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Summer 5-24-2020

Resiliency and Resources for Students Affected by Adverse Childhood Experiences

Melanie Russ

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RESILIENCY AND RESOURCES FOR STUDENTS AFFECTED BY ADVERSE

CHILDHOOD EXPERIENCES

MELANIE RUSS

EDCI 541 INDIVIDUAL RESEARCH

May 24, 2020

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Signature of Project Advisor

Peter Vernimb, Ed. D.

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Assistant Professor

Abstract

Educating today's youth has many challenges, but the ever-growing population of students who have experienced adverse childhood experiences poses the greatest difficulty to educational professionals due to the lack of resources and knowledge available. Many students who have experienced adverse childhood experiences have unwanted behaviors that educators are not equipped to deal with due to the lack of knowledge of trauma-informed care. Trauma-informed care needs to be integrated into all schools. This will allow equal access to public education for all students, even those seen as troubled due to circumstances beyond their control.

There are many factors that can influence the resiliency and social-emotional health of students who have been affected by adverse childhood experiences. As schools begin to recognize the symptoms of trauma and educate staff members on this recognition, schools will begin to see more students succeed. The strategies to deal with students who have been impacted by trauma need to be easily available to educators to allow all students to have access to a positive school climate that is conducive to learning, not just students unaffected by trauma. Often, students affected by ACEs are seen as problems with no solutions. This mindset needs to change, just as the mental health of our youth is ever-changing.

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The number of children exposed to adverse childhood experiences is increasing at an alarming rate.   Children who have been affected by adverse childhood experiences have faced varying degrees of abuse throughout their childhood to include sexual, mental, physical, emotional and substance abuse which can significantly alter the health and well-being of a child (Soleimnapour, Geirerstanger, & Brindis, 2017) (Sciearaffa, Zeanah, P., & Zeanah, C, 2018). The negative effects of adverse childhood experiences and the lack of resources available to students exposed to adverse childhood experiences are disheartening. The integration of trauma-informed care in our schools needs to become a priority if the desire for all students to succeed continues to remain at the forefront of our policymakers.

Along with the integration of trauma-informed care, resources such as screening inventories measuring a student's resiliency or the number of adverse childhood experiences, a child has experienced need to be available to use with students suspected of having been exposed to ACEs. Once educated in trauma-informed care, educators will be more apt to recognize the signs of trauma within a child. Educators can utilize the screening inventories to guide future interactions with students who have been affected by trauma.

Purpose

There are an increasing number of students experiencing adverse childhood experiences and trauma within our schools. Educators lack resources and knowledge to aid these students in personal growth and often see these students as problems with no solutions. The need to integrate trauma-informed care within our schools is imperative as schools move forward. The academic success of students who have experienced ACEs is dependent upon schools recognizing the trauma facing our youth, increasing resources available to these students and

integrating intervention programs which can be used by staff members to meet the needs of this

ever growing population.

Problem Statement

How do resources available to students who have experienced adverse childhood

experiences affect student resiliency and social emotional health?

Rationale for the Study

Multiple studies (Frydman and Mayor, 2017; Crosby, 2015; Mendelson, Tandon,

O'Brennan, Leaf & Ialongo, 2015) have illustrated the negative effects adverse childhood

experiences and trauma can have on our youth. Students experiencing adverse childhood

experiences have great difficulty achieving academic success and functioning in school settings

because of the behaviors exhibited by these students due to trauma. Many trauma-informed care

intervention programs can be integrated into our schools to aid educators in recognizing and

dealing with students who have been negatively affected by adverse childhood experiences.

Such programs as The 4 Rs Program explained by Aber, Brown, Jones, Berg and Torrente in

*School-based strategies to prevent violence, trauma and psychopathology: The challenges of

going to scale* or Multiplying Connections described by Meg Walkley and Tory L. Cox in

Building Trauma-Informed Schools and Communities, can be integrated into daily instruction to

benefit all students, not just those affected by adverse childhood experiences. The need to create

trauma-informed care within our schools is necessary, as the mental illnesses our youth face are

increasing at alarming rates.

Definitions

ACE Adverse Childhood Experience   ACE is a term used to describe types of abuse,

neglect and other traumatic childhood experiences that impact later health and well-being.

Adolescence   The period of life from age 11-21 years.

Adolescent Dialectical Behavior Therapy   A state-of-the-art, evidence-based form of cognitive

behavioral therapy for teenagers and adults who experience significant trouble managing their

emotions, thoughts and behaviors.

Anxiety   A feeling of worry, nervousness, or unease, typically about an imminent event or

something with an uncertain outcome.

Baseline Data   Something, such as a set of data, used as a basis for comparison or as a

control in a study.

Behavior Intervention Plan   is a plan that is based on the results of a

functional behavioral assessment (FBA) and, at a minimum, includes a description of the

problem behavior, global and specific hypotheses as to why the problem behavior occurs

and intervention strategies that include positive behavioral supports.

Cognitive Development   How children think, explore and figure things out. It is the

development of knowledge, skills, problem solving and dispositions, which help children to

think about and understand the world around them.

Depression   Having feelings of severe despondency and dejection.

Domestic Violence   Violent or aggressive behavior within the home, typically involving the

violent abuse of a spouse or partner.

Emotion Regulation Skills   Encourages present-focused awareness, through experiential
practices like observing the breath, identifying emotions, responding thoughtfully rather than
impulsively and tolerating distress.

Emotional Abuse   Any kind of abuse that is emotional rather than physical in nature. It can
include anything from verbal abuse and constant criticism to more subtle tactics such as
intimidation, manipulation, and refusal to ever be pleased. Emotional abuse can take many
forms.

Functional Behavior Assessment   A process that identifies specific target behavior, the
purpose of the behavior, and what factors maintain the behavior that is interfering with the
student's educational progress.

MEB Disorder   Referring to a mental, emotional and/or behavioral disorder.

Mental Illness   Also called mental health disorders, refers to a wide range
of mental health conditions — disorders affecting mood, thinking and behavior. Examples
of mental illness include depression, anxiety disorders, schizophrenia, eating disorders and
addictive behaviors.

Neglect   The act of being uncared for.

Physical Abuse   Any intentional act causing injury or trauma to another person or animal
by way of bodily contact. In most cases, children are the victims of physical abuse, but adults can
also be victims, as in cases of domestic violence or workplace aggression.

Psychoeducation   Addresses the nature and effects of stress

Psychosocial Adjustment   A reflection of an individual's psychological wellbeing that is
influenced by their experiences in the social arena.

Resilience   Staying calm and in control when faced with a challenge.

Sexual Abuse Also referred to as molestation, is abusive sexual behavior by one person upon
another.

Social-Emotional Health   A child's developing capacity to form secure relationships,
experience and regulate emotions and, explore and learn.

Social Functioning   The way in which people perform their social roles, and the structural
institutions that are provided to sustain them.

Social Role   A role is a set of connected behaviors, rights, obligations, beliefs, and norms as
conceptualized by people in a social situation. It is an expected or free or continuously changing
behavior and may have a given individual social status or social position.

Social Work   Is an academic discipline and profession that concerns itself with
individuals, families, groups and communities in an effort to enhance social functioning and
overall well-being.

Substance Abuse   The overindulgence in or dependence on an addictive substance,
especially alcohol or drugs.

TIC Trauma Informed Care An approach, based on knowledge of the impact of trauma, aimed
at ensuring environments and services are welcoming and engaging for service recipients and
staff.

TSS Trauma Specific Services   Programs, interventions, and therapeutic services aimed at
treating the symptoms or conditions resulting from a traumatizing event(s).

Toxic Stress   A response can occur when a child experiences strong, frequent, and/or prolonged
adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or
mental illness, exposure to violence, and/or the accumulated burdens of family economic
hardship—without adequate adult support.

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Traumatic Stress   Unpredictable stress that elicits a feeling of horror and helplessness

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Literature Review

The number of children exposed to adverse childhood experiences is increasing at an

alarming rate.   Children who have been affected by adverse childhood experiences have faced

varying degrees of abuse throughout their childhood to include sexual, mental, physical,

emotional and substance abuse that can significantly alter the health and well-being of a child

(Soleimnapour, Geirerstanger, & Brindis, 2017; Sciearaffa, Zeanah, P., & Zeanah, C, 2018).   It

has been reported that over 50% of adolescents in the United States, ranging in age from 12-17

years, have experienced at least one adverse childhood experience, with over 20% having

experienced two or more experiences (Soleimnapour, Geirerstanger, & Brindis, 2017).   Many

studies have reported adverse childhood experiences have negative effects on the social-

emotional health and cognitive development of adolescents.   Some children who have

experienced adverse childhood experiences battle with depression and anxiety as others exhibit

behaviors seen as troublesome and problematic by their teachers and peers.   The effects of

adverse childhood experiences, resources available to students exposed to adverse childhood

experiences, trauma-informed care for schools and the role of social workers in the resiliency of

students affected by adverse childhood experiences are examined throughout this literature

review.

Adverse Childhood Experiences

Adverse childhood experiences and trauma are having negative, lasting effects on the

social-emotional health and cognitive development of our youth (Mendelson, Tandon,

O'Brennan, Leaf, & Ialongo, 2015).   According to Foster, Gower, Borowsky, and McMorris,

"ACE include verbal, physical and sexual abuse by a caregiver, parental substance misuse or

abuse, parental intimate partner violence, and parental incarceration, often co-occur and have a

strong, graded relationship to heal behavior problems (e.g. the likelihood of poorer outcomes

increases as the number of ACE experienced increases)" (p. 11). These ACE experiences lead to

trauma symptoms exhibited by students to include isolating oneself, aggressive behaviors,

experiencing difficulties with attention and self-control which lead to negative impacts on the

child's learning (Frydman and Mayor, 2017). The prevalence of these negative impacts is seen

by educators who are not properly equipped to deal with the troubled youth. Without trauma-

informed care, educators find it extremely difficult to address the symptoms of a child who has

experienced adverse childhood experiences (Frydman and Mayor, 2017).

With over half of adolescents in the United States having experienced at least one

adverse childhood experience and more than twenty percent having experienced two or more

experiences, it is crucial to increase the resources available to students to aid in their resiliency

(Soleimnapour, Geirerstanger, & Brindis, 2017). Soleimanpour et al. also state the following:

In fact, there is a much higher prevalence of these negative impacts among adolescents

aged 12 to 17 after experiencing more than on ACE. With 3 or more ACEs, nearly half

(48%) of youth experience low engagement in school, 44% cannot stay calm and

controlled and 41% demonstrate externalizing behaviors (p. 109).

The number of children experiencing adverse childhood experiences are astounding and

preventative measures need to be taken to lessen the effects of ACEs. By creating trauma-

informed schools to address the needs of this ever-growing population, schools can begin to

address the challenges a trauma child may face and aid in the overall resiliency of the child.

Effects of Adverse Childhood Experiences on Our Youth.

Researchers believe stress can induce healthy reactions to various circumstances a child

may face and may be viewed as a positive growth experience for a child (Oral, Ramirez, Coohey,

Nakada, Walz, Kuntz, Benoit, & Peek-Asa, 2015). Oral et al., 2015 also suggest that if a child

lacks a nurturing, supportive environment, sustained stressors over time can lead to toxic stress.

There are two primary systems involved in stress response according to Oral et al., 2015, the

hypothalamic-pituitary-adrenal (HPA) axis and the sympathetic nervous system. These two

systems work together to control the effects that stress can have on one's system. In serious

cases where stressors are involved, cortisol, norepinephrine and epinephrine from the adrenal

cortex are released into the body causing sugar levels to be off, heart rate and blood pressure to

rise and breathing rates can increase (Oral et al., 2015). With these hormonal changes occurring,

learning is not a priority for a child. They prioritize and direct focus to coping with the physical

impact stress has on his or her body, making it exceedingly difficult to achieve success in school

(Oral et al., 2015).

     Not only can stress affect a child physically, the effects of toxic stress can lead to changes

in relationships or even self-isolation (Scott and Mayor, 2017). Children who have experienced

adverse childhood experiences can exhibit outward attention seeking behaviors but can also

exhibit isolation and seclusion behaviors as well. Such internal issues as depression and

debilitating anxiety can consume a child who has experienced adverse childhood experiences

(Scott and Mayor, 2017). Educators need to be trained on how to recognize the various

symptoms of a child who has experienced trauma, which can vary greatly within each individual.

Resources Available to Students Who Have Experienced Adverse Childhood Experiences

     Although there are limited resources available to students who have experienced adverse

childhood experiences, there are positive effects of the incorporation of trauma informed care

within schools to aid in the resiliency of students who have been affected by trauma. Trauma

informed care aids staff in recognizing the signs and symptoms that a student has experienced

trauma. Both (Deckard, 2001) and (Oral et. al, 2016) suggest students who have experienced adverse childhood experiences can show signs of self-isolation, withdrawal from peers and have internal factors such as depression and thoughts of self-harm to begin affecting a student's performance in school. If educators can be trained through trauma informed care, they can begin to recognize these signs and offer students who have experienced adverse childhood experiences strategies and resources that will aid in their resiliency.

Trauma Informed Care. Oral et. al, stated**, "**A program, organization or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures and practices, and seeks to actively resist re-traumatization" as cited by the Substance Abuse and Mental Health Services Administration (SAMHSA), (2015, p. 231). There are six basic principles to TIC as described by Oral et., al (2016): 1) safety 2) trustworthiness and transparency; 3) peer support; 4 collaboration and mutuality5) empowerment of voice and choice; and, 6) cultural, historic and gender issues (SAMHSA 2015, pp. 3-22).

Frydman and Mayor (2017) agree with the suggestion of Overstreet and Matthew (2011) to implement a public health model approach to the integration of TIC within schools to address trauma. Schools need to partner with public health institutions to address the ever-growing mental health needs of our youth. Teachers alone are not equipped to deal with the full scale of the mental health issues that accompany students who have experienced adverse childhood experiences (Frydman and Mayor, 2017). Along with training schools and incorporating programs to aid in TIC, teachers need assistance in treating the mental health of our students beyond the capacity of an overworked school psychologist. Crosby states, "Trauma-informed

education requires buy-in from administrators, disciplinary policies that are sensitive to students,

staff professional development, and strong relationships between school staff and mental health

professionals" (p. 224, as cited by Oehlberg, 2008). There needs to be a working relationship

between schools and mental health professionals to have effective trauma-informed care take

place within our schools. Crosby (2015) also emphasizes:

> Helping traumatized students to be successful requires a departure from the status quo,
>
> where all staff are knowledgeable about trauma and effective ways to address it. It also
>
> requires school practitioners to consider the impact on students' ecologies, and the
>
> potential for trauma-informed practices in improving these ecologies. This ensures that
>
> traumatized youth are not simply discarded as nuisances to the school setting but are
>
> embraced and cultivated into individuals who can build for themselves a better future (p.
>
> 229).

Often students who have been affected by adverse childhood experiences are problems rather

than people. To embrace these troubled students, a change in mindset for the school must be

adopted. Many intervention programs schools adopt when transitioning into a trauma-informed

care mindset share the philosophy of training the staff to be compassionate when dealing with

students who have faced adverse childhood experiences (Mendelson et. al, 2015).

School Programs for Trauma-Informed Care in Schools. There are programs schools

can begin to integrate into the curriculum which will aid in the resiliency of students who have

been affected by adverse childhood experiences. These programs would benefit all students, not

just those affected by ACEs (Mendelson et. al, 2015). Mendelson et.al (2015) suggest all

students can benefit from the mindfulness strategies offered through intervention programs as.

Many schools concentrate on behavior issues accompanying trauma such as disruptive behaviors

and aggression, but according to Mendelson et. al (2015), schools need to change their focus to include students who internalize trauma which may lead to depression and isolation.

The RAP Club provides a 12-session intervention and "[t]argets school success by providing students with evidence-based skills for regulating emotions and making effect decisions" (Mendelson et. al, 2015, p. 143). The RAP Club was created based on the work of a treatment program that concentrated on trauma called Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) (Mendelson et. al, 2015). The National Child Traumatic Stress Network reported SPARCS, "[w]as found to improve various difficulties-including trauma, depressive, and anxiety symptoms, impulsivity, attention, and risk behaviors" (Mendelson et. al, 2015, p. 143). Students participating in this intervention had two 45-minute sessions twice a week over a six-week period (Mendelson et. al, 2015). These students did not miss important instruction time, as the sessions were held during a resource block and the intervention was found to have positive effects on coping strategies for students who had been affected by adverse childhood experiences and benefiting the climate of the school for all students (Mendelson et. al, 2015).

Another program yielding positive results on students who have been affected by adverse childhood experiences is the Reading, Writing, Respect and Resolution (4Rs) (Aber, Brown, Jones, Berg & Torrente, 2011). Aber et. al (2011) state, "[e]levated rates of child psychopathology are commonly associated with exposure to violence and trauma" (p. 412). Schools need to become a place of focus for preventative measures when dealing with trauma because school is where the students spend much of their time (Aber et. al, 2011). There are two basic components to the 4Rs program. The first component is focused on grades K-5 and is a literacy-based curriculum focused on conflict resolution and social-emotional learning (Aber et.

al, 2011). The first component consists of seven units with 21 lessons. The second component is the professional development provided to the staff on how to implement the 4Rs program (Aber et. al, 2011). The first component is centered on children's books with varying themes the students can connect to their own lives, followed by social-emotional learning lessons (Aber et. al, 2011). The professional development component offers teachers 25 hours of training followed by classroom coaching (Aber et. al, 2011). The 4Rs Program has proven to have positive impacts on all students involved, not just those who have been affected by adverse childhood experiences. Aber et. al (2011) suggest this program can become a consistent, integrated part of daily instruction within schools. If the consistent incorporation of The 4Rs program takes place, it can "significantly improve the quality of key aspects of children's social settings such as the quality of their classroom interactions with teachers and peers, and reduce the risk of aggressive behavior, depression, and ADHD, three of the most ubiquitous form of psychopathology associated with exposure to trauma and violence" (Aber et. al, 2011, p. 417).

Walkey and Cox firmly believe that a school needs to strongly consider the design of an intervention program and the guidelines to prevention and intervention foundational measures before committing to an intervention program (2013). Multiplying Connections is a program that created an acronym, CAPPD, aiding schools in becoming more trauma responsive (Walkey & Cox, 2013). CAPPD was created as a reminder to staff to remain calm when dealing with trauma-induced situations, attuned to the body language of children, be present in the situation with a child that that has experienced an adverse childhood experience, be predictable in the routines developed with children and as a reminder to not let the emotions of a child escalate your own (de-escalate) (Walkey & Cox, 2013). The acronym serves as a reminder of how to

create positive relationships with children who have been exposed to adverse childhood experiences.

Conn, Urbach, Butler, King & Yussman (2018) state, "[r]esiliency skills, such as self-regulation and community connection, are teachable and can mitigate the negative impact of ACEs" (p. S50). During a study, students who had experienced three or more ACEs were identified and attended small group sessions every week for an eight-month time frame (Conn et. al, 2018). The weekly sessions used an Adolescent Dialectical Behavior Therapy (A-DBT) curriculum (Conn et. al, 2018). The results of this intervention showed an improvement in overall resilience in the students participating and the classroom performance of the participants after the intervention was comparable to their peers (Conn et. al, 2018).

The state superintendent of schools in Washington state adopted a "compassionate approach to learning and teaching" (Walkey & Cox, 2013, p. 125) and released the "10 Principles of Compassionate Schools" which can be used as a guide for a school adopting a trauma-informed care. These principles are centered on altering the culture and climate of the school by providing training for all involved while concentrating on compassion and communication using data to identify students affected by trauma (Walkey & Cox, 2013). The school social worker plays an integral role in implementing any trauma-informed intervention program within a school.

Role of the School Social Worker

A school social worker has an integral role in the implementation of any trauma-informed intervention program a school may try. According to the School Social Work Association of America, "School social workers are trained mental health professionals who can assist with mental health concerns, behavioral concerns, positive behavior support, academic, and classroom

support, consultation with teachers, parents and administrators as well as provide individual and

group counseling and therapy" (Retrieved from www.sswaa.org "Role of School Social

Worker," 2019). A school social worker is a trained mental health professional. Much of the

research supporting the implementation of trauma-informed care within our schools suggests

schools partner with mental health professionals to further support students who have been

affected by adverse childhood experiences. Not only are school social workers trained mental

health professionals, they have access to mental health organizations schools may not have

access to on their own. Frydman and Mayor (2017) state, "[s]chool social workers should be

aware of public health models promoting prevention, data-driven investigation, and broad-based

trauma interventions" (p. 238).

Frydman and Mayor (2017) suggest school social workers employ a preventative

approach to trauma and take a lead role in educating the staff of school systems in trauma-

informed care. Frydman and Mayor state, "[f]acilitating this implementation will help to

establish a tone and sharpened focus with the school community, norming the process of

articulating and engaging with traumatic material" (p. 245). Likewise, Walkley & Cox (2013)

have similar beliefs that school social workers should have a leadership role in leading their

schools towards becoming trauma informed. Social workers are often key members of a

behavior team for a student, creating Behavior Intervention Plans and often observing a student

during a Functional Behavior Assessment (FBA). Social workers are able to use the knowledge

gained from an FBA plus the knowledge of trauma-informed school intervention programs to

identify students who have internalized the effects of an adverse childhood experience as well as

the students who are exhibiting outward behavioral changes due to the ACE.

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School social workers should take a lead role in providing education on trauma-informed

care and the prevalence of trauma within our schools to not only the school, but to the

surrounding community. Trauma can be viewed as a very negative, intimidating topic to those

who are uneducated of its prevalence and negative effects.

Positive Relationships

As schools move in the direction of becoming trauma-informed, great emphasis needs to

be placed on strong, positive relationships between staff and students. Students spend more time

with teachers than they do their own families during the school year. This time needs to be built

on the foundation of strong, positive relationships which create safety for a student who has been

affected by adverse childhood experiences. Walkey & Cox (2013) believe once students feel

safety has been established for their physical and emotional being, the powerful impact of

positive relationships will create a climate of "respect and generosity of spirit" within a school

(p. 126). Foster, Gower, Borrowsky & Morris (2017) share the same beliefs by stating,

"[s]upportive relationships with adults outside the family have been shown to help youth cope

with adverse circumstances, both physiologically and psychologically" (p. 31). Foster et. al

(2017) goes on to state "positive student-teacher bonds have demonstrated benefits for

psychosocial adjustment" (p. 31). At the heart of the solution to aid students with adverse

childhood experiences should be a strong, positive relationship with an adult within the school.

Summary

Isolation, aggression, attention issues and lack of self-control are some of the multitude

of negative, lasting effects that adverse childhood experiences can have on youth. The

importance of creating trauma-informed environments to address the needs of children affected

by ACEs is becoming more apparent as the number of children experiencing adverse childhood

experiences continues to grow at an alarming rate. Educators need to be trained on how to

recognize children who have been affected by trauma. Over half of the adolescents in the United

Stated have experienced at least one adverse childhood experience (Soleimnapour, Geirerstanger,

& Brindis, 2017). Trauma-informed care programs providing mindfulness strategies to aid in

student regulation of the negative emotions evoked by exposure to adverse childhood

experiences are critical to the success of these students.

The important role of a social worker within a school needs to be recognized. A social

worker is a trained mental health professional who has the ability to educate the staff on trauma-

informed care through various school programs. A social worker also plays a crucial role in

working with families to provide resources to aid in the resiliency of a child affected by an

adverse childhood experience. Social workers can offer strategies aiding educators in building

positive relationships with students affected by adverse childhood experiences.

Methodology

The study employs a structured interview to voluntary participants to identify education

professionals' perception of resources available to students who have experienced adverse

childhood experiences and to gather data on teacher preparedness when dealing with students

who been affected by adverse childhood experiences and the resiliency of these students.

Method of Inquiry

A structured interview of staff working with children who have been affected by adverse

childhood experiences will uncover educational professionals' perceptions of resources available

to these students. Research supports the lack of resources for these students, especially when

dealing with the resiliency of these students and suggests the need for the incorporation of

trauma-informed care within our schools. Teacher knowledge of the intervention programs

available to schools through the incorporation of trauma-informed care will also be gathered

through the structured interview process. By interviewing teachers who work closely with

students who have been affected by adverse childhood experiences, data were collected on

principal, counselor and teacher perception of the preparedness, knowledge and resources

available to staff to aid students who have experienced ACEs.

Procedures

Participants were recruited using letters explaining the purpose and goal of the research

project. Staff members that provided consent were enrolled into the study. The study was

approved by the university Institutional Review Board and the participating school division,

Spotsylvania County (VA) Public Schools.

Staff members were invited to participate in the study. The staff members chosen to

participate in the study included the principal, the school counselor and three classroom teachers.

Participants were scheduled for a structured interview session via telephone. The staff members

provided consent to allow and audio recording of their responses to occur. During the interview

session, the following four questions were asked of the staff member:

1. Children regularly exposed to certain parental behaviors like spousal abuse may

   internalize their feelings about what is happening to either of their parents. You

   may have children in your classes who are affected by these acts. There are more

   examples, of course, and are termed Adverse Childhood Experiences. Have you

   worked with a student you suspected or was identified as having an ACE? If so,

   what did you see in terms of behaviors? If not, I am going to give you several

   examples of behaviors caused by ACEs. After each behavior, tell me if you have

seen this behavior with one or more of your students (Sudden withdrawal from peers, angry outbursts, signs of anxiety, daydreaming or difficulty paying attention to tasks). What challenges did you have in working with the student(s) that exhibited the above behaviors?

2. If you have worked with a student who is demonstrating behaviors caused by ACEs, what resources might you want to have available to you? What support might you need to help the student develop coping strategies so s/he can be able to fully participate in learning? What external supports (e.g., counseling, group work) would be helpful for a child affected by an ACE?

3. Education professionals develop a "tool bag" of strategies to help children develop academic skills and to grow socio-emotionally. We know children today face a host of ever-changing challenges-even traumatic experiences. Let's say you are mentoring a new teacher. What "tools" would you suggest a new education professional use when aiding a child affected by an ACE? What might be additional training and access should new education professionals have?

4. Education professional wear many hats and assume more roles than "just a teacher." Education professionals, at times, assume the role of a parent, a counselor, a nurse, a mediator and often that of a mental health professional helping students navigate through traumatic experiences. Throughout the foundational courses offered to someone seeking a degree in education, do you feel that enough emphasis is placed on learning about the social-emotional health of a child? If so, what courses have prepared you to aid a child who has been affected by an adverse childhood experience? If no, what courses do you feel

need to be integrated into preparing educators to deal with the effects of trauma

on our youth?

The researcher did both an audio recording and written transcription of the responses

provided by interview participants. The data were then organized into a table of responses that

compared each of the respondent's responses, finding common themes among the perceptions of

educational professionals. Upon transcribing the responses of each interviewee, a table was

created logging the various responses to each interview question to the research to find common

patterns and themes. The data were then examined further to contrast varying perceptions of the

challenging behaviors displayed by students who had experienced an adverse childhood

experience, resources available to education professionals to aid in the resiliency of these

students, tools and strategies for new education professionals entering the field and preparation

to deal with the mental health challenges of students.

Findings and Conclusions

Five education professionals were asking to participate in a structured interview process

that included four questions addressing the resiliency and resources available to students who

have experienced one or more adverse childhood experiences. The participants included a

principal (respondent 4), a school counselor (respondent 2) and three classroom teachers

(respondents 1, 3 and 5). At the heart of every education professional is the desire for all

students to succeed, no matter the external factors that a child may be faced with such as adverse

childhood experiences. A thematic analysis approach was used to analyze the data collected

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during the structured interview process to identify common patterns and themes within the

responses. Various common patterns and themes emerged from the structured interview process.

The most common theme which surfaced was the passion and empathy each education

professional described through his/her responses to the interview questions. The data collected

supported the need for the implementation of trauma-informed care within our schools.

Figure 1: Themes discovered from Meta-Analysis

Respondent	Challenging Behaviors Witnessed	Lack of Resources Available	Lack of Training	Lack of Preparation
1 (Teacher)	X	X	X	X
2 (Counselor)	X	X	X	X
3 (Teacher)	X	X	X	X
4 (Principal)	X	X	X	X
5 (Teacher)	X	X	X	X

As shown in *Figure 1*, all respondents stated they had witnessed challenging behaviors

from students who had experienced one or more adverse childhood experiences. When asked if

s/he had worked with a student s/he had suspected or was identified as having an ACE,

respondent 5 stated, "No." When specific behaviors were listed that normally accompany a

student who had been affected by an ACE, respondent 4 stated, "I guess I have worked with

students who have been affected by trauma or an adverse childhood experience and I did not

even know it." The initial response from Respondent 5 suggests a comprehensive understanding

of what adverse childhood experiences and trauma itself are lacking for this education

professional. Respondent 4 stated, "Absolutely, in all shapes and forms" when asked if s/he had

worked with a student suspected of or having been labeled as having experienced an ACE.

Respondent 4 suggested that all education professionals need to assume that each child they are

working with has experienced some sort of traumatic event in his or her life. With this

assumption, education professionals can have a trauma-responsive outlook on public education.

The differing perceptions of respondent 4 and 5 are based on each individual's knowledge of the

effects of trauma on youth, which supports the ever-growing need for schools to become trauma

informed.

Respondent 1 referred to the ever-growing needs of youth pertaining to trauma-informed

care stating, "The challenging behaviors witnessed by students affected by an adverse childhood

experience affect the collective whole of a classroom." Respondent 3 agreed with Respondent 1

stating, "When a student that has been affected by an adverse childhood experience has a bad

day, we all have a bad day." The perceptions of the effects of the challenging behaviors

presented by students who have been affected by adverse childhood experiences were deemed

negative by all respondents, having a lasting impact on a student's overall academic

performance.

The perceptions of respondents 1, 3 and 5 allowed for a more detailed explanation of

challenging behaviors displayed by students who have experienced at least one adverse

childhood experience due to the time spent with the student within the classroom setting. The

perceptions of respondents 2 and 4 varied due to the role these individuals play in the life of a

student who has been adversely affected by trauma. The roles of respondents 2 and 4 take on

more of an intervention approach when challenging behaviors are displayed by the student,

rather than working with the student closely within a classroom setting.

Figure 1 also illustrates that all respondents feel there is a lack of resources available to

education professionals, lack of training, and preparation to aid a student who has been affected

by an adverse childhood experience. The need for trauma-informed care training emerged as a

major factor. The perception of the need for trauma-informed care varied among the respondents,

but the overall need was evident in all responses. Respondent 4 expressed a broader view for the training of educational professionals on trauma. S/he suggested to use a "tiered approach to embedded professional development for the staff." S/he explained "Tier 1 would be the basic comprehension of what trauma is and how to recognize the effects of trauma within our student body." "Tier 2 would involve research-based, effective instructional strategies to be implemented within the classrooms to reach all students, even those adversely affected by trauma," according to Respondent 4. The last tier described by Respondent 4 was "The identification of students that needed to be referred to a Trauma Response Team that would then offer more intense, and at times, resources outside of the school to be provided by the school social worker." The tiered approach described by respondent 4 has yet to be implemented within the school. The tiered approach described by respondent 4 would bring trauma-informed care to the forefront and aid in the overall comprehension of what trauma is and how to aid in the resiliency of students affected by adverse childhood experiences.

The need for additional training in trauma and the mental health issues facing students was expressed by all classroom teachers interviewed. Respondents 1, 3 and 5 each expressed that the need for trauma-informed care needs to be a priority for all building leaders. Although respondent 4 described a tiered approach to address the need for training for staff, one must question why this tiered approach has yet to be put into action by building leaders within the school. Respondent 1 referenced that often professional development opportunities are tied to funding. S/he even expressed that a college course s/he was teaching online was cut because there was no funding and stated, "Mental health in education was not seen as a "core" class. It was viewed as an elective course and not seen as a priority for education professionals." S/he went on to explain that the need for education professionals to be educated on trauma and the

effects of trauma on our youth is often spoken of by policy makers as a "hot topic" but is sadly not funded.

Although the other respondents referenced the need for trauma-informed care, the perceptions of what this looked like were different from that of Respondent 4. Respondents 1 and 3 referenced the need for education professionals to understand how a child's brain works and how the brain of a child experiencing an ACE differs from that of a child who has not. Respondent 2 shared that, "I am not prepared to respond to the questions pertaining to trauma-informed care because I feel I do not have enough knowledge about trauma-informed care to speak in detail about it." The fact that respondent 2 serves as a school counselor, the lack of knowledge s/he expressed is alarming. Research supports that a school counselor and social worker within a school are prime resources for not only the students affected by adverse childhood experiences, but also as resources for the families of these students. Respondent 2 stated that, "As a counselor, my role looks different from a classroom teacher. I run small groups that can focus on various social skills students affected by trauma are struggling with. But, I do not have many strategies, other than breathing strategies that I can offer these students." She offered examples of mindfulness strategies and breathing techniques, such as "pizza breaths" that she uses with students who are displaying challenging behaviors due to adverse childhood experiences but emphasized that she would like to further research trauma and its effects on youth because s/he realizes the need is alarming among our students and was not prepared to answer the interview question at this time.

Respondent 3 shared a similar perception referencing, "Even if educators know what trauma is, they do no know how to recognize the effects of trauma in students because it presents itself differently with each child." S/he went on to say, "A child who has witnessed spousal

abuse by one parent to another is going to have different behaviors than a child who has been

sexually abused." Respondent 3 stated, "I do not know how to deal with the differing traumas

because what works with one child is not going to work with another." S/he also suggested

education professionals have a "Trauma Reference Guide" that lists the specific types of trauma

a child could have experience, how it affects the child (both academically and socially) and

various responses an education professional could use with a student who has been affected by

an adverse childhood experience. S/he stated, "As a fairly newer teacher, this would help me

greatly when dealing with students who have been affected by trauma and would be a great

resource for a new teacher."

Figure 2 Challenging Behaviors Witnessed

Respondent	Sudden Withdrawal from Peers	Angry Outbursts	Signs of Anxiety	Daydreaming or Difficulty Paying Attention
1 (Teacher)	X	X		X
2 (Counselor)		X	X	
3 (Teacher)		X	X	
4 (Principal)	X	X	X	X
5 (Teacher)	X	X	X	X

Angry outbursts have been witnessed by all respondents as illustrated in *Figure 2*.

Sudden withdrawal from peers and difficulty paying attention were witnessed by 60% of the

respondents. Anxious behaviors were witnessed by 80% of respondents interviewed. At least

two of the behaviors associated with students that have been affected by adverse childhood

experiences were witnessed by all five respondents. Respondents 2 and 4 often see more

aggressive, angry behaviors due to the role they play in the lives of students who have been

affected by adverse childhood experiences. A classroom teacher would be more likely to witness

the inability to focus or withdrawal from peers than a building principal or school counselor.

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Respondents 1, 2, 3 and 5 all referenced the need for consistent, universal strategies to address these challenging behaviors exhibited by children who have been affected by adverse childhood experiences. Breathing techniques, common language, cool down areas within the school, and mindfulness activities were all common themes emerging from the responses of respondents 1, 2, 3 and 5. Respondent 4 had a broader perception of challenging behaviors making reference to the ability to have "More knowledge about a student than the classroom teacher due to the access to the student affected by an adverse childhood experiences or trauma." A building principal is often involved in situations which require confidentiality, not allowing a principal to fully share all of the knowledge s/he has about the traumatic situation a child may be experiencing. A student's best interest is at the heart of all education professionals, regardless of the role the professional plays in the life of that child. The classroom teacher needs to be appropriately involved and kept abreast of the external traumatic factors affecting a student with an ACE to aid in the resiliency of this student. Research supports communication between school, family and mental health professionals working with the child outside of the school setting aids in the resiliency of a student who has been affected by an adverse childhood experience (Frydman and Mayor, 2017).

Common patterns that surfaced during the structured interview process were the behaviors exhibited by students who had been affected by adverse childhood experiences and the lack of training for educational professionals on trauma-informed care. The respondents also felt they needed training on the different ways trauma presents itself in students. Foundational courses that offer an understanding of how the brain works after experiencing trauma need to be offered to those seeking a degree in education according to the respondents.

Four of the five education professionals interviewed suggested that core classes with a

mental health focus should be integrated into education degree programs. These four

respondents felt strongly that the way mental health presents itself in education needs to be

offered to those seeking a degree in education. They also stated a basic understanding of how

the brain works after experiencing an adverse childhood experience would greatly benefit those

seeking a degree to become an education professional. An individual seeking a degree in

education should have a firm foundation and understanding of how trauma affects the

development of a child and the adverse effects trauma can have on a child according to four of

the respondents.

The common behaviors demonstrated by students who had been affected by adverse

childhood experiences witnessed by the educational professionals interviewed included angry

outbursts, defiance, throwing classroom items, depressive behaviors, inability to focus and

challenging authoritative figures. Only one interviewee responded, "No," when asked if s/he had

a student in the classroom was suspected as being (or was aware) affected by an adverse

childhood experience. When specific examples of behaviors who students who have been

affected were listed, s/he then said, "Yes," after learning these behaviors were related to a child

who had experienced an adverse childhood experience.

All interviewees expressed the need for trauma-informed care to be integrated into

schools and the need for training on how to respond to trauma. Respondent 1 stated, "Anyone

looking to go into the field of education needs to take any and all courses and professional

development opportunities on trauma and trauma-informed care available to them. I am a

veteran teacher with my doctorate degree and I still do not feel that I, myself, have enough

knowledge on trauma-informed care to fully be able to help students affected by adverse

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childhood experiences to the best of my ability." Research supports respondent 1 for the need for

all schools to become trauma-informed to aid students who have been affected by adverse

childhood experiences.

Recommendations for Further Study

Figure 3: Recommendations

Respondent	Professional Development on Trauma-Informed Care	Resources Available to Education Professionals	Integration of Mental Health Courses Within an Education Degree	Professional Development on How to Recognize Effects of Trauma on Students
1 (Teacher)	X	X	X	X
2 (Counselor)	X		X	X
3 (Teacher)	X	X	X	X
4 (Principal)	X			X
5 (Teacher)	X	X	X	X

Public education needs to take a preventative approach toward addressing the needs of

students who have been adversely affected by trauma through ACEs. As shown in *Figure 3*, all

respondents expressed the need for professional development for education professionals on

trauma-informed care. It is imperative for the success of students who have been affected by

adverse childhood experiences education professionals are offered the training to recognize

trauma and how to respond to the effects of trauma within our youth.

With the ever-growing mental health needs of our youth, individuals seeking a degree in

education need to have courses integrated into the program which address how a child's brain

works after experiencing an adverse childhood experience. Respondent 1 referenced a college

course she was instructing at a university centered around mental health in education was cut due

to budget issues. She stated, "It was disheartening that the mental health of our youth was seen

as an elective course and not a core course within the curriculum of those seeking a degree in

education." Both Respondent 3 and Respondent 5 referenced the need to understand how a child's brain works after experiencing trauma and how educators may be able to recognize trauma within students but, do not know what to do after the recognition. Respondent 5 suggested a tiered approach to trauma-informed care within our schools, "Tier 1 is basic understanding of what trauma is and what it looks like in our students, Tier 2 would be successful instructional practices and strategies in classrooms having students who have been affected by ACEs and Tier 3 would be education on the referral process for a student who has been affected by an adverse childhood experience to a Trauma-Response Team." Whether a tiered approach to trauma-inform care or the integration of mental health course in our collegiate programs, the need for more education on how trauma is affecting our youth was evident throughout this structured interview process.

School intervention programs incorporating trauma-informed care need to be further researched. Intervention programs can alleviate the negative effects adverse childhood experiences can have on students and provide educators with needed resources to successfully aid in the resiliency of students who have been affected by one or more adverse childhood experiences. Training and professional development for educators about the mental health concerns our youth may demonstrate, the negative impacts adverse childhood experiences may have on our youth and effective strategies through trauma-informed care should become a priority within our schools. Changes in the policies and practices currently in place within college institutions that provide people pursuing a degree in education with a firm foundation in mental health could a topic of interest for further research.

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