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Educators' Experiences with Disruptive Behavior in the Classroom

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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 their findings. This project is neither a Master's thesis nor a dissertation.

Abstract

Disruptive behavior in the elementary school setting has become an increasing concern for educators, school personnel, and mental health professionals. There is more time spent on discipline and redirecting, which can impact the other students in the classroom. In particular externalizing behaviors, aggressive or hyperactive acts, are at the forefront of concern for many teachers. This research further explored the educators' description of disruptive behavior, insight to the sources of the behavior, and interventions available for child mental health services. This study also explored if behaviors differed for children who had a history of trauma versus other childhood mental health concerns. The experiences of seven elementary school educators were gathered through qualitative semi-structured interviews. The educators varied in length of teaching from seven months-four years. The data was analyzed and then coded. The themes gathered from the data included: description of disruptive behavior, age related behavior, causes of disruptive behavior, trauma in the classroom, family support, teacher accommodations, and school mental health services. These findings suggest all of the educators have had experience working with children who have a history of trauma. It was reported that disruptive behavior in the younger lower grade levels were a product of traumatic experiences; but the children in the upper grade levels (fourth and fifth) displayed behaviors not necessarily related to a history of trauma. The educators all noted the importance and use of the mental health services at their school. Future research and implications discussed.

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Introduction

The environment of elementary education has been changing over the years. Teachers are spending more time on discipline than on classroom instructions due to an increase in off task and poor behaviors (Rosenberg and Jackman, 2003). It has been stated that the most difficult dilemma facing elementary schools is "troubled" behavior. (White Algozzine, Audette, Marr, Ellis, 2001). There is an increase of children in classrooms with behavioral problems (White et. al., 2001) and children seeking services for disorders, such as emotional and behavioral disorders (EBD) (Miller, 2006) and attention deficit hyperactive disorder (ADHD) which is the number one diagnosed mental health disorder for children (Akinbami, Lui, Pastor, Reuben, 2011). There has been an increasing desire for understanding disruptive behavior in elementary classrooms (Bru, 2009; McCarthy, Lambert, O'Donnell, & Melendres, 2009; and Finn, Pannozzo, & Voelkl, 1995) and how teachers respond to children who interfere with the classroom environment (Dyrness, 2006). Disruptive behavior in the classroom takes away attention from other students (Finn, Pannozzo, & Voelkl, 1995), impairs the classroom learning environment (Bru, 2009), and increases teacher burnout rate (McCarthy, Lambert, O'Donnell, & Melendres, 2009).

One of the largest concerns currently facing teachers is children who externalize their emotions (Henricsson, & Rydell, 2004). These behaviors include but not limited to: "destructive and aggressive behavior, defiance, temper tantrums, impulsive and hyperactive behaviors" (Henricsson, & Rydell, 2004, p.112). The behaviors engaged in by these children interfere with their learning and it has been found that disruptive

children have lower grades and an increased dropout rate later in their education career (Finn et. al., 1995).

There are many reasons for the source of a child's disruptive behavior in the classroom. In a study by Dery, Toupin, Pauze, Verlaan (2004) found that, of the children sampled, the most common disruptive behavior disorders were attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder (CD). The researchers also discovered internalizing disorders among the children sampled (which include such diagnoses as depression and generalized anxiety disorder).

In addition, when compared to other common childhood mental health conditions, children who have experienced trauma demonstrate similar symptoms that can be confused with symptoms of other common childhood mental health conditions such as "inability to concentrate, and lashing out verbally or physically" in the classroom (Sitler, 2008, p.120). Some students who have experienced trauma in childhood also display aggressive tendencies towards others as well as demonstrate low academic performance (Sitler, 2008). Through classroom observations the National Child Traumatic Stress Network (NCTSN) state that common disruptive behaviors may include: anxiety, fear, irritability, aggression, are no longer able to appropriately read social cues, and have an increased difficulty ~~to~~ with obeying instructions or tolerating "criticism" from teachers (NCTSN, 2008).

There are many reasons why social workers should be interested in sources of disruptive behavior in the classroom as well as an educator's perceptions of children's behavior. As noted, there are similarities in the symptoms associated with common childhood mental health disorders (such as ADHD) and trauma. It is important for social

workers collaborate with teachers to acknowledge mental health needs of children at schools. The purpose of understanding the source of a child's disruptive behavior is not so the educator treats the child differently in the classroom setting, but rather be able to assist the child in receiving appropriate mental health services. Early intervention and detection of childhood mental health disorders has been found to increase effectiveness of treatment and being aware of the sources of disruptive behavior can more efficiently help children with their mental health needs. It is valuable to explore educator perceptions of sources of disruptive behavior because educators are often the entry point for children who need additional support as well as relying on their experiences to describe the child's behavior for mental health evaluations. It is important to acknowledge that educators' training on child mental health disorders or common symptoms is different than that of a social worker; and the collaboration of social workers and educators are necessary for giving children the proper mental health services in a school setting.

Literature Review

The following literature review will describe the definition of disruptive behavior, how the behavior affects the other students in the classroom, and how teachers handle the challenging students in their classroom. This literature will address the common diagnosable disruptive behavior disorders: attention deficit hyperactive disorder (ADHD), conduct disorder (CD), oppositional defiant disorder (ODD), and posttraumatic stress disorder (PTSD). Then, the effects of trauma on child behavior and how those experiences may be acted out in the classroom as disruptive behavior will be explored. Lastly, find out teachers' perspectives of trauma's effect on behavior.

Defining Disruptive Behavior

Ideally students would come to school with certain skills in the classroom such as control and cooperation (Lane, Givner, and Pierson, 2004), as well as an ability to follow directions, interact pro-socially, control anger, and respect physical boundaries (Lane, Givner, Pierson, 2004). Stacks (2005) states that behavioral issues in the elementary school setting are usually divided into groups, externalizing or internalizing. Disruptive behaviors that fail to comply with the educators expectations and those that educators find challenging are the externalizing behaviors that can be defined as "destructive and aggressive behavior, defiance, temper tantrums, impulsive and hyperactive behaviors" (Henricsson, & Rydell, 2004, p.112). These students have higher levels of negative relationships with teachers and other students, including negative interactions despite receiving more attention from the teacher (Henricsson, & Rydell, 2004).

Externalizing behaviors receive more attention than other behaviors due to the fact that they interrupt classroom time and put the teacher/student relationships in more stress. There are internalizing behaviors that can also be disruptive. Henricsson & Rydell (2004) define internalizing behaviors as, "unhappiness, anxiety, somatic complaints, and loneliness" (p.112). Stacks (2005) give another definition adding, "are reflective of internal states like anxiety, depression, and withdrawal" (p.269). It is noted that internalizing behaviors are important but externalizing behaviors are more disruptive in a classroom setting according to teachers (Stacks, 2005).

Disruptive Children in Classrooms: Academic Outcomes and Influence on Peers

Finn, Pannozzo, & Voelkl (1995) examined the academic success of students who were labeled either disruptive or inattentive. The inattentive students were defined as,

"individuals who fail to engage in learning activities or who may even strive to disengage" (p.421). The disruptive students were defined by the definition cited in Spivack & Cianci (1987) "which a child teases [or] torments classmates, interferes with others' work, is…drawn into noise making, reprimand and control" (p.54). The findings suggest that the children who were neither disruptive nor inattentive scored higher on the academic tests and it was concluded that the defined off task behavior resulted in lower learning as reflected by the academic tests. Also, on the academic tests given the disruptive children scored higher than the inattentive children. Children who were labeled as disruptive and inattentive did not produce significantly lower academic scores than the other children who had one specific label. The researchers explain that it is important to notice not only the children who are noticeably disruptive but also the inattention children. As a student gets older it is proposed that learning habits and behavior in the classroom may be hard to change once a pattern has been established (Finn, Pannozzo, & Voelkl, 1995).

Similarly, Bru (2009) investigated academic outcomes with disruptive students. The research included student and teacher reporting on academic outcomes. The questions that assessed misbehavior of a student included: speaking with other students without permission, disturbing others, talking out of turn, and disturbing the teacher (Bru, 2009). Unlike results found in Finn, Pannozzo, & Voelkl (1995), Bru (2009) did not find significant lower academic outcomes for classrooms with disruptive students; but at the same time student reports were used which could have reporting bias that could have altered the results. Regardless of the significance of the academic outcomes, students

reported that they were unable to concentrate and that "noisy" classrooms were a concern to teachers and students with or without disruptive students.

Educator's Response to Disruptive Behavior

The classroom environment is important for the students to learn but also for the teachers because of burn out rates. McCarthy et. al. (2009) states that "teaching is a demanding profession" and teacher burnout rate has been a concern in the education world (p.282). Burnout stress can happen to any teacher regardless of the number of years of teaching. Burnout rate can be attributed to the school, educator's coping skills, and also classroom stress. The number of special needs children, adult helpers in the room, and other tasks outside of the classroom can contribute to teacher burnout. Researchers have explored that a teacher's success in the classroom and perceived stress has been linked to having challenging children in their classroom (McCarthy et. al., 2009).

Professional achievement by teachers and stress levels can be influenced if teachers perceive themselves having more children with special needs which promote unequal classrooms (McCarthy et. al., 2009). It has been found that teachers report children without any disabilities, children with specific learning disabilities, and children with ADHD are the most disruptive or hard to teach in class (Westling, 2009). In reaction to children's behavior which included, "defiance, and noncompliance, disruption, and socially inappropriate behavior" (Westling, 2009, p.59), teachers have been found to most likely reinforce positive behavior first, followed by changing the classroom, and then changing the curriculum (Westling, 2009).

Regardless of having children with known disabilities, managing behavior is stressful. Clunies-Ross, Little, & Kienhuis (2008) compared teacher questionnaires about

their classrooms with actual observations of the classrooms. The researchers were interested in whether proactive or reactive strategies were used to manage classroom behavior. Proactive strategy is defined as the teacher making rules for the classroom and giving appropriate praise for students following directions or appropriate behavior. In essence it is "preventing bad behavior" (Clunies-Ross, Little, & Kienhuis, 2008, p.695) and setting the stage for a more positive approach for reacting to disruptive behavior. Reactive strategies are defined as usually following misbehavior, such as giving consequences. Teachers reported that the most challenging behaviors were Talking Out Of Turn (TOOT) and Hindering Other Children (HOC). TOOT included calling out of turn, talking when other students were talking, and talking with the teacher was talking. HOC was when students were disrupting or distracting other children and consequently spending less time on their school work. HOC and TOOT increased teacher stress, personal stress, and spending more time on discipline (Clunies-Ross, Little, & Kienhuis, 2008).

The findings indicate that the teachers who more often used reactive strategies had more stress which was related to workload, misbehavior, and limited resources in the classroom. Reactive strategies were related to students who were off task, which was also indicated on the teacher reports that state they had to manage student behavior five or more times a day.

Similarly, Martin, Linfoot, & Stephenson (1999) note that teachers help improve student behavior but at the same time this can increase stress. The research was conducted to see how a teacher's confidence in the classroom related to reacting to a child's misbehavior. It was found that teacher confidence in managing student's

behavior was linked to how the teacher's responded to misbehavior in the classroom. The results showed that the more concern a teacher had about a student's behavior the more likely the teacher was to refer a child to other school staff. The authors were unclear if the referral to other school staff was a negative or positive action. It was also found that teachers used non-physical punishment more often to control student behavior which included "verbal reprimands and detaining the child" (Martin, Linfoot, & Stephenson ,1999, p.350).

Ratcliff, Jones, Costner, Savage-Davis, & Hunt (2010) emphasized interactions between teachers and students impact not only social but academic growth. The authors observed second and fourth grade teachers to examine teacher-student interactions. Half of the teachers in the sample were rated as "strong" and the other half of the teachers were rated"needs improvement" by their principal. The four teacher interactions that were included in the study were:

- Teacher normative control, when the teacher asked students to change their behavior;
- Teacher remunerative control, when the teacher manipulated a reward system to control student behavior;
- Teacher coercion, when the teacher used physical force, took away property or freedom, or threatened to do either;
- Teacher retreatism, when the teacher failed to react when students' violated written or stated rules for conduct (p.308).

The results show that teachers who were rated as needs improvement were three times more likely to use normative control strategies than teachers who were rated as strong. It was observed that teacher frustration with behavior lead to begging students to behave. The misbehavior in the classrooms included but not limited to talking out of turn, walking around the classroom, and talking back, or arguing with the teacher. In contrast the strong teachers used more reward systems as a management technique. Praise for

following directions was found more often in the strong rooms. Students in classrooms rated as needs improvement spent less time on task than the students in classrooms rated as strong. The teachers in the classrooms rated as needs improvement spent more time managing behaviors than on classroom instructions which are proposed by the authors as a decrease in the amount of learning in the classroom. In comparison the classrooms rated as strong "spent more time keeping students on task by asking questions, and providing feedback which is further evidence that increases in behavior management problems tend to decrease opportunities for teaching and learning" (Ratcliff, Jones, Costner, Savage-Davis, & Hunt, 2010, p.310). Ratcliff, Jones, Costner, Savage-Davis, & Hunt (2010) discuss the cycle of misbehavior which consists of:

1. The student misbehavior
2. Teacher's attempt to control misbehavior
3. Student persistence in continued misbehavior
4. Teacher retreating in frustration
5. Increase in student's misbehavior (p.312-313).

The research proposes that the "strong" teachers were, "alert and redirecting off-task behavior, avoiding retreating, using appropriate praise and rewards, and being aware of pacing and keeping children engaged" (Ratcliff, Jones, Costner, Savage-Davis, & Hunt 2010, p.313). Finn, Pannozzo, & Voelkl (1995) also state that teachers can make a big difference in their classrooms by responding to disruptive behavior by making changes to the lessons, asking students to read out loud, calling on certain students more often to improve academic growth.

Defining Disruptive Behavior as Diagnosable Mental Health Disorders

Attention deficit hyperactivity disorder is the "most common diagnosed behavioral disorder" (U.S. National Library of Medicine, 2011). ADHD according to DSM- IV-TR (2000) is defined by six or more inattention symptoms or six or more

hyperactivity-impulsivity symptoms. The inattention symptoms outlined by the DSM-IV-TR (2000) include:

- Often Fails to give close attention to detail or makes careless mistakes in schoolwork, work, or other activities
- Often has difficulty sustaining attention in tasks or play activities
- Often does not seem to listen when spoken to directly
- Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace(not due to oppositional behavior or failure to understand instructions)
- Often has difficulty organizing tasks and activities
- Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort
- Often loses things necessary for tasks or activities
- If often easily distracted by extraneous stimuli
- Is often forgetful in daily activities (p.65)

The hyperactivity symptoms outlined by the DSM- IV-TR (2000) include:

- Often fidgets with hands or feet or squirms in seat
- Often leaves seat in classroom or in other situations in which remaining seated is expected
- Often runs about or climbs excessively in situations in which it is inappropriate
- Often has difficulty playing or engaging in leisure activities quietly
- If often on the go or often acts as if driven by a motor
- Often talks excessively (p.66).

The impulsivity symptoms include:

- Often blurts out answers before questions have been completed
- Often has difficulty waiting turn
- Often interrupts or intrudes on others (p.66).

The symptoms must occur before the age of seven, the symptoms must appear in two or more settings, impairment at school, with social situations, and are not accounted for by another disorder. According to the U.S. National Library of Medicine (2011) ADHD is diagnosed when a child has difficulty with attention, hyperactivity, and impulsive behavior that is not normal for the child's development.

Statistics for ADHD range from three to five percent in elementary school population (U.S. National Library of Medicine, 2011) and two to eighteen percent (Rowland, Lesene, Abramowitz, 2002). Generally males receive the diagnosis more

frequently than females. Some researchers believe that there may be a genetic influence for the cause of ADHD. It has been expressed by the U.S. National Library of Medicine (2011) that it is challenging to diagnose ADHD simply due to the fact that the disorder can be thought to be a different disorder or a child may have co-occurring disorders,(more than one disorder). Many children who have ADHD are not diagnosed and not all disruptive children are correctly diagnosis with the disorder. Parent and teacher evaluations of a child should be completed if symptoms are lasting more than six months. The National Library of Medicine (2011) suggests an extensive psychological evaluation of the child and family, developmental, mental, nutritional, physical, and psychosocial evaluation should be made prior to a diagnosis.

The symptoms most associated with ADHD, attention and behavioral, can also be viewed in children who are "bored, who have been abused, or who have various form of psychopathology other than ADHD" (Rowland, Lesene, Abramowitz, 2002, p. 164). Children with ADHD usually have co-occurring disorder. Disorders that co-occur with ADHD include but are not limited to: various learning disabilities, oppositional defiant disorder, conduct disorder, Tourette syndrome, depression, anxiety, and bipolar (Rowland, Lesene, Abramowitz, 2002).

Like ADHD, conduct disorder (CD) is another behavioral disorder diagnosis. Mental Health of American (2012) states that between six-eighteen percent of males and two- nine percent of females have the disorder in the general population. The DSM- IV-TR (2000) gives the definition of Conduct Disorder as,

> A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three or more of the following criteria in the past 12 months, with at least one criterion in the past 6 months (p.68).

The symptoms are divided into categories in the DSM- IV-TR (2000) as aggression to people/animals, destruction of property, deceitfulness or theft, and serious violations of rules.

The symptoms of aggression to people and animals in the DSM- IVTR (2000) include:

- Often bullies, threatens, or intimidates others
- Often initiates physical fights
- Has used a weapon that can cause serious physical harm to others
- Has been physically cruel to people
- Has been physically cruel to animals
- Has stolen while confronting a victim
- Has forced someone into sexual activity (p.68).

The symptoms of destruction to property in the DSM- IV-TR (2000) include:

- Has deliberately engaged in fire setting with the intention of causing serious damage
- Has deliberately destroyed others' property (p.68).

The symptoms of deceitfulness or theft in the DSM IV (2000) include:

- Has broken into someone else's house, building, or car
- Often lies to obtain goods or favor or to avoid obligations
- Has stolen items of nontrivial value without confronting a victim (p.68).

The symptoms of serious violations of rules in the DSM IV (2000) include:

- Often stays out at night despite parental prohibitions, beginning before age 13 years
- Has run away from home overnight at least twice while living in parental or parental surrogate home (p. 69-69).

Similar to ADHD and other behavioral disorders, to be diagnosed with conduct disorder the symptoms the child displays must be significantly interfering with their life socially or in school (DSM- IV-TR, 2000). There may be genetic and environmental causes that could potentially cause the onset of conduct disorder. Children with parents who have been diagnosed with CD have higher rates of developing the disorder. Processing social cue information is hard for children with CD and they are often not liked by their classmates or peers as they have-difficutly-with empathy and often are viewed as aggressive.

CD symptoms are most likely to interfere with peers and at a school setting (Mental Health America, 2012). Teachers may find these students frustrating because

they do not do well with authority figures and with statements like "You must do…" and "You need to" (Minnesota Association for Children' Mental Health, 2012). Children with CD will often refuse direction, will not complete assignments, fight with other students, and demonstrate a poor school attendance record. Adding to the complexity, children whose social environment includes crime and poverty may persuade a child to engage in more anti-social behavior (MACMH, 2012). Children may use anti-social behavior for "protective" or "cultural" measures, so getting a complete psychological evaluation of a child is necessary if CD is suspected. Kazdin (1995) illustrates children with CD may have a "decreased baseline automatic nervous system" (As cited in Searight, Rottnek, Pharm (2001)), which can cause them to seek this behavior (anti-social behavior or crime acts) for sensation.

Oppositional defiant disorder (ODD) is a behavioral disorder that is most commonly associated with conduct disorder. Both of these disorders have similar features but oppositional defiant disorder usually occurs prior to the diagnosis of conduct disorder (Russel, Rottnek, Pharm, 2001). The DSM- IV-TR (2000) outlines the definition of oppositional defiant disorder as, a pattern of negative and defiant behavior that has lasted at least 6 months with 4 or more symptoms which include:

- Often loses temper
- Often argues with adults
- Often actively defies or refuses to comply with adults requests or rules
- Often deliberately annoys people
- Often blames others for his or her mistakes or misbehavior
- If often touchy or easily annoyed by others
- If often angry and resentful
- Is often spiteful or vindictive (p.70).

This behavior can be part of normal development for toddlers and early adolescents (American Academy of Child & Adolescent Psychiatry, 2011) but becomes

an issue when it occurs too frequently for the age of the child. A psychotic or mood disorder must be ruled out and the behavior must be interfering with a child's functioning at school and at home (DSM- IV-TR, 2000). Roughly one-sixteen percent of school aged children have been diagnosed with ODD but the cause is unclear (AACAP, 2011). Preschoolers who displayed symptoms of ODD may engage in temper tantrums, "talking back", and exhibiting difficulty with authority figures (Markward & Bride, 2001). The American Psychological Association (1994) has suggested that ODD has a genetic component (As Cited in Markward & Bride, 2001). Like many other disorders, co-morbidity is high with ADHD. There is a possibility that ODD could be misdiagnosed for ADHD. Early interventions and treatment is very important for families and children with ODD (Markward & Bride, 2001). It is helpful for families if a school social worker can distinguish between ADHD, CD, and ODD and be able to offer referrals to a clinician that can perform a proper evaluation.

Another diagnosis that has potential to cause disruption in the classroom is post-traumatic stress disorder (PTSD). The DSM- IV-TR (2000) defines the type of trauma that a person has to experience to be diagnosed with PTSD have to include "threatened death or serious injury" and have the person have "intense fear, helplessness, or horror" (p.218-219). Normal reactions after a trauma may include but are not limited to: fear, anxiety, depressed state, guilt, shame, anger, and other behaviors to cope (U.S. Dept. Veteran Affairs, 2007c). Children who have witnessed a traumatic event to be considered post-traumatic stress disorder may feel helpless and scared. PTSD can develop after a person is exposed to a traumatic event. Even though traumatic events are common, 60% of men and 50% of women are experience at least one trauma in their

lives (U.S. Dept. Veteran Affairs, 2007a), PTSD is not very common in children as a diagnosis.

Experiencing a trauma does not automatically result in a diagnosis of PTSD. Only about seven-eight percent of people develop PTSD with women being more likely than men to develop the disorder (U.S. Dept. Veteran Affairs, 2007a). To be diagnosed with PTSD, children need to have re-experiencing symptoms, avoiding behavior, and increased arousal symptoms. A person needs to have at least one re-experiencing symptoms which are outlined in the DSM- IV-TR (2000):

- Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
- Recurrent distressing dreams of the event Note: In children, there may be frightening dreams without recognizing able content
- Acting or feeling as if the traumatic event were recurring Note: In young children, trauma specific reenactment may occur
- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event (p.219).

There needs to be three notions of avoidant behavior which may be: "avoiding thoughts or situations, inability to recall important details of the trauma, feeling detached from others, and restriction of emotional range" (Forness, Walker, Kavale, 2003, p.46). The avoidance symptoms outlined in the DSM- IV-TR (2000) include:

- Efforts to avoid thoughts, feelings, or conversations associated with the trauma
- Efforts to avoid activities, places, or people that arouse recollections of the trauma
- Inability to recall an important aspect of the trauma
- Markedly diminished interest or participation in significant activities
- Feeling detachment or estrangement from others
- Restricted range of affect
- Sense of a foreshortened future (p.219-220).

A child must also have two out of five symptoms of increased arousal which include:

- Difficulty Falling or staying asleep

- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response (p.220).

Some children who have experienced trauma are more likely to develop PTSD than others. Witnessing violence and being involved in any sexual trauma have the highest rates for symptoms of PSTD in children (Copeland, Keeler, Angold, Costello, 2007, & Levendosky, Hutch-Bocks, Semel, Shapiro, 2002). There are PTSD symptoms present in 90% of children who are sexually abused, 77% who witness a shooting, and 35% who experience community violence (U.S. Dept. Veteran Affairs, 2007b). Symptoms can also be more common in children with multiple trauma experiences, anxiety disorders, and family fighting (Copeland et. al., 2007). In order to develop PTSD, children do not necessarily have to witness violence but simply live in a household where domestic violence occurs (Levendosky et. al., 2002).

Diagnosing PTSD in children has been found difficult for researchers because the characteristics such as "hyperaroused, impulsive, aggressive, and defiant" can also be found in children with PTSD, ADHD, ODD, and other disruptive disorders (Thomas and Guskin, 2001). Several studies have begun testing the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy an Early Childhood (DC 0-3) to test for early diagnoses due to young children not being able to verbalize their symptoms (Thomas & Guskin 2001; Thomas & Clark 1998). Thomas & Guskin (2001) and Thomas & Clark (1998) examined disrupted behavior in young children between the ages of 0-4 using Diagnostic Classification 0-3, which is an addition to the DSM-IV-TR (2000) used for young children. The authors suggest that the observable behavior is actually a result from the child's internal stress.

Of the 64 children assessed the most common diagnoses from the DC-03 were traumatic stress disorder 23%, disorder of affect 41%, and regulatory disorder 30%. The most common DSM- IV-TR (2000) diagnoses that were given using the same children were adjustment disorder 30%, oppositional defiant disorder 14%, dysthymia 14%, and attention deficit Hyperactivity Disorder 13%. The authors suggest that using an adaptive diagnosing tool may be useful to identify key risk factors that may influence the diagnosis of disruptive disorders. The authors illustrate that a child's trauma re-experiencing symptoms may appear to be symptoms in the DSM- IV-TR (2000) for other disorders other than PTSD (Thomas & Guskin, 2001).

Trauma's Effects on Children and Possible Cause of Disruptive Behavior

According to The National Child Traumatic Stress Network (2008) trauma is defined as "an experience that threatens life or physical integrity and that overwhelms an individual's capacity to cope" (p.9). A child's development and cultural background have an effect on how the trauma impacts one's life. Some traumatic events may have more effect on some people but not affect the functioning for others (NCTSN, 2008). Various situations that can cause a child/adult to experience trauma include but are not limited to emotional abuse, sexual abuse, physical abuse, witnessing violence, war, witnessing a natural disaster, or losing a loved one (Thomas and Guskin, 2001; Carrion, Weems, and Reiss, 2012; & Cook et al., 2005).

Several different studies have explored how trauma and stress can impact various aspects of a child's life (De Young, Kenardy, Cobham 2011; Thomas and Guskin, 2001; Carrion, Weems, and Reiss, 2012; & Cook et al., 2005). In the U.S. 54% of nine –thirteen year olds have been exposed to at least one traumatic event (Alisic, 2012). The ways

trauma effects young kids has been discovered through the knowledge of the impact is has on adults; but the knowledge base on young child mental health is a growing field (De Young and Kenardy, 2011).

Children who experience trauma can develop biological and attachment (relationship with their primary caregiver) impairments. This can then impact a child's affect regulation(regulating their emotions), dissociation, behavioral problems, cognition, and self-esteem (Cook et al., 2005). A child that witness or experience trauma first hand may have an insecure attachment which makes it more difficult for a child to display copying mechanisms if adults in their lives have not modeled those skills (Cook et al., 2005).

Brain development can also be altered with the experience of stress. Trauma can lead to alteration in the brain, which may change affect regulation, or the way a child recognizes emotions (Cook et al., 2005). For example, children with PTSD have been found to have smaller hippocampus's, which is involved in memory and emotional regulation (Carrion, Weems, and Reiss, 2007). When trauma occurs during the growing developmental stages, a child's brain's organization and structure can be altered (Perry, Polland, Blakley, Vigilante, 1995). Perry et. al. (1995) suggests a child's reaction to trauma is based on adaptive survival responses. In general girls are more likely to produce more avoiding/ depressed symptoms and boys tend to show more symptoms of hyperactivity and lack of behavior control.

Complex trauma has been shown to can cause deficits in judgment, planning, and organizing along with uncontrollable behavior. A lower cognitive ability has been found in elementary age children even when taking out other variables such as poverty (Cook et

al. 2005). All aspects of a child's life can be affected by going through stress or trauma. All aspects of a child's life can be affected by going through stress or trauma, including having a negative self-worth or self-identity (Cook et al., 2005).

Educator's Perceptions of Working with Children with a Trauma History

Due to the amount of contact classroom teachers have with students, the teacher can be highly influential in a child's life. "One out of every four children attending school has been exposed to a traumatic event that can affect learning and /or behavior" (NCTSN, 2008, p.4). The high amount of trauma exposure is desensitizing youth but also teachers. Teachers report that violence exposure is more common and more professional collaboration for helping children heal from "emotional scarring" is needed in the school systems (Kenmore, Mann, Steinhaus, Thompson, 2010). According to the NCTSN (2008) observable behaviors of children who have been through a traumatic event varies and some children do not show signs of distress, or internalized behaviors. Some signs in the school setting include buy not limited to: anxiety, fear or worrying about their safety, moody, decrease in attention, withdrawal from favorite activities, anger, inability to get along with peers or adults, nightmares, unable to sleep, and change in academic success (NCTSN, 2008).

Teachers have expressed that working with children who have a trauma history can be emotional (Lucas, 2007). To understand the emotional toll teacher's experience, Lucas (2007) interviewed teachers at La Casa, a residential program for youth whose families have been impacted by Aids. The teachers at this placement almost become second parents to the children which increases the burnout rate due to the emotional nature of talking with the children at the facility. The teachers felt like they could make a

difference in the lives of the children but at the same time there were negative aspects of the job. Some children were filled with "fear, anger, and emotional and physical strain" (Lucas, 2007, p.86). The teachers went through grief and loss if a child left the facility due to being adopted. The work itself took a toll on the teachers, "Teachers say they feel burned out, stressed, exhausted, and saddened. Caring, nurturing, loving, empathetic people cannot escape the emotional weight of this type of work" (Lucas 2007, p.87). Along with the interviews the research explored the teacher's coping mechanisms and ways to help with coping. The coping skills mentioned in the study pertain to setting realistic goals when working with children who have experienced trauma and realizing that the teachers do not have control over the situations that arise in a child's life. Coping mechanisms were stated to be very important for not only the mental health of the teachers but also for the "quality" of the work and support they would be able to provide for future students.

Traumatic experiences are common in the lives of elementary age students. Due to this fact it is necessary to conduct further research regarding the educator's knowledge of how to work with children who have experienced trauma (Alisic et al., 2012; Alisic, 2012). To support this concept, Alisic et al. (2012) administered a questionnaire of 765 teachers; this study found that 89% of teachers had worked with one or more students who had experienced trauma. Contributing factors depended on the teacher's teaching experience, attendance of trauma focused training, and the number of traumatized kids they had worked with previously. Only nine percent of teachers had training for trauma within the last three years of the study. Many teachers found it difficult to not get emotionally involved and one out of five teachers found it difficult to give appropriate

attention daily to the children who had experienced trauma. Alisic et al. (2012) states that children may not be getting the adequate help they need if their teachers are unsure of their role.

Likewise, Alisic (2012) conducted interviews of teachers that had interacted with children who had been exposed to trauma. The questions focused on the general background of the teacher, their experience working with trauma, if there were specific school protocols, colleague support, and if they could recognize children who needed support for trauma exposure. The teachers who participated were involved with children being exposed to war, parental loss, maltreatment, and violence. The findings report that many children engaged in negative behaviors including crying, screaming, and throwing things to deal with stress. Teachers found it difficult to find a balance how much attention to give the children because they did not want them to feel "special" or get undesired attention. Children also displayed various symptoms of withdrawal or acting out in the classroom. Alisic (2012) states that more trauma focused courses for teachers should be explored because many were unsure when children needed to be referred to mental health services that could not be provided by the classroom teacher. This study has prompted this researcher's interest in exploring teacher's perceptions of the source of disruptive behavior in the classroom, the similarities of the symptoms of common diagnosable disruptive disorders and trauma, and what obstacles teachers face when working with a child who needs mental health services.

Conceptual Framework Ann Gearity's Developmental Repair Model

The source of disruptive behavior in the classroom is not black and white. There are many diagnoses, which contain many variables that have an impact on behavior. Ann

Gearity created a model used at Washburn's Day Treatment Center for Children in Minneapolis, MN. The Developmental Repair model helps understand the thinking and behaviors of young children who have experienced trauma, or as Gearity calls them, children at risk. There are four different parts that create the model: Relating, Feeling, Thinking, and Acting.

The first part of the model is the Relating, or called Forming a Co-Regulating Partnership. The model uses language that is for adults who are working with children in a day treatment setting but it will be discussed how the model can parallel to staff and children in a school setting. The first phase is the process of an adult showing a child their life, thoughts, and feelings are important. The children who are at risk have trouble regulating their emotions, "when adults recognize that these children appear out of control on the outside because they feel out of control on the inside, our thinking and acting shifts" (Gearity, 2009, p. 37). The beginning step is the child and adult participating in a relationship where feelings are talked about when a child seems agitated and may act in a disruptive manner. "Our interest is more on the child than on the behavior" (Gearity, 2009, p.46). It should be expected that children will misbehave but the model is centered on the notion that despite the behavior the adults working with the disruptive children are reliable and genuinely care about the well- being of the children.

The second part of the Developmental model is Thinking: Helping Children Use their Minds. This stage is having the child start to understand that they have a mind and other people have their own mind. The child starts to become aware of their own thoughts. In normal development children learn how to reflect or mentalize through interactions with their caregivers. The adults express sharing their thoughts and

verbalizing their interactions with the child. As expressed, "You are thinking I wanted to hurt you but I don't. It was an accident that you got hurt and I'm sorry that they happened. I didn't want it to happen to you" (Gearity, 2009, p.52). The skills within this step also include self-awareness and problem solving that the adult models for the child.

The third step of the model is called Feeling, and Recognizing Emotions. Children at risk are only able to fully understand a limited number of emotions, and the most common emotion is anger. "Very at risk children display anger to manage fear, hurt, and sadness. These other motions cause children to fell exposed and passive, especially when adults react by becoming more angry and attacking" (Gearity, 2009, p.56). Adults use words to articulate feelings the child is experiencing. An adult shows the child that their experiences are understood. The concept of empathy is introduced and talking about the stories of the child's life while working with the child.

The last step in the Developmental Repair Model is Acting, or in other words Managing Behaviors. "When children act, we look for what their behaviors are telling us-and them-about what they need" (Gearity, 2009, p.61). The behaviors that a child shows are not ignored but the focus is on the child and more so understanding their internal system. This phase is allowing the child to feel somewhat in control of themselves but the adults working with them still hold them to abide by social norms, i.e. no hitting, throwing objects etc. Gearity (2009) mentions that fighting has been a way of life for the children at risk so oppositional behaviors are going to occur but adults should continually try to connect and engage with these children.

The Developmental Repair model was created for working in a Day Treatment Facility with children who have experienced trauma but some of main concepts could be

used by schools to work with disruptive children. Time, staff, and funds may create differences between a treatment facility and a school but the way adults react to children with behaviors in the classroom could be found in the Developmental Repair model. The key concepts in the phases understand that the child's behavior, in a way, is a coping mechanism and it is important to recognize the behavior but also what is that behavior trying to tell the adults surrounding that child. Is a child throwing something because they are frustrated or have become upset? It may be difficult for some children who are not able to regulate their emotions or verbal their needs to show their words through disruptive behavior. It would be hard to categorize all children and say that this model could indefinitely work with every child who displays disruptive behavior in the classroom; but it allows adults reconsider a different way to work with children who have behavior that are not appropriate in a school setting.

Research Question

Research has mentioned that PTSD has been challenging to diagnosis in children and other disruptive behavior diagnoses have gained more attention including; ADHD, ODD, and CD. With the growing number of children with mental health needs and common symptoms among disorders the need for intervention and prevention in schools is becoming more necessary. Does trauma have a bigger impact in our children's behavior than educator's and social workers are aware but not able to be diagnosed in children? What are teacher's experiences with working with disruptive children and attitudes of trauma being a source of disruptive behavior as opposed to other common child mental health disorders?

Method

Research Design

A qualitative research study was conducted to explore perspectives of educators about working with children with trauma and discussing the source of disruptive behavior in the classroom. Interviews were utilized to gather an educator's voice on children's behavior and enrich our understanding of current mental health needs of elementary age children.

Sample

The researcher recruited seven educators who worked with elementary age children to participate in the current study. Participants differed on years of teaching, age, grade of students, and location of school but had experience working with children in a classroom setting. Five of the interviews were conducted in person and two of the interviews were conducted over the phone. The initial recruitment strategy was through professional contacts in the school district area and then snowball sampling was utilized (Berg, 2009). The participants recruited through professional contacts were asked to recommend other educators for participation in the study.

Human Participant

Before contacting potential participants the research proposal was approved by St. Catherine University Institutional Review Board (IRB). Prior to conducting the interviews, participants were given a consent form that described the purpose of the study, informed the participants the interview would be audio taped, explained that the interview would be transcribed, transcription results of the interview would used in

research findings, and noted that the respondent's participation was voluntary and could terminate involvement at any time. The study did not contain any elements of deception and no harm towards the participants. The IRB level of risk was exempt because the researcher was conducting interviews with professionals about their experiences. All data, including transcription of interviews, was kept locked in the researcher's home, either paper data collected or on a computer. Data will be destroyed May 25th, 2013.

Instrument

The interview schedule was created from previous research that discussed educators working with children who have gone through trauma. Alisic (2012) conducted a qualitative study interviewing teachers on their perspectives on working with children who experienced trauma. A guide for the semi structured interviews was conducted within the article; which became the base for the current study interview schedule. The Alisic (2012) study asked questions about experiences, talking with other staff about working with children and trauma, what teachers wanted for support, and other questions revolving around school protocols for working with children with mental health concerns. Questions from the Alisic (2012) that were useful in the current study included:

- Does your school have a protocol with regard to trauma?
- What are your habits of guiding families to mental health care?
- How do you exchange about the topic of children and trauma with colleges?
- Which situations make you nervous?
- What kind of support would you like to have in those situations? (p.53).

See Appendix B for final interview schedule. The questions addressed aspects of working with children who were disruptive in the classroom, the educator's experiences with working with children who have experienced trauma, possible explanation of resources,

and what educators felt was necessarily to feel more confident working with children who have mental health needs.

Data Collection

The intricacy of the research questions allowed for a qualitative semi-structured interview to be used to collect the data because according to Berg (2009), a qualitative approach is able to focus on "emerging language" which gives meaning through the participant's responses. The emotion and life experiences revolved around the subject of trauma as a source of disruptive behavior in the classroom cannot be captured with quantitative data analysis. Experiences are better expressed through a qualitative interview (Berg, 2009).

After IRB approved the proposal, the data was gathered. The initial participants recruited for the study were through professional contacts in the area school district. A convenient location was set for each interviewee. After the participant signed the consent form, the semi-structured interview took place, which lasted 20-40 minutes per individual interview. The interviewee was asked if they knew any other educators who would be able to add beneficial data to the research. The Snowball Sampling Template from the St. Catherine IRB website outlined the process for the current research's sampling method. The researcher gave the initial professional contacts the researcher's contact information. No participants were gathered through the snowball sample method. The participant was thanked for their time and a Trauma Resource Sheet, created by the researcher, was available for the educators if desired. There was no incentive (material gift) that was incorporated in this study.

Data Analysis

The interviews were recorded on an Apple iPhone 4 device and were transcribed into a Word Document on the researcher's computer. To analyze the data, a content analysis theory was used from the transcribed interviews. Content analysis involved looking at the data to find "patterns, themes, biases, and meanings" (Berg, 2009). Categories were formed from the data and the researcher already had in mind a few themes that could potentially emerge from the data. Similar to Alisic (2012), the researcher predicted similar themes to emerge such as: educator's concern over the definition of the teacher role, mental health role in the classroom, diverse needs of students, feel unable to meet needs of students, emotional toll or burnout from working with challenging children, and more educational training on working with children who have experienced trauma.

Researcher Bias

The researcher had previous history working with children in an elementary school setting. Many had experienced various kinds of trauma. The bias may influenced the types of questions on the interview schedule and how the researcher developed themes in the finding. The proposal's faculty chair approved the interview schedule to decrease the amount of researcher bias.

Strengths/Limitations

There were strengths for using an interview as a method for gathering data. A semi-structured interview allowed the researcher to have a set of predetermined questions but also allowed flexibility so the interviewer could have the ability to go beyond the questions that were asked and to clarify (Berg, 2009). For the purpose of the exploratory

research, the researcher was able to explore other questions if needed and the interviewer did not feel constricted by the interview schedule if it was a typical standardized interview. It allowed the participant and the researcher to have in-depth discussions about the research topic.

An interview was helpful when the researcher wanted to gather accurate and complete information. Many other factors stated in Monette, Sullivan, & Delong (2011) made an interview an appealing qualitative research gathering technique. An interview also allowed questions to be asked for clarification during the interview process, and the interviewer could use observable nonverbal communication if it was needed in the research, able to control who for who was really answering the questions unlike a mailed survey, and to be flexible with data gathering. The nature of the exploratory study allowed the participant to discuss questions/topics not on the interview schedule.

There were a few disadvantages of the interviewing process itself. Interviewer bias could have existed. There was also some form of a working or previous relationship between the respondent and the interviewer which could have altered the interview based on the familiarity of the researcher.

The major limitation of the current study was that the small sample. The results from the study cannot be generalized to the general public due to the limited sample size. Due to the nature of the sample the data collected is suggestive rather than conclusive (Monette et. al., 2011).

Findings

The qualitative interviews described the experiences of seven elementary school teachers; three kindergarten, two first grade, one fourth grade, and one fifth grade

teacher. The experience level of the teachers ranged from being in their first official year to going on their fourth year of teaching. This sample was compiled of relatively new teachers and all have had some experiences working with disruptive children along with children who have experienced some kind of trauma. There were seven major themes that were gathered from the semi-structured interviews that related to disruptive behavior in the classroom which included: description of disruptive behavior, age related behavior, causes of disruptive behavior, trauma in the classroom, family support, teacher accommodations, and school mental health services.

Disruptive Behavior in the Classroom

The first theme that was gathered from the data included the educator's descriptions of the disruptive behaviors in their classrooms. The educators also mentioned what were the most difficult behaviors to manage in a classroom setting. Disruptive behavior occurred on a daily basis for the educators and many mentioned that there were a few students in their classroom that were above and beyond the normal behavior for that age group. Behaviors were very specific to each child. The disruptive behaviors described in the interviews included: not following directions, bothering other kids, making noises, being off task, wandering around the room, talking to other classmates, blurting out answers, asking the teacher numerous questions multiple times a day, throwing things, yelling, self-stimulation, and frequent bowel accidents.

Teacher One mentioned that the hardest behaviors to deal with in a Kindergarten classroom were students who are off task and not following directions. The redirecting and frequency of repeating directions becomes frustrating. In the midst of teaching, Teacher One found herself getting off track because of having to give her students

constant reminders for directions or interrupting disputes among students. She said at times her job is"draining" and described getting off task in the classroom:

> *Things that make me stop and redirect constantly [are the hardest behaviors] like if I give them a redirection and I say could you please not do that and then they are right back at it, cause then I have to immediately get back at them and I lose my train of thought and the kids lose their train of thought and then I am totally off task.*

She was very aware of her disruptive students and how they distract other students. She described the impact the disruptive students have on other students and how others react to the common distractions in class:

> *Then you have to deal with the kids next to him too, if a kid is really disruptive I try not to have the same student sitting next to them all the time because that can really hinder their ability to learn and do their best too, it's just kind of a community where the class works together where eventually it will flow.*

Teacher Six and Teacher Seven also taught kindergarten, but their description of behaviors of the children were very specific to the individual child. Teacher Six discussed her concerns about three children in her class that showed disruption above and beyond their peers. One of her Kindergarteners could be found masturbating in class, another one was very physical with other children, and her third child had frequent bowel accidents. Teacher Seven had one kindergartener who displayed tantrums, crying, shouting, and growling that had been escalating throughout the year. The teachers both acknowledged that kindergarteners were going to be disruptive because of their young age; but the students that they are concerned about show out of the ordinary behavior, which included more crying outbursts or physical aggression towards other children.

Similar to many of the kindergarten teachers, those that taught first grade had three or four students that they specifically thought of during the interview. Teacher Five was in her fourth year of teaching first grade; and stated that the hardest behaviors to

work with in the classroom were the children with ADHD. The fact that a child is diagnosed with ADHD from their primary doctor does not mean that the child automatically receives special education services, which can be difficult as a teacher. This respondent found it challenging especially if the child was not getting any treatment for ADHD in terms of medication or counseling services. She felt that the children with ADHD are less intentional with their behavior as compared to her other students who have more emotional behavior disruptions. She saw the ADHD as something that is less controllable because it is a neurobiological disorder. Teacher Five described her awareness of the effects of ADHD on some of her students: *It's their body, and trying to really find ways to get them to stay on track when they are, they have an imbalance and they can't do anything about it.*

Teacher Four discussed as a first year teacher the difficulties of learning how to deal with her student's behavior. She stated she struggled with acknowledging the need of one student versus the needs of the rest of the students. The importance of getting that one student back on track was important, especially because she did not have an aid in her classroom. She also indicated that she is challenged to think of the needs of the whole classroom before the needs of one particular student. Teacher Four discussed one of her most challenging students: *it has been a personal struggle of mine since he has been in my classroom because it is crazy how one student's behavior or a few students' behavior can really affect the overall atmosphere you have in your classroom.* She also mentioned that the constant behavior from that same student can get overwhelming, *I think that child with the constant blurting and the constant reminders, and just the assumption that I will take care of it...that is an interesting journey.*

Teacher Two and Teacher Three did not describe any severe behavioral problems; but claimed that they had some disruptive behavior in their fourth and fifth grade classrooms. They both noted that the disruptions were more peer related, which included trying to receive attention from their peers. Teacher Two talked about how kids may act differently because of a fight with a friend that could take place outside the classroom, *kids come to me in tears because of a friendship issue, so that can throw off how they are feeling and acting as well.* Both teachers mentioned that having the students engaged in the classroom activity was important for on task behavior. Teacher Two thought that the behavior she was witnessing involved decisions that the children are making in their independent work time, *In 5th grade I think it has a lot to do with choice and the choices that they make in the classroom. So I would say it would have to deal with a lot with who they are sitting by, what the activity is, if they are engaged in it or not.*

Age Related Behavior

Three out of the seven educators had experience teaching two grade levels and expressed that the grade levels made a difference in the behaviors in the classroom. Overall, all the grades levels seem to have a combination of disruptive behavior but the older grades seemed to be more concerned about gaining peer attention. The younger children showed disruption that involved more talking out of turn and redirecting. The data revealed that the older grade level teachers witnessed less physical violence or behavioral disputes as compared to the younger grade levels.

Teacher Two is currently teaching fifth grade, but taught second grade last year. The disruptive behaviors were related to peer groups as the kids got older. It seemed that the younger children were just trying to figure out the rules at school and how to work

with other children. The younger kids would have more arguments and the older children had more talking with their friends when they are supposed to be quiet during independent work time. Teacher Two explained the nature of the fifth grade classroom as compared to her experiences in a second grade classroom:

> *Fifth grade is a lot more social, it is more of a friend, a whole circle of friends so they get more social and disruptive, but not in a mean way. In second grade it was a lot of petty arguments, I mean they are learning about the rules and not getting along with each other, I had an EBD student who would walk out of the room sometime.*

Another example of this was given by Teacher One. She mentioned differences between the grade levels for disruptive behavior. She taught fourth grade but has also taught kindergarten music, gym, and art classes. It was stated that keeping on task in a Kindergarten classroom was very difficult because they cannot process too much at once; but quiet reminder games caught on better with the younger grades than the older kids. Due to the age of the younger students it was expressed that redirecting will inevitably be incorporated for teaching five and six year olds. Teacher One discussed her students who are often getting on task and in need of redirecting*: Some of it I just have to let go, sometimes I will call on students if they are not paying attention, redirecting and going over directions multiple times especially for those kids who need it, the ones who are distracting other students too, they are good at placing blame.*

Teacher Three hypothesized why the older grades may not see so many disruptive behaviors as compared to the younger grades. She worked at an EBD Center Base school and she said that she has never seen her EBD students in her classroom, because they are not able to last a full day in mainstream education. When asked if the younger grades in her school experienced more severe behavioral outbursts she stated, *Especially in the younger grades because they aren't identified [identified with EBD] yet, you know, it's*

sad to say that we need to get them out of a mainstream classroom it's not fair to the rest of the students either if their meltdowns are making disruptions in their learning. Many of the students who were diagnosed with EBD were not mainstreamed with the other children. The school had their own EBD teachers and classroom for those students. In contrast, Teacher Three also explored the notion that children were less influenced by the advice of their teacher as they got older, *The younger they are does mean something because they want to impress teachers you know they like to be liked by their teachers and it's cool to like your teacher when you are younger.*

Causes of Disruptive Behavior

The educators hypothesized several sources of the disruptive behavior in their classroom. Teachers recognized that students were not able to learn efficient coping skills so in turn; disruptive behavior resulted in the classroom. It was difficult for educators to generalize the causes for all students and explained that causes were specific to each individual child. Each student's life experiences were different which influenced their behavior in one form or another. The educators attributed the following reasons for disruptive behavior attention, ADHD, parenting style, development, and trauma.

The majority of participants mentioned attention, either peer or teacher related, as a source of disruptive behavior. Children might not be getting adequate attention at home so school has been a place where children displayed behaviors to get attention as mentioned by Teacher One, *many times they will seek attention too, if they are not getting what they need met they will act out in negative ways to get attention or to receive some other feeling.* Educators talked about giving these children extra tasks to do in the classroom or calling on them more often to make the children feel "special." Educators

hoped that with the sense of importance in the classroom, their attention seeking behavior would decrease. It was not stated that this was always effective for eliminated behaviors. Blurting out funny responses to teacher's questions, pushing, making silly noises, and doing funny things in the classroom are ways a child may seek out peer attention. Teacher One had many observations of what the children did after being "goofy" in the classroom,

> *Many times in the classroom children will act out and then look around the room, Ok who is laughing, they don't necessarily do it when they are by themselves, to have an audience and to get a rise out of the teachers, sometimes kids will avoid being seen a certain way, my fourth grader didn't want to be the low student so then he thought Oh I'll be the silly student.*

Children who wanted the attention of the teacher asked many questions throughout the day and sat close to the teacher during large group time. Teacher Five described one of her students who had acted out in class by hitting, screaming, and throwing objects in the room, but believed the behaviors were attention seeking:

> *I think a lot of her behavior is her wanting attention that she does not get at home, and her mom is trying to get back into school and get her life back in order too, it is a hard balance…when I look at the root of her behavior I think she just wants attention*

ADHD was mentioned as a possible cause of disruptive behavior. The children diagnosed with this disorder cannot keep their bodies still for a long period of time at school. *Teacher Five explained, "I think my students with ADHD, it's a lot with that just figuring out, you know they are still little so figuring out what they need to be successful.* It could be difficult working with children in first grade who were diagnosed with ADHD because parents and educators were still finding routines that worked best for that child to succeed in school.

Development was a big factor, especially working with kindergarten students. The children were only five and six years old and had not spent a lot of time in a structured setting, like school, with rules that need to be followed. There were children who already have an Individual Education Program (IEP) for special education services in kindergarten due to a previous diagnosis of a developmental disorder. Children who have disorders such as Autism, Developmentally Delayed, a specific learning disability, EBD, and ADD/ADHD impact their ability to understand social rules in school. Another factor of the children being so young is that there were not a lot of diagnosed children but the respondents mentioned that a lot of observation recoding of behavior happened in Kindergarten. For educators, this was their first time meeting with the families and building a connection. Teacher One talked about meeting her student's families and gaining knowledge about her students, *It is the first time that teachers are learning about the family situations and it is very interesting to see the students and hear the stories.*

Disruptive behavior could be apparent in school because how rules were enforced at home is different from how they were enforced at school. The kindergarten educators noted that parenting style could influence how children act in school. If a child had a parent who did not discipline at home for not following rules, the child would resist following the rules at school because they had been shown there was little consequence to not doing what you were told. Teacher Six responded that the behavior of a child who knows they were disruptive and breaking the rules was different than a child who had a developmental disorder, such as Autism. Teacher Seven explored the idea that consequences at home make a difference and meeting with the family helped the educator learn how rules were enforced at home:

> *[Kids] are so egotistical at that age which is developmentally fine but there are those kids who know how to adjust and listen to adults and respect them and there are those kids who do not. Usually when I meet their parents and interact with their parents it becomes clear, ok so this is why you are the way you are, that's not 100% of the time though.*

Traumatic events had caused some disruptive behavior in the classroom according to several lower grade level educators. The children were so young they had not been able to develop healthy coping skills; so the disruptive behavior was witnessing how the children handle the stress in their lives. Teacher Five talked about a young boy who was born with Fetal Alcohol Syndrome and was taken away from his mother at a young age. He had little consistency in his life and little things make him upset, *It is really hard for him to deal with and move on from things and he gets really angry and upset, I have to be very consistent with him and he has a schedule on his desk.*

Another educator described her kindergartener who would masturbate in class. Concerns had been noted to the parents and the mother had taken the child to a specialist. The child did not display other signs of abuse in the classroom but the educator was still worried about this child's past:

> *I am worried that maybe in her past somebody has done something to her, it's a cause of comfort for her, and maybe it's just something that feels good so she does it, however she gets really severe and intense and gets red in the face, very extreme so I am worried if she has been touched by someone, sexually abused by some sort…*

This behavior could be a coping mechanism that she had learned to soothe herself when stressed. This type of behavior had come to be very disruptive in the classroom.

Generally, understanding the cause of the behavior was deemed important from an educator's point of view. The problems appeared in the classroom but they cannot be solved solely by treating the problem. A participant expressed her concern that as an educator she was just putting a "band aid" on a child's problem during school but cannot

change the behavior. The disruptive behavior had not changed for months even though she had talked with the child and worked with him on his behavior in the classroom. She felt like she has not been able to help her children change their behavior in the classroom. She responded about her children who display disruptive behavior but she was unable to find a cause to the behavior, *Problems are like icebergs, you might just see the tip of them which is the behavior but a lot of times there is trauma and different things beneath the water that you don't even realize is happening and that is the problem that you have to try and fix, not just the tip*.

Trauma Related to Disruptive Behavior

This emotional theme depicts the children who the educators believed or knew who had experienced trauma and their behavior as it was displayed in the classroom. Some educators did not define trauma as a source of disruptive behavior but when asked, acknowledged that could play a role in behavior difficulties at school. Several educators had strong inclinations that their children with behavioral issues in class had some type of trauma in their past. It was difficult for them to state for certain it was a specific trauma that was the cause of their behavior but the trauma most likely heavily influenced the child's behavior.

Teacher One mentioned a little kindergarten boy who had been in foster care since he was young and his body was 60% covered with scars and burns. She said that he breaks down and gets very upset if games do not go his way in class. It has been hard for him to be patient with the other kids but was slowly getting more adaptable to routines, most likely as a result of a new foster family, *he is super happy and excited about his new family that he just got in the beginning of the week so that was really good to see that he*

is adjusting to that but I can only imagine what being in a totally new family and having to adjust to everything would be like.

Teacher Four described a case of one of her first grade boys who was having trouble coping with his feelings in class. His mother was taken away a few years ago for narcotic charges. One the first day of school for his "share time" he talked about being excited his mother was able to get into the workhouse and leave prison. The educator had no time to intervene during his share time and was concerned about how his behavior in class was connected to his mother. It is unknown for certain if the behavior was due to seeing his mother be taken away or having a shift in the primary attachment figure. Teacher Four talked about connecting her student's past, his mother who was in prison, to his behaviors in class:

> *Those kinds of stories break my heart because you realize that trauma has definitely affected him...he will have a lot of emotional breakdowns, and so extremely emotionally involved with him, he gets easily frustrated and then will just break down and start crying, and so he doesn't have good mechanisms or problem solving strategies.*

This little boy not only had emotional outbursts but also the need to be physically close to his teacher. During class reading time he would sit next to the teacher and has put his hand on her foot while she read the class a story. She realized that his need for touch may have been attributed to his past, *my heart breaks for this child he just needs to be touched, he needs to be loved, given a hug and told I love you, told I am proud of you, you are doing a great job, so of course I would let him sit there and touch my foot*.

Another educator talked about a student who had large outbursts in class, screamed, and even hit the teacher. This first grade girl's mother was 14 years old when she had her, and grandma was very involved with helping to raise the child. As a result due to strict housing rules at the grandmother's apartment complex, the first grade girl

and her mother had to move. Since she was not able to live with grandma she became visibly more upset in class. There was a clear behavior change after leaving grandma's care; so after losing that important attachment figure in her life her behavior started to "deteriorate." The girl was being evaluated for EBD and possibly an ADHD diagnosis, but the educator was hesitant about putting a diagnosis on her student:

> *We were trying to get her to go get more testing done to see if she has a ADHD piece to her behavior, is does seem like she has a hard time focusing at times, but that could be something else, it's easy sometimes all students oh they have ADHD, that kind of not a popular diagnosis but it kind of is, you know especially in 1st grade push anyone or push parents to seek out that because when you are 6 or 7 you are a little rambunctious.*

Teacher Six described disruptive behavior that was different than all the other respondents. She had a kindergartener who had encopresis (difficulty to control one's bowels) that lead to accidents during the school day, which were thought to be related to his family dynamics. Abuse had been questioned this year and last year he broke his leg. His story about how he broke his leg changed before and after his mother came to the school. He seemed to be afraid being touched on the shoulder or a pat on the head. The parents divorced and it was believed that life at home was stressful. Teacher Six talked about feeling worried about her student possibly being neglected:

> *I'm worried they are neglecting him because when he has accidents they are not sending fresh underwear with him, I have to just either buy some of my own or use some from the school, they don't check his backpack, last week there were three pairs of dirty underwear in his backpack..it's sad they don't check his backpack.*

Teacher Three described a student who was homeless and had withdrawn behaviors in the classroom. There was no kind of diagnosis for this child, and her student did not talk about any previous traumatic life experience. She had assumed that her student felt differently than the other children and to misbehave could be a way for the student to fit in or be liked by peers. She explained that he did not have motivation in the

classroom to get work completed and could be found sleeping during lessons. She talks about his experience in the classroom:

> *So not knowing where he was going to sleep or not having a place to sleep, right away I didn't notice a lot, he didn't have that much motivation to begin with, just keeping in mind and just how much you can push a fourth grader when they don't know where they are sleeping tonight…how much love to show him versus strictness, so trying to balance that.*

Mental Health Diagnosis was a subtheme that emerged related to the children with a trauma history. Educators were asked if they knew if the children with a trauma history who were disruptive in the classroom had any diagnosed mental health or other disorders. Half of the educators said that ADHD/ADD and Emotional and Behavioral Disorder (EBD) were found among the children who had a trauma history. Teacher One talked about the reality that many students who had a trauma history were diagnosed with EBD: *sometimes it will be EBD, that's a big one, just because those kids tend to be more explosive they hold things in and when they cannot hold it in anymore they just let it out and that is in the long run, it is diagnosed as EBD.*

Many lower grade level educators explained the difficulty in diagnosing the kindergarten and first grade students due to their age. Teacher Four described her experience with her students given diagnoses at a young age:

> *1st grade is a difficult grade to do that with because a lot of those, if a child is diagnosed with something for the most part, again this is my first year, so I am not totally versed in all of it, but from my understanding, the majority of the children who are diagnosed with something have a pretty general special education they slap them with, they are reassessed for an IEP when they turn seven, then they are looked at more closely…the students who have experienced trauma in my classroom are not on IEP's for diagnosis at this point.*

Importance of Family Support for Children's Success in School

Another theme that emerged from the data was the importance of a sense of a family connection with the school. It had been stated how important it was for the

educators to know family systems to best serve the needs of their students. Children who were not receiving support at home might need extra help at school for completing homework. Children might not be getting the best sleep if they do not have an adult to help set a bedtime. A kindergarten teacher explained that one of her students was not focused during the day and very distracting mainly due to him being tired, *A boy from a low income family last year told me he had to set his own alarm clock and that's why he was late for school because he forgot to set it, and sometimes he would say I can't get to sleep because my mom was having a party at my house.*

The educators made it know that if they did not have good communication with the family it was challenging to report behavior or to try and figure out a way to support that student. One educator reflected on the importance of the family connection:

> *The more connection you have with family the better, so there are those helicopter parents who kind of drive you crazy but I would rather have that because some of these students if they are dealing with something from the past seek you do have to keep that in mind, the kids I'm working with are fragile they are still learning so it's good to know if something has come up.*

The lower grade level teachers reported that since the children were so young, the school experience was relatively new; so the educators only gained a little information about their student's home life. A Kindergarten teacher reported how a kindergarten teacher was different than educators because of the little knowledge of a student's family, *With Kindergarten position it's hard to get a good sense of the kid's home life because you don't get to know their parents or hear those stories that are going on at home as much.* Regardless if the student had a trauma in their background the educators believed the importance of knowing what was going on at home, which may be an indicator of the

behaviors at school. An educator explained about a restless boy in her class who had no consistency at home:

> *The little boy who can't sit still and has been in five different Kindergartens, there is no communication, if there is no communication between home and school how is a student supposed to thrive, it's crazy how you can find out stuff after the fact, you can really open your eyes and ok this is what they are dealing with, then I just care so much more but at the same time you don't want to handicap or anything too.*

Additional Accommodations initiated by Educators

Many educators adapted lessons or classroom materials for their disruptive students, including those who had trauma related experiences. Knowing the cause of the behavior, especially if it was something that was related to trauma or family events, could help teachers at school know if they needed to give that child extra support. For instance Teacher Three discussed a student in her class that she knew was in a homeless shelter. Knowing the child did not have a consistent living situation made the educator more relaxed about turning in homework or knowing how much to motivate that child academically. The child's mind would not be focused on school so realizing a child's motivation to succeed in school depended on various circumstances, *Obviously you want the best for the child and letting them fail out of school no matter what their trauma is probably not the best for them so really pushing them is important but knowing sometimes they might just need a little less pushing.*

Another educator explained it was helpful to gain information about her student's lives because it might impact what comments she made in class. This educator had her own trauma related experience when she was young. She had lost her father when she was in kindergarten and gave her teachers credit for giving her a little extra attention during her time of stress. She could relate to some of her student's issues and hoped to

be seen as a consistent supportive figure. She talked about a time when she monitored what she has said to a kindergarten girl who had lost her father:

> *If I'm drawing in class family portraits having them draw a family portrait, and this little girl if I asked where is your dad, that might hit something and actually she drew her dad in and I didn't say anything about it, just left it alone because I didn't know how it would affect her and just general comments, Oh that is a nice picture, so just knowing those little things, what to avoid and where to help.*

Another teacher incorporated talking about grief with her Kindergarteners as a result of three out of her 15 students had lost a parent within the last few years. She got a few books on grief and tried to talk to the individual children about the issue first to start building a relationship. She realized that the children needed more "counseling" support then they were receiving. Incorporating the issue to the rest of the classroom was difficult because she did not necessarily know what she was doing but felt extra steps to talk about the issue needed to be done.

> *I said, some of us have lost a goldfish and some of us have lost cats and dogs, some our grandparents, and some of us have even lost our mom and dad, I know that it is not counseling but I'm trying to do a little with that because I think it needs to be addressed.*

Another teacher responded that it could be helpful to know the history because then as an educator you knew how to help, especially if you have been through the same conditions. When Teacher Two was young her parent's got divorced, so when one of her student's seemed to be struggling with the issue she reached out to help. The girl would cry at school and eventually opened up about the situation. The teacher helped the girl write a letter to her mom and dad saying how the divorce was impacting the girl's ability at school. She said that in the letter she helped explain she had been a child of divorced parents too. The parents were very appreciative of the letter. At first she did not know

why the girl was acting upset in class. She reflected back on the experience of being unsure of what was going on with certain kids in class:

> *It's kind of eye opening to sit back and think wow there could be something really serious going on with this student and when you are teaching you get caught up in what you are doing at the time, I think it is important as an educator to step back and think about the possibilities going on and what you are seeing.*

Mental Health Services

All of the seven participating educators reported having some mental health service, but with various degrees of services that were available at the school. The schools had various professionals working with the kids that included: social workers, psychologists, EBD teachers, special education teachers, behavioral specialists, and counselors. Some of the schools had break rooms if certain students needed an extra break. In some instances Para professionals would help take children out of the classroom if they needed time out of the classroom.

Social workers were utilized in many instances for children who needed extra support. The social workers had large workloads but the educators were appreciative of the services that they were able to provide. Two teachers explained how there was not enough time in the day for the teacher to attend to all of the children's emotional needs and still be able to teach everything that needed to get done. Teacher Three reported that some children were not ready to talk to the teacher about something and that she couldn't wait for the student to resume teaching. Teacher Two acknowledged the time constriction as an educator and found value in the school social work role. She talked about the challenge of being available to talk with students: *You don't have time to sit there and wait for them to talk to you, I say I'm here for you if you want to talk, but we have to*

move on, so it's important to have that role of the social worker in the school for that purpose.

The social workers were able to help children on an individual level but many teachers found the groups led by the social worker to have a positive influence on the children who were disruptive or dealing with trauma in their lives. Teacher One, who had been involved in her own Grief and Loss group as an elementary school student found it helpful to be in a group of kids who had experienced the same situation, *If they have something in common they can talk in common and they can look more positively on life, and just deal with what they are going through, I had a lunch group, it made me feel special.*

The majority of the teachers had a social worker in their building and also a psychologist who was available a few days a week. Teacher Six had a different experience of getting help with her students, as her school only had a K-12 counselor. She discussed how her principal was very supportive and she could send children down to her office if they needed to be out of the classroom but that there was a need for more mental health services in her school. The counselor's focus was helping the older students find colleges and scholarships. The counselor was supposed to help the younger kids but due to time restrictions it was not possible. She was advocating for the school to hire another counselor for the upcoming year:

> *Another thing that frustrates me and I think we are going to try and get better at this, they are just slow to support, that one boy who is fighting and swearing sometimes, I would really like some support and help with him, like I mentioned I hope we can hire someone, I think that would be good for the teachers and the kids…the principal is pretty supportive so that's good for me.*

Respondents noted that there were not protocols that were specific to working with children with trauma but many of the teachers explained the system that their school had in place for helping a child with behavioral difficulties in class. Collaborative meetings such as Response Intervention Teams and Child Study were available for a teacher to talk about a student's difficulties in the classroom and the group could brainstorm accommodations to enhance the learning ability for the specific student. Teacher Seven explained the groups at her school:

> *I do a lot with RTI, Response Team Intervention, if they [a child in her classroom] are being disruptive there is a meeting that we can go to and get ideas and put them on interventions, and different plans to reduce that behavior, they encourage you to track data, and then the next step is Child Study, a group that takes on a wide variety of things.*

Some of the teachers responded that protocols were put in place for children with an Individualized Education Program (IEP's). Even some children in first grade or kindergarten already had an IEP. Certain children, who's IEP stated they needed so much time with extra services they were given time with the Social Worker or Special Education teachers. Another teacher worked at an EBD Center based school with EBD teachers to help with those students. This center had a specific protocol on how to respond to a child's emotional meltdown in class.

Findings Summary

The current exploratory research was conducted to investigate educator's experiences with disruptive behavior in their elementary school classrooms. The researcher was interested in finding out if disruptive behaviors were displayed by children who had a trauma history or if the behaviors came from children who had common childhood disorders (such as ADHD). The researcher was also looking to see if the children with a trauma history were diagnosed with any disorders because the past

literature has found common behaviors between children who have a trauma history and those with a childhood disorder such as ADHD. Overall, the researcher wanted to find out if behaviors displayed by children with trauma resemble some children who may have a disorder but no trauma history.

The current research found that many disruptive behaviors were displayed by children with various backgrounds. The younger grade level teachers noted that most of their disruptive children had a trauma history. About half of those children were diagnosed with ADHD/EBD or started to become evaluated for specific disorders. At the same time the educators stated that many young children do not have diagnoses yet in kindergarten or first grade because of the difficulty diagnosing young children. The older grade level educators more often attributed their disruptive behavior to other causes instead of trauma, such as gaining peer attention in class.

Discussion

The qualitative research explored seven elementary school educators' experiences with behavior in their classrooms. Similarities and differences from the themes generated from the interview data and previous literature will be discussed. Many of the educators experienced externalizing disruptive behaviors on a daily or almost daily basis. Student's behavior varied among the age group of children. Younger student's behavior was more about following rules, while older children had behavior related to peer interactions. There were several sources of disruptive behavior found in the classroom which included: attention, ADHD, parenting style, development, and trauma. Although not all educator's declared trauma as a source of disruptive behavior, later when they were asked if trauma played a role in disruptive behavior, all of the educator's agree it did to a certain degree.

The connection between a student's home and school was found important for a student's success in school. Teachers felt the need to accommodate lesson plans or make special requests for students with a disruptive behavior or a trauma history. Lastly, mental health services were utilized by all the educator's, who believed the role of their mental health staff was essential for the support of some of their students. The themes found in the qualitative interviews included: description of disruptive behavior, age related behavior, cause of disruptive behavior, trauma in the classroom, family support, teacher accommodations, and school mental health services.

Description of Disruptive Behavior

The first theme, disruptive behaviors, supports the current research identified in this paper's literature review. Teachers in this study described talking out of turn, not following directions, and being off task as some of the more difficult behaviors in the classroom. Similar to Henricsson & Rydell (2004), the current research found externalizing behavior, such as aggressive, defiance, or hyperactive behaviors more difficult to handle in the classroom. Similar to previous research, redirecting children after talking out of turn was increasing, less time was spent on the actual curriculum (Clunies-Ross, Little, & Kienhuis, 2008), and more time was spent on discipline (Rosenberg & Jackson, 2003). The ability to learn for other students was impacted by disruptive students (Finn, Pannozzo, & Voelkl, 1995). Teachers had witnessed disruptive behavior in the classroom inhibiting other student's ability to learn and keep them on task. Some teachers found the atmosphere of their classroom changing with the addition of disruptive students (Bru, 2009). Educators reported being frustrated because they did

not know the root of the behavior and /or they do not see a change in the child's behavior after implementing interventions.

The externalizing behaviors (aggressive, impulsive, hyperactivity) caught the educator's attention. However it is important to note that one teacher discussed a student whose behavior was internalized, which could be defined by unhappiness, anxiety, or loneliness behaviors (Henricsson & Rydell, 2004). A teacher discussed a student who was homeless and would withdraw from the classroom. Previous research discussed that inattentive students had lower scores on academic tests as compared to off task or disruptive students (Finn, Pannozzo, & Voelkl, 1995). Academic grades were not reported by the teachers in this study but it was reported that students who were disengaged from school were more likely to not turn in homework. It may be even more important to acknowledge the inattentive students as their behaviors may be linked to lower grades.

Age Related Behavior

The findings suggest that the age of the student may influence the type of disruptive behavior displayed in the classroom. Previous research had explored studies with different age groups, but had not found distinct patterns related to grade levels (Ratcliff et. al., 2010). Several of the educators had taught different age levels and could see a difference in the behavior. Younger children had disruptive behavior due to an adjustment to learning the rules of school and how to get along with other children. However the older students, their disruption was more peer related or peer involved. The kindergarten and first grade teachers frequently discussed students talking out of turn and the constant redirecting their students as a source of frustration. The teachers talked about

trying to figure out what would work best for their disruptive students but none of the educators were able to find a cure for their constant behaviors. The fourth and fifth grade teachers reported less talking out of turn and redirecting as a main behavior. Fighting with friends occurred to be a bigger issue as the children got older. The peer conflicts in this study seemed to be more disruptive in the older children. Children were labeled the "funny" child or the "class clown" in the older grades, as behavior was related to getting their classmates attention. These children wanted peer attention because they could not do the work and/ or they felt different than the other kids (homelessness, divorce, lower socioeconomic status)

Causes of Disruptive Behavior

The causes or sources of the disruptive behavior in the classroom found in the data were partially consistent with the previous research. The educator's recalled attention, ADHD, parenting, development, and trauma as sources for the disruptive behavior. The respondents mentioned many students engage in behaviors to gather additional attention from the teacher or their peers. Similar to previous research, (Hendricsson & Rydell, 2004), externalizing behaviors received more attention from the teacher and involved more interrupting class time to redirect students.

Like Westling (2009), teachers found behaviors that could be found in children with ADHD very disruptive, and that treatment such as medication or counseling may help those children function in class. One teacher acknowledged that the ADHD behaviors were the hardest because it was a neurobiological disorder and there were only so many accommodations she could make in her classroom for those students to be successful. In addition, teachers reported having children diagnosed with ADHD or any

disorder at a young age was challenging. Teacher Five had a young girl who was being evaluated for EBD but was not sure if there was an ADHD component to her behavior. ADHD had been difficult to diagnose because there may be a genetic component and there could be some co-occurring disorders that go along with ADHD (Rowland, Lesene, Abramcwiz, 2002). Teacher Five, like many of the teachers, were hesitant to say for sure their students qualify for a diagnosis (in the lower grade levels) because the children were still growing and have not experienced the school environment for a long period of time.

In contrast, the previous research did not emphasize parenting as a source of disruptive behavior. The previous literature explored other childhood diagnoses such as oppositional defiant disorder, conduct disorder, and post-traumatic stress disorder as sources of disruptive behavior, but they were not found in the current data. The educators mentioned Emotional And Behavior Disorders when they were talking about some of their students who had externalizing behaviors, which was not found in the literature review.

Trauma in the Classroom

The respondents were very aware of the fact that some of their students had been through trauma. The educators themselves had to some degree their own personal experiences of trauma or at least had experience working with children with a trauma history. Similar to Cook et. al. (2005), these children were showing attachment problems (little boy who touched an educators foot during reading time), affect regulation (the children who were unable to calm themselves after getting frustrated, instead would yell, scream), behavioral problems (girl who would hit her teacher and throw objects across the room), and self esteem (boy who acted out because he did not want to be the “low

student"). Many teachers discussed that appropriate copying skills were not yet learned by their disruptive students; so when they were frustrated with something instead of verbalizing their need shutting down, yelling, crying were ways to show distress. The attachment between the student and their caregiver could show their learned copying skill in the classroom.

Many of the traumatic experiences mentioned in the interviews were related to family dynamics; whether it was divorce, lack of contact of a parent, family system moving into new environment, or possibly neglectful parents. Insecure attachment with their caregiver could result in non-effective coping (Cook et. al., 2005). It was mentioned by several educators that trauma has many dimensions and how a child handled a traumatic event was specific to each child. What one child views as traumatic another child may not and the types of traumas that the educators were aware of were different for each classroom.

Similar to Lucas (2007), at times the educators felt burned out and found it hard to not give more attention or care to the student after realizing their trauma backgrounds (Alisic et. al., 2012). Two of the educators had their own traumatic or impactful experiences growing up, one lost her father in kindergarten and another teacher's parents divorced when she was young. The teachers were able to support their students with similar trauma experiences in the classroom. It was easier for them to relate as they had experienced similar feelings.

Family Support

The theme of family support for a student's success at school did not relate to the previous research in this paper's literature review. This theme stressed the importance of

communicating with the family of a child who was having behavior difficulties in the classroom. The responsibility was placed on the caregivers of the student to help organize and complete homework; but if the child had an inattentive parent the child was left to learn those skills without adult support or modeling. Support could be in the form of the parent helping with homework or helping a child set his alarm clock. The teachers acknowledge that if family support was not present at home various forms of disruptive behavior may be more likely with those students.

One teacher hypothesized that if students are getting in trouble at school the biggest threat is a call home but if there is not a supportive parent at home, the call will not feel like a consequence. Although parenting was named a source of disruptive behavior it related also to family support. Behaviors at school will be easier to manage if the educator knows how behaviors are disciplined at home. Knowing about a child's family life helps the teacher know how the child has learned certain skills. One teacher mentioned that she understands the work habits of her students after meeting with parents. The main connection with some of the children who have trauma histories is that there is no connection between school and home. That is where the frustration appears with the educators as they know the student may need extra support at school. However with no communication minimal interventions at school can be accomplished.

Teacher Accommodations

Additional accommodations for student success focused on changes the educator created in the classroom for students with a trauma history and those with disruptive behavior. Similar to Finn, Pannozzo, & Voelkl (1995), teachers would adjust the lessons or give children extra tasks to improve academic success in the classroom. Several

educators reported that if they knew the child had attention seeking disruptive behaviors they would appoint extra classroom tasks.

Educator's altered how they taught to incorporate lessons for those children who have experienced trauma. One teacher added a grief activity in her classroom as a result of one-third of her classroom had lost a parent within the last few years. To have the lesson relate to the rest of the class, she talked about losing goldfish or other pets. Her school did not have appropriate counseling services for the younger children so she thought the idea of death needed to talk about on kindergarten level. Another teacher knew one of her students had lost her father, so she did not make a father comment when looking at this girl's family portrait. Another educator had experienced divorce when she was in grade school so when one of her student's parents was divorcing, she helped write a letter to the parents. These accommodations were unique to each child but had proved to be needed for the students as reported by the educators.

School Mental Health Services

In contrast to Alisic (2012), the respondents of the current research were knowledgeable of the different steps to take or who to talk to if they were having behavioral difficulties in their classroom. Unlike the previous research explored in this paper's literature review, the educators explained which of their students were getting additional services or being tested for different disorders. A few realized after the interview that they wanted to bring their student to an intervention team meeting or talk with other school professionals about a child's behavior. Like Alisic et. al. (2012) the respondents did not mention specific trauma training but they all had to various degrees their own experiences working with or their own past trauma. Many reported being

interested in knowing more about trauma because throughout the interview they seemed more interested in the relationship between trauma and a child's behavior.

The educators said that they utilized available mental health professionals. Many of the social workers and counselors were reported to have full case loads. All of the teachers were grateful for the help of the other professionals as it had been difficult for many to balance teaching a class when one student was in distress. The social workers worked with students who had disruptive behavior on an individual and group level. One teacher talked about her own experiences being in a Grief and Loss Lunch group. She said it made her feel special and that was a way she was able to get some extra attention in school.

For one teacher in particular, her school had a K-12 grade counselor. Even though her school was in a rural setting with a reduced population, she explained that the younger children needed a counselor. Her counselor was working with the high school students for finding colleges, but had recognized many needs of her kindergarten students for counseling services. She knew that she was not a counselor, but felt the need to give those children some kind of mental health related service. This educator had been proactive about requesting another counselor for the school because they had additional money in the budget for the following year.

Strength and Limitations

The general purpose of the study was to gain a better understanding of disruptive behavior in the classroom, what the behavior looked like, the cause, and if trauma could have any impact on the behavior of the children who are disruptive. The main strength of the current research was exploring the emotional narratives of seven elementary school

teachers on their experiences with disruptive behavior. The data gathered depicts real experiences, frustrations, and opinions of current elementary teachers who witnessed disruptive behavior on daily basis. The educators were able to feel open about sharing their observations of the children and their past personal stories of death and divorce. Each educator had previously worked with students who had a trauma history, had children in their current classrooms that had a trauma history, and/ or had their own trauma experiences.

The educators were very aware of their students and their trauma histories. This could be attributed to the educator's age. Most of them were younger and just starting their teaching career. These educators could have participated in more information trainings for trauma or childhood mental health. Their education could have changed how they view behaviors in their classroom. Their awareness could be due to more training included in their education or more knowledge base of how trauma impacts a child's behavior.

The sample itself could be a limitation to the study. Only seven educators were interviewed; so due to the small sample size the data cannot be generalized. Five out of the seven participants were professional contacts, with a previous relationship between the respondent and the interviewer, which could have altered the interview. The educators were new to the teaching professional. The teacher with the most experience had four years of teaching experience. Data gathered from educators with more experience teaching could produce different view points on the issues. There was not an even distribution of teachers for each grade level. The majority of the educators

interviewed taught kindergarten or first grade. The results could be different if there were more teachers from all grade levels participating in the study.

Implications for Social Work Practice

Social work practice is directly related to the current research because social workers are able to provide direct individual and group services to children with disruptive behavior, regardless of the source. All of the educators found support working with mental health professionals and services provided to benefit the children who were having difficulty managing behaviors in the classroom. The social workers may be able to connect with the families of the children; which have been found to be difficult for the majority of the teachers. It is valuable information for other school personnel to acknowledge the importance of the role of a mental health provider, to strengthen not only job security but to explore the role of the mental health provider.

Implications for Policy

More programs or trainings to educate teachers on helping children who have a trauma history could be helpful for educators; even though generally the educators interviewed had a sense of how to handle disruptive behaviors. The educators in this study were open to learning more about what trauma looks like in the classroom and how to best work with children who have experienced trauma.

This research supports the need for policy programs that provide money for special education and mental health services in the schools. It was reported in this study by an educator that her students were not able to receive adequate mental health services at school. The only reason for her school not being able to provide services is due to budgeting.

While it is important for educators to be knowledgeable about how to handle children with a trauma history it is not their job to teach and counselor children too. There should be an increased focus on the need of mental health professionals in schools. With budget cuts educators may feel the need for dual roles within the classroom but we have to remember their profession is teaching and counseling children is out of their scope of practice. The current research has explored the importance of not only special education social workers but also regular education social workers. One educator felt she had to incorporate counseling teachings in her classroom about grief. This is out of her line of work, while in good intention; this is not the role of an educator. The dual roles performed by an educator could influence additional teacher burnout, impact the other students in the classroom, and may or may not provide the necessary services for the child in need of counseling. This research also displays the importance for educators to be knowledgeable of community resources if the school lacks adequate mental health services.

Implications for Future Research

Further research should continue to explore the connection between trauma and disruptive behaviors. There was an overall sense that the teachers believed that trauma could impact behavior to some degree but there were numerous other factors that could be involved. One theme that emerged from the data, parenting and how that impacts a child behavior would be an interesting exploratory research project. The educators seemed eager to learn more about how a child's past can greatly affect their ability to learn or use healthy coping mechanisms in school.

Surprising to the researcher, many educators talked about EBD during the interviews, as compared to ADHD or other diagnoses. More research is needed to explore the connection between EBD, trauma, and disruptive behavior in the classroom. Few of the educators worked directly with EBD students but there was an overall sense that those students often shut down, have difficulty concentrating, and have angry outbursts; which are comparable to Increased Arousal symptoms of PTSD as described in the DSM-IV-TR (2000).

Conclusion

Similar to Henricsson and Rydell (2004), a difficult task to "face" as a teacher is children who display externalizing behaviors in the classroom. Disruptive behavior is witnessed by elementary school teachers on a daily basis in their classrooms. More time is spent on discipline and redirecting students and less on the actual lesson plans (Rosenberg and Jackman, 2003). The study has shown that there are various sources of a child's behavior, which could be caused by a neurobiological disorder such as ADHD, or more emotional causes such as a traumatic event.

An educator in the current study reported that her student's behaviors are like "icebergs." She was only able to see the tip, the behavior, but that there was so much more of a child's history that is underneath the water. There can be various reasons for a child's disruptive behavior but that should become the focus of school personnel rather than the behaviors themselves.

Regardless of the cause of the behavior communication and support from a child's family is important for a child's academic success. Educators go out of their way for additional classroom accommodations for children who are disruptive or have a trauma

history. The respondents in this study care about the wellbeing of their students; and try to figure out ways to be successful and knowing when the child needs some extra support, in terms of seeing the social worker or an Intervention meeting. Social workers and other mental health professionals have an important role in the schools to provide extra support for children. There needs to be adequate mental health staff stationed in schools depending on populations size because it has been shown that it can make a difference. Educators and mental health professionals need to continue to be advocates for government funding for school mental health services. Schools may feel unable to fund for a mental health professional but eventually the educators receive the biggest burden. They may feel responsible for providing small counseling type talks in class to compensate for the lack of services available at their school, as told by an educator in the current study.

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Appendix A: Blank Consent Form

Educator's Perspective of the Source of Disruptive Behavior in the Classroom
INFORMATION AND CONSENT FORM

Introduction:

You are invited to participate in a research study investigating teacher perspectives on disruptive behaviors in the classroom and possible sources of the behavior. This study is being conducted by Kari Jacobsen, a student at St. Catherine University/University of St. Thomas under the supervision of Sarah Ferguson, a faculty member in the Department of Social Work. You were selected as a possible participant in this research because you are an educator who has worked with elementary school age children. Please read this form and ask questions before you agree to be in the study.

Background Information:

The purpose of this study is to explore educator's perceive of disruptive behavior in the classroom, their insight to sources of the behavior, and concerns regarding interventions for child mental health services. In addition, the study will explore how similar or different behaviors are in children who have experienced a trauma history versus other common childhood mental health concerns. Approximately 10 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to participate in an audio recorded interview. The interview will consist of questions regarding experiences working with children with disruptive behavior, the perceptions of the sources of disruptive behavior, knowledge of disruptive behavior and connection with trauma, and their knowledge of mental health services in their school with a focus on children who have experienced trauma. This study will take approximately 45-60 minutes per individual interview.

Risks and Benefits of being in the study:

There is no risk.

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

Compensation:

There is no compensation for this research project.

Confidentiality:

Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented.

I will keep the research results on a locked computer and only I and my advisor will have access to the records while I work on this project. I will then destroy all original reports (including audio taping of interview) and identifying information that can be linked back to you on May 25th, 2012.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University/ University of St. Thomas in any way. If you decide to participate, you are free to stop at any time without affecting these relationships. The participant also has the right to not answer any question(s) that makes the participant feel uncomfortable.

New Information:

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

Contacts and questions:

If you have any questions, please feel free to contact me, Kari Jacobsen (952) 261-6583. You may ask questions now, or if you have any additional questions later, the faculty advisor, Sarah Ferguson (651) 690-6296, will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739.

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

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time.

I consent to participate in the study and agree to be audio recorded.

_____

Signature of Participant Date

_____

Signature of Researcher Date

Appendix B: Interview Schedule

Which grade do you teach?

How long have you worked with this age?

How many years have you been an educator?

Do you have any disruptive behavior in your classroom? If so what does that behavior look like?

Follow up Question if the educator replies that there are disruptive students in the classroom. Do you know if there has been a trauma history with that student?

From an educator's perspective what are the sources or causes of disrupted behavior?

What is your experience working with children who have experienced trauma?

What is your definition of trauma?

What role do you believe trauma has in disruptive behavior?

What kind of symptoms or diagnoses did these children with trauma have?

Does the school have mental health services?

Does the school you work at have a protocol for working with children who have experience trauma?

Appendix C: Trauma Resource Sheet

Trauma Resources
Websites

- The National Child Traumatic Stress Network Child Trauma Toolkit for Educators. www.NCTSN.org.
- Minnesota Association for Children's Mental Health www.macmh.org
- Mental Health America http://www.mentalhealthamerica.net
- Washburn Center for Children www.washburn.org

Authors

- Alan, Sroufe and June Fleeson- Attachment and Early Relationships
- Ann Gearity- Created Developmental Model based out of Washburn Treatment Center for Children
- Bruce Perry- Information on Neurobiology of Trauma
- Bessel A. van der Kolk- Written articles on Childhood Trauma and Abuse
- Daniel Siegel- Brain growth, attachment