children in a school setting. The following information is provided in order to help you make an informed decision whether or not you would like to participate. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Amanda Berg, MSW graduate student, research advisor Mary Nienow, and the School of Social Work at the University of St. Thomas. This study was approved by the Institutional Review Board at the University of St. Thomas.

Background Information

The purpose of this study is to research how social workers identify and work with children in schools who have experienced trauma. I will be using qualitative content analysis and interviewing school social work professionals in order to answer this question. While there are no direct benefits, this may provide some insight into the current level of knowledge and interventions in schools provided for children who have experienced trauma.

Procedures

If you agree to participate in this study, I will ask you to do the following things: Meet with me for approximately one hour and answer questions about your job and experience treating children who have experienced trauma. We will meet at a convenient location of your choosing, keeping in mind that we may want privacy for confidentiality. I will audio-tape the interview as well as taking notes. I will transcribe the interview and code the data into themes. The transcription will refer to you only by initials, not by name. The data will be included in the final research paper and presentation. I will destroy the audio tape after transcription and you will not be identified in the presentation or the paper. There will be 8-10 participants in this study. You may receive a copy of the final paper, if requested, and you are invited to attend the final research presentation at University of St. Thomas.

Risks and Benefits of Being in the Study

The study has risks. Risks include emotional distress, which is possible because participants will be asked to talk about their experiences with children who have experienced trauma. This could be distressing to think about a child's traumatic experience as well as your experience with learning

about the trauma. The other risk is recalling traumatic or distressing events, which could cause emotional distress. You may decline to answer any question that you feel may cause you emotional distress. I encourage you to seek professional counseling to address this distress.

There are no direct benefits for participation in this study.

Privacy

Your privacy will be protected while you participate in this study. You will have control over the location of the interview, timing, and circumstances of sharing your information.

Confidentiality

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you. The types of records I will create include recordings, transcripts, meeting notes, and computer notes and records. The recordings will be immediately downloaded to my private laptop which is password protected, then destroyed on the recording device. When I have completed transcription of the recording, I will destroy the recording. Transcriptions will be in a password-protected file on my password-protected laptop. No names will be attached to transcriptions, only initials. All paper notes will be locked in my personal file cabinet in my home. They will be destroyed after the final paper has been submitted. While traveling, all paper documents will be locked in a file lock-box in the back of my vehicle. The only person who will be allowed access to any of the data besides myself will be my research chair. All signed consent forms will be kept for a minimum of three years upon completion of the study. Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

Voluntary Nature of the Study

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with any individuals, employers, cooperating agencies, institutions, or the University of St. Thomas. There are no penalties or consequences if you choose not to participate. If you decide to participate, you are free to withdraw at any time without penalty or loss of any benefits to which you are otherwise entitled. Should you decide to withdraw, data collected about you will not be used, it will be destroyed. You can withdraw by informing me that you no longer want to participate in the research by phone, email, or in person. You are also free to skip any questions I may ask.

Contacts and Questions

My name is Amanda Berg. You may ask any questions you have now. If you have questions later, you may contact me at 612-916-4687 or berg0369@stthomas.edu. You may also contact my research advisor, Mary Nienow at 651-295-3774 or nien3538@stthomas.edu. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 or muen0526@stthomas.edu with any questions or concerns.

Statement of Consent

I have had a conversation with the researcher about this study and have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I give permission to be audio recorded during this study.

You will be given a copy of this form to keep for your records.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix C

Interview Schedule

- 1.) Tell me about your job as a social worker in a school/ educational setting.
- 2.) What are some common issues you see in your work with school age children?
- 3.) How do you address concerns about a child's mental health?
- 4.) In what ways did your social work education prepare you to work with children who have experienced trauma?
 - Describe any other training on trauma informed care you have experienced?
 - has any been through the school?
- 5.) How would you define and describe trauma?
- 6.) Tell me about your experience with identifying symptoms of trauma?
 - Other school staff?
 - What symptoms have you identified?
 - What if there is no background to support trauma diagnosis?
- 7.) Tell me about the relationships between children who have experienced trauma and their teachers.
 - What concerns do teachers have regarding children who have experienced trauma?
 - relationships between children who have experienced trauma and their peers?
- 8.) Describe similarities and differences you have experienced between children of different races and genders who have experienced trauma.
- 9.) How do the behavior staff at your school view and manage children who have experienced trauma?
 - Does it differ from they way they view and manage children with behavior issues?
- 10.) What do you see as major challenges in the school setting for children who have experienced trauma?
 - Are there learning issues?
 - Behavioral issues?
 - Long-term effects?
- 11.) What steps would you, as a school social worker, take to address the issues that arise for children who have experienced trauma?
- 12.) Is there anything else you think would be important for me to know about your work?