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Trauma responsive elementary schools in Virginia

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Abstract

School systems and personnel are beginning to recognize the immense impact that trauma has on their student populations and take initiative to address these factors within the school building using trauma responsive practices. School personnel are likely to encounter the effects of trauma on a regular basis in the management of behavioral concerns, which have a dose-response relationship to traumatic experiences. School principals are leaders in the school building and have a large influence on school-wide practices, thus are in the unique position to alter policy and practice. The current study examined Virginia elementary school principals' level of trauma training, use of trauma responsive practices, perceptions of their school's trauma awareness and effectiveness of trauma responsive practices, and barriers to implementation of trauma responsive practices. The data collected from the study supported the need for more staff training, recognizing teachers as key stakeholders in the transition to become more trauma responsive, and more resources directed towards this endeavor in schools, including mental health professionals.

Trauma Responsive Schools in Virginia

The negative impact of trauma is irrefutable, greatly impacting physical and mental health, behavior, relationships, and our communities as a whole, and evidence of such will be demonstrated in the following literature review. There has recently been an initiative to address trauma in a more comprehensive manner, implementing trauma responsive care in different systems that serve communities such as hospitals, community service boards, and schools. Public schools, because of the copious amount of time children spend there and the large population they serve, in particular, have the unique opportunity to provide instrumental support to children impacted by trauma and mediate the effects before they become calamitous. Research has indicated the success of a trauma responsive framework within schools, showing improvement in a variety of different measures. This study sought to identify effective trauma responsive practices and barriers to implementing trauma responsive practices in Virginia schools. Information is needed to inform trauma responsive training to enhance the success and impact of schools implementing trauma responsive frameworks in schools.

Imagine a child born into a family with two parents addicted to drugs. Let us call this child David. David's parents are more concerned with where they are getting their next fix than they are with holding baby David, feeding him, and creating a strong relationship with their bundle of joy. Baby David cries almost constantly. The neighbors call Child Protective Services. David is removed from the home and placed in foster care. David is bounced around from foster home to foster home. Some of the homes are okay and others are not. David encounters physical and sexual abuse while working his way through the system. David has been exposed to trauma. David is currently in a stable foster home. It is now time for David to begin school. David has many

problems at school. He is aggressive with his peers and teachers, he does not listen to or follow directions, he has an explosive temper, and he cries when he does not get his way.

At school A, David is seen as a problem child. Teachers and staff do not know anything about trauma and do not consider why David acts the way that he does. They think that he needs more punishment in order to learn his lesson. David's teacher thinks he needs to be evaluated, because there is "something wrong with him". The teachers and staff are afraid of him and treat him like a ticking time bomb, gingerly stepping around him and avoiding him. They only point out when David has done something wrong. Teachers and staff yell at him when he has done something wrong. This scares David and he reacts with aggression. David does not have any strong relationships with anyone in the school. There are many school policies that are zero-tolerance that result in suspensions. His behaviors only seem to be getting worse after he is suspended.

At school B, they practice a trauma responsive approach. The teachers and staff are well versed in what trauma is, what it looks like in students, and things they can do to improve the outcomes of students affected. The school has social and emotional learning inserted in their curriculum. The students are taught self-regulation skills. The teachers and staff in David's school try to build a relationship with him, asking him about his weekend, connecting with him about his favorite activities, and telling him what a nice smile he has. They encourage and reinforce when he shows his good qualities. They try to make him feel safe and let him know he is an important part of their school community. They remain calm and do not yell to express disapproval. They express disapproval of his actions when he does something wrong without expressing disapproval of him (you did a bad thing, but that does not mean you are bad). They recognize the symptoms of burnout and secondary trauma and address it when they see it in others and in themselves. The school practices disciplinary strategies that focus on safety of students and are less punitive in

nature and more rehabilitative or restorative. The school identifies that David is a student who needs more support than other students and he receives targeted interventions such as counseling, check in and check out services, and collaboration with his caregivers. David still has outbursts, but his prosocial behaviors are increasing, and office referrals are decreasing.

Literature Review

Trauma Definition and Impact

Trauma lacks an agreed upon universal definition. For the purpose of this research, trauma will be defined using the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2019 individual trauma definition, "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

SAMHSA's (2019) broad conceptualization and guidelines of trauma-informed care in practice is defined as, "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; Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and Seeks to actively resist re-traumatization." SAMHSA's framework can be instituted into any system, including schools.

Missouri utilizes the Missouri Model (2014), a developmental framework that conceptualizes the changes that progress as organizations seek to better support individuals within the system who may be impacted by trauma. Within this framework, systems seeking to utilize a trauma-informed approach fall on a continuum of preparation for those affected by trauma and

identification of position on the continuum can bring awareness to areas to improve upon (Missouri Model, 2014). The first step towards a trauma-informed school is Trauma Awareness, a general understanding of how common trauma is and consideration of how it impacts the staff and population served. Within Trauma Awareness, school leaders recognize that trauma affects their population. Trauma Aware principals actively acquire knowledge about trauma and make training available that includes the definition of trauma, prevalence, causes, impact, etc. Stakeholders are given resources to find more information, and brainstorming takes place to determine what next steps might be (Missouri Model, 2014). Staff in a Trauma Aware school know what trauma is and how it affects themselves, their students, and their colleagues.

The next step on the continuum of trauma-informed systems is Trauma Sensitivity. Trauma sensitive schools consider different aspects of trauma-informed care including safety, choice, collaboration, trustworthiness, and empowerment and how these coincide with their school systems. They contemplate what ramifications there would be to implementing trauma-informed care within their school, and they prepare for changes (Missouri Model, 2014). The school goes through a process of self-assessment to determine strengths, resources, and barriers in their progression to a service model that is consistent with trauma-informed care. School leaders (principals) prepare the school for the change and initiate reflection to gauge readiness for change (Missouri Model, 2014). The school staff identify staff members who embody the values of trauma-informed care as leaders and the school hires people whose behaviors and attitudes align with trauma-informed principles. The school identifies what role students and families will have in this change and how to include these stakeholders (Missouri Model, 2014). The school also begins to consider logistics of universal screening of trauma, as well as potential resources and referral options for trauma specific treatment. Indications that a school is within the Trauma

Sensitive step include: inclusion of trauma in the mission statement or other policies, trauma training is required for all staff, trauma information is accessible to staff and parents in the form of posters, flyers, and handouts, and administration recognizes and responds to compassion fatigue in staff (Missouri Model, 2014).

Trauma Responsivity is the next step towards a trauma-informed school. At this point, the school has begun to alter their culture and organization to account for trauma (Missouri Model, 2014). This is the point at which planning and action takes place and procedures in all systems (cafeteria staff, transportation staff, administration, teachers, etc.) are reconsidered with the intent to better accommodate those with trauma backgrounds (Missouri Model, 2014). Staff is better supported through self-care support, supervision models, staff development, addressing of staff trauma, and performance evaluations in the trauma responsive stage. Staff begins to more concretely apply trauma foundations to their behaviors and practices in their specific roles (Missouri Model, 2014). Language is embedded throughout the infrastructure that corresponds with safety, choice, collaboration, trustworthiness, and empowerment. In Trauma Responsivity, universal screening for trauma takes place and trauma-specific assessment and treatment is offered to those who need them, either at school or to an outside referral. Additionally, there is a predetermined plan in place for crises that reflects trauma-informed values (Missouri Model, 2014).

The final stage of the trauma-informed care framework is Trauma Informed. This is a school that has made trauma responsive procedure and policy the norm throughout the building. The trauma framework has become so ingrained in the school that it no longer depends on a few leaders. The school works with other partners to build collaboration in being trauma informed. The trauma-informed school measures the impact of trauma on students, progress monitors the

implementation of their trauma-informed practices, assesses their fidelity in application of a trauma-informed model, and uses data to inform all decisions made (Missouri Model, 2014). They have revised their policies and procedures to reflect their trauma-informed values and actively seek to reduce the stigma of trauma. They additionally have interventions for staff facing secondary trauma and progress monitor the impact of these interventions. Those who make hiring decisions actively seek to hire candidates who have knowledge in trauma and support trauma-informed values. Trauma-informed schools require that all staff employ trauma-informed practices with students, other staff, and families of students. They additionally offer coaching and consultation to staff to improve trauma-informed skills on-site when needed.

Felitti et al. (1998) determined in their work that the impact of trauma continues long after the traumatic events initially occur, demonstrating a strong relationship between the number of adverse experiences a person goes through as a child and their future health outcomes. Felitti et al. (1998) found that adults who had adverse childhood experiences (ACES) were more likely to engage in or to have a risk factor for the leading causes of death, in smoking, severe obesity, physical inactivity, depressed mood, and suicide attempts. The occurrence of these factors was significantly increased with more adverse childhood experiences.

Additionally, they found a graded positive relationship between adverse childhood experiences and later alcoholism, use of illicit drugs (and injection of illicit drugs), greater than or equal to 50 intercourse partners, and history of an STD (Felitti et al., 1998). Adults with more varied adverse childhood experiences (across different categories: psychological, physical, sexual, or substance abuse, mental illness, mother abused, or imprisoned family member) were found to be much more likely than those without adverse childhood experiences to suffer from diabetes, chronic bronchitis, emphysema, skeletal fractures, hepatitis or jaundice, and to rate their personal

health to be poor. Controlling for age, gender, race, and educational attainment, the researchers still found that more adverse childhood experiences resulted in much higher risk of later disease conditions: ischemic heart disease, cancer, chronic bronchitis or emphysema, history of hepatitis or jaundice, skeletal fractures, and identifying their own personal health to be poor (Felitti et al., 1998).

Anda et al. (2006) found evidence corroborating the original Adverse Childhood Experiences (ACE) study, in that the more adverse childhood experiences an individual had, the more likely they were to have experienced disturbances. It was found that higher ACE scores increased the risk of sleep disorders, severe obesity, and multiple somatic symptoms. Additionally, substance abuse likelihood also increased with exposure to adverse childhood experiences (Anda et al., 2006). Mental health disturbances identified in the Anda et al. study (2006) include panic reactions, depressed affect, anxiety, hallucinations, high perceived stress, and anger management difficulties. The risk of all these outcomes was found to be strongly related to participants' adverse childhood experiences.

Although there is most certainly a large correlation between the adverse childhood experiences a person has had and their personal traumatization, it is essential to differentiate between adverse childhood experiences and trauma. Adverse childhood experiences are the objective history of events a person has been subjected to and trauma is a more subjective experience as a result of those events. Someone can undergo adverse childhood experiences and due to resiliency factors never experience traumatization.

Delaney-Black et al. (2002) found that after controlling for confounding variables such as gender, caregiver intelligence, home environment, SES, and prenatal substance exposure, there was found to be a relationship between exposure to violence and the child's IQ and reading ability.

Children exposed to violence and experiencing stress related to that trauma were found to have IQs that were 7.50 points lower (*SD* = 0.50) and reading achievement scores that were 9.80 points lower (*SD* = 0.66) than their peers (Delaney-Black et al., 2002).

Hurt, Malmud, Brodsky, and Giannetta's 2001 study found that children who had been exposed to violence were more likely to experience increased anxiety and depression, more exposure to violence was linked to lower grade point averages and more school absences. Hurt et al. (2001) found that caregiver report of their child's anxiety did not correlate well with the child's perceived anxiety, indicating that subjective feelings of children are not always perceived by adults, highlighting the importance of gathering well-being information from children themselves. This identifies a need for schools to ask students about their subjective feelings of distress, rather than the parents or teachers of students. Children who reported experiencing or observing more violence indicated feeling less competent in school and had more behavioral problems (Hurt et al., 2001).

Blodgett and Lanigan (2018) found that among a random sample of 2,101 children from kindergarten through sixth grade, 44% of the children had exposure to ACEs and 13% of had exposure to 3 or more ACEs. Within their study, they used regression analyses to determine that there is a dose-response effect between poor school attendance, behavioral issues, inability to meet grade-level standards in mathematics, reading, or writing, and number of ACEs.

DePrince, Weinzierl, and Combs (2009) found that children affected by family-related trauma (as opposed to trauma unrelated to the family and children unaffected by trauma) were more likely to have lower executive functioning as measured by working memory, inhibition, auditory attention, and processing speed tasks. Even when the researchers controlled for the

children's anxiety symptoms, and socioeconomic status, trauma exposure explained some of the variance in executive functioning performance.

Cook et al. (2005) have found that children who have experienced a subtype of trauma, complex trauma (characterized by multiple exposures, invasive and interpersonal nature to the trauma, such as abuse or neglect), are at risk for problems in several domains: attachment, affect regulation, dissociation, behavioral control, cognition, and self-concept. Within attachment, these children experience boundary problems, distrustfulness, social isolation, interpersonal difficulties, and problems taking others' perspectives and attuning to others' emotions. These children may face difficulty with emotional self-regulation, labeling and expressing feelings, knowing and describing their internal feelings, and communicating their wishes and needs (Cook et al., 2005). Due to these affect regulation deficits, these children are prime candidates for social-emotional learning curriculum.

In the dissociation category, children impacted by trauma are at risk to have amnesia, depersonalization and derealization, consciousness in two or more distinct states, diminished memory for state-dependent events, and distinct alterations in states of consciousness (Cook et al., 2005). These factors all suggest that traumatized children may benefit from extra repetition and more explicit instruction. Children who have experienced trauma also have reduced ability to control impulses, behavior that is self-destructive, aggression, compulsive self-soothing behaviors, sleep problems, eating disorders, substance abuse, oppositional behavior, trouble comprehending and following rules, and reenactment of trauma in behavior or play.

Cognition of children who have undergone trauma is impacted in several ways, including: problems regulating attention and executive functioning, decreased sustained curiosity, difficulties processing new information, deficits in task completion and focus, problems with object

constancy, planning and anticipation shortfalls, learning difficulties, language development concerns, and issues orienting to space and time (Cook et al., 2005). Children impacted by trauma have impaired self-concept, poor sense of identity, areas of effect are seen in their generally lower self-esteem, sentiments of shame and guilt, and body image problems. Cook et al.'s findings demonstrate ample evidence that students affected by trauma will need more support in the school setting than their peers.

School Interventions

Schools can improve student's feelings of safety by offering unconditional positive regard (UPR). UPR for the purpose of this research is the "idea that you always give value and respect to all individuals, including students" (Rossen, 2016). UPR in the school requires that you offer students acceptance for who they are unconditionally; that is not a requirement or expectation to condone their behavior. Despite what a student has done, a student affected by trauma may need to hear that they will still be appreciated, cared for, and they will still have support in their education and development (Rossen, 2016). This offers stability that a child impacted by trauma has likely not had before, nor is it reliant upon contingencies of things that they struggle to control such as their behavioral regulation. An example of this in practice includes welcoming a student who has just returned to school from a suspension and telling them, "We missed you and are happy to have you back" (Rossen, 2016). Rossen recognizes that transitioning to more effective school discipline in the form of decreasing suspension and expulsion demands systematic change including shift of thinking and policy which necessitates significant time, energy, and collaboration.

Rossen and Cowan postulated in 2013 that in order to effectively identify traumatized students, schools need to take the multitiered system of supports (MTSS) approach which allows

for a universal framework that gives support to all students (even those who are not affected by trauma), integrates different programs, and identifies risk before it becomes a problem. A trauma responsive MTSS model encourages well-being of all facets of student life, identifying concerns among academics, social and emotional functioning, and mental and physical health (Rossen & Cowan, 2013). Support is provided to all students, including programming that addresses improvement of school climate and conditions for learning in a holistic fashion. Traumatized students are at risk for feeling disconnected from school, not feeling safe, and expressing a lack of trust, so a positive school climate is essential for building their resiliency factors. Examples of tier one support provided to all students are physical activity programs, social and emotional learning curriculum, violence prevention programs, positive behavior supports, and changes to discipline practices (Rossen & Cowan, 2013). Allowing all students to receive these supports encourages prevention of serious academic, social, emotional, and physical and mental problems to occur, especially considering the school may never explicitly know about some students' traumas. In the incidences where a student needs more targeted or individual intervention, an MTSS framework helps identify those who need more support.

Trauma Responsive Programs

The Healthy Environments and Response to Trauma in Schools (HEARTS) program is one example of a set of initiatives and a framework that a school can take to become more trauma responsive (Dorado, Martinez, McArthur, and Leibovitz, 2016). Dorado et al. (2016) studied the implementation of HEARTS, which incorporated a trauma responsive approach that involves the whole school using a multitiered systems of support framework similar to what Rossen and Cowan suggested (2013). A perspective encouraged through this framework is the idea that trauma-impacted children's behaviors are the result of them adapting to their environments in order to

survive their circumstances, rather than seeing them as “problem behaviors”. Promoted rhetoric to support this perspective is asking, ‘what has happened to you?’ rather than ‘what is wrong with you?’ to children impacted by trauma.

HEARTS, in addition to the multitiered framework, focuses on three levels of support: students, caregivers, and the school system (Dorado et al., 2016). HEARTS uses an empirically supported theoretical basis, Attachment, Self-Regulation, and Competency (ARC), to guide their trauma responsive care. Attachment in the ARC theory includes building skills for caregivers such as managing affect and attunement skills and encouraging family routines and rituals. Self-regulation encompasses teaching the child to identify their affect and emotions, the way they express these feelings, and how to control or cope (Dorado et al., 2016). ARC facets are all related to improved school performance, so it is an effective theory to integrate into schools that aim to be trauma responsive. The HEARTS program’s objectives included: (1) understand trauma and stress, (2) establish safety and predictability, (3) foster compassionate and dependable relationships, (4) promote resilience and social emotional learning, (5) practice cultural humility and responsiveness, and (6) facilitate empowerment and collaboration (Dorado et al., 2016).

To begin, the HEARTS program comprehensively trained teachers and all other school staff on how trauma effects learning, teaching, behavior, relationships, and communities as a whole. The HEARTS team addressed different ways that the effects of trauma could be combated regardless of the role of employment in the school (Dorado et al., 2016). The HEARTS team used “horse” and “rider” metaphor, for the participants to better grasp the material. The “rider” is the “learning/thinking brain” and has the full picture and perspective of what is going on and is able to make rational decisions and learn. The “horse” is the “survival/emotional brain”, that behaves impulsively based on instinct to protect itself based off emotion. When the “rider” and “horse” are

working in conjunction with each other, they are productive, but when a trauma trigger occurs, the "rider falls off the horse," and the "learning/thinking brain" is not able to function (Dorado et al., 2016). Behavioral consequences are not effective in these moments and may even escalate the trauma response, instead, focus should be placed upon meeting the student's safety needs and getting their "rider" back on their "horse" by encouraging self-regulation.

Another step the HEARTS program includes is teaching school staff how they may be inadvertently affected by their students' traumas in the realm of burnout and secondary trauma (Dorado et al., 2016). Following that, the program teaches coping resources and strategies to meet the needs of those who do recognize burnout or secondary trauma in themselves or others. Tier two interventions in HEARTS program schools involved adding a HEARTS trained clinician to the development teams of behavioral intervention plans and changing discipline policies to be more supportive and less punitive. Tier three interventions for trauma impacted students focused on providing trauma-specific, culturally competent therapy (using ARC foundations) and collaboration among mental health providers and caregivers to comprehensively address areas of need. Collaboration is also fostered between mental health providers and teachers and other school staff who are involved with the student, so that the trauma responsive interventions can be integrated into the student's every day environment.

Dorado et al. (2016) found that among school staff in their HEARTS schools there was a significant increase in knowledge on how to practice in a trauma responsive manner and how to address trauma. Additionally, student school engagement also significantly improved after the implementation of the HEARTS program, a 28% increase in students' ability to learn, 27% increase on students' time spent on tasks in the classroom, 36% increase on students' time in the classroom, and a 34% increase in students' school attendance. Between the year prior to the

HEARTS program implementation and first year of implementation, there was 32% decrease in total incidents and 43% decrease in physical aggression student incidents (Dorado et al., 2016). Five years after the implementation of the HEARTS program, total incidents were down by 87% and physical aggression incidents were down 86% (compared to data collected the year prior to implementation). While there was not a decrease between out-of-school suspensions after the first year of HEARTS implementation, after five years there was a 95% decrease in out-of-school suspensions (Dorado et al., 2016). Mental health providers at the HEARTS schools also measured their client progress using the psychometrically sound Child and Adolescent Needs and Strengths (CANS) scale and found that there was a decrease in clients' symptoms related to trauma in all five different areas and improvement in adjustment to trauma, affect regulation, intrusions, attachment, and dissociation.

Von der Embse, Rutherford, Mankin, and Jenkins' work (2018) corresponds with that of previous authors in implementation of a multitiered systems of support model incorporated with universal screening, teacher training, and mental health services offered in schools to tackle the problems experienced by students affected by trauma. In addition, their model included effective classroom management coaching. Von der Embse et al. found preliminary data to support a significant reduction in suspensions and disciplinary referrals after implementation of their model.

Perry and Daniels (2016) employed a similar framework to the previous researchers who sought to implement trauma responsive care, particularly training school staff and community members on trauma responsive practices (including self-care as a professional), identification of students needing trauma responsive support (coordination of care with community services), trauma responsive services for students, and coping skills education for students' current symptoms and potential future stresses. Perry and Daniels found that among their work with school

staff and community members, 97% (31 out of 32) of respondents were satisfied with the trauma training, all 32 participants reported that they had learned something, and 30 found that the training was useful. Within the study, they had school staff identify students' whose families were having difficulty providing basic needs and connected the families with a care coordinator who orchestrated helping the families meet their needs with community partnerships. The care coordinator served 19 families during this pilot study.

McIntyre, Baker, Overstreet, and the New Orleans Trauma-Informed Schools Learning Collaborative evaluated what potential training could look like for school personnel regarding trauma in their 2018 study. The researchers implemented a two-day foundational professional development training on trauma with a goal of increasing teacher knowledge and acceptability. McIntyre et al. (2018) measured learning through a 14-item multiple choice measure given pre and post intervention testing knowledge of trauma responsive approaches, including questions on the prevalence of trauma, the impact on the brain, behavioral and learning supports that are necessary for students, SAMHSA's trauma approach principles, and secondary traumatic stress in educators. Twenty percent of teachers at pretraining demonstrated mastery on the measure and 70% demonstrated mastery post training, indicating that teacher knowledge can be significantly increased with trauma training.

McIntyre et al. (2018) determined that among teachers who believed that a trauma responsive school approach did not fit their school system, the more these teachers learned about the trauma responsive approach, the less acceptable it became to them. This caveat highlights the need to initiate change in a systematic way, addressing stakeholders' concerns before implementation.

Mendelson, Tandon, O'Brennan, Leaf, and Ialongo (2015) demonstrated that within a targeted group intervention for students impacted by trauma, which involved mental health counselor facilitation and evidence-based cognitive behavioral and mindfulness strategies, teachers rated student participants better in emotion regulation, social and academic competency, classroom behavior, and discipline post intervention. Stein et al. (2013) found that trauma exposed students, who were actively demonstrating post-traumatic stress disorder (PTSD) and depression symptoms and who participated in cognitive behavioral intervention group mediated by school mental health clinicians saw a significant decrease in PTSD and depression symptomology. A decrease was also noted in parent reported measures of psychological and social dysfunction, and problems reported within the classroom by teachers.

Discipline Policies

Rossen (2016) discourages schools from implementing discipline policies that are too punitive; this includes the overutilization of suspension and expulsion for problems that occur frequently but have small impacts, such as insubordination. Positive discipline approaches are an effective alternative (Rossen, 2016). Ineffective suspension and expulsion practices may be beneficial to teachers and administrators (if only, temporarily) according to Rossen (2016). During Rossen's presentations to school counselors, administrators, and school resource officers, he has met pushback from some who question how students will learn to follow the rules and respect authority without the use of punishment. Rossen responds that students affected by trauma are more likely to engage in behaviors in which the consequences include exclusionary punishment, but these behaviors are shaped by their trauma (2016). These students' traumatic experiences have led to a predictable response pattern in which they have adapted to the danger in their

environments. The most important component of this perspective of effective school discipline is "unconditional positive regard" according to Rossen.

Zero tolerance policies increase the chances of re-traumatization in students impacted by trauma (Dorado, Martinez, McArthur, & Liebovitz, 2016). Further, there is no evidence that zero tolerance policies are effectively keeping schools safer or more efficacious in discouraging future occurrences according to the American Psychological Association's (APA) task force's 2008 review (APA, 2008). One of the general assumptions of proponents for zero tolerance policies is that when you remove students who break school rules, it will create a school environment better for learning for the students who were not removed. This assumption is incorrect in that higher rates of extremely punitive actions (expulsion and suspension) are associated with lower ratings of satisfaction with school climate (APA, 2008). In conjunction, there is no evidence that zero tolerance policies with consequences of expulsion and suspension decreases the incidence of future violations and instead the review (APA, 2008) found that students punished using zero tolerance policies were more likely to misbehave and have more consequent suspensions in the future. Further, these same students were also found to be more likely to drop out or have delayed graduations.

The APA task force (2008) also found that despite the expectation that zero tolerance policies would decrease overrepresentation issues in discipline, there is no support for this in the research and there still are disproportionate numbers of students of color and those with disabilities facing disciplinary action such as suspension and expulsion. Not only do zero tolerance policies discriminately affect students of color and students with disabilities, but these policies do not take psychological development into account when doling out punishment. Suspension and expulsion policies disregard the level of the student's development in which they may not be able to act

independently of peer influence or understand and weigh potential risk or future implications (APA, 2008). Risks of zero tolerance policies are high, including the potential to promote alienation, rejection, and disruption of healthy relationships with adults in the school building (APA, 2008).

Alternatives to zero tolerance policies that promote safety in school buildings and deter violence follow a framework of primary prevention with three levels of intervention: primary prevention strategies that aim to benefit all students, secondary prevention strategies that aim to reach students who are at risk of perpetrating violence or environmental disruption, and tertiary strategies in which students who have exhibited disruptive or violent behavior are the targets of intervention. Measurable outcomes that demonstrate improvement in these targets include decrease of office referrals, school suspensions, expulsions, and higher ratings on measures of school climate (APA, 2008).

The APA zero tolerance task force (2008) in compiling their review developed recommendations for schools to reform zero tolerance policy. Their recommendations include: adding more flexibility to current policies, particularly in inviting expertise from teachers and considering the context of the offense, encouraging teachers and other staff members to keep lines of communication open with parents, operationally defining rule violations and training all staff so that they are able to handle them. Rather than amplifying minor disruptions by sending students to administration, refrain from using zero tolerance policy unless the behavior has the potential to cause harm to others.

The task force also recommended implementing discipline that emphasizes a model of increased consequence relative to the gravity of the offense, require school resource officers to undergo training in child development, put preventative measures into place to improve climate,

community, and belongingness, and promote relationship building among at-risk students. Further, the APA zero tolerance task force encourages training teachers in culturally informed classroom behavior management and instruction.

Teachers

Luthar and Mendes (2020) revealed that teachers in their study (who worked in self-described trauma-informed schools) expressed sentiments of compassion fatigue. Several teachers described distress related to fear of not responding correctly to their students' stresses, specifically because they were trained how to educate students, not provide emotional support. One respondent reported often being "asked to put myself in harm's way in dealing with students' behavioral problems". Other obstacles teachers noted included evaluative policies, that evaluate teachers on measures outside of their control such as student truancy, and high stakes standardized testing, which does not take into consideration that students are often not "emotionally available"' to learn according to teachers (Luthar & Mendes, 2020) . Among mitigating factors that the teachers believe would help, they request more staff who specialize in behavioral and emotional support needs, more training, and overall policy changes. Interestingly, in terms of training, one teacher expressed desire to have the training come from outside of the school, as they feel inherent to this training is their own vulnerabilities, so they felt uncomfortable with the training being done internally. The notable quote stated, "Any such training is going to involve discussions of painful issues that our students bring to us. These issues push our own buttons. And many of us will feel vulnerable, and quite possibly, afraid to reveal our own vulnerabilities, especially if the training is being done by someone internal like the school's psychologist." (Luthar & Mendes, 2020, p. 151)

In terms of policy changes, there was acknowledgment that there are benefits to keeping disruptive children in the regular classroom whenever possible, but teachers felt that this at times

forced them to focus less on teaching. One teacher stated, “I just want to be able to hand it over to someone qualified, on our staff, when I feel like I simply can’t manage what I’m confronted with. Managing some students’ behaviors sometimes takes so much time and energy away from what I’m supposed to be doing.” (p. 151) Teachers also highlighted the need for policy that mandated social-emotional learning (SEL) in the regular curriculum. A barrier to SEL implemented with fidelity was noted to be due to lack of infrastructure, including personnel and training (Luthar & Mendes, 2020).

Measures of Trauma-Informed Care

Baker, Brown, Wilcox, Overstreet, and Arora (2016) discuss barriers to trauma-informed care, specifically a lack of empirically sound measures to assess trauma-informed care (TIC) in practice. The formation of a psychometrically stable measure of trauma-informed care allows for staff and system’s evaluation of attitudes related to TIC and staff buy-in, as well as information related to implementation and fidelity of TIC. Baker et al. developed the Attitudes Related to Trauma-Informed Care (ARTIC) scale to overcome these problems in the field of TIC. The ARTIC’s 7 subscales include (a) underlying causes of the problem behavior and symptoms, (b) responses to problem behavior and symptoms, (c) on-the-job behavior, (d) self-efficacy at work, (e) reactions to the work, (f) personal support of TIC, and (g) system-wide support for TIC. At the time the literature review was composed, the ARTIC was the only measure of trauma-informed care found in a thorough review. Other measures, including those measuring TIC fidelity are in the process of being developed.

Virginia Schools

The Virginia Department of Education’s (VADOE) website offers some information and links to resources for educators to increase their knowledge of trauma (Virginia Department of Education, 2020). When searching “Trauma Informed” on the VADOE website, there are

memorandums posted regarding the impact of trauma and multiple available slide shows for review, but these resources are not targeted towards teachers and many of them are several years old.

School Psychology

School psychologists have unique training that pertains to trauma, even if no explicit trauma education or training has occurred. They are one of the few professionals in the school building with intensive mental health training and they often have the opportunity to provide professional development and influence within their school buildings. Even so, as much as 75.6% of school psychologists report having zero (17.1%) to minimal (58.5%) education or training on the topic and 22% report they have no confidence in working with trauma impacted children (Gubi et al., 2019). Additionally, there is a huge differential between the trauma responsive work that school psychologists would like to be doing and what they are actually doing, in areas such as implementing trauma responsive system wide practices, training teachers and staff, screening trauma symptoms and exposure, and delivering trauma responsive interventions (Gubi et al., 2019). School psychologists identify (in order of most prevalence reported) that they need more training, time, and flexibility in their roles in the school (Gubi et al., 2019).

The Current Study

The current study identified trauma responsive practices that Virginia elementary principals use and perceive as effective, barriers to implementation, and needs to become more trauma responsive. Valuable insight was gathered in regards to training and professional development in the state. The proposal for this research project intended to determine the prevalence of trauma responsive elementary schools in Virginia, but due to limited response rate, this was not able to be addressed in the present study. The following research questions were the focus of this study:

1. What is the average amount of training related to trauma in Virginia elementary schools among administrators?
2. What trauma responsive practices are schools in Virginia using?
3. What do administrators perceive as effective practices in their schools for students with trauma?
4. What barriers do schools have to implementing trauma responsive practices and policies?

Methods

Participants

Participants in the study included a sample of as many elementary school principals as could be recruited to take the study. Participation in the survey was voluntary and no incentive was given for completion. IRB approval was provided by James Madison University. Twenty-one respondents signed consent and participated in the study, but only twenty completed the survey. One participant stopped at question ten, likely due to time constraints or a lack of desire to complete a long answer question. Approximately one fourth of respondents had been an administrator for four years or less. The largest portion of respondents (38.1%) had been an administrator for between five and nine years and another 28.57% for ten to fourteen years. One respondent had been administrator for over fifteen years (seventeen years).

Mean of students served at the schools of the respondents was 528.1 students, with one school having as few as 100 students and one having as many as 875. Five respondents (23.8%) indicated their school served a suburban community and sixteen (76.19%) reported their school served a rural community. None of the respondents served a school in an urban community. Nearly forty percent (38.1%) of respondents (n=8) served students from mostly lower class families, 52.38% (n=11) served mostly students somewhere between lower and middle class, and one respondent served students from mostly middle class families and another one served students

from somewhere between middle and upper class families. No principals responded that they served students coming from mostly upper class families.

Materials

The survey was developed by the researcher after a thorough review of the literature. The literature guided development of the survey based on available information and need for additional information. See Appendix A for a full copy of the survey. Some questions required participants to select a single answer, some encouraged them to "select all that apply", and other questions had participants fill in their own response.

The survey was distributed through a Qualtrics link to participants' email accounts and included twenty items with multiple choice and fill-in-the-blank options. Once participants had elected to participate in the survey and clicked on the link, the consent form was provided on the first page (see Appendix B for a copy of the consent form used). If participants indicated that yes, they consented to participate, the rest of the survey would then be presented. The first page was a consent form which included the survey topic, an estimate of the time expected to take to complete, and assurance that participants' answers are anonymous. The consent page also informed participants of potential risks, i.e. feeling discomfort, and that they may discontinue taking the survey at any time. SAMHSA's definition of trauma was presented to the respondents within the survey as well, so there was a consistent framework being used when responding to the survey questions. Information was provided on how to contact the experimenter, should any questions arise. Demographic information such as gender, number of years in an administrative position, and community classification, was collected on the following page. Information regarding the participant's current level of training in trauma responsive practices and where the training was

acquired (i.e. conferences, graduate training program, professional developments, et cetera) was collected.

Procedure

The experimenter recruited participants through connection with the pupil personnel services director or a person of equivalent position who served the school system. The pupil personnel services director email was identified using the Virginia Department of Education's (DOE) staff by school divisions page. A point of contact was determined and contacted in all 133 school districts represented in Virginia. The pupil personnel services director received an email with the purpose of the study, requesting their help with distribution of the Qualtrics link to surveys which they could choose to distribute to their elementary school principals via email. In the case of a few emails that were returned, another administrative contact was identified from that district on the DOE page.

Analysis Plan

The quantitative data were analyzed using descriptive statistics through the Qualtrics statistical analysis program. The qualitative data were analyzed by determining patterns within responses and transferring those into categories using the 'cut and sort' method (Ryan & Bernard, 2003). From there, the categorical data were examined using descriptive statistics.

Survey items one through four identified general demographic information. Survey items five and six addressed research question 1. Survey items seven and eight addressed research question 2. Survey item nine addressed research question 3. Survey items ten through thirteen aimed to gauge prevalence of trauma responsive practices and principals, but instead due to limited participants, served to inform research question 1. Survey items fourteen through seventeen served

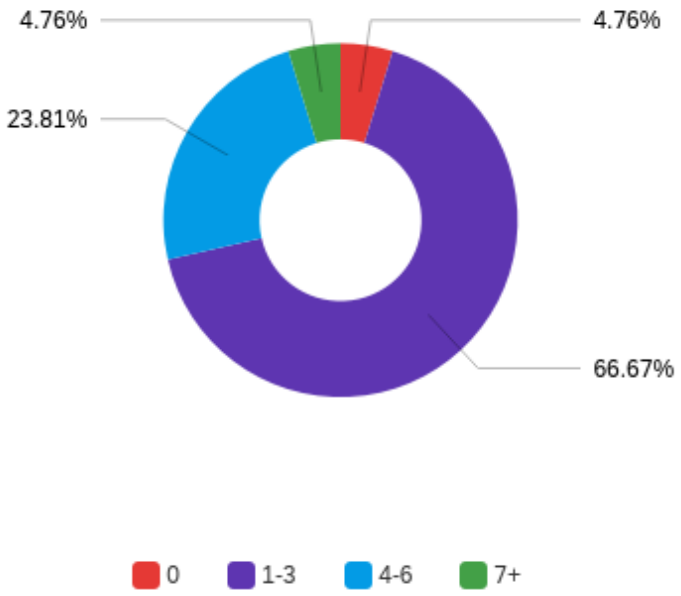
to answer research question two. Lastly survey items eighteen and nineteen addressed research question 4.

Results

In reference to research question 1, most of the respondents had received between one and three formal trainings related to trauma (66.67%). Approximately one fourth (23.81%) of the principals reported that they had received between four to six formal trauma trainings. One tenacious individual indicated that they had received over seven formal trauma trainings. One respondent indicated that they had not received any formal training related to trauma (see Figure 1).

Figure 1

Number of Formal Trainings Attended by Participants

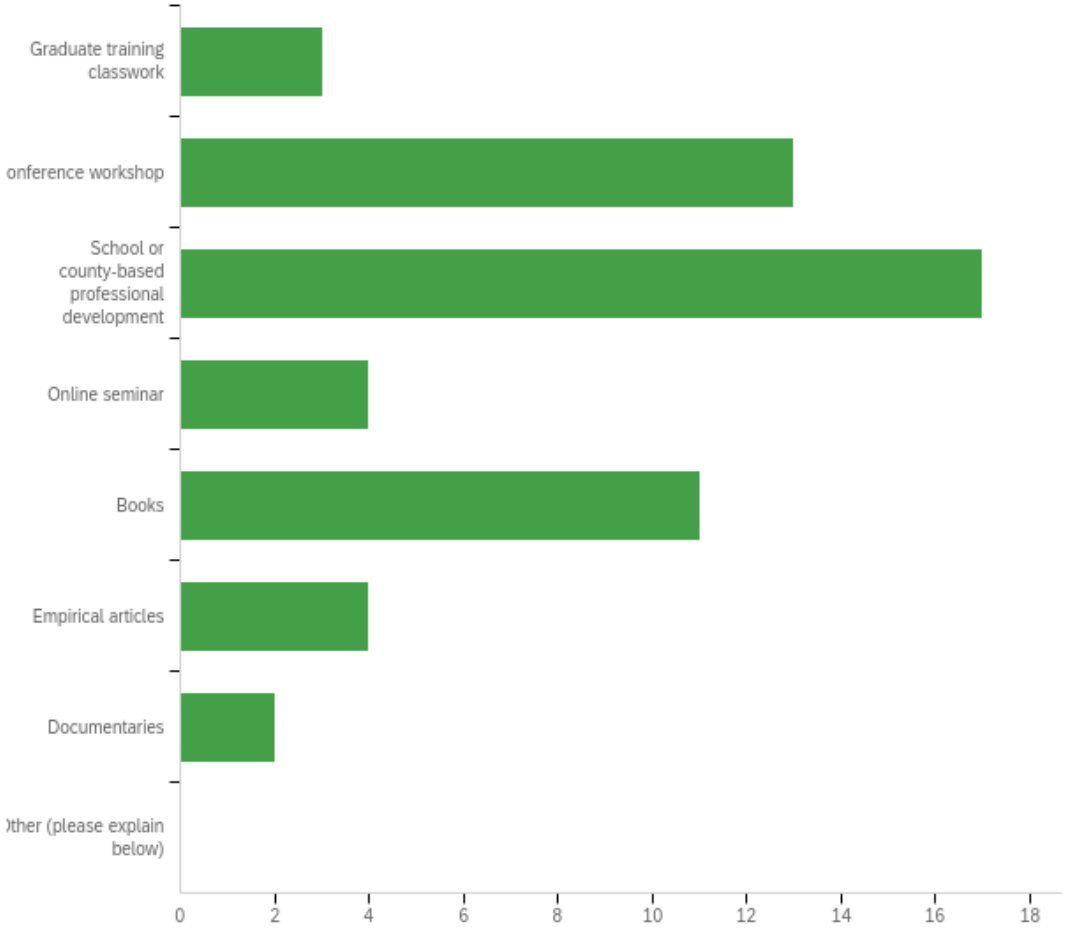


In regards to where respondents received their trauma training, most respondents (n=17, 80.95%) had received at least one of their trainings through school or county-based professional development. A large portion had also participated in a conference workshop related to trauma

(*n*=13, 61.9%) or read books related to trauma (*n*=11, 52.38%). Four participants indicated that they had participated in an online seminar related to trauma (19.05%), another four had read empirical articles related to trauma, and three had learned about trauma during graduate training classwork (14.29%). Two participants reported watching documentaries related to trauma (9.5%). See Figure 2 below for a summary of where participants received training from.

Figure 2

Type of Training Received



Many principals responded that they were confident in their ability to describe how trauma may be impacting a student's behavior and educational outcomes (*n*=10, 50%) and another sizeable group reported being somewhat confident (*n*=7, 35%). Two participants reported being

very confident (10%) and only one respondent (5%) reported being not very confident. When asked whether they considered themselves to be a trauma responsive principal, 90% of the participants surveyed indicated yes. All the principals surveyed indicated that their schools had at least begun to consider trauma, with 30% (six individuals) reporting that their school is aware of how common trauma is and has begun to consider how it may be affecting their students and staff (Trauma Awareness, Missouri Model, 2014). Ten of the principals reported that their school had begun to explore the principles of trauma-informed care and were working daily to prepare for the change of adopting those principles (Trauma Sensitivity, Missouri Model). The last four participants indicated that their school has begun to change their organizational culture to highlight the role of trauma, having all levels of staff rethink their routines and infrastructure (Trauma Responsivity, Missouri Model). No participants reported that their school had yet reached the point of having had made trauma responsive practices the organizational norm, where the model is so embedded that it no longer depends on a few leaders, and there is ready access to mental health professionals when needed (Trauma Informed, Missouri Model).

In reference to research question 2, when asked about trauma responsive practices that are employed, the vast majority of respondents indicated that their schools use positive discipline approaches (n=18, 85.71%), hold counseling groups (n=18, 85.71%), and foster strong relationships between students and school staff (n=17, 80.95%). Other common practices in use that were reported included Multi-Tiered Systems of Support (MTSS) for social, emotional, and behavioral concerns (n=14, 66.67%), training for teachers on trauma (n=13, 61.9%), collaboration with community mental health providers (n=13, 61.9%), and family/community engagement (n=10, 47.62%). To a lesser extent, respondents also reported that their schools had a school-wide social-emotional learning curriculum (n=5, 23.81%) and utilized universal screening for trauma

or social/emotional concerns (*n*=3, 14.29%). See Table 1 for a summary of trauma responsive practices used. Of note, all respondents indicated that their school used at least one of these practices. Specific practices that principals added that they believe classify as trauma responsive practices included the Responsive Classroom Curriculum (three participants) and Sanford Harmony (one participant), both of which are social-emotional learning curriculums.

Table 1

Trauma Responsive Practices

Practice	*n*	Percent of Respondents
Positive discipline	18	85.71
Counseling	18	85.71
Relationships	17	80.95
MTSS	14	66.67
Teacher training	13	61.9
Community mental health collaboration	13	61.9
Family/community engagement	10	47.62
SEL curriculum	5	23.81
Universal screening	3	14.29

Seventeen (85%) of the respondents indicated that their school has looked at changes in data, including in and out of school suspensions, and attendance as a response to implementing trauma responsive practices. Many of the respondents (*n*=15, 75%) also reported that their school does not enforce zero tolerance discipline policies either. Half of the principals (*n*=10, 50%) indicated that their discipline policies were halfway between being mostly flexible and mostly rigid, a "3" on a Likert scale. None of the respondents reported having discipline policies any more rigid than a "3" in this study. Five principals (25%) indicated that their policies were mostly flexible, "1" on the scale, and the other five (25%) were a "2" on the Likert scale.

Principals were asked what the protocol at their schools is in the circumstance that a student is repeatedly insubordinate towards a teacher, where safety is not a concern. Most prevalently,

principals mentioned a behavior intervention of some type (*n*=11, 55%) and collaboration (*n*=11, 55%). Behavior interventions reported included check-in/check-out programs, restorative practices, reflection sheets, counseling, and positive reflection building. Collaboration indicated a tendency towards holding a meeting or conference with the parent, teacher, student, administrator, and/or counselor, calls to the parent, and referral to a Multi-Tiered Systems of Support or problem-solving team. Principals also reported the use of punitive action (*n*=7, 35%) such as in school and out of school suspension, time outs, and office referrals. Many principals reported only resorting to these punitive actions as a last recourse. Some participants indicated some analysis of the student's behavior may take place (*n*=5, 25%) in the form of an FBA/BIP and simply trying to identify the antecedents or causes of the behavior. Two participants (10%) reported that the response to the insubordination would depend on other factors such as the student's age, the student themselves, the student's relationship with their teacher, and how many times it happens. One participant (5%) reported that their teachers are trained to manage these difficulties within the classroom.

In examining research question 3, principals were asked what practice they perceive as most effective in addressing the needs of students impacted by trauma, eleven principals highlighted the need for relationship building (55%). The next most common response mentioned provision of counseling services or a therapeutic space, by six respondents (30%), one of which who specifically cited school psychologists and school social workers within this response. Other responses that were perceived to be most effective included providing faculty and staff training (*n*=5, 25%), partnering with community mental health agencies (*n*=4, 20%), communication or collaboration with families (*n*=3, 15%), positive behavior management (*n*=1, 5%), a social-emotional learning curriculum (*n*=1, 5%), and a school-based intervention program (*n*=1, 5%).

See Table 2 below for a summary of perceived most effective practices in addressing the needs of students.

Table 2

Perceived Most Effective Practices

Practice	*n*	Percent of Respondents
Relationship building	11	55
Counseling	6	30
Faculty training	5	25
Community collaboration	4	20
Family collaboration	3	15
Positive behavior management	1	5
SEL curriculum	1	5
Intervention program	1	5

In response to research question four, the barriers that principals reported in being more trauma responsive, six participants (30%) identified that their staff had not had training in trauma, two (10%) stated there is not support from their teachers, and two stated that they do not believe that trauma affects the students at their school (10%). Other noted barriers included having experienced their own trauma, so it "hits close to home" for them (n=1, 5%), their school lacking accreditation or being in jeopardy of losing it (n=1, 5%), belief that it is not a school's role to address trauma (n=1, 5%), lack of support from their leadership (n=1, 5%), and lack of support from the community or parents (n=1, 5%).

When given the opportunity to identify their own circumstances or barriers they face in implementing trauma responsive practices, there were six respondents (30%) who identified that while they or their staff had training, they had not had *enough* training. Two principals (10%) indicated that while they want to use trauma responsive practices, this has resulted in their staff not feeling supported, as the staff wishes to see more punitive action, or there is fear that it could lead to teacher attrition (noted in a county where there reportedly is high teacher attrition). One of

these respondents even noted how their staff had been through trauma training and still expected the principal to enact punitive measures due to their perception of being demeaned by the student and their intolerance of that. There was also mention of need for more resources by five participants (25%), including lack of funding (*n*=2, 10%), deficit of mental health professionals (for students and staff) (*n*=1, 5%), and lack of time, because it can be very time intensive to individualize the response to the student (*n*=2, 10%). One principal indicated that while they did have central office support in a vision for trauma responsiveness, there were some contradicting discipline guidelines which did not consider trauma or align with trauma responsiveness. Two respondents reported that while they or their staff had received the training, actually enacting those practices in the moment could be difficult.

Ninety percent of respondents identified a need for more mental health supports for students, 70% indicated that there is a need for more training, and 45% indicated that teachers needed more self-care for their school to be more trauma responsive. Forty percent of the participants indicated that they needed more teacher buy-in and 20% reported a need for more flexibility in their discipline policy. Some also identified a need for more central office support (15%) and more administrative support in the building (5%) to become more trauma responsive. One response suggested by a principal included a desire for more funding to carry out their initiatives in order to purchase incentives, books to match their curriculum, continuous training, provision of group and individual counseling for students, and additional school social workers and psychologists. Another response indicated that a principal felt that Medicaid's current policies, along with their removal of therapeutic day treatment (TDT) counselors from schools, are not best suited to support students. This individual reported that they felt that the removal of the TDT counselors left students re-traumatized as their supports were "ripped out from under them."

Discussion

The present study examined the perceptions of a small group of Virginia elementary school principals related to trauma responsiveness. The participants were asked questions related to trauma responsive practices their schools use, effectiveness of those practices, their level of training and where training occurred, barriers to trauma responsiveness, and perceived level of their own and their school's trauma awareness. The results showed that most respondents had received at least one trauma training and many respondents had received at least one of their trainings through their school system. The majority of participants exhibited some confidence in their ability to describe how trauma may impact students' behaviors and educational outcomes, and a similar portion considered themselves to be a trauma responsive principal. All of the participants indicated their schools had at least begun to consider trauma in a systematic format, but none had reached the point of having made trauma responsive practices the organizational norm. The most commonly used trauma responsive practices in these schools included positive discipline approaches, counseling groups, and strong student-staff relationships. Over three fourths of participants' schools had looked at changes in data in response to implementation of trauma responsive practices. Principals reported that their disciplinary policies tended to be more flexible than rigid. The most common response when asked what they believe the most effective trauma responsive practice was relationship building. The most common barriers to trauma responsiveness reported were that staff had not had training in trauma (30%) or that there had not been *enough* staff training (30%). One fourth of participants also noted a need for more resources appointed to trauma responsive efforts. When asked what was needed to make their schools more trauma responsive, 90% specified more mental health support. Additional research is needed in Virginia

to further examine the prevalence of trauma responsive efforts in schools and the fidelity of schools in their efforts.

The responses provided to address research question 1 identify that most of the participants had received at least one training related to trauma, with two thirds having had between one and three trainings. Even so, participants indicated that they felt they had not had enough training. Considering that most participants had received at least one of their trainings from their district, this highlights the need for districts to be providing these opportunities, as this may be the only opportunity some educators get to receive this training. This may suggest the opportunity for school psychologists to develop and present these presentations to their schools and counties. On the other hand, Luthar and Mendes (2020) found that some teachers may be resistant to trauma trainings that are provided by internal entities due to the vulnerability inherent to these trainings. This lends itself to considerations of making trauma trainings safer places, such as forming small breakout groups, setting group norms, not training teachers in the same sessions as their superiors, and potentially partnering with another school psychologist to offer trainings to each other's schools.

According to Chafouleas et al., 2016, trauma training should include information regarding the prevalence and impact of trauma, including the neurobiological factors, de-escalation, and self-care for staff with consideration of vicarious trauma. Trauma trainings should emphasize building knowledge, skills, and motivation in order for trainees to utilize this learning. In addition to this preliminary training, staff need continued training that utilizes specific trauma responsive classroom strategies and coaching that helps teachers accurately implement their skills and strategies, which increases effectiveness and sustainability of training (Chafouleas et al., 2016).

The principals vastly reported that they were confident in their ability to describe how trauma impacts student behavior and educational outcomes, which leads to the question of validity of their confidence. The question of fidelity also arises when considering the high levels of participants who reported themselves to be trauma responsive and their schools to be considerate of trauma impacted students, which highlights the need for a measure of fidelity.

In examining responses to survey items that addressed research question 2, principals reported the use of positive discipline approaches, counseling groups, strong relationships, MTSS, staff training, and collaboration with community mental health providers, as trauma responsive practices that their schools used. These practices are all valuable methods in line with the research, but these numbers were slightly lower than the numbers you would expect considering the high number of respondents who claimed to be trauma responsive principals. This may be in part attributable to the barriers that were reported by the principals. Curiously, despite universal screening being a foundational component of MTSS and over half of participants reporting use of MTSS, only three participants reported use of universal screening for trauma or social/emotional concerns. This highlights a concern that potentially only students impacted by trauma with externalizing behaviors are being identified as needing extra support. Surprisingly, only 4.5% of participants indicated that their school uses a school-wide social-emotional learning (SEL) curriculum. This may be due in part to factors such as high stakes standardized testing, but highlights a deep misunderstanding on the part of decision makers; children cannot succeed academically if their basic social and emotional needs are not met. Considering the availability of free SEL programs such as Sanford Harmony, schools have relatively few obstacles to implementing a SEL curriculum.

Of note, most of the participants' schools collect and monitor data in response to implementing trauma responsive practices. This is essential in demonstrating the effectiveness of these policies and practices in order to maintain their support from families, teachers, and school leadership. Disciplinary policies most frequently reported were in line with current research, in that most principals' schools do not enforce zero tolerance policies, have flexibility for considering different circumstances, and promote behavioral intervention and collaboration among stakeholders related to the child. Even so, administrators reported the of use of punitive action, which is not in line with current research as effective in reducing the behavioral problems.

Addressing research question 3, in asking participants what they perceive to be most effective for working with students impacted by trauma, around half of participants identified relationship building. On an individual level, relationship building is one of the most important interventions cited in research. Other responses given were also largely parallel to what research states, demonstrating the proficiency of the participants.

Finally, examining research question 4, across the literature and the responses from the present study, barriers to schools include a need for more mental health staff to provide trauma responsive care. Many of the principals in the present study reported relying on counseling groups as one of their main methods of being trauma responsive. While this is an important component of trauma responsiveness, many times school counselors are limited in how many groups they are able to facilitate and how many students can be served through them. Considering the high prevalence of students impacted by trauma in the schools, this calls for the importance of having multiple mental health providers in the school building and lowering the student to provider ratio. School psychologists and school social workers are also qualified professionals who can assist in the endeavor to hold groups and provide individual counseling for students impacted by trauma.

While this study provided valuable insight to the perspective of administrators of elementary schools, it also provided some information regarding teachers as well. Responses given by the principals regarding the teachers indicate that teachers may not feel as if they are being supported when trauma responsive practices are being used, even when they have received trauma training. This highlights the need to encompass teachers more in this movement as valuable stakeholders, because without their support, administrators find it hard to actually implement trauma responsive disciplinary practices. Those leading the trauma responsive initiatives need to take a system's change perspective when transitioning to more trauma responsive schools.

Limitations

The methodology of the present study, in addition to the closures as a result of the novel coronavirus, led to several limitations in the collection of participants. In contacting the pupil personnel services director, points of contact in smaller, rural districts were much more likely to respond saying that they would pass the information along. Those in larger districts often did not respond, or if they did, they would direct the researcher to their research approval committee for their district, where the approval process could take up to several months. Despite having applied to several districts for research approval in March, no approval had been granted at the time the results of this research were written, possibly due to school closures. As such, the sample size of the present study was limited and planned inferential statistics could not be used, nor do the results necessarily represent Virginia as a whole. Due to response bias, it is possible that these participants are more attuned to trauma than the average principal. Some of the points of contact responded by saying that they had recently undergone county trauma training or that trauma was something that they were beginning to consider in their districts.

Future studies should aim to expand on the present research by achieving a higher response rate in order to observe prevalence of trauma responsiveness across the state. Additional studies are needed during normal school operations (outside of coronavirus closures) to determine prevalence and together offer a broader response and understanding of these practices. Lastly, measuring fidelity of schools in their pursuit of trauma responsiveness would likely inform schools on how to improve their efforts and better support students. More research is needed to develop measures of fidelity and examine their effectiveness in shaping trauma responsive policies and practices in schools.

References

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., Dube, S. R., & Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology, 174–186. https://doi.org/10.1007/s00406-005-0624-4

American Psychological Association Zero Tolerance Task Force. (2008). Are Zero Tolerance Policies Effective in the Schools? *American Psychologist*, *63*(9), 852–862.

Baker, C. N., Brown, S. M., Wilcox, P. D., Overstreet, S., & Arora, P. (2016). Development and Psychometric Evaluation of the Attitudes Related to Trauma-Informed Care (ARTIC) Scale. *School Mental Health*, *8*(1), 61–76. https://doi.org/10.1007/s12310-015-9161-0

Blodgett, C., & Lanigan, J. D. (2018). The Association Between Adverse Childhood Experience (ACE) and School Success in Elementary School Children. *School Psychology Quarterly*, *33*(1), 137–146.

Chafouleas, S.M., Johnson, A.H., Overstreet, S. *et al.* Toward a Blueprint for Trauma-Informed Service Delivery in Schools. *School Mental Health* **8,** 144–162 (2016). https://doi.org/10.1007/s12310-015-9166-8

Cook, A. (2005). Complex Trauma in Children and Adolescents, (July 2014). https://doi.org/10.3928/00485713-20050501-05

Delaney-black, V., Covington, C., Ondersma, S. J., Nordstrom-klee, B., Templin, T., Ager, J., Janisse, J., & Sokol, R. J. (2002). Violence Exposure, Trauma, and IQ and/or Reading Deficits Among Urban Children. *Arch Pediatr Adolesc Med*, *156*, 280–285.

Deprince, A. P., Weinzierl, K. M., & Combs, M. D. (2009). Child Abuse & Neglect Executive function performance and trauma exposure in a community sample of children ☪, *33*, 353–361. https://doi.org/10.1016/j.chiabu.2008.08.002

Dorado, J., Martinez, M., McArthur, L., & Leibovitz, T. (2016). Healthy Environments and Response to Trauma in Schools (HEARTS): A whole-school, multi-level, prevention and intervention program for creating trauma-informed, safe and supportive schools. School Mental Health, 8, 163-176.

Embse, N. Von Der, Rutherford, L., Mankin, A., & Jenkins, A. (2018). Demonstration of a Trauma - Informed Assessment to Intervention Model in a Large Urban School District. *School Mental Health*, (0123456789). https://doi.org/10.1007/s12310-018-9294-z

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study, *14*(4), 245–258.

Fleitas, M. (Ed.). (2019, January 14). Trauma and Violence. *SAMHSA*. Retrieved from https://www.samhsa.gov/trauma-violence

Gubi, A. A., Strait, J., Wycoff, K., Vega, V., Brauser, B., & Osmon, Y. (2019). Trauma-Informed Knowledge and Practices in School Psychology: A Pilot Study and Review. *Journal of Applied School Psychology, 35:2,* 176-199. DOI: 10.1080/15377903.2018.1549174

Hurt, H., Malmud, E., Brodsky, N. L., & Giannetta, J. (2001). Exposure to Violence, *155*, 1351–1356.

Luthar, S.S. & Mendes, S.H. (2020) Trauma-informed schools: Supporting educators as they support the children, International Journal of School & Educational Psychology, 8:2, 147-157, DOI: 10.1080/21683603.2020.1721385

McIntyre, E. M., Baker, C. N., Overstreet, S., & The New Orleans Trauma-Informed Schools Learning Collaborative (2018, November 29). Evaluating Foundational Professional Development Training for Trauma-Informed Approaches in Schools. *Psychological Services*. Advance online publication. http://dx.doi.org/10.1037/ser0000312

Mendelson, T., Tandon, S. D., Brennan, L. O., Leaf, P. J., & Ialongo, N. S. (2015). Brief report : Moving prevention into schools : The impact of a trauma-informed school-based intervention, *43*, 142–147.

Missouri Model: A Developmental Framework for Trauma Informed Approaches, MO Dept. of Mental Health and Partners (2014).

Perry, D. L., Daniels, M. L., & Perry, D. L. (2016). Implementing Trauma — Informed Practices in the School Setting : A Pilot Study. *School Mental Health*, *8*(1), 177–188. https://doi.org/10.1007/s12310-016-9182-3

Rossen, E. (2006). Unconditional Positive Regard and Effective. *Oxford Clinical Psychology*. Retrieved from http://www.oxfordclinicalpsych.com/page/effective-school-discipline/featured-article-unconditional-positive-regard-and-effective-school-discipline

Rossen, B. E., & Cowan, K. (2013). The Role of Schools in Supporting Traumatized Students. *Principal's Research Review*, *8*(6), 1–8.

Ryan, G. W. & Bernard, H. R. (2003). Techniques to Identify Themes. *Field Methods, 15*, 85-109.

Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Elliott, M. N., & Fink, A. (2003). A Mental Health Intervention for Schoolchildren Exposed to Violence. *JAMA*, *290*(5), 603–611.

Virginia Department of Education. (n.d.). VDOE Search Results Trauma. Retrieved June 4, 2020, from http://www.doe.virginia.gov/home_files/search_results/vdoe-search.shtml?cx=000783915327965917031:ydjbl4xbjqo&cof=FORID:10&ie=UTF-8&q=Trauma&sa=Search

Appendix A

"Web" / "Email" Consent to Participate in Research (confidential research)

Identification of Investigators & Purpose of Study

You are being asked to participate in a research study conducted by Aleksa Putnam from James Madison University. The purpose of this study is to examine trauma sensitive practices in Virginia elementary schools. This study will contribute to the researcher's completion of her educational specialist degree thesis.

Research Procedures

This study consists of an online survey that will be administered to individual participants through Qualtrics (an online survey tool) via email. You will be asked to provide answers to a series of questions about the practices your school uses related to trauma. Should you decide to participate in this confidential research you may access the anonymous survey by following the web link located under the "Giving of Consent" section.

Time Required

Participation in this study will require 10 minutes of your time.

Risks

The investigator does not perceive more than minimal risks from your involvement in this study (that is, no risks beyond the risks associated with everyday life).
The investigator perceives the following are possible risks arising from your involvement with this study: discomfort related to discussion of trauma.

Benefits

Potential benefits from participation in this study include a greater understanding of what schools currently are doing in the realm of trauma sensitive care for students and will better inform future training and support needs in the state of Virginia.

Confidentiality

The results of this research has the potential to be presented at a conference. While individual responses are anonymously obtained and recorded online through Qualtrics (a secure online survey tool), email data is kept in the strictest confidence. Responding participant's email addresses will be tracked using Qualtrics for follow-up notices, but names and email addresses are not associated with individual survey responses. The researchers will know if a participant has submitted a survey, but will not be able to identify individual responses, therefore maintaining anonymity for the survey. The results of this project will be coded in such a way that the respondent's identity will not be attached to the final form of this study. Aggregate data will be presented representing averages or generalizations about the responses as a whole. All data will be stored in a secure location accessible only to the researcher. Upon completion of the study, all information will be destroyed. Final aggregate results will be made available to participants upon request.

Participation & Withdrawal

Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind.

Questions about the Study

If you have questions or concerns during the time of your participation in this study, or after its completion or you would like to receive a copy of the final aggregate results of this study, please contact:

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Questions about Your Rights as a Research Subject

Dr. Taimi Castle
Chair, Institutional Review Board
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This study has been approved by the IRB, protocol #20-1398

Giving of Consent

I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. The investigator provided me with a copy of this form through email. I certify that I am at least 18 years of age. By clicking on the link below, and completing and submitting this confidential online survey, I am consenting to participate in this research.

- Yes
- No

Appendix B

For the purpose of the following research, trauma will be defined using the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2019 individual trauma definition, "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

1. Are you an elementary school administrator?
    a. Yes
    b. No

2. How many years have you been in an administrative position? (This includes associate and assistant administrator positions)

3. Roughly how many students does your school serve?

4. How would you classify the community your school serves?
    a. Urban
    b. Suburban
    c. Rural
5. How would you classify the economic background of the students who attend your school?
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a. Mostly lower class
b. Somewhere between lower and middle class
c. Mostly middle class
d. Somewhere between middle and upper class
e. Mostly upper class

6. How many formal trainings have you received related to trauma-informed practices?
    a. 0
    b. 1-3
    c. 4-6
    d. 7+

7. What kind of training have you received related to trauma-informed practices? (Select all that apply)
    a. Graduate training classwork
    b. Conference workshop
    c. School-based professional development
    d. Online seminar
    e. Books
    f. Empirical articles
    g. Documentaries
    h. Other (please explain)

8. What trauma-informed practices is your school using? (Select all that apply)
    a. Social-emotional curriculum
    b. Positive discipline approaches
    c. Training for teachers on trauma
    d. Fostering strong relationships between students and school staff

e. Multi-tiered Systems of Support for social/emotional/behavioral concerns
f. Universal screening for trauma and/or social/emotional concerns
g. Counseling groups
h. Collaboration with community mental health providers
i. Family/community engagement
j. My school does not utilize any of these practices

9. If there is anything not mentioned in the selection above that you are doing that you believe qualifies as trauma-informed, please explain below:

10. What practice do you perceive as most effective in addressing the needs of students affected by trauma?

11. What is your confidence level in being able to describe how trauma may be impacting a child's behavior and educational outcomes?
    a. Not at all confident
    b. Not very confident
    c. Somewhat confident
    d. Confident
    e. Very confident

12. Would you consider yourself to be a trauma responsive principal?
    a. Yes
    b. No

13. Classify your school:
    a. My school has not considered trauma
    b. My school is aware of how common trauma is and has begun to consider how it may be affecting our students and staff
    c. My school has begun to explore the principles of trauma-informed care (safety, choice, collaboration, trustworthiness, and empowerment) and works daily to build consensus around the principles, consider implications of adopting principles within the organization, and is preparing for change
    d. My school has begun to change our organizational culture to highlight the role of trauma. At all levels (bus drivers, janitors, front desk staff, cafeteria staff, teachers, administrators) of my school, staff have begun to rethink the routines and infrastructure
    e. My school has made trauma responsive practices (changing the system on all levels to account for trauma) the organizational norm. The trauma model has become so accepted and thoroughly embedded that it no longer depends on a few leaders. My school works with other partners to strengthen collaboration around being trauma-informed. We have ready access to mental health professionals (school psychologists, social workers, counselors, licensed professional counselors) when needed

14. Have you looked for changes in data (OSS, ISS, attendance) as a response to implementing trauma responsive practices?
    f. Yes
    g. No

15. Does your school enforce zero tolerance policies?
    h. Yes
    i. No

16. What would you classify the flexibility of your school's disciplinary policies? (1 being mostly flexible, 5 being mostly rigid)
    1. (mostly flexible)
    2.
    3.
    4.
    5. (mostly rigid)

17. What is the disciplinary protocol at your school if a child is insubordinate towards a teacher (and safety is not a concern)?

18. What barriers does your school have to being more trauma responsive?
    f. I have experienced trauma of my own, so it "hits too close to home"
    g. My school is not accredited or is in jeopardy of losing accreditation
    h. I do not believe that it is a school's role to address trauma
    i. I do not believe that trauma affects the students at my school
    j. There is not support from the higher powers (superintendent, school board, etc.)
    k. There is not support from the teachers
    l. There is not support from the community/parents
    m. We have not had training in trauma
    n. Other (please specify)

19. What additional supports are needed to become more trauma sensitive?
    a. Central office support
    b. Teacher self-care
    c. Teacher buy-in
    d. More flexibility in discipline policy
    e. More administrative support in the building
    f. More mental health support for students
    g. Other (please specify)