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Urban Elementary Teachers' Perceptions of Challenging Behaviors and Childhood Trauma

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Trauma

by

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

Abstract

This research study explored urban elementary school teachers' perceptions toward and responses to trauma-related challenging behaviors in their students. Review of current literature focused on the effects of childhood trauma, trauma in urban schools, and the characteristics of trauma-informed schools. A quantitative research design was used. Data was collected through the distribution of an online survey. Sixty-eight participants completed a 71-item survey about challenging behaviors and childhood trauma. Descriptive and inferential statistics were used to analyze data. The findings showed that participants encountered many challenging and trauma-related behaviors in their classrooms. Higher levels of teacher knowledge about trauma and challenging behaviors were found to be associated with less reported difficulty in managing challenging and trauma-related behaviors, more confidence in working with challenging and trauma-related behaviors, and lower levels of teacher stress. Implications for social work practice and policy include the importance of the school social worker's role in providing support for understanding and responding to childhood trauma in schools, and the need for more trauma-informed practices in urban schools, especially increased teacher and staff training and support for responding to childhood trauma.

Keywords: urban schools, childhood trauma, challenging behaviors

Acknowledgements

Table of Contents

List of Tables

List of Figures

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As the profound and long-lasting effects of childhood trauma become more widely recognized and studied, the importance of caregivers' and professionals' responses and interventions for traumatized children has also become an important issue, especially for schools. Teachers play a critical role in the lives of their students, especially for children who are exposed to the effects of trauma. According to the National Child Traumatic Stress Network (NCTSN) ("What Is Child Traumatic Stress?", 2003), one in four children attending school has been exposed to a traumatic event, such as physical or sexual abuse, domestic violence, bullying, community violence, death, illness, homelessness, natural disaster, or other trauma. In particular, complex trauma, which is the exposure to multiple traumatic events– such as repeated abuse or neglect– and which often occurs within the caregiving system, can have devastating and lasting effects on a child's development (van der Kolk, Blaustein, Cook, & Spinazzola, 2003). Childhood trauma can hinder normative development, a child's ability to form secure attachments, and has been linked to poor academic outcomes, including lower achievement test scores, poor grades, and higher rates of suspension, expulsion, and school failure (Wolpol, Johnson, Hertel, & Kincaid, as cited by Crosby, 2015).

In the past 20 years, researchers such as Bruce Perry, Bessel van der Kolk, and other mental health professionals have explored childhood trauma and its profound and lasting effects on a child's development. These researchers have sought to understand how trauma affects children and how to best help them heal. Research in the area of child trauma has examined the unique ways that children respond to threat, as well as the myriad of effects that exposure to traumatic stress can have on a child's physical, mental, emotional, and social well-being.

Classroom teachers in elementary schools spend dozens of hours in direct contact with their students each week, and can therefore be an incredibly important supportive adult in a child's life. Their close proximity to students also gives them opportunity to identify behavioral concerns or signs and symptoms of traumatic exposure in students (Alisic, Bus, Dulack, Pennings, & Splinter, 2012). Teachers are in a position to be vital in supporting children through recovery from trauma, but some research indicates that elementary school teachers have uncertainties about their role and how they can assist children effectively after traumatic experiences (Alisic et al., 2012).

Many mental health providers and educators have identified trauma-informed care as a hot topic and have focused additional resources on studying this concern. As more schools seek to become "trauma-informed", more teachers and administrators are aware of the importance of addressing the pervasive effects of childhood trauma and traumatic stress. Creating trauma-informed schools can benefit student performance, school behavior, student attendance and retention, and teacher satisfaction, as well as reduce student and staff stress, suspensions and expulsions, and the need for special education services (Oehlberg, 2008).

The importance of addressing trauma in schools and understanding children's behaviors in the classroom through a trauma lens cannot be understated. To be successful, trauma-informed education requires the full participation of teachers and administrators, as well as adequate staff development and training, discipline strategies that are sensitive to students' needs, and strong relationships between schools and mental health professionals (Oehlberg, 2008). This paper will explore the scope and prevalence of childhood trauma in school settings and look at how teachers in elementary schools understand childhood trauma and respond to the symptoms and effects of trauma in their students.

Literature Review

The following literature review will explore the nature of childhood trauma and its various forms, its prevalence, and its effects on a child's development, behavior, and learning. Special attention is given to the effects of abuse and neglect, as child maltreatment is a particularly insidious and devastating form of childhood trauma, and one of the most common types of trauma. The characteristics of urban trauma and the effects of childhood trauma in schools is then reviewed, including an exploration of trauma-informed schools and the challenges faced by teachers in urban settings working with traumatized students.

What is Childhood Trauma?

Traumatic experiences in childhood can take many forms. Trauma occurs when a child experiences an intense event that harms, or threatens to harm, his or her emotional or physical well-being ("What Is Child Traumatic Stress?", 2003). Trauma can be understood as severe distress, harm, or suffering resulting from an overwhelming mental or emotional pain or physical injury (Aratani, Cooper, Dababnah, Knitzer, & Masi, 2007), and child traumatic stress describes the psychological reaction that some children have to a traumatic event or experience ("Understanding Child Traumatic Stress", n.d.*).* Lenore Terr, a psychiatrist who has worked extensively with traumatized children, defines childhood trauma as "the mental result of one sudden, external blow or a series of blows, rendering the young person helpless and breaking past ordinary coping and defensive operations" (Terr, 2003, p. 323). Terr (2003) identifies two basic types of childhood trauma—Type I traumas, which are the result of a single traumatic event, and Type II traumas, which result from long-standing or repeated traumatic events.

The most common sources of traumatic stress for young children are accidents, physical trauma/injuries, abuse, neglect, and exposure to domestic or community violence ("Early Childhood Trauma", 2010). There are a wide range of other events and experiences that may be considered traumatic for a child, including motor vehicle accidents, acts of violence, terrorism, medical procedures, unexpected death or separation of a loved one, and life-threatening natural disasters ("Understanding Child Traumatic Stress", n.d.*).* The well-known Adverse Childhood Experiences (ACE) study, a decade-long study by the Centers for Disease Control and Prevention and the Department of Preventative Medicine in San Diego, measured ten types of traumatic childhood experiences, which included: physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, violent treatment of mother, mental illness of a family member, substance abuse of a family member, parental separation or divorce, and incarceration of a family member (Anda & Felitti, 2003). The study found that two-thirds of participants reported at least one ACE, and that ACES were risk factors for a wide range of physical and mental health symptoms (Anda & Felitti, 2003).

Complex trauma, which refers to exposure to multiple traumatic events, typically occurs when a child is chronically abused or neglected (van der Kolk, Blaustein, Cloitre, Cook, DeRossa, Ford, Hubbard, Kagan, Lanktree, Liautaud, Mallah, Olafson, Spinazzola, & Sprague, 2007). This is similar to Type II traumas described by Terr (2003). Professionals in the trauma field adopted the term "complex trauma" to describe the experience of multiple and/or chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature and with an onset early in life (van der Kolk, 2005). Complex trauma consists of simultaneous or sequential instances of maltreatment (physical abuse, sexual abuse, emotional abuse and neglect, witnessing domestic violence) that begin in early childhood, are chronic and ongoing, and occur

within the caregiving system, which children rely on for safety and stability (van der Kolk et al., 2003). The lack of safety and security that results from complex childhood trauma can lead to emotional dysregulation, loss of a secure base and sense of safety, and an inability to detect or respond appropriately to danger cues (van der Kolk et al., 2003). Complex childhood trauma can have damaging effects on a child's physiology, emotions, learning, ability to think and concentrate, impulse control, self-image, and relationships ("Impact of Complex Trauma", n.d.).

Prevalence of Childhood Trauma

While it is difficult to know exactly how many children experience traumatic events in the US each year, childhood trauma is a serious and widespread problem. The National Child Traumatic Stress Network reports that one in four children in the US will experience a traumatic event before age 16 ("What Is Child Traumatic Stress?", n.d.). In 1994, Perry, Pollard, Blaicley, Baker, and Vigilante (1995) reported that conservative estimates of the annual number of children in the US experiencing a traumatic event—anything from abuse or neglect, witnessing domestic or community violence, natural disasters, or surviving an accident or injury-- exceeded four million. Bessel van der Kolk, a prominent researcher in the field of child trauma, reported in 2005 that over three million children are reported for abuse and/or neglect in the US each year, of which about one million reports are substantiated (van der Kolk, 2005). More recently, according to the US Department of Health and Human Services (USDHHS) Child Bureau (2015), there were an estimated 679,000 substantiated claims of child abuse and neglect in the US in 2013, which equals a rate of about 9 victims per every 1,000 children in the population. The ACE study found that two-thirds of the adult participants experienced at least one adverse childhood experience (Anda & Felitti, 2003). According to the National Child Traumatic Stress Network, a study of children aged two to five found that more than half (52.5%) had experienced

a severe stressor in their lifetime; older children experience exposure to traumatic stressors at similar rates ("Early Childhood Trauma", 2010).

Of the 679,000 reported cases in 2013, a large majority of child maltreatment victims were neglected-- 79.5% (USDHHS, 2015). Additionally, 18% were physically abused, nine percent were sexually abused and nearly nine percent were psychologically maltreated (USDHHS, 2015). In a survey conducted by the National Child Traumatic Stress Network in 2002, interpersonal victimization was the most prevalent type of traumatic exposure among children served by trauma intervention services, with 59.3% of children served experiencing psychological maltreatment, which included emotional abuse, verbal abuse, and emotional neglect (van der Kolk et al., 2003). Emotional maltreatment was followed by traumatic loss at 55.6%, impaired caregiver (i.e. caregiver mental illness or substance abuse) at 47.1%, domestic violence at 45.8%, sexual maltreatment/assault at 40.8%, neglect (physical, medical, or educational) at 33.8%, physical maltreatment/assault at 28.1%, and terrorism at 18.4% (van der Kolk et al., 2003).

Childhood abuse and neglect may be the number one public health issue faced in our country (Wylie, n.d.). In 2013, an estimated 1,520 children died of abuse and neglect in the US (USDHHS, 2015). Thousands more live in the "long shadow of trauma" (Wylie, n.d, p. 1) caused by exposure to chronic abuse and neglect. Since one out of every four children will experience a traumatic event before age sixteen ("What Is Child Traumatic Stress?", n.d.) it is vital to understand the effects of traumatic events and how to help children who are affected by symptoms of traumatic stress.

The Child's Response to Threat

When encountered with situations perceived as dangerous, the human body and brain have "very primitive, deeply ingrained physical and mental responses to threat"; the most familiar of which have been labeled the 'fight' or 'flight' reactions" (Perry et al., 1995, p. 277). When a threat is perceived by the parts of the brain that assess danger, which include the amygdala, hippocampus, locus coeruleus, and hypothalamic-pituitary-adrenal axis (Perry, 2001), an "alarm reaction" is initiated (Perry et al., 1995, p. 277). This alarm sets in motion a threat response by way of the sympathetic nervous system, which prepares the body to respond to the threat in physiological and psychological ways (van der Kolk et al., 2003; Perry et al, 1995).

Physiologically, the body reacts to a dangerous situation with increased heart rate and blood pressure, changes in breathing and muscle tone, increased sweating, and a sense of "butterflies" in the stomach (van der Kolk et al., 2003; Perry et al., 1995). Psychologically, a person confronted with a threatening situation experiences emotional upset, agitation, hyperalertness, and hypervigilance, allowing for increased awareness of the environment and tuning out of noncritical information to allow for intense focus on the perceived threat (van der Kolk et al., 2003; Perry et al., 1995). Once the neurobiological response to danger is activated, the body is prepared for defense against the threat. There are two major responses to threat— hyperarousal, which leads to "fight or flight" behaviors, and dissociation, which leads to "defeat" or "giving up" behaviors (Perry et al., 1995, p. 280).

Hyperarousal response. When a child faced with danger responds with hyperarousal, or the "fight or flight" response, an increase of the neurotransmitter norepinephrine in the body regulates a full-body fear response to the threat that prepares either to fight with or run from the perceived threat (Perry et al., 1995). The brain regions affected by the hyperarousal response

play a critical role in regulating a child's arousal level, vigilance, affect, behavioral irritability, locomotion, attention, stress response, sleep, and the startle response; these neurobiological functions become impaired as a result of repeated exposure to threat and hyperarousal (Perry, 2001).

The hyperarousal or "fight or flight" response is a commonly understood reaction to danger. However, infants and young children are not capable of effectively fight or flee a threat (Perry, 2001). They more commonly use their limited behavioral repertoire to engage in a combination of adaptive responses that are designed to bring a caretaker to defend them—the initial hyperarousal response (Perry et al., 1995). An infant or young child faced with threat or danger will use changes in facial expressions, body movements, and most importantly, vocalization/crying to draw a caregiver's attention to them and elicit protection; this response is effective if a caregiver responds and is able to feed, warm, sooth, fight for, or flee with the infant (Perry, 2001). Unfortunately, this response is not always effective, especially when a caregiver is abusing or neglecting the child. When attempts to gain a caregiver's attention and protection fail, infants and children will often move into a dissociative response (Perry et al., 1995).

Dissociative response. The first reaction in the face of a continuing threat when attempts to gain a caregiver's response have failed is often to "freeze"—a lack of movement or activity that is an adaptive advantage, allowing for one to organize and figure out how to respond to the threat in the face of increasing anxiety and decreased cognitive processing (Perry et al., 1995). Freezing can move into full dissociation if an infant or child is truly terrorized (Perry et al., 1995). Dissociation can be understood as "disengaging from stimuli in the external world and attending to an 'internal' world; examples of dissociation include daydreaming, fantasy, depersonalization, derealization, fugue states, and in extreme cases, fainting or catatonia (Perry

et al., 1995; Perry, 2001). Perry et al. (1995) noted that when immobilization, inescapability, or pain are involved, as is often the case with abused or neglected infants and young children, dissociative responses are more predominant. When infants and young children are physically unable to escape abuse or neglect, dissociative responses allow them to mentally and emotionally remove themselves from the traumatic situation (Painter & Scannapieco, 2013). Traumatized children engage in a variety of dissociative techniques, from "going to a different place", assuming hero or animal personas, a sense of "watching a movie that I was in", or the sensation of "just floating", all of which describe classic depersonalization or derealization responses (Perry et al., 1995, p. 281). The dissociative response is a far less-researched and less-understood reaction to traumatic stress in children (Painter & Scannapeico, 2013).

Both the hyperarousal response and the dissociative response to trauma are adaptive strategies designed to aid in escape from or survival of dangerous situations. When children are presented with threatening or dangerous situations, their brains initiate a "total-body mobilization" to confront the challenge—their physiological, behavioral, cognitive, emotional, and social functioning change to respond to the threat (Perry, 2001, p. 15). These physical and psychological reactions to threat can be distressing, but are very useful in dangerous situations-- they are the human body's normal and adaptive way to protect itself and prepare to confront threats (van der Kolk et al., 2003). However, if children repeatedly experience traumatic events in the early years of life, these trauma responses can become maladaptive, deeply ingrained ways of understanding and interacting with the world. Children exposed to traumatic events, especially repeated, ongoing traumas, may have longer-lasting physical and psychological reactions to traumatic stress that can have significant impacts on their physical and mental health (van der Kolk et al., 2003).

'States Become Traits': Trauma Alters the Brain

Children respond to and are affected by trauma in different ways than adults; they are more vulnerable to traumatic experiences than adults are (Perry & Pollard, 1998). Experiences can change the mature, adult brain, but experiences during critical periods of early childhood, including traumatic events, actually organize brain systems (Perry et al., 1995). When trauma occurs during infancy or childhood, it has the potential to influence the permanent organization of the brain and all future functional capacities of the child (Perry et al., 1995). This can be described by the idea that, in neurodevelopment, "states become traits"—if hyperarousal or dissociative responses to traumatic events are activated long enough, there will be molecular, structural, and functional changes in a child's brain (Perry, 2001, p. 8). During chronic abuse, neglect, or other trauma, a child lives in a constant fear state, and over time, this fear state becomes a trait of the child's way of being in the world (Perry et al., 1995). The child becomes sensitized to the hyperarousal and/or dissociative responses to threat, and everyday stressors that previously would not have provoked a response now elicit exaggerated reactivity from the child (Perry et al., 1995). When prolonged, the adaptive responses to trauma can become maladaptive traits that have profound effects on the traumatized child's emotional, behavioral, cognitive, social, and physical functioning (Perry et al., 1995).

Children who are exposed to chronic traumatic stress develop pathways in their brain for the fear response initially caused by the trauma and create memories that automatically trigger the response without conscious thought; their once-adaptive strategies for surviving trauma become a maladaptive response to the world (Painter & Scannapeico, 2013). Children who remain in such a state of hyperarousal will overact to triggers that other children do not find threatening (Painter & Scannapeico, 2013). They develop persisting physiological hyperarousal

(increased/irregular heart rate, increased muscle tone, increased startle response, sleep problems), problems with affect regulation, and hyperactivity (Perry, 2001). When children use dissociative strategies repeatedly over time to survive traumatic events, they may develop persisting dissociative symptoms, including withdrawal, somatic complaints, dissociation, anxiety, depression, helplessness, and dependence (Perry, 2001). Children who have been traumatized and have developed sensitized hyperarousal or dissociative responses may often employ the "freezing" strategy when they feel anxious, and it is often labeled as "oppositional-defiant behavior" by unknowing teachers or caregivers (Perry et al., 1995, p. 278).

Studies have shown that, while the response to trauma varies from person to person and depends on a variety of factors, males are generally more likely to respond to trauma with hyperarousal, and females are more likely to respond with dissociation (Perry, 2001). As a result of this gender difference, males are more likely to develop "externalizing" symptoms and present as aggressive, impulsive, reactive, and hyperactive, while females are more likely to show "internalizing" symptoms and present as anxious, dissociative, and dysphoric (Perry, 2001, p. 8).

Impact of Childhood Trauma

Children are uniquely vulnerable to the effects of traumatic events. They depend on adults for safety, protection, and nurturing, and when abuse, neglect, or other traumatic events interfere with a child's physical and emotional needs being met, it can have devastating and long-lasting effects. Childhood trauma can even increase likelihood of poor health and early death—the ACE study results found that the presence of adverse childhood experiences increased risk factors for many of the leading causes of death in the US, including smoking, alcohol abuse, obesity, physical inactivity, use of illicit drugs, promiscuity, and suicide attempts (Anda & Felitti, 2003). Traumatic events can affect every domain of a child's functioning,

including physiological state, attachment, affect and behavior regulation, cognition, and self-concept, and if not addressed, these impairments can continue into adulthood.

Physiological effects. A child who is repeatedly exposed to traumatic experiences is continually put into an alarm state in response to danger. Children who grow up constantly in fear or exposed to extreme stress may not develop a normal immune system or stress response, and constant stress during infancy and early childhood interferes with the normal development of the brain and nervous system ("Impact of Complex Trauma", n.d.).

Persisting maltreatment, abuse, neglect or caregiver dysfunction in infancy and childhood can lead to a "lifelong reactivity" to stress ("Impact of Complex Trauma", n.d., p. 10). Over time, a child who experiences persistent hyperarousal due to trauma may exhibit physical effects such as motor hyperactivity, behavioral impulsivity, sleep problems, rapid heart rate, hypertension, and a variety of neuroendocrine abnormalities (Perry et al., 1995). When confronted with stressful situations, even when there is no real threat, a traumatized child may experience significant physiological reactivity, such as rapid breathing, heart pounding, or they may simply shut down ("Impact of Complex Trauma", n.d.). Children exposed to toxic stress and trauma do not follow a natural bodily rhythm with stress hormones peaking in the morning and gradually decreasing during the afternoon in early evening; rather, traumatized children have high levels of stress hormones continuously throughout the day (Australian Childhood Foundation, 2010). When a child's body continues to stay "on alert", they may have difficulties sleeping or eating, startle or jump at noises easily, become irritable or easily angered, have trouble concentrating or paying attention, and may have recurring somatic symptoms like headaches or stomachaches or problems eating and sleeping ("Understanding Child Traumatic Stress", n.d., p. 5; ACF, 2010). Other physical effects of trauma can include sensorimotor

developmental problems, difficulties with coordination, balance, and body tone, and increased

medical problems across a wide span, including pelvic pain, asthma, skin problems, autoimmune

disorder, and pseudoseizures (van der Kolk et al., 2003).

Children who have experienced complex trauma often suffer from body dysregulation

and an impaired ability to respond to the external environment—they may overreact or

underreact to sensory stimuli ("Impact of Complex Trauma", n.d.). This can be manifested as

hypersensitivity to sounds, smells, touch, or light, and the inability to feel pain, touch, or internal

physical sensations in their bodies ("Impact of Complex Trauma", n.d). As a result, traumatized

children may injure themselves without feeling pain, may suffer from physical ailments without

being aware of them, or, conversely, may complain of chronic bodily pain for which no physical

cause can be determined ("Impact of Complex Trauma", n.d). Adults with histories of trauma

have also been shown to have more chronic physical conditions ("Impact of Complex Trauma",

n.d).

Attachment. The concept of attachment and its vital impact on a person's development

and relationships through life was pioneered by researchers such as John Bowlby and Mary

Ainsworth. Attachment, described by Ainsworth, Blehar, Waters, and Wall (1978) as the "bond,

tie, or enduring relationship" (p. 7) between a child and his or her caregivers, is very important—

it is how children learn to trust others, regulate emotions, interact with the world, develop a sense

of whether the world is safe or unsafe, and come to understand his or her value as an individual

("Impact of Complex Trauma", n.d).

Infants and young children "learn to regulate their behavior by anticipating their

caregivers' response to them" (van der Kolk, 2005, p. 39). Secure attachments develop when a

caregiver responds to their child's needs and is provided with stimulation and nurturing; insecure

attachments result from failures to meet a child's needs and to establish a "secure dyadic relationship" with the child (van der Kolk et al., 2003, p. 8). When a traumatic event occurs that is too overwhelming, or when a caregiver is the source of the distress through abuse or neglect, children are unable to modulate their arousal levels and their capacity to "process, integrate, and categorize" what is happening to them (van der Kolk, 2005, p. 40). Thus, the majority of abused or neglected children have difficulty developing strong, healthy attachments with caregivers, since their experience has taught them that the world is an unsafe, unpredictable place and they cannot rely on others for help ("Impact of Complex Trauma", n.d).

Over 80% of maltreated children have been found to have insecure attachment patterns (van der Kolk et al., 2003). When a caregiver is "emotionally absent, inconsistent, frustrating, violent, intrusive, or neglectful", children are likely to become distressed and unable to develop a sense that their external environment is dependable and can provide relief (van der Kolk, 2005, p. 5). Erratic, hostile, abusive, or rejecting caregiving leaves a child feeling helpless, abandoned, and unable to feel a sense of control or stability (van der Kolk et al., 2007; van der Kolk, 2005). Insecure attachments may be further classified as avoidant, ambivalent, or disorganized ("Impact of Complex Trauma", n.d).

Avoidant attachment patterns commonly form when caregivers are predictably and repeatedly rejecting or dismissive; ambivalent attachment patterns are often formed when caregivers who alternate between detachment and neglect to excessive intrusiveness in predictable patterns; and disorganized attachment patterns have been associated with a lack of co-regulation from caregivers that often results in a complex and pervasive disruption of biopsychosocial development in children ("Impact of Complex Trauma", n.d).).

The most common effect of child maltreatment on attachment is that the maltreated child is essentially rejected by caregivers, which leads to a myriad of developmental and emotional problems (Perry, 2005). Developmental delays associated with insecure attachment include delays in language and verbal processing, motor skills, cognitive functioning, and social behaviors; these difficulties stem from an inadequate caregiving and a lack of consistent and enriching experiences in early childhood (Perry, 2005; van der Kolk et al., 2003).

Impaired attachment styles of traumatized children can lead to uncertainty about the reliability and predictability of the world, problems with personal boundaries, distrust and suspiciousness of others, social isolation, interpersonal difficulties, difficulty attuning to other people's emotional states and perspective-taking, and difficulty enlisting other people as allies (van der Kolk et al., 2003). Maltreated children may engage in "indiscriminant attachment"— they may hug strangers and act affectionately toward adults indiscriminately, behavior which is not really a display of true affection, but rather safety-seeking behavior (Perry, 2005, n.p.). Paradoxically, children who have impaired attachment styles due to maltreatment may also show aggression and cruelty to others, since they learn that abusive behavior is a "normal" or "right" way to interact with others, and their ability to empathize with others, control impulses, and understand the impact of their behavior is impaired (Perry, 2005, n.p.).

Affect regulation. Children who experienced trauma often have an impaired ability to regulate their emotions and affect. This can be seen in difficulty with emotional self-regulation, problems with knowing and describing their internal states, difficulty describing their feelings and internal experience, and difficulty communicating wishes and desires (van der Kolk et al., 2003). Deficits in the capacity to regulate emotions can be broadly categorized in three ways:

deficits in the capacity to identify internal experiences, difficulty with the safe expression of emotions, and impaired ability to modulate emotions (van der Kolk et al., 2003).

Complex developmental trauma inhibits the connection of the right and left hemispheres of the brain, so traumatized children are not able to integrate their experience of feeling states (a right hemisphere function) with words and constructs for their emotions (a left hemisphere function) (ACF, 2010). Traumatized children do not easily understand their own emotions, have a difficult time using language to express emotions, and are not able to interpret or understand the emotions of others (ACF, 2010). Children who are maltreated in infancy or early childhood may form implicit memories of angry or frustrated faces that are encoded in the amygdala, and similar feelings of shame or rejection may be triggered when they see the same facial expressions on others later, but without conscious awareness (Oehlberg, 2008).

Emotional regulation is also difficult for traumatized children. Toxic stress can act as a switch that turns off "top down-brain circuits from the cortex that are responsible for regulating the intensity of emotional and sensory experiences stored and handled in the lower structures of the brain", which dominate the traumatized child's functioning (ACF, 2010, p. 33; Perry, 2001). Impairments in affect regulation lead to difficulty in both self-regulating and self-soothing for traumatized children, and they may display "dissociation, chronic numbing of emotional experience, dysphoria and avoidance of emotional situations (including positive experiences), and maladaptive coping strategies (e.g., substance abuse)" (van der Kolk et al., 2007, p. 5).

Emotions themselves can be perceived as threatening for traumatized children—"negative and critical feelings, such as confusion, shame, guilt, disgust, and worry" can trigger memories of the trauma and set off the stress response (ACF, 2010, p. 33). Traumatized children

have an increased risk for major depression and for developing depressive symptoms earlier and for a longer duration (van der Kolk et al., 2007).

Cognition. Childhood trauma can have a significant impact on a child's cognition and ability to process information. A traumatized child living in a constant fear state is less efficient at processing and storing verbal information than a child living in a safe environment (Perry, 2001). The ability to "internalize new verbal cognitive information" depends on the frontal lobe and other cortical areas being activated, which in turn requires a "state of attentive calm"—a state traumatized children rarely achieve (Perry, 2001, p. 11). As a result, traumatized children often have difficulties in attention regulation and executive functioning skills, problems with processing novel information, difficulty focusing on and completing tasks, learning difficulties, problems with orientation in time and space, acoustic and visual perceptual problems, impaired comprehension of complex visual-spatial patterns, and problems with language development and perception (van der Kolk et al., 2003).

Difficulties with cognitive organization can leave traumatized children with "a more primitive, less mature style of problem-solving", often relying on aggression (Perry, 2001, p. 11). The impairments in cognition and processing found in traumatized children can also lead to difficulty planning and anticipating events, problems with understanding object constancy, a lack of sustained curiosity, problems understanding personal contribution to what happens (van der Kolk et al., 2003).

Traumatic stress also impacts a child's memory systems. Narrative memory is often lost, meaning children lose the ability to make sense of their experiences (ACF, 2010). Episodic memory is impacted through difficulty with remembering events that happened during the day or week, including who they were with or what they learned, and working memory is damaged as

well, which means children are not able to hold information long enough for it to be deemed valuable by the brain—instead of information being stored, it is simply forgotten, meaning that learning is difficult for traumatized children (ACF, 2010).

      Behavioral regulation. Behavioral control is an area of impairment commonly seen in children who have experienced trauma. A child in a persistent alarm state has an altered sense of time, lack of foresight or ability to think about the future (since the traumatized child is focused on immediate survival), and a primitive survival response in the brain that triggers reflexive, impulsive, and aggressive action against a perceived threat (Perry, 2001). For the traumatized child, immediate reward is most reinforcing, while delayed gratification is impossible; the consequences of behavior are almost inconceivable; and thoughtful reflection on behavior—including violent or aggressive behavior—is impossible (Perry, 2001). Thus, traumatized children often display poor modulation of impulses, self-destructive behavior, aggression toward others, pathological self-soothing behaviors, oppositional behavior or excessive compliance, and difficulty understanding and complying with rules (van der Kolk et al., 2003).

      Children who have experienced abuse or neglect may attempt to process or communicate their traumatic experiences through re-enactment in day-to-day behavior, interactions with others, or through their play (van der Kolk et al., 2003). They may re-enact behavioral aspects of their trauma through aggression, sexualized behaviors, or controlling relationship dynamics, either as automatic behavioral responses to the environment or as attempts to gain control or mastery over their traumatic experiences (van der Kolk et al., 2003). In lieu of adaptive coping strategies, impairments in behavioral self-regulation in traumatized children can also increase the risk for risky sexual behaviors, criminal activity, eating disorders, substance abuse, and suicide (van der Kolk et al., 2003).

Self-concept. When children experience repeated instances of harm and/or rejection, along with the failure to achieve age-appropriate skills that accompanies complex developmental trauma, they are likely to develop an ingrained sense of themselves as "ineffective, helpless, deficient, and unlovable" (van der Kolk et al., 2003, p. 16). Impairments in a traumatized child's sense of self-concept can be exhibited as a lack of continuous, predictable sense of self, a poor sense of separateness from others, disturbances in body image, low self-esteem, and feelings of shame or guilt (van der Kolk et al., 2003). When maltreated children perceive themselves as powerless or incompetent, they are more likely to blame themselves for the trauma and have difficulty reaching out for and accepting support from others (van der Kolk et al., 2007).

Traumatic stress symptoms and related disorders. There are many symptoms of traumatic stress in children, which vary from child to child. When a child utilizes a predominantly hyperarousal response to trauma, they are at risk of developing persisting hyperarousal-related symptoms and disorders such as posttraumatic stress disorder (PTSD), attention-deficit/hyperactivity disorder (ADHD), and conduct disorder (Perry, 2001). Traumatized children are also more likely to develop depression and anxiety (van der Kolk et al, 2007; van der Kolk et al., 2007).

Some traumatized children will experience symptoms severe and persistent enough to meet criteria for posttraumatic stress disorder (PTSD) ("What Is Child Traumatic Stress?", 2003). Children with PTSD will re-experience their trauma through flashbacks, hallucinations, nightmares, recollections, re-enactment or repetitive play (Minnesota Association for Children's Mental Health, 2014). They will also suffer from physical reactions and emotional distress to reminders of the trauma, along with fear and/or avoidance of places, things, or situations that remind them of the traumatic event (MACMH, 2014). Other symptoms associated with PTSD

include inability to recall aspects of the trauma, difficulty concentrating and being easily scared, self-destructive behavior, irritability, impulsiveness, anger or hostility, depression, and or overwhelming sadness or hopelessness (MACMH, 2014).

Urban Areas and Childhood Trauma

Children living in poor, urban areas face many challenges that affect their learning and development. As Santiago, Stump, and Wadsworth (2009) state, "living with persistent poverty damages one's psychological health" (p. 218). Low income and socioeconomic status limit financial resources and opportunities for families, and low-income neighborhoods are rife with poverty, unemployment, and high residential mobility rates, leading to communities that have fewer resources, less cohesiveness, and higher crime rates (Britt, 1994; Brooks-Gunn, Duncan, & Aber, 1997, as cited by Santiago et al., 2009).

Many children in the US grow up in poverty. According to the National Center for Child Poverty, approximately 22% of American children live below the poverty line of $23,624 a year for a family of four—that is about 16 million, or one in five, children (Jiang, Ekono, & Skinner, 2015). There is a growing body of research that indicates that "growing up in low-income, urban environments exposes children to severe and ongoing trauma" (Osofsky & Feinchel, 1993; Reiss & Price, 1996; van der Kolk, Blaustein, & Spinazzola, 2005, as cited by Kiser, 2006, p. 211). Investigations of poor, inner-city, primarily African-American children have found extremely high rates of exposure to trauma—from 70% to 100%— in this population (Dempsey, Overstreet, & Moley, 2000; Reiss & Price, 1996; South & Crowder, 1999, as cited by Kiser, 2006).

Children in low-income, urban neighborhoods are faced with poor daily living conditions, as they often spend time in homes, schools, and neighborhood facilities that are crowded, poorly maintained, improperly heated and cooled, have inadequate plumbing and lighting (Elliott, Elliott, Huizinga, Rankin, Sampson, & Wilson, 1996; Polivka, Lovell, & Smith, 1998, as cited by Kiser, 2006). They are more likely to experience stressors such as family chaos, family conflict, violence, incarceration or death of a family member, and maltreatment and/or neglect than children in affluent communities (Kiser, 2006).

Impact of Childhood Trauma in Schools

Childhood trauma can have profound and pervasive effects on a child's functioning. It can impact their ability to cope with stress, manage emotions, interact with others, learn, and process information. This can lead to especially significant challenges in the school settings. Understanding the trauma response and the ways in which childhood trauma affects students is important for understanding and responding to students who have experienced trauma. Traumatized children often exhibit behavioral problems, learning challenges, and difficulty interacting with teachers and peers.

The traumatized student's behavior in the classroom. The behavior problems of traumatized children can be understood as once-helpful adaptations to a dangerous environment, that, when used in a safe environment, are now maladaptive (Perry, 2001). Childhood trauma in students often "masks itself in classroom behaviors that can easily be interpreted erroneously" (Sitler, 2009, p. 120). That is, traumatized children may be identified as misbehaving, disobedient, defiant, or oppositional if the source of their behaviors is not understood to be the result of traumatic experiences. Traumatized students are often in a state of hyperarousal and will display unpredictable and/or impulsive behavior, aggression toward others, and over- or

under-responding to sensory stimuli such as loud noises, bells, sirens, doors slamming, lighting, physical contact, or sudden movements) physical contact, or sudden movements (Perry, 2001; "Trauma Toolkit For Educators", 2008**).** They may have intense reactions to reminders of their traumatic event or perceived threats, such as becoming defensive when they feel others are violating their personal space, "blowing up" when corrected or told what to do by an authority figure, fighting or becoming aggressive when criticized or teased by others, or resisting transition and/or change ("Trauma Toolkit For Educators", 2008, p. 4).

On the other hand, children who have experienced trauma may not act out in the classroom. Children who have responded to chronic abuse or neglect with a primarily dissociative response may appear quiet, withdrawn, or emotionally numb (Perry, 2001; "Trauma Toolkit For Educators", 2008). This is more often the response of females, while hyperarousal and disruptive behaviors are more often the response of males (Perry, 2001). Children who have experienced trauma but do not have behavioral problems in the classroom often "fly beneath the radar" and may not get the help they need, but they may have symptoms of avoidance or depression that are just as serious as the symptoms of the acting-out student ("Trauma Toolkit For Educators", 2008, p. 11).

In the Developmental Repair treatment model for working with children who have experienced complex trauma and who present with aggressive and disruptive symptoms, Anne Gearity (2009) describes some behavioral characteristics of traumatized children. Traumatized children can have confusing interactions with adults and peers that interfere with functional classroom behavior--- they may expect adults to be harsh or unavailable and may provoke the reactions they expect from adults, or they may assume that their needs will be ignored so they rarely seek or accept help from adults (Gearity, 2009). With children who have experienced

complex trauma, requests that ask for compliance, which are often made in the classroom setting, often turn into power struggles (Gearity, 2009). Traumatized children are constantly on alert, perceiving danger much of the time; they may react with anger and aggression when they feel sad, surprised, or disappointed, and can react to others' emotions with aggressive behaviors that can quickly become out of control (Gearity, 2009). The pervasive behavioral effects of children who have experienced trauma can greatly impact their behavior in the classroom, which affects their ability to socialize and learn at school.

The traumatized student's learning in the classroom. As described earlier, the traumatized child is stuck in a persistent state of physiological arousal, which, according to Perry (2001), explains why a traumatized child can sit in a classroom but not learn. The ability to process and store new information, and therefore learn successfully in a classroom, requires the brain to be in a state of calm that a traumatized child with a constantly-activated fear arousal response does not often reach (Perry, 2001). The traumatized child's brain is primarily controlled by sub-cortical and limbic brain systems that respond to danger and fear, rather than the higher cortical regions necessary for focus, verbal processing, and information storage; a traumatized child quite literally has "different parts of the brain 'controlling' his functioning than a child that is calm" (Perry, 2001, p. 11).

Traumatic stress, as noted earlier, also interferes with memory systems—narrative memory, episodic memory, and working memory are all impaired (ACF, 2010). Without adequately functioning memory storage and recall, new information is difficult to consolidate and learn (ACF, 2010). Anne Gearity (2009) notes that traumatized children show low frustration tolerance, which also makes new learning difficult. They can have difficulty

remembering the past, and cannot think about or explain their own experiences, and have poor language and problem-solving skills, which impacts their ability to learn (Gearity, 2009).

Because of these differences in the brain of a child who has experienced trauma, two students in a classroom can have the same IQ and be presented with the same information from the teacher, but if one child has been traumatized and one has not, the child that has not been traumatized "can focus on the words of the teacher, and using the neocortex, engage in abstract cognition", while the traumatized child will be "focused on non-verbal information—the teacher's facial expressions, hand gestures" and will seem distracted and inattentive (Perry, 2001, p. 10). Teachers often observe maltreated or traumatized students as "bright but can't learn easily", and they are often labeled as learning disabled (Perry, 2001, p. 11). The impact of trauma on school performance is seen in lower GPA, higher rates of school absences, increased drop-out rates, more suspensions and expulsions, and decreased reading ability among children who have experienced trauma ("Trauma Toolkit For Educators", 2008).

Teacher stress in urban environments. Teaching is, in itself, a challenging and demanding profession, and even more so within urban settings. Urban schools are often underfunded, understaffed, and under-resourced, and this places increased demands and stress on teachers. The students in urban schools are more likely to come from chaotic homes and live in poverty, which leads to increased challenging behaviors and demands in the classroom. Many urban schools are located in neighborhoods with high poverty and crime rates (Horvath, Johnson-Reid, Van Dorn, Wei, & Williams, 2007). As noted above, urban students are more likely to be exposed to violence, abuse, neglect, or other traumatic experiences, and students with trauma exposure are more likely to exhibit behavior problems.

A study by Lambert, McCarthy, O'Donnell, and Melendres (2009) surveyed 451 teachers from urban elementary schools in a southeastern US region to explore the relationship between elementary teachers' experience, stress, and coping resources and their burnout symptoms. They found that individual teachers' perceptions of the balance of available resources and their work demands, rather than differences in their school environments, was most predictive of burnout (Lambert et al., 2009). Teachers who reported emotional exhaustion also reported higher perceived demands and greater imbalance of demands and classroom resources, and teachers were more likely to experience burnout the longer they worked at a school (Lambert et al., 2009). These findings point to the importance of understanding how the demands of teaching in urban environments can impact teacher stress and effectiveness.

Children living in poor, urban areas are at risk for exposure to a variety of traumatic stressors, and, as previously described, children who have experienced trauma exhibit a variety of challenging behaviors in the classroom. The "problem" behaviors that traumatized children often demonstrate can present unique and stressful challenges for teachers, especially if they are not equipped to deal with challenging behaviors or to understand the reasons behind them. A study by Henricsson and Rydell (2004) of elementary teacher-child relations found that, compared to students without problematic behaviors, students with externalizing problem behaviors (aggressive or disruptive behaviors) participated in conflicted and angry interactions with teachers more often, had more negative teacher relations according to both teacher- and self-reports, and had less positive self-perceptions, while students with internalizing problem behaviors (withdrawal, uncertainty, etc) had higher levels of conflict and more dependent teacher relations.

As cited by Lambert et al. (2009), a study by Kusherman, Lambert, McCarthy, & O'Donnell (2006) and Lambert, McCarthy, O'Donnell, and Melendres (2007) found that teachers' perceptions of stress are related to higher numbers of challenging students. A majority of 70 teachers surveyed in a study by David Westling (2010) viewed challenging behaviors as having an adverse effect on them and their students. Most of the teachers in this study also felt that challenging behaviors were learned and could be improved, but felt that they were not adequately prepared in their professional training to deal with challenging behaviors (Westling, 2010).

Teacher response to trauma. When students have experienced trauma, teachers may have a difficult time understanding how to best help and support them in the classroom. A study by Alisic, Bus, Dulack, Pennings, and Splinter (2012) of 765 teachers in the Netherlands found that more than half of the teachers surveyed found it difficult to not get too emotionally involved when working with traumatized children, to find the line between their role as teacher and the role of mental health providers, to know when children need mental health care from a professional, to know the best ways to support children after trauma, and to know where they could find information about traumatic stress. Alisic et al. (2012) found that, out of the 765 teachers surveyed, 63% did not feel they knew well how to determine when traumatized students needed mental health care, only nine percent had had any formal training on trauma, and half of the teachers expressed difficulty with managing their emotional involvement when working with traumatized students.

Teacher response to challenging behaviors. Difficult or disruptive student behaviors, including those that can result from exposure to traumatic experiences in childhood, can greatly impact a classroom environment and pose a challenge for teachers. A majority of the teachers

surveyed by Westling (2010) agreed or strongly agreed that challenging behavior takes up a

significant amount of their time, increases their stress levels, reduces learning for the student

with challenging behaviors as well as the other students in the class, and that challenging

behavior makes them less effective as teachers. A notable 44% of general education teachers

agreed that challenging behaviors makes them think about quitting their jobs (Westling, 2010).

Since childhood trauma can lead to a host of challenging behaviors, it is important that teachers

who work in areas where there are high rates of poverty and trauma have the support and

resources they need to respond effectively to challenging behaviors.

Trauma-Informed Schools

In response to the growing body of evidence that trauma is widespread, and trauma can

affect every aspect of a person's life, and that people can often heal from trauma with the right

supports, the idea of "trauma-informed" care has become increasingly well-known as a way to

meet the needs of traumatized individuals (Fallot & Harris, 2001, p. 2). Trauma-informed care

refers to services that incorporate an "understanding of the prevalence and impact of trauma and

the complex paths to healing and recovery", and are "designed specifically to avoid re-

traumatizing those who come seeking assistance as well as staff working in service settings"

(Fallot & Harris, 2001, p. 2).

In the context of schools, the idea of trauma-informed care is especially important, since

most children, including those who have experienced trauma, will spend a large part of their days

in a classroom. As Cole, Eisner, Gregory, and Ristuccia (2013) described in the Trauma and

Learning Policy Initiative publication "Helping Traumatized Children Learn: Creating and

Advocating for Trauma-Sensitive Schools", "a trauma-sensitive school is one in which all

students feel safe, welcomed, and supported and where addressing trauma's impact on learning

on a school-wide basis is at the center of its educational mission" (p. 11). Barbara Oehlberg

(2008, p. 3), a child trauma researcher and consultant, named many benefits of trauma-informed

schools:

- Improved academic achievement and test scores

- Improved school climate

- Improved teacher sense of satisfaction and safety in being a teacher

- Improved retention of new teachers

- Reduction in student behavioral outbursts and office referrals

- Reduction in stress for staff and students

- Reduction in absences, detentions, and suspensions

- Reduction in student bullying and harassment

- Reduction in the need for special education services/classes

- Reduction in drop-outs

Trauma-informed schools, also referred to as trauma-sensitive schools, are designed in

function and policy to support the individual needs of students and account for the challenges

that students who have experienced trauma face in the classroom. While trauma-informed

practices certainly benefit children who have experienced trauma, they are undoubtedly

beneficial for all students.

Characteristics of trauma-informed schools. Cole et al. (2013) describe the key attributes

of a trauma-sensitive school. In a trauma-sensitive school, leadership and staff share an

understanding of the impacts of trauma on learning and the need for a school-wide approach

(Cole et al., 2013). Incorporating counselors, school psychologists, and mental health specialists

in the school setting to assess students' needs and help develop interventions, along with forming

partnerships with trauma-specific mental health providers in the community, is also an important

part of trauma-informed care in schools (Oehlberg, 2008). The trauma-sensitive school supports

all students to feel safe, physically, social, emotionally, and academically, and addresses

students' needs in holistic ways by taking into account students' relationships, self-regulation,

academic competence, and physical and emotional well-being (Cole et al., 2013). Trauma-

sensitive schools explicitly connect students to the school community and provide multiple

opportunities to practice newly developing skills (Cole et al., 2013). In a trauma-sensitive school,

teamwork is vital, and staff share responsibility for all students (Cole et al., 2013). Finally,

leadership and staff in a trauma-sensitive school anticipate and adapt to the ever-changing needs

of its students (Cole et al., 2013).

In her book *Trauma-Sensitive Schools: Learning Communities Transforming Children's Lives, K-5*, Susan Craig (2016) describes several important aspects of trauma-sensitive schools.

First and foremost, children need to feel safe at school. A safe learning environment is crucial for

a trauma-sensitive environment. In addition to ensuring a physically safe and comfortable

building, schools can create a sense of safety within classrooms by following predictable

classroom routines, using calendars, charts, and visual timers, and providing adequate warning

for transitions so children know what to expect from their environment (Craig, 2016).

Utilizing supportive instructional techniques that promote student success is also

important in trauma-sensitive schools. Scaffolding instruction that gradually adds to and builds

upon a student's existing skills to learn new material is helpful for children with trauma histories

because it reduces the amount of working memory needed to manage low-level skills and

increases a student's capacity to develop higher-level executive functioning skills (Craig, 2016).

Ensuring that material is presented to students in a variety of modalities is another helpful

trauma-sensitive approach that allows students to choose the modality that is best for them and

gives them control over their learning environment (Craig, 2016). Encouraging autonomy and

providing opportunities for choice-making in the classroom empowers students and provides a

sense of control that is often lacking in other parts of their lives (Craig, 2016).

Craig (2016) notes that teachers are in a unique position to help shape and change

traumatized children's perspective on the world and views of themselves as learners and

achievers. Positive feedback, encouragement, and praise is important for all children, and

especially for traumatized children, it instills confidence, optimism, and hope that is lacking from

their internal view of the world (Craig, 2016). As Craig (2016) states, specific praise from

teachers and staff about students' effort and hard work builds their awareness of their capacity

for persistence and self-control.

Tiered support system. Craig (2016) describes a three-tiered system of support for

trauma-sensitive schools. Tier One-level supports, which reflect educational best practices, are

universal across the school and are supports built in for all students in a school (Craig, 2016).

Tier One includes practices such as customizing instruction for a child's readiness level, school-

wide behavioral support systems, and utilizing language and instructional pacing that is

developmentally appropriate (Craig, 2016). According to Craig (2016), these interventions at

Tier One will be enough for 85% of students in a school; the other 15% may need more

specialized or intense interventions at a higher level. For these students, Tier Two supports refer

to skill-based interventions that can be provided in small groups within the classroom by the

teacher or an educational specialist, which may include stress management or social skills

interventions (Craig, 2016). Tier Three is the most specialized and intense level of support---

individual interventions that occur daily for a short period of time, often for students who are

coping with a crisis and have a have level of need, such as those who experience the death of a loved one or placement in foster care (Craig, 2016).

Understanding the effects of childhood trauma and the ways in which teachers in urban schools understand and respond to the many emotional and behavioral impacts of trauma is important to creating school environments that support children exposed to trauma to allow them to learn and succeed in life. The research question for this study is twofold: How do urban elementary school teachers understand and respond to the impact of childhood trauma and the behavioral concerns associated with it? How do urban elementary school teachers perceive their role and effectiveness in working with traumatized students?

Conceptual Framework

This study uses Trauma-Informed Care as the conceptual framework and lens through which childhood trauma and its impacts in urban schools are viewed. Trauma-informed care refers to a service model that utilizes knowledge and understanding of trauma and its impacts to provide services and design supportive environments that avoid re—traumatization and promote healing and recovery for people who have experienced trauma (Fallot & Harris, 2001). In the context of schools, trauma-informed or trauma-sensitive schools use knowledge about trauma to design school and classroom environments that provide a sense of safety, predictability, support, and success for all students, and especially those who experience traumatic events or life circumstances.

Trauma-informed care in schools includes teacher training about childhood trauma, positive school-wide behavior response systems, teaching methods and modalities that promote success in learning, and safe and supportive classrooms. Given the prevalence of childhood

trauma in poor urban environments, it is especially important that urban schools create trauma-informed environments and that urban teachers have the training and support they need to help their students succeed and to cope with the challenges of working with students who have experienced childhood trauma.

Methods

Research Design

This quantitative research study used a cross-sectional survey consisting of 71 items to collect data from urban elementary teachers about their beliefs about challenging behaviors and working with children who have experienced trauma. The survey items consisted of various five-point rating scale items and multiple choice questions and was modeled after two different surveys found in the research (Alisic et al., 2012 and Westling, 2010). Descriptive and inferential statistics were used to analyze the data collected and answer the research questions.

Sample

The research survey was offered to teachers in local urban elementary schools. Survey participants were recruited via email using email addresses obtained from public school websites. See Appendix A to view the script used in recruitment emails. A total of 75 survey responses were gathered; however, seven survey respondents did not answer any items. After accounting for these blank survey responses, a total of 68 participants took the survey. Of these 68 respondents, 59 completed the survey in its entirety, while nine respondents answered some but not all of the items on the survey. The nine respondents who partially completed the survey were not excluded from analysis.

Protection of Human Subjects

This research project was submitted to the University of St Thomas' Institutional Review Board (IRB) in order to ensure the protection of the human subjects and the ethical collection of data. The University of St Thomas IRB approved this research project. Human subjects in this research study were protected through confidentiality and informed consent. See Appendix B to view the complete informed consent page. Information for coping with any potential secondary trauma was provided at the end of the survey via information and links to online resources. See Appendix C to view post-survey secondary trauma and self-care resources.

Recruitment process. Participants were recruited via email, through the use of publicly available email addresses on school websites. The researcher contacted teachers at local public elementary schools via email to explain the purpose of the study and provided a link to complete the survey online.

Confidentiality. Survey data was collected through Qualtrics, an online survey system, and was kept completely confidential. No identifying information was gathered from participants as part of the survey, and the researcher had no knowledge of participants' identities. Data was stored in a password-protected hard-drive.

A chance to enter a drawing for a $25 e-gift card to Amazon was offered as an incentive for participation in the study. Email addresses were collected on Qualtrics separately from survey answers and were not linked to participants' answers on any survey items. After completing the survey, participants were prompted continue to a separate screen to enter their email address if they wished to be entered in the drawing. After data collection was completed, one participant was chosen randomly as the winner of the drawing. This participant was contacted individually

via the email address they provided and was sent the link to their e-gift card, but otherwise, there was no additional contact or follow-up with participants of this study.

Informed consent. Participants in this study were informed that taking the survey was completely voluntary, that they were able to decline or opt out at any time, and that they did not have to answer any question they did not want to. Informed consent was obtained by an informed consent page on Qualtrics that participants were required to read and acknowledge before proceeding to the survey questions. The informed consent page was the first screen of the online survey, and included information about the purpose of the study, the voluntary and confidential nature of the study, the possible risks and benefits associated with the study, information about the prize drawing, and contact information for the researcher. Before continuing to the survey, respondents were required to indicate consent by checking three separate boxes stating that they had read and agreed to the consent information, were at least 18 years of age, and consented to participate in the study.

Data Collection Instrument and Process

Data was collected through an online survey program, Qualtrics. Qualtrics is a web-based survey software available for use by the University of St Thomas School of Social work faculty, staff, and students. Urban elementary teachers were contacted via email and provided with a link to complete a survey online through Qualtrics. If teachers decided to participate in the study, they were able to follow the link provided and were directed to the Qualtrics informed consent page and survey.

Survey. The 71-item survey used in this research study was developed by the researcher and drew from two surveys discovered in the literature, one about challenging student behaviors

(Westling, 2010) and another about teacher perceptions about handling childhood trauma in the classroom (Alisic et al., 2012). The survey created for this research study consisted of three main sections: a challenging behaviors section, a childhood trauma section, and a demographic section. See Appendix D to view the complete survey.

Challenging behaviors section. The Challenging Behaviors section consisted of 44 items related to challenging student behaviors, teacher perceptions of attributions of challenging behaviors, and different interventions for challenging behaviors. Challenging behaviors were defined and described in the survey as follows:

Defiance and noncompliance: A student refuses to follow directions or comply with adult instructions (e.g. not participating in required activities, challenging authority, purposely ignoring rules, etc).

Destruction: A student damages significant property (e.g. intentionally breaking items, tearing up books or other materials, destroying classroom equipment, etc).

Disruption: A student interferes with the normal flow of activities (e.g. interrupting instruction, interfering with group activities, etc).

Illegal behavior: A student engages in acts that violate public laws (e.g. theft, vandalism, technology abuse, substance abuse, carrying weapons, etc).

Physical aggression: A student physically attacking another person (e.g. hitting, kicking, fighting, etc, either teachers/staff or peers).

Verbal aggression: A student verbally attacking another person (e.g. taunting, challenging, name-calling, swearing, threatening, etc, either teachers/staff or peers).

Self-injury: A student causing physical damage to oneself (e.g. self-hitting, self-biting, etc).

Social withdrawal: A student demonstrates reluctance to participate in normal activities, tending to retreat and avoid interpersonal contacts (e.g. isolation, refusing to participate in classroom or recreational activities, failure to engage or interact with peers, etc).

Socially inappropriate behavior: A student engages in unacceptable behavior (making inappropriate sounds, talking too loudly, talking about inappropriate subjects, making offensive gestures, etc).

Stereotypy/repetitive behaviors: A student engages in repetitive acts (hand flapping, spinning, twirling, etc).

Participants were asked to report how often they see these challenging behaviors on a five-point scale (1=never; 5=very often (once a day or more). Other items asked participants to report on a five-point scale (1= strongly disagree to 5= strongly agree) whether they thought challenging behaviors could be attributed to various factors, including personality, disability, home/community influences, and trauma, abuse, and neglect. The final part of the Challenging Behaviors section listed different interventions/responses to challenging behaviors, such as observing the student, sending the student out of class, verbal reprimands, social and tangible reinforcement, taking away privileges, changing curriculum or interactions, identifying triggers, and others, and asked participants to report how often they used the responses (Not At All, Occasionally, or Frequently). The Challenging Behaviors section can be viewed its entirety in the survey in Appendix D.

Childhood trauma section. The Childhood Trauma section consisted of two vignettes of hypothetical students exhibiting behaviors associated with trauma, and items related to teacher difficulty in managing and responding to these behaviors. One vignette described a student with externalizing behaviors associated with a traumatic response (verbal and physical aggression, destruction, disruptive behaviors, etc), and the other described a student with internalizing behaviors associated with a traumatic response (withdrawal, isolation, refusal to participate, etc). Gender was purposely excluded from both vignettes in order to minimize bias in participant responses, and the students were only referred to as "J" and "L". In addition, the term "trauma" was not directly named in the vignettes or related survey items, but traumatic symptoms were instead described behaviorally in order to minimize bias in participant responses. Items in this section included questions about difficulty in responding to J and L, balancing the needs of J and L with the needs of their class, knowing when J and L needed additional help/services, and teachers' perceptions of their effectiveness and importance with students like J and L. The Childhood Trauma section can be viewed its entirety in the survey in Appendix D.

Demographic section. The Demographic section of the survey consisted of 14 items. The purpose of the Demographic section was to gather necessary demographic information for understanding the survey population and comparing groups in relation to responses about challenging behaviors and childhood trauma. Demographic items included gender, age, highest degree held, length of time teaching, and information about previous training and education related to trauma. The Demographic section can be viewed its entirety in the survey in Appendix D.

Data Analysis

Data was analyzed through use of Statistical Package for Social Sciences (SPSS), a statistical analysis program available through the University of St. Thomas. Descriptive and inferential statistics were used to analyze the data. To address the research questions and analyze the data, several scales were developed by the researcher by combining items into groups. The scales created for data analysis are described below. The coefficient alpha was calculated for each scale to determine the level of reliability of the scales.

Trauma/behavior knowledge scale. The Trauma/Behavior Knowledge scale consisted of seven items related to knowledge and training about trauma and challenging behaviors. The items in the Trauma/Behavior Knowledge scales were operationalized as follows: "I received adequate preparation through my schooling to deal with most challenging behavior"; "I receive adequate ongoing in-service preparation to deal with most challenging behavior"; "Have you received any trauma-specific training in the last 3 years?"; "How much information about childhood trauma did your professional teaching program provide?"; "How much training or information does your school or district provide teachers and staff about childhood trauma?"; "Is your school 'trauma-informed' or working on becoming 'trauma-informed'?"; and "Rate your level of knowledge about the effects of trauma on the brain and learning". The coefficient alpha for the Trauma/Behavior Knowledge scale was $\alpha = .673$, which is slightly less than the .70 threshold considered acceptable for applied research. This means that 67.5% of score variance is due to true score variance for this scale.

Trauma difficulty scale. The Trauma Difficulty scale consisted of nine items related to difficulty in managing aspects of the student vignettes. The items in the Trauma Difficulty scale were preceded by the prompt "With children like J. and L. how difficult is it for you to:" and

were operationalized as follows: "Balance attending to the child and looking after the rest of the class?"; "Balance attending to the child and avoiding to put him/her in a special position?"; "Balance attending to the child and making the situation too heavy?"; "Avoid taking the problems home?"; "Decide where my task ends and the task of a social worker or psychologist begins?"; "Know what is best to do to support them?"; "Know when they need mental health care to recover?"; "Know what to discuss about the challenges with the children themselves and with the class?"; and "Know where to get answers to your own/parents'/children's questions?" The coefficient alpha for the Trauma Difficulty scale was α = .854, which is an acceptable coefficient alpha as it is above the .70 threshold considered acceptable for applied research. This means that 85.4% of score variance is due to true score variance for this scale.

Teacher confidence scale. The Teacher Confidence scale consisted of six items related to respondents' level of confidence in their ability and role in working with challenging behaviors and childhood trauma. These items were operationalized as follows: "I have sufficient knowledge and skills to deal with most challenging behavior"; "I have increased my ability to deal with most challenging behavior since I started teaching"; "I feel that I am an effective teacher to students like J. and L."; "I play an important role in the lives of students like J. and L."; "How confident do you feel working with students who have experienced trauma, abuse, or neglect?"; and "How important do you perceive your role in working with students who have experienced trauma, abuse, or neglect?" The coefficient alpha for the Teacher Confidence scale was α = .679, which is slightly less than the .70 threshold considered acceptable for applied research. This means that 67.9% of score variance is due to true score variance for this scale.

Teacher stress scale. The Teacher Stress scale consisted of six items related to respondents' level of confidence in their ability and role in working with challenging behaviors

and childhood trauma. These items were operationalized as follows: "Challenging behavior takes up a significant amount of time"; "Challenging behavior increases my level of stress"; "Challenging behavior interferes with my ability to be an effective teacher"; "Challenging behavior makes me think about quitting or question whether teaching is the right career for me"; "[With children like J. and L. how difficult is it for you to] Balance attending to the child and looking after the rest of the class?"; and "[With children like J. and L. how difficult is it for you to] Avoid taking the problems home?" The coefficient alpha for the Teacher Stress scale was $\alpha = .678$, which is slightly less than the .70 threshold considered acceptable for applied research. This means that 67.8% of score variance is due to true score variance for this scale.

Punitive response scale. The Punitive Response scale consisted of four items from the behavioral responses/interventions that are considered punitive in nature. These items were preceded by the prompt "Please indicate how often you utilize the following strategies to deal with challenging behaviors:" and were operationalized as follows: "Use time-out"; "Send students to office or behavior staff"; "Take away desired privileges or activities"; and "Verbally reprimand students". The coefficient alpha for the Punitive Response scale was $\alpha = .766$, which is an acceptable coefficient alpha as it is above the .70 threshold considered acceptable for applied research. This means that 76.6% of score variance is due to true score variance for this scale.

Supportive response scale. The Supportive Response scale consisted of ten items from the behavioral responses/interventions that are considered supportive in nature. These items were preceded by the prompt "Please indicate how often you utilize the following strategies to deal with challenging behaviors:" and were operationalized as follows: "Directly observe student and take notes"; "Interview others to determine causes of behavior"; Identify triggers of behaviors";

"Determine function to teach acceptable behavior"; Use social reinforcement (smiles, praise, or other positive reactions) for positive behavior"; "Use tangible reinforcement (treats, prizes, or other physical rewards) for positive behavior"; "Change my interactions with students"; "Change classroom arrangements or conditions"; "Change curriculum or teaching approach"; and "Use a formal behavior intervention plan". The coefficient alpha for the Supportive Response scale was $\alpha = .746$, which is an acceptable coefficient alpha as it is above the .70 threshold considered acceptable for applied research. This means that 74.6% of score variance is due to true score variance for this scale.

Environmental attributions scale. The Environmental Attributions scale consisted of three items related to attributions for challenging behaviors that are environmental in nature rather than individual. These items were operationalized as follows: "Many challenging behaviors are attributable to trauma, abuse, or neglect"; "Many challenging behaviors originate in the home or community"; and "Many challenging behaviors are learned". The coefficient alpha for the Environmental Attributions scale was $\alpha = .671$, which is slightly less than the .70 threshold considered acceptable for applied research. This means that 67.1% of score variance is due to true score variance for this scale.

Results

The purpose of this research project was to explore how urban elementary teachers understand and respond to challenging behaviors associated with childhood trauma, how they perceive their role and effectiveness in working with students who exhibit the symptoms of childhood trauma, how childhood trauma and challenging behaviors impact urban elementary school teachers' experiences as teachers, and how urban elementary teachers' personal knowledge and experience with childhood trauma impacts their ability to effectively work with

students who have experienced trauma. More specifically, the research questions for this study were: How do urban elementary teachers understand and respond to the effects of childhood trauma and the challenging behaviors associated with it? How do urban elementary teachers perceive their role and effectiveness in working with children who have experienced trauma?

Participant Demographics

The participants in this study were 68 urban elementary teachers from a Midwestern US urban area. The participants were overwhelmingly female: 95% of participants (61) identified as female, and 5% (3) identified as male (four participants did not report gender). The age distribution of participants in this study was varied, with 45% of participants reporting an age under 40 old and 55% reporting an age over 40 years old. Sixteen participants (25%) reported being age 30 or under; thirteen participants (20%) were between 31 and 40 years old; fifteen participants (24%) were between 41 and 50 years old; ten participants (16%) were between 51 and 55 years old, and nine participants (14%) were over 55 years old (five participants did not report age). Most participants (45; 70%) reported a master's degree as the highest degree they held, while the rest reported a bachelor's degree (15; 23%) or "other" (4; 6%) as their highest degree held (four participants did not report degree).

The majority of participants (75%, or 48 respondents) were general education teachers. Fourteen participants (22%) were special education teachers, and two (3%) described themselves as "other" (four participants did not report what type of teacher they were). When asked how long they have been teaching, 18 participants (28%) reported teaching for one to five years; twelve participants (19%) for six to ten years; nine participants (14%) for 11 to 15 years; seven participants (11%) for 12 to 20 years; eight participants (13%) for 21 to 25 years; and 10 participants (16%) for more than 25 years (four participants did not report length of time

teaching). An overwhelming majority of participants (89%; 57 respondents) reported that between 76% and 100% of the students at their school qualified for free or reduced lunch, an indication of high rates of poverty at many participants' schools. Five percent of participants (3) reported that 26% to 50% of the students at their school qualified for free or reduced lunch, and another five percent (3) reported that 51% to 75% qualified. One participant (2%) answered "not sure", and four participants did not report percentage of students receiving free or reduced lunch at their school.

Descriptive Statistics

Challenging behaviors. Respondents in the survey indicated observing a wide range of challenging behaviors in their classrooms. The most frequently reported challenging behaviors reported by participants were disruption (66% encountered on a daily basis), defiance/noncompliance (56% daily), socially unacceptable behavior (49% daily), and verbal aggression (46% daily). The least frequently reported challenging behaviors were illegal behavior (1% encountered on a daily basis) and self-injury (3% daily). Figure 1 (below) depicts the means for challenging behaviors reported by respondents.
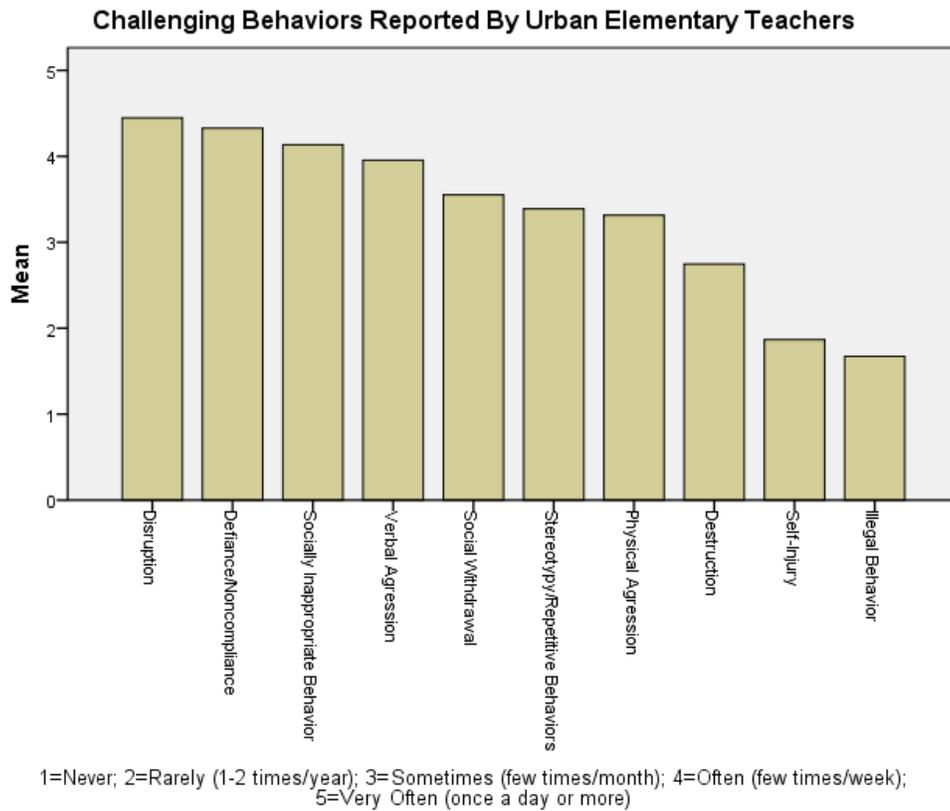
Figure 1. Challenging behaviors reported by urban elementary teachers.

Challenging behavior attributes and impacts. Ninety-six percent of participants (64) responded that they agreed or strongly agreed that many challenging behaviors can be attributed to trauma, abuse, or neglect. Seventy percent of participants (46) agreed or strongly agreed that many challenging behaviors can be attributed to a physical/medical reason, while 69% percent of participants (45) agreed or strongly agreed that many challenging behaviors can be attributed to disability, 33% (22) agreed or strongly agreed that many challenging behaviors can be attributed to personality. Eighty-eight percent of participants (59) agreed or strongly agreed that many challenging behaviors are learned, 87% percent of participants (58) agreed or strongly agreed

that many challenging behaviors originate in the home or community, and almost all participants (99%) agreed or strongly agreed that challenging behaviors can be improved.

Overall, respondents reported that challenging behaviors have a significant impact on their experience as teachers. All respondents (66) reported that they agreed or strongly agreed with the statement "Challenging behavior takes up a significant amount of time", while 94% (62) agreed or strongly agreed that challenging behavior increases their stress level. A majority of participants (83%; 55) agreed or strongly agreed that challenging behaviors interfere with their ability to be effective as a teacher. Forty-six percent of participants (30) agreed or strongly agreed that challenging behavior causes them to think about quitting or question whether teaching is the right career for them. All participants (66) agreed or strongly agreed that challenging behaviors reduce the learning of the student with challenging behaviors, and 97% of participants (64) agreed or strongly agreed that challenging behaviors reduce the learning of other students.

Responses to student vignettes. In response to items about the student vignettes, respondents reported that was most difficult to balance attending to the child and looking after the rest of the class (55% or 35 responded very difficult or extremely difficult); decide where their task as teacher ends and the task of a social worker or psychologist begins (50% or 31 responded very difficult or extremely difficult); and avoid taking the problems home (48% or 30 responded very difficult or extremely difficult). Ninety percent of participants (56) agreed or strongly agreed that they teach many students who behave in ways similar to those described in the vignettes. When asked to report which student would be more challenging to work with, 40% (25) reported that they would be equally challenging, while 33% (21) reported that "J", the child with externalized challenging behaviors, would be most difficult, and 19% (12) reported that

"L", the child with internalized challenging behaviors, would be most difficult. A majority of

participants (76%; 60) agreed or strongly agreed that they play an important role in the lives of

children similar to those described in the vignettes, and 75% (48) agreed or strongly agreed that

they are effective teachers to children similar to those described.

Childhood trauma role and response. Most participants (93%; 59) reported that they

perceive their role in working with students who have experienced trauma as very important.

Ninety-five percent of participants (60) responded "yes" when asked if they respond in different

or special ways to a student's challenging behaviors when they are aware that the student has

experienced trauma, abuse, or neglect. When asked how confident they feel working with

students who have experienced trauma, abuse, or neglect, 67% of participants (42) responded

"somewhat confident", 24% (15) responded very confident, and 10% (6) responded "not

confident at all".

Childhood trauma training. When asked to reflect on how much training or information

they had received about childhood trauma, 48% of participants (31) reported that that had not

received any information about childhood trauma in their professional teaching program. Thirty-

eight percent of participants (24) reported that they had received a little information about

childhood trauma from their professional program, 13% (8) reported that they had received some

information, and 1 participant (2%) reported they had received a lot of information. When asked

how much training or information about childhood trauma was provided to teachers and staff by

the school or district they were employed by, 11% (7) reported no training or information, 46%

(29) reported a little, 37% (23) reported some, and 6% (4) reported a lot. Forty-four percent of

participants (28) reported that their school was trauma-informed or working toward becoming

trauma-informed, while 19% (12) reported their school was not trauma-informed, and 38% (24)

were not sure. When asked to rate their level of knowledge about the effects of trauma on the

brain and learning, 31% (20) rated their level of knowledge as "a little", 42% (27) reported "a

fair amount", and 27% (17) reported "a great deal".

Inferential Statistics

        Correlation between trauma/behavior knowledge and trauma difficulty. The

researcher examined the relationship between participants' level of trauma knowledge

(Trauma/Behavior Knowledge Scale) and perceived difficulty in working with students

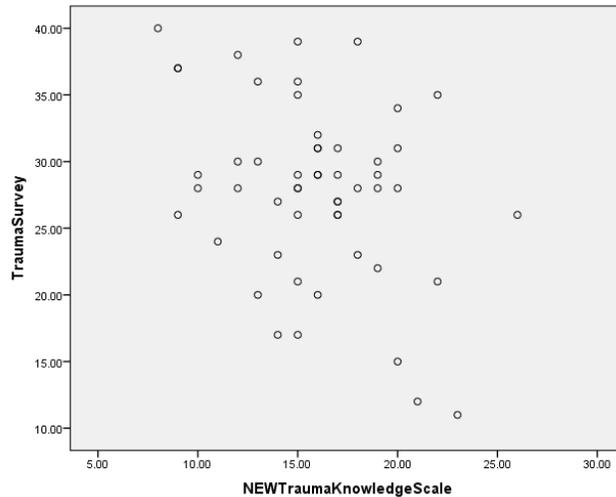exhibiting challenging behaviors associated with trauma (Trauma Difficulty Scale).

Table 1. *Correlation Between Trauma/Behavior Knowledge and Trauma Difficulty*

		Trauma Knowledge Scale	Trauma Difficulty
Trauma Knowledge Scale	Pearson Correlation	1	-.344[*]
	Sig. (2-tailed)		.012
	N	62	53
Trauma Difficulty	Pearson Correlation	-.344[*]	1
	Sig. (2-tailed)	.012	
	N	53	54

*. Correlation is significant at the 0.05 level (2-tailed).

Table 1 shows the inferential statistics of the relationship between the two variables,

Trauma/Behavior Knowledge and Trauma Difficulty. The calculated correlation (r=-.344, *p* <

.05) indicates a weak to moderate negative relationship between these variables. The p-value

(.012) is < .05, indicating a statistically significant relationship between trauma knowledge and

perceived difficulty with trauma behaviors. The negative r-value indicates that participants'

scores on the Trauma/Behavior Knowledge Scale and the Trauma Difficulty Scale are inversely

related. Therefore, as participants' level of trauma and challenging behavior knowledge

increases, their perceived level of difficulty in working with students exhibiting challenging

behaviors associated with trauma decreases. The scatterplot in Figure 2 depicts these results.

Figure 2. Relationship between trauma/behavior knowledge and trauma difficulty.

Correlation between teacher confidence and trauma difficulty. The researcher

examined the relationship between participants' level of confidence in working with trauma and

challenging behaviors (Teacher Confidence Scale) and perceived difficulty in working with

students exhibiting challenging behaviors associated with trauma (Trauma Difficulty Scale).

Table 2 shows the inferential statistics of the relationship between the two variables, Teacher

Confidence and Trauma Difficulty.

Table 2. *Correlation Between Teacher Confidence and Trauma Difficulty*

		Confidence Scale	Trauma Difficulty
Confidence Scale	Pearson Correlation	1	-.297*
	Sig. (2-tailed)		.036
	N	58	50
Trauma Difficulty	Pearson Correlation	-.297*	1
	Sig. (2-tailed)	.036	
	N	50	54

*. Correlation is significant at the 0.05 level (2-tailed).

The calculated correlation (r=-.297, $p < .05$) indicates a weak negative relationship between these variables. The p-value (.036) is $< .05$, indicating a statistically significant relationship between level of confidence and perceived difficulty with trauma behaviors. The negative r-value indicates that participants' scores on the Teacher Confidence Scale and the Trauma Difficulty Scale are inversely related. Therefore, as participants' level of confidence in working with trauma and challenging behaviors increases, their perceived level of difficulty in working with students exhibiting challenging behaviors associated with trauma decreases. The scatterplot in Figure 3 depicts these results.
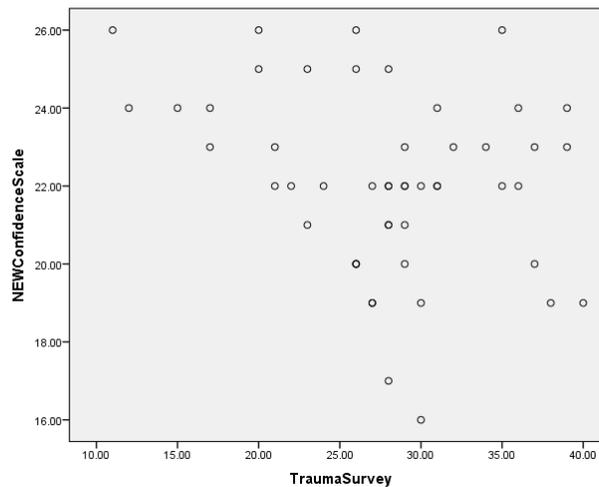

Figure 3. Relationship between teacher confidence and trauma difficulty.

Correlation between trauma/behavior knowledge and teacher confidence. The

researcher examined the relationship between participants' level of trauma/behavior knowledge

(Trauma/Behavior Knowledge Scale) and level of confidence in working with trauma and

challenging behaviors (Teacher Confidence Scale).

Table 3. *Correlation Between Trauma/Behavior Knowledge and Teacher Confidence*

		Trauma Knowledge Scale	Confidence Scale
Trauma Knowledge Scale	Pearson Correlation	1	.598**
	Sig. (2-tailed)		.000
	N	62	58
Confidence Scale	Pearson Correlation	.598**	1
	Sig. (2-tailed)	.000	
	N	58	58

**. Correlation is significant at the 0.01 level (2-tailed).

Table 3 shows the inferential statistics of the relationship between the two variables,

Trauma/Behavior Knowledge and Teacher Confidence. The calculated correlation (r=.598, $p <$

.01) indicates a moderate to strong relationship between these variables. The p-value is < .01,

indicating a statistically significant relationship between trauma knowledge and teacher

confidence. The positive r-value indicates that participants' scores on the Trauma/Behavior

Knowledge Scale and the Teacher Confidence Scale are directly related. Therefore, as

participants' level of trauma knowledge increases, their level of confidence in working with

trauma and challenging behaviors also increases. The scatterplot in Figure 4 depicts these results.
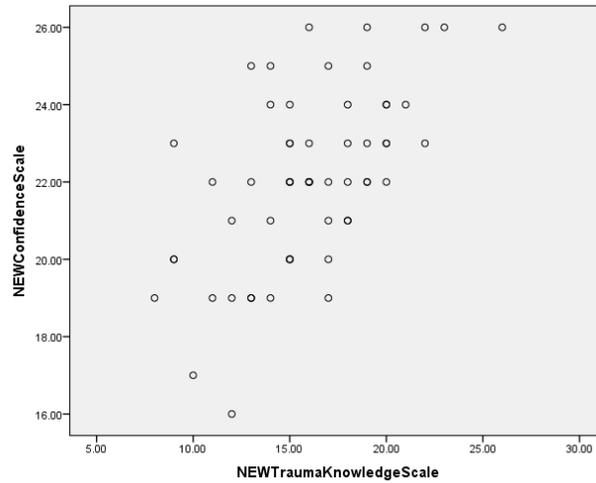
Figure 4. Relationship between teacher confidence and trauma/behavior knowledge scale.

Correlation between trauma/behavior knowledge and teacher stress. The researcher

examined the relationship between participants' level of trauma/behavior knowledge

(Trauma/Behavior Knowledge Scale) and reported level of stress (Teacher Stress Scale).

Table 4. *Correlation Between Trauma/Behavior Knowledge and Teacher Stress*

		Trauma Knowledge Scale	Teacher Stress Scale
Trauma/Behavior Knowledge Scale	Pearson Correlation	1	-.546[**]
	Sig. (2-tailed)		.000
	N	62	62
Teacher Stress Scale	Pearson Correlation	-.546[**]	1
	Sig. (2-tailed)	.000	
	N	62	63

**. Correlation is significant at the 0.01 level (2-tailed).

Table 4 shows the inferential statistics of the relationship between the two variables,

Trauma/Behavior Knowledge and Teacher Stress. The calculated correlation (r=-.546, $p < .01$)

indicates a moderate to strong negative relationship between these variables. The p-value is <

.01, indicating a statistically significant relationship between trauma knowledge and teacher

stress. The negative r-value indicates that participants' scores on the Trauma/Behavior

Knowledge Scale and the Teacher Stress Scale are inversely related. Therefore, as participants'

level of trauma knowledge increases, their reported level of stress decreases. The scatterplot in

Figure 5 depicts these results.
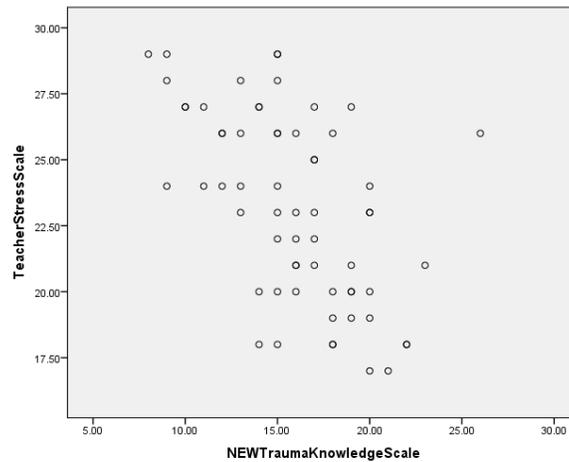
Figure 5. Relationship between teacher stress and trauma/behavior knowledge.

Correlation between teacher confidence and teacher stress. The researcher examined

the relationship between participants' level of confidence in working with trauma and

challenging behaviors (Teacher Confidence Scale) and reported level of stress (Teacher Stress

Scale).

Table 5. *Correlation Between Teacher Confidence and Teacher Stress*

		Confidence Scale	Teacher Stress Scale
Confidence Scale	Pearson Correlation	1	-.403[**]
	Sig. (2-tailed)		.002
	N	58	58
Teacher Stress Scale	Pearson Correlation	-.403[**]	1
	Sig. (2-tailed)	.002	
	N	58	63

**. Correlation is significant at the 0.01 level (2-tailed).

Table 5 shows the inferential statistics of the relationship between the two variables, Teacher Confidence and Teacher Stress. The calculated correlation (r=-.403, $p < .01$) indicates a moderate negative relationship between these variables. The p-value (.002) is $< .01$, indicating a statistically significant relationship between level of confidence and reported stress. The negative r-value indicates that participants' scores on the Teacher Confidence Scale and the Teacher Stress Scale are inversely related. Therefore, as participants' level of confidence in working with trauma and challenging behaviors increases, their reported level of stress decreases. The scatterplot in Figure 6 depicts these results.
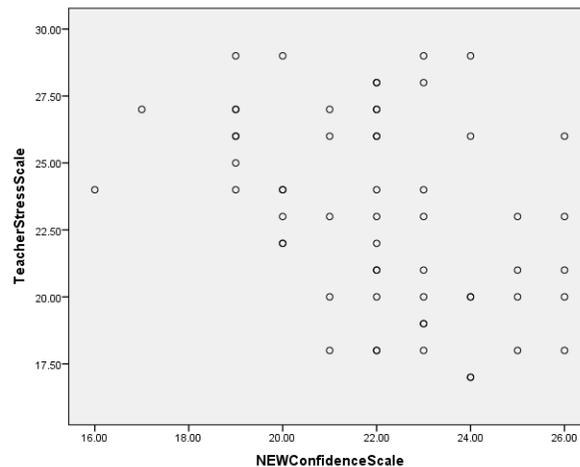
Figure 6. Relationship between teacher confidence and teacher stress.

Correlation between trauma/behavior knowledge and punitive behavior responses.
The researcher examined the relationship between participants' level of trauma knowledge (Trauma Knowledge Scale) and use of punitive responses to challenging behaviors (Punitive Response Scale).

Table 6. *Correlation Between Trauma/Behavior Knowledge and Punitive Response*

		Trauma Knowledge	Punitive Response
Trauma Knowledge	Pearson Correlation	1	-.018
	Sig. (2-tailed)		.891
	N	62	61
Punitive Response	Pearson Correlation	-.018	1
	Sig. (2-tailed)	.891	
	N	61	64

Table 6 shows the inferential statistics of the relationship between the two variables, Trauma Knowledge and Punitive Response. The calculated correlation (r=-.018, *p*> .05) indicates a weak negative relationship between these variables. The p-value (.891) is > .05, indicating that the relationship between trauma knowledge and punitive behavior responses is not statistically significant. The scatterplot in Figure 7 depicts these results.
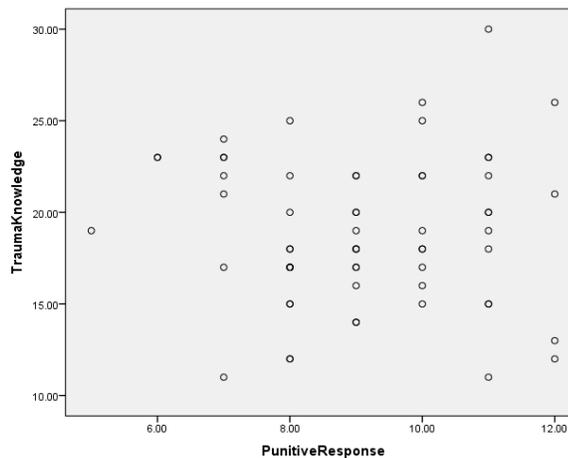

Figure 7. Relationship between trauma/behavior knowledge and punitive response.

Correlation between trauma/behavior knowledge and supportive behavior responses. The researcher examined the relationship between participants' level of trauma knowledge (Trauma/Behavior Knowledge Scale) and use of supportive responses to challenging behaviors (Supportive Response Scale).

Table 7. *Correlation Between Trauma/Behavior Knowledge and Supportive Response*

		Trauma/Behavior Knowledge	Supportive Scale
Trauma/Behavior Knowledge	Pearson Correlation	1	.158
	Sig. (2-tailed)		.224
	N	62	61
Supportive Scale	Pearson Correlation	.158	1
	Sig. (2-tailed)	.224	
	N	61	64

Table 7 shows the inferential statistics of the relationship between the two variables,

Trauma/Behavior Knowledge and Supportive Response. The calculated correlation (r=.158, *p>*

.05) indicates a weak positive relationship between these variables. The p-value (.224) is > .05,

indicating that the relationship between trauma/behavior knowledge and supportive behavior

responses is not statistically significant. The scatterplot in Figure 8 depicts these results.
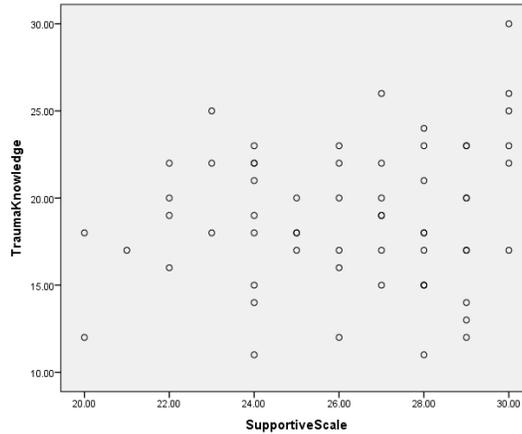

Figure 8. Relationship between trauma/behavior knowledge and supportive response.

Discussion

The above findings highlight some important trends among urban elementary teachers and their perceptions and responses to childhood trauma and related challenging behaviors in the classroom. First of all, an overwhelming majority of the teachers surveyed (96%) either agreed or strongly agreed that many challenging behaviors can be attributed to trauma, abuse, or neglect. This suggests that, in general, the urban elementary teachers surveyed are very aware of the significant impacts of childhood trauma, abuse, and neglect on their students' behaviors. Most of the participants in this study (95%) reported that they responded differently to students' challenging behaviors when they were aware of trauma, abuse, or neglect in the student's life. This further suggests that the urban elementary teachers surveyed have an understanding of the significant impact of trauma on children and behavior. This is important because in order for teachers to respond in supportive and empathetic ways to students who have experienced trauma, it is vital that they understand how powerful the effects of childhood trauma on behavior and social-emotional functioning can be. As identified in the research, the close proximity that teachers have to students gives them the unique opportunity to be one of the first people to identify signs and symptoms of childhood trauma in a student and assist with intervention (Alisic et al., 2012).

An overwhelming majority (89%) of the urban elementary teachers surveyed in this study reported that between 76% and 100% of the students at their school qualified for free or reduced lunch. This indicates high rates of poverty at many of the participants' schools. It is likely that many of the teachers surveyed encounter high rates of childhood trauma in their student population—as indicated by existing literature, living in poverty can be damaging to psychological well-being (Santiago et al., 2009), and children in low-income, urban

neighborhoods are often faced with poor daily living conditions and are more likely than children

in affluent communities to experience stressors such as family chaos, family conflict, violence,

incarceration or death of a family member, and maltreatment and/or neglect (Kiser, 2006).

The teachers surveyed reported experiencing many challenging behaviors on a regular

basis in their classrooms. The most frequently reported challenging behaviors teachers in this

study reported on a daily basis were disruption (66%), defiance/noncompliance (56%), socially

unacceptable behavior (49%), and verbal aggression (46%). While it cannot be determined that

all of these challenging behaviors stem directly from childhood trauma, the reported observed

behaviors are congruent with existing research that describes traumatized students as often in a

state of hyperarousal and displaying unpredictable and/or impulsive behavior, impulsive

behavior, aggression toward others, and over- or under-responding to sensory stimuli (Perry,

2001; "Trauma Toolkit For Educators", 2008**).** Students who have experienced trauma are

constantly on alert, perceiving danger much of the time; they may react with anger and

aggression when they feel sad, surprised, or disappointed, and can react to others' emotions with

aggressive behaviors that can quickly become out of control (Gearity, 2009); they may have

intense reactions to reminders of their traumatic event or perceived threats, such as becoming

defensive when they feel others are violating their personal space, "blowing up" when corrected

or told what to do by an authority figure, fighting or becoming aggressive when criticized or

teased by others, or resisting transition and/or change ("Trauma Toolkit For Educators", 2008, p.

4)--- all behaviors that could be externally expressed as the challenging behaviors that teachers in

this study reported seeing often in their classrooms. Ninety percent of the teachers surveyed

agreed or strongly agreed that they teach many students who behave in ways similar to those

described in the student trauma behavior vignettes; this suggests that the urban teacher

population surveyed encounter many students who have experienced trauma and/or exhibit challenging behaviors, which points to the need for increased education and support for these teachers.

Also of significance is that teachers in this study who reported more knowledge and education about childhood trauma and how to respond to challenging behaviors related to trauma also reported higher levels of confidence, lower levels of stress, and less perceived difficulty in working with children who exhibit signs of trauma. Similarly, teachers who indicated higher levels of confidence in working with trauma and challenging behaviors also reported lower levels of stress. This suggests that providing teachers with training, education, and support related to working with childhood trauma is beneficial in helping teachers feel successful and more confident in working with traumatized students. Since some research indicates that elementary school teachers have uncertainties about their role and how they can assist children effectively after traumatic experiences (Alisic et al., 2012), the findings from the present study suggest that one way to better equip teachers to help traumatized students is to provide them with more training and education around childhood trauma.

A review of the existing literature also found that higher rates of challenging student behaviors were associated with greater teacher stress and more teacher-student conflict (Henricsson & Rydell, 2004). The current study found that lower levels of confidence and knowledge around childhood trauma and challenging behaviors were associated with increased teacher stress, which further supports the idea that urban elementary teachers could greatly benefit from increased support and education around childhood trauma and challenging behaviors.

Implications for Social Work Practice

These findings have important implications for social work practice, particularly for school social workers. School social workers have an important role in the school setting as a mental health professional with a person-in-environment, strengths-based perspective that contrasts more traditional academic views of learning and behavior. As a link between students, teachers, and communities, school social workers are in a unique and valuable position to offer teachers the support and training they need to work successfully with students who have experienced trauma.

School social workers are also an important part of the student support team within a school setting and can use their specialized training and knowledge about trauma and behavior to assist with challenging behaviors, help traumatized students de-escalate, interpret challenging behaviors in the context of trauma for teachers, and assist in creating supportive environments with the effects of trauma in mind. As Cole et al. (2013) described in their work about trauma-sensitive schools, leadership and staff should share an understanding of the impacts of trauma on learning and the need for a school-wide approach to supporting students, and trauma-sensitive schools explicitly connect students to the school community, support all students to feel safe, physically, social, emotionally, and academically, and address students' needs in holistic ways by taking into account students' relationships, self-regulation, academic competence, and physical and emotional well-being (Cole et al., 2013).

The importance of trauma-informed practices in schools is especially important for school social workers to consider. As the NASW Code of Ethics (2008) states, the primary goal of social work is "to help people in need and to address social problems". Since one in four children attending school has been exposed to a traumatic event ("What Is Child Traumatic

Stress?", 2003), childhood trauma is certainly a social problem that significantly impacts

students and schools, and school social workers have a responsibility to understand how trauma

affects students and how teachers and school communities can best support students who have

experienced trauma. Incorporating mental health specialists, including social workers, in the

school setting to assess students' needs and develop and implement effective interventions for

students who have experienced trauma is an important part of trauma-informed care in schools,

and school social workers are a vital member of a trauma-informed team (Oehlberg, 2008).

Implications for Policy

The findings from this research indicate that providing urban elementary teachers with

training and education related to childhood trauma is a crucial element to teacher confidence and

perceived effectiveness in working with students with trauma-related challenging behaviors. This

supports information found in the research that creating trauma-informed schools can benefit

teacher satisfaction as well as reduce student and staff stress and lead to a decrease in disruptive

student behaviors (Oehlberg, 2008). Nearly half (48%) of all participants in the current study

reported that they had not received any information about childhood trauma in their professional

teaching program, and 57% reported receiving no (11%) or only a little (46%) information or

training on childhood trauma from the school or district where they worked.

Since most participants reported that they worked with high numbers of students who

have experienced trauma and encountered many challenging and trauma-related behaviors on a

daily basis, it is vital that teachers receive better training and information about childhood trauma

and its effects on learning and development. The findings from the current study as well as the

existing literature support the idea that information about childhood trauma should be required

material in teacher education and training and should be taken into consideration when determining school policies and procedures.

Implications for Research

This study's findings point to some important areas for continued research. For example, further research to better understand urban elementary teachers' responses to challenging behaviors and the different kinds of disciplinary responses and interventions that are used will be helpful in developing more successful behavioral intervention programs in schools. Further research to explore teachers' stress levels in high-trauma student populations and what teachers need to feel supported and confident in urban schools is also important, since more supported and confident teachers is an important part of building stronger and more successful school communities.

The current study did not find a significant correlation between teacher knowledge of trauma and challenging behaviors and punitive or supportive responses to challenging behaviors, but this could be another area for further research. The existing literature suggests that supportive responses such as positive feedback, encouragement, and praise are especially important for traumatized children, and that a tiered support system that provides increased individualized interventions is most supportive for students with high behavioral and educational needs (Craig, 2016). Therefore, it is important that urban elementary teachers have the support they need to intervene with challenging behaviors in supportive ways.

Strengths and Limitations

The primary strength of this study is that it highlights the important role teachers have in the lives of students who have experienced trauma, and captures urban elementary teachers'

perceptions and responses to childhood trauma and the challenging behaviors associated with it. As more schools work toward becoming "trauma-informed" and understanding the needs of students who have experienced trauma, it is vital to understand teachers' attitudes and perceptions about the effects of childhood trauma and their understanding of how it impacts challenging behaviors in the classroom in order to best support both teachers and students.

There were several limitations to this study. The sample size, while it exceeded the suggested minimum number of participants, was still relatively small compared to the overall pool of urban elementary teachers. A strictly quantitative approach was somewhat limiting in that it did not allow for the researcher to fully capture individual teachers' experiences in as much depth as a qualitative approach might have. Also, this study was limited to public elementary schools in an urban area—private schools and charter schools were not included.

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Appendix A

Recruitment Email

Dear [*name*],

My name is Megan David and I am a student from the Master of Social Work program at the University of St. Thomas/St Catherine University. I am writing to invite you to participate in my research study about urban elementary school teachers' beliefs, perceptions, and responses to challenging behaviors in the classroom. You are eligible to be in this study because you are an elementary school teacher in an urban area. I obtained your contact information from your school's website.

If you decide to participate in this study, you will complete a 15-20 minute online survey. Participation in this study is completely voluntary. You can choose to be in the study or not. You can stop the survey at any time, and you can skip any questions you do not want to answer. To participate in this study, you can access the survey by clicking the link below. If you have any questions about the study, please email at madavid@stthomas.edu or contact me at 612-386-5415.

Participants in this survey will be offered the opportunity to be entered into a drawing for a $25 e-gift card to Amazon as a thank you for participating. If you want to be considered for the drawing, you will be prompted to provide your email address after completing the survey. Email addresses will not be linked to any answers on the survey.

Click this link to take the online survey:

http://stthomassocialwork.qualtrics.com/SE/?SID=SV_6nxBSUexSzUnnaR

Thank you very much!

Sincerely,

Megan David

Appendix B

Informed Consent

You are invited to participate in a research study about urban elementary school teachers' beliefs, perceptions, and responses to challenging behaviors in the classroom. You are eligible to participate in this study because you are an elementary school teacher in an urban area and student behaviors associated with childhood traumatic experiences. The following information is provided in order to help you make an informed decision about whether or not you would like to participate. Please read this consent page before agreeing to be in the study.

This study is being conducted by Megan David, a graduate student in the Master of Social Work program at the University of St. Thomas. The research process is being supervised Renee Hepperlen, PhD, faculty at the University of St. Thomas. This study was approved by the Institutional Review Board at the University of St. Thomas.

Background Information

Elementary school teachers who work in urban setting face unique stress and challenges in their classrooms. The purpose of this study is to explore the urban elementary teachers' perceptions of and responses to challenging student behaviors and student behaviors associated with childhood traumatic experiences.

Procedures

If you agree to participate in this study, I will ask you to complete a 15-20 minute online survey.

Risks and Benefits of Being in the Study

The study has minimal risks, which include the potential for mild emotional distress and/or recalling traumatic/distressing memories about working with challenging students or students who have experienced trauma. For more information about secondary trauma in educators, visit https://traumaawareschools.org/secondaryStress or https://childtrauma.org/wp-content/uploads/2014/01/Cost_of_Caring_Secondary_Traumatic_Stress_Perry_s.pdf.

For teacher self-care tips and resources, visit http://education.qld.gov.au/studentservices/natural-disasters/resources/tip-sheet-teacher-self-care.pdf or http://www.mindfulteachers.org/p/mindful-but-busy-teachers.html. These resources will be provided again upon completion of the survey.

There are no direct benefits to participating in this study.

Compensation

You will be offered the opportunity to be entered in a drawing for a $25 e-gift card to Amazon as incentive to participate in the study. After completing the survey, you will be prompted to enter your email address if you would like to be entered in the drawing. One participant will receive the gift card, and the drawing will take place no later than March 1st, 2016.

Privacy

Your privacy will be protected while you participate in this study. The data collected from your survey answers will be stored on the Qualtrics online survey program. A specific user name and password will be required to access the data. Only the researcher will have the user name and password. You will not be asked to provide any identifying information during this survey. If you choose to provide your email address to be entered into the drawing to win a $25 Amazon e-gift card, your email address will be collected separately from the survey and will not be linked to your answers on any survey items. Your email address will not be shared or used for any other purpose than to contact you if you win the prize drawing.

Confidentiality

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you. The types of records I will create include computer records of data responses. Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

Voluntary Nature of the Study

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with any individual or agency or with the University of St. Thomas. There are no penalties or consequences if you choose not to participate. If you decide to participate, you are free to withdraw at any time without penalty or loss of any benefits to which you are otherwise entitled. Should you decide to withdraw, data collected about you will not be used. **You can withdraw by simply exiting out of the survey at any time. You are also free to skip any question on the survey that you do not want to answer.**

Contacts and Questions

My name is Megan David. You may ask any questions you have about this study by contacting me or my research advisor at any time during or after the research procedures. You may contact me at [phone number] or [email address]. You may contact my research advisor, Renee Hepperlen, at [phone number] or [email address]. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 or [email address] with any questions or concerns.

Please ask yourself the following questions to make sure you understand the study. If you cannot answer a question, please re-read the above information or contact the investigator with questions before participating in the study.

What will I be asked to do if I choose to participate in this study?

What are the risks to participating in this study?

How can I withdraw from this study?

Who can I contact if I have questions about this study?

Statement of Consent

Please indicate your consent by checking the boxes:

☐ I have read and understand the above information.

☐ I am at least 18 years of age.

☐ I consent to participate in the study. I understand that by continuing to the survey, I give my consent to participate in this study.

Appendix C

Post-Survey Secondary Trauma and Self-Care Resources

Thank you for completing this survey! Dealing with challenging behaviors and working with children who have experienced trauma can be difficult. The following resources are provided for your use:

From the National Child Traumatic Stress Network's Child Trauma Toolkit for Educators:

"There is a cost to caring." - Charles Figley

Trauma takes a toll on children, families, schools, and communities. Trauma can also take a toll on school professionals. Any educator who works directly with traumatized children and adolescents is vulnerable to the effects of trauma—referred to as compassion fatigue or secondary traumatic stress— being physically, mentally, or emotionally worn out, or feeling overwhelmed by students' traumas. The best way to deal with compassion fatigue is early recognition.

TIPS FOR EDUCATORS:

1. Be aware of the signs. Educators with compassion fatigue may exhibit some of the following signs:

- Increased irritability or impatience with students
- Difficulty planning classroom activities and lessons
- Decreased concentration
- Denying that traumatic events impact students or feeling numb or detached
- Intense feelings and intrusive thoughts, that don't lessen over time, about a student's trauma
- Dreams about students' traumas

2. Don't go it alone. Anyone who knows about stories of trauma needs to guard against isolation. While respecting the confidentiality of your students, get support by working in teams, talking to others in your school, and asking for support from administrators or colleagues.

3. Recognize compassion fatigue as an occupational hazard. When an educator approaches students with an open heart and a listening ear, compassion fatigue can develop. All too often educators judge themselves as weak or incompetent for having strong reactions to a student's trauma. Compassion fatigue is not a sign of weakness or incompetence; rather, it is the cost of caring.

4. Seek help with your own traumas. Any adult helping children with trauma, who also has his or her own unresolved traumatic experiences, is more at risk for compassion fatigue.

5. If you see signs in yourself, talk to a professional. If you are experiencing signs of compassion fatigue for more than two to three weeks, seek counseling with a professional who is knowledgeable about trauma.

6. Attend to self-care. Guard against your work becoming the only activity that defines who you are. Keep perspective by spending time with children and adolescents who are not experiencing traumatic stress. Take care of yourself by eating well and exercising, engaging in fun activities, taking a break during the workday, finding time to self-reflect, allowing yourself to cry, and finding things to laugh about.

Resource: Figley, C.R. (1995). Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. New York: Brunner/Mazel, Inc.

From "The Cost of Caring: Secondary Traumatic Stress and the Impact of Working with High-Risk Children and Families" (Bruce Perry, ChildTrauma Academy, 2014):

Self-Care Strategies for Combating Secondary Trauma

Physical	Psychological	Emotional	Workplace
Sleep well	Self-reflect	See friends	Take breaks
Eat well	Pleasure reading	Cry	Set limits
Dancing	Say "no"!	Laugh	Peer support
Walking	Smile	Praise yourself	Get supervision
Jogging	Solitude	Humor	Use vacations

For more information about secondary trauma in educators, visit https://traumaawareschools.org/secondaryStress or https://childtrauma.org/wp-content/uploads/2014/01/Cost_of_Caring_Secondary_Traumatic_Stress_Perry_s.pdf.

For teacher self-care tips and resources, visit http://education.qld.gov.au/studentservices/natural-disasters/resources/tip-sheet-teacher-self-care.pdf or http://www.mindfulteachers.org/p/mindful-but-busy-teachers.html.

Appendix D

Trauma and Challenging Behaviors Survey

Challenging Behavior Survey

Instructions: Please complete the following questions to reflect your opinions as accurately as possible. Your information will be kept strictly confidential.

How often do the following challenging student behaviors cause a significant disruption in your classroom?

Defiance and noncompliance: A student refuses to follow directions or comply with adult instructions (e.g. not participating in required activities, challenging authority, purposely ignoring rules, etc)

   1= never   2= rarely—once or twice during a school year   3= sometimes—a few times a month

          4= often—a few times a week   5= very often—once a day or more

Destruction: A student damages significant property (e.g. intentionally breaking items, tearing up books or other materials, destroying classroom equipment, etc)

   1= never   2= rarely—once or twice during a school year   3= sometimes—a few times a month

          4= often—a few times a week   5= very often—once a day or more

Disruption: A student interferes with the normal flow of activities (e.g. interrupting instruction, interfering with group activities, etc)

   1= never   2= rarely—once or twice during a school year   3= sometimes—a few times a month

          4= often—a few times a week   5= very often—once a day or more

Illegal behavior: A student engages in acts that violate public laws (e.g. theft, vandalism, technology abuse, substance abuse, carrying weapons, etc)

   1= never   2= rarely—once or twice during a school year   3= sometimes—a few times a month

          4= often—a few times a week   5= very often—once a day or more

Physical aggression: A student physically attacking another person (e.g. hitting, kicking, fighting, etc, either teachers/staff or peers)

   1= never   2= rarely—once or twice during a school year   3= sometimes—a few times a month

          4= often—a few times a week   5= very often—once a day or more

Verbal aggression: A student verbally attacking another person (e.g. taunting, challenging, name-calling, swearing, threatening, etc, either teachers/staff or peers)

   1= never   2= rarely—once or twice during a school year   3= sometimes—a few times a month

          4= often—a few times a week   5= very often—once a day or more

Self-injury: A student causing physical damage to oneself (e.g. self-hitting, self-biting, etc)

    1= never   2= rarely—once or twice during a school year   3= sometimes—a few times a month

            4= often—a few times a week   5= very often—once a day or more

Social withdrawal: A student demonstrates reluctance to participate in normal activities, tending to retreat and avoid interpersonal contacts (e.g. isolation, refusing to participate in classroom or recreational activities, failure to engage or interact with peers, etc)

    1= never   2= rarely—once or twice during a school year   3= sometimes—a few times a month

            4= often—a few times a week   5= very often—once a day or more

Socially inappropriate behavior: A student engages in unacceptable behavior (making inappropriate sounds, talking too loudly, talking about inappropriate subjects, making offensive gestures, etc)

    1= never   2= rarely—once or twice during a school year   3= sometimes—a few times a month

            4= often—a few times a week   5= very often—once a day or more

Stereotypy/repetitive behaviors: A student engages in repetitive acts (hand flapping, spinning, twirling, etc)

    1= never   2= rarely—once or twice during a school year   3= sometimes—a few times a month

            4= often—a few times a week   5= very often—once a day or more

Challenging Behavior Survey

Instructions: Please answer the following questions to reflect your opinions about challenging student behaviors as accurately as possible. In this survey, "challenging behaviors" refers to any of the previously mentioned behaviors: defiance/noncompliance, destruction, disruption, illegal behavior, physical aggression, verbal aggression, self-injury, social withdrawal, socially inappropriate behavior, or stereotypy/repetitive behaviors.

Beliefs about Challenging Behavior

Many challenging behaviors are attributable to the student's personality.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

Many challenging behaviors are attributable to a physical/medical reason.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

Many challenging behaviors are attributable to disability.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

Many challenging behaviors are attributable to trauma, abuse, or neglect.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

Many challenging behaviors originate in the home or community.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

Many challenging behaviors are learned.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

Many challenging behaviors can be improved.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

Confidence in Ability to Deal with Challenging Behavior

I received adequate preparation through my schooling to deal with most challenging behavior.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

I receive adequate ongoing in-service preparation to deal with most challenging behavior.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

I have increased my ability to deal with most challenging behavior since I started teaching.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

I have sufficient knowledge and skills to deal with most challenging behavior.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

Effects of Challenging Behavior

Challenging behavior takes up a significant amount of time.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

Challenging behavior increases my level of stress.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

Challenging behavior interferes with my ability to be effective as a teacher.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

Challenging behavior makes me think about quitting or question whether teaching is the right career for me.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

Challenging behavior reduces learning of the student with challenging behavior.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

Challenging behavior reduces learning of other students.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

Strategies for Dealing with Challenging Behavior

Please indicate how often you utilize the following strategies to deal with challenging behaviors:

Directly observe student and take notes

1= never   2= rarely   3= sometimes   4= frequently   5= very often

Interview others to determine causes of behavior

1= never   2= rarely   3= sometimes   4= frequently   5= very often

Identify triggers of behaviors

1= never   2= rarely   3= sometimes   4= frequently   5= very often

Determine function to teach acceptable behavior

1= never   2= rarely   3= sometimes   4= frequently   5= very often

Use social reinforcement (smiles, praise, or other positive reactions) for positive behavior

1= never   2= rarely   3= sometimes   4= frequently   5= very often

Use tangible reinforcement (treats, prizes, or other physical rewards) for positive behavior

1= never   2= rarely   3= sometimes   4= frequently   5= very often

Measure behavior by counting it or timing it

1= never   2= rarely   3= sometimes   4= frequently   5= very often

Address out-of-classroom conditions (family problems, lack of basic needs, etc)

1= never   2= rarely   3= sometimes   4= frequently   5= very often

Change my interactions with students

1= never   2= rarely   3= sometimes   4= frequently   5= very often

Change classroom arrangements or conditions

1= never   2= rarely   3= sometimes   4= frequently   5= very often

Change curriculum or teaching approach

1= never   2= rarely   3= sometimes   4= frequently   5= very often

Ignore behavior

1= never   2= rarely   3= sometimes   4= frequently   5= very often

Use time-out

1= never   2= rarely   3= sometimes   4= frequently   5= very often

Take away desired privileges or activities

1= never   2= rarely   3= sometimes   4= frequently   5= very often

Verbally reprimand students

1= never   2= rarely   3= sometimes   4= frequently   5= very often

Send students to office or behavior support staff

1= never   2= rarely   3= sometimes   4= frequently   5= very often

Use a formal behavior intervention plan

1= never   2= rarely   3= sometimes   4= frequently   5= very often

Trauma Behaviors Survey

Instructions: Please read the following vignettes describing two students who demonstrate challenging behaviors in the classroom and answer the questions below to reflect your opinion as accurately as possible.

J. is constantly in trouble in class, and seems to have significant problems understanding and completing grade-level work. J. seems to be "set off" very easily, and will become verbally and physically aggressive with little or no provocation. When upset, J. will throw chairs, rip papers off the wall, and hit or kick other students. J. will overreact to small mishaps or perceived slights from others with anger and aggression that doesn't seem to match the situation. J. hardly ever seems to be calm or relaxed.

L. is a quiet, withdrawn student. L. often refuses to participate in classroom activities and rarely interacts with other kids. L. has a hard time paying attention and often seems "spaced out". L. seems sad or scared most of the time, and does not respond to adults who offer to talk to her or help her. L. frequently complains of headaches and stomachaches, and asks to go to the nurse's office often. L. does not have any close friends in the class, and will try to hide in the bathroom during lunch or recess.

With children like J. and L. how difficult (1 = *not difficult at all* to 5 = *extremely difficult*) is it for you to:

Balance attending to the child and looking after the rest of the class?

1=not difficult at all   2= slightly difficult   3= somewhat difficult   4= very difficult 5= extremely difficult

Balance attending to the child and avoiding to put him/her in a special position?

1=not difficult at all   2= slightly difficult   3= somewhat difficult   4= very difficult 5= extremely difficult

Balance attending to the child and making the situation too heavy?

1=not difficult at all   2= slightly difficult   3= somewhat difficult   4= very difficult 5= extremely difficult

Avoid "taking the problems home"?

1=not difficult at all   2= slightly difficult   3= somewhat difficult   4= very difficult 5= extremely difficult

Decide where my task ends and the task of a social worker or psychologist begins?

1=not difficult at all   2= slightly difficult   3= somewhat difficult   4= very difficult 5= extremely difficult

Know what is best for you to do to support them?

1=not difficult at all   2= slightly difficult   3= somewhat difficult   4= very difficult 5= extremely difficult

Know when they need mental health care to recover?

1=not difficult at all   2= slightly difficult   3= somewhat difficult   4= very difficult 5= extremely difficult

Know what to discuss about the challenges with the children themselves and with the class?

1=not difficult at all   2= slightly difficult   3= somewhat difficult   4= very difficult 5= extremely difficult

Know where to get answers to your own/parents'/children's questions?

1=not difficult at all   2= slightly difficult   3= somewhat difficult   4= very difficult 5= extremely difficult

I play an important role in the lives of children like J. and L.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

I feel that I am an effective teacher to students like J. and L.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

I teach many students who have behaved in similar ways to J. and L.

1= strongly disagree   2= disagree   3= neutral/not sure   4= agree   5= strongly agree

Of these two students, who would be more challenging for you to work with?

J.   L.   Both would be equally challenging   Not sure   Prefer not to answer

Teacher Demographic Information

Instructions: Please answer the following informational questions about your demographics and your teaching experience and training. The survey will be concluded after these questions.

What is your age?

20-30   30-40   40-50   50-60   60-70   Prefer not to answer

What is your gender?

Male   Female   Other   Prefer not to answer

What is your highest degree?

Bachelor's degree   Master's degree   Other   Prefer not to answer

How long have you been teaching?

Less than 1 year   1-5 years   6-10 years   10-15 years   16-20 years
20-25 years   25+ years   Prefer not to answer

Are you a general education teacher or a special education teacher?

General education teacher   Special education teacher   Other   Prefer not to answer

Do you respond in different or special ways to students' challenging behaviors when you are aware that they have experienced trauma, abuse, or neglect?

Yes   No

What percentage of your students qualify for free/reduced lunch?

0-25%   26-50%   51-75%   76-100%   Unsure   Prefer not to answer

Have you received any trauma-specific training in the last 3 years?

No   Yes—a little   Yes--- a fair amount   Yes--- a great deal   Prefer not to answer

How much information about childhood trauma did your professional teaching program provide?

None   A little   A fair amount   A great deal   Prefer not to answer

How much training or information does your school provide teachers and staff about childhood trauma?

None   A little   A fair amount   A great deal   Prefer not to answer

Is your school "trauma-informed" or working on becoming "trauma-informed"?

Yes   No   Unsure   Prefer not to answer

Rate your level of knowledge about the effects of trauma on the brain and learning:

None   A little   A fair amount   A great deal   Prefer not to answer

How confident to do you feel when working with students who have experienced trauma, abuse, or neglect?

Not confident at all   Somewhat confident   Very confident   Not sure   Prefer not to answer

How important do you perceive your role in working with students who have experienced trauma, abuse, or neglect?

Not important at all   Somewhat important   Very important   Not sure   Prefer not to answer

Thank you for completing this survey!

Click below to enter the prize drawing for a $25 Amazon e-card by entering your email address. Your email address will not be linked to your answers on any survey items. Your email address will not be shared or used for any other purpose than to contact you if you win the drawing. The drawing will take place no later than March 1st, 2016.