KEY THEMES FOR IDENTIFYING TRAUMA INFORMED CARE BEST PRACTICES WITHIN SECONDARY EDUCATION

By

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ABSTRACT

KEY THEMES FOR IDENTIFYING TRAUMA INFORMED CARE BEST PRACTICES WITHIN SECONDARY EDUCATION

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Trauma informed care is a growing trend present today in multiple organizations and institutions. There are a variety of methods, theories, and interventions currently being employed that directly relate to trauma and a trauma informed care approach. This study investigates those trauma and trauma informed care practices to better understand which work, under what conditions, and which ones do not. The information gathered will help to provide a foundation for a sustainable trauma informed care system and approach.

This was a qualitative study utilizing interviews and questionnaires to reveal trauma informed care best practices. Five participants with varying degrees of expertise in Trauma Informed Care were chosen at random in order to investigate their best practices for implementing trauma informed care within a secondary education setting. When the interviews were concluded, the most common themes that a-rose were physical and psychological safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, cultural and historical backgrounds, environmental effects, and governance and leadership. Practices that reflect those themes

were reported to be the most effective for a trauma informed care approach by the participants.

The themes that arose in this study generally reflected those laid out in the literature. There was a relation between the themes uncovered and the practices used. It appeared that the data was then analyzed to determine which specific practices are associated with each theme in order to get a better understanding of the way each is used in the classroom in order to gain the most benefit and success from a trauma informed care approach.

ACKNOWLEDGEMENTS

I would like to dedicate this thesis to my wife Stephanie for her continued love and support over the last few years it took to complete this project. I appreciate everything she did to help me along the way.

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INTRODUCTION

Trauma exists today amongst many people, including children. Trauma is becoming more and more prominent amongst youth. Nearly 47.9% of children from ages 12-17 have experienced trauma in their lifetime, with 23% experiencing more than one. Trauma can be defined as a psychological and/or emotional response to an event or an experience that is deeply distressing or disturbing. It affects all aspects of life, including, but not limited to, education. There are a lot of ways to combat the effects of trauma. One approach being used increasingly in education is Trauma Informed Care (TIC).

Trauma Informed Care is an organizational structure and treatment framework that involves aspects of understanding, recognition, and responding to the effects of all types of trauma. Trauma informed care emphasizes physical, psychological, and emotional safety. It helps to rebuild a sense of control and empowerment that can improve a person's chances for success.

No one is immune to trauma or the impact it may cause. Trauma affects individuals, families, relationships, communities (by disrupting healthy development) and contributes to mental health issues. The effects of untreated trauma can have long-term effects. Everyone pays the price when a community produces multiple generations of people with untreated trauma. Traumatic experiences can also have an impact on learning, behavior and relationships at school by diminishing concentration, memory and the organizational and language abilities children need to succeed. With these impacts,

schools will experience more attendance issues, higher rates of assertive discipline, classroom management issues, as well as lower overall grades and test scores.

People who have been traumatized need support and understanding from those around them. Becoming trauma informed means recognizing that people often have many different types of trauma in their lives and developing familiarity with the outward manifestations of trauma which can differ widely. Understanding the impact of trauma is an important first step in becoming a compassionate individual and contributing to a community that can mitigate the effects. There are many ways an individual can become trauma informed, and many practices an individual can employ in order to have a trauma informed care approach. In the following chapters I will explore the definition, consequences, identification and treatment involved in trauma informed care at the secondary level of education. In doing so, I will explicate a variety of proven methods for developing a school wide approach to TIC.

LITERATURE REVIEW

Introduction

For the past few years trauma-informed care has emerged as an effective approach to addressing the challenges many students face in educational settings. Trauma informed care has made head way in many areas including law enforcement, social work and, most recently, education. The approach focuses on past and present trauma experienced by an individual and the tools needed to help that individual heal, progress and gain stability. Trauma informed care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma informed care also emphasizes physical, psychological and emotional safety for both consumers and providers and helps survivors rebuild a sense of control and empowerment (Adams, 2010; Bath, 2008; Berson & Baggerly, 2009; Deprince, Weinzieral & Combs, 2009; Eslinger, 2013; Fecser, 2014; Hebert, 2013; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Pizzolongo & Hunter, 2011; Steinbrink, 2013; Sundborg, 2017; VanderWegen, 2013; Wright, 2017).

This study will investigate trauma informed care and identify best practices that can be utilized by educators at the secondary level of education when working with individuals who have experienced trauma. This literature review will include past and current trends of utilizing the trauma-informed-care approach and will discuss the current prevalence of trauma among individuals, specifically focusing on children and

adolescents. This review will also focus on common characteristics and traits of individuals who have experienced trauma, collections of current measurement tools and research-based interventions to address the effects of trauma, differences in socio-economic status, the relationship socio-economic status and the level and type of trauma commonly experienced, and best practices to mitigate the effects utilized by educational organizations.

Prevalence

According to a Substance Abuse and Mental Health Services Administration (SAMHSA) report in 2011, a great number of people are exposed to or witness trauma during childhood. In a study performed by the National Survey of Children's Exposure to Violence (NatSCEV) in 2012, interviews and surveys of children and youth up to age 17 were conducted on their most recent exposure to several major categories of violence, including peer and internet victimization. These categories examined children's exposure to violence in the home, school, and community (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009). The findings showed:

> Twenty-six percent of children in the United States will witness or experience a traumatic event before the age of four. More than 60% of children were exposed to at least one type of violent event in the past year. More than 10% reported five or more exposures to violence. About 10% of children have suffered from child maltreatment, were injured in an assault, or witnessed a family member assault another family member. About 25% were victims of robbery or witnessed a violent act. Finally,

> nearly half of the children and adolescents were assaulted at least once in the past year ("National Center," 2017, p.2).

Trauma can be the result of intentional violence, such as child abuse, physical or sexual, psychological maltreatment, neglect, exploitation, or domestic violence, which includes actual or threatened physical and/or sexual violence, or the effect of emotional abuse between adults in an intimate relationship (Hebert, 2013; Hernandez, 2014; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017). Exposure to these traumatic experiences, and the resulting emotional deregulation, loss of direction, and the loss of the ability to detect or respond to danger cues, often sets off a chain of events leading to subsequent and/or repeated trauma exposure in adolescence and adulthood (Hebert, 2013; Hernandez, 2014; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017).

Baggerly and Berson (2009) have also indicated that children around the world are being exposed to traumatic events at a troubling rate. Large, nationally representative studies of children in the United States have reported that 71% of children have been exposed to at least one potentially traumatic event in the past year, and almost 70% of children have experienced multiple exposures in their lifetime. From this, one can decipher that trauma is being experienced at an alarming rate by individuals who may not have the skills or methods to cope with such harsh experiences (Hebert, 2013; Hummer,

Dollard, Robst & Armstrong, 2010; Juarez, 2014; Oehlberg, 2014; Sundborg, 2017; Wright, 2017).

Exposure to these traumatic experiences, and the resulting emotional deregulation, loss of direction, and the loss of the ability to detect or respond to danger cues, often sets off a chain of events leading to subsequent and/or repeated trauma exposure in adolescence and adulthood (Hebert, 2013; Hernandez, 2014; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017).

While traumatic events can happen to anyone at any time, there are certain risk factors that make some individuals more likely to experience physical, emotional and psychological trauma (Bath, 2008; Goodwin-Glick, 2017; Hernandez, 2014; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017). Individuals who experience an unsafe environment, separation from a parent or loved one, a serious or life-threatening illness, sexual and/or physical abuse, verbal abuse, domestic violence, and/or neglect can increase the risk of experiencing the effects of trauma during an individual's lifetime (Bath, 2008; Oehlberg, 2014; Goodwin-Glick, 2017).

Potential Causes of Trauma

No one is immune to the impact of trauma (Bath, 2008; Goodwin-Glick, 2017; Hernandez, 2014; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017). Trauma affects individuals, families, and communities by disrupting healthy development,

adversely altering relationships, and contributing to mental health issues including substance abuse, domestic violence, and child abuse. When a community produces generations of people with untreated trauma it can lead to an increase in crime, loss of wages, and threat to the stability of family (Bath, 2008; Goodwin-Glick, 2017; Hernandez, 2014; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017).

Children and youth experience stress when they undergo a heightened state of arousal due to traumatic events, such as the death of a loved one or a natural disaster (Bath, 2008; Goodwin-Glick, 2017; Hernandez, 2014; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017). Secure relationships and community supports can help a child recover from stress. However, in the absence of these supports, experiencing such trauma may exceed a child's capacity to cope with and respond to stress, thus elevating the stress level and putting the child's physical, social, and emotional developmental trajectory at risk ("National Child," 2005).

There are many factors and potential influences that can lead to trauma (Bath, 2008; Goodwin-Glick, 2017; Hernandez, 2014; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017). A person can experience psychological trauma as a result of exposure to an extremely stressful life event or enduring condition that can overwhelm an individual's perceived ability to cope with the circumstances. It is not only the actual event or enduring conditions that are traumatic, it is the individual's perception of those

life circumstances and their ability and capacity to deal with the condition (Bath, 2008; Goodwin-Glick, 2017; Hernandez, 2014; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017). The effect of experiencing a significantly distressing event differs. Even when two individuals experience the same negative event, it is possible that only one may demonstrate the symptoms of trauma caused by that event (Bath, 2008; Goodwin-Glick, 2017; Hernandez, 2014; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017).

Traumatic experiences often involve a threat to life or safety, but any situation that leaves an individual feeling overwhelmed and isolated can be traumatic, even if it does not involve physical harm (Bath, 2008; berson & Baggerly, 2009; Goodwin-Glick, 2017; Hernandez, 2014; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017). It is not the objective fact(s) that determine whether an event is traumatic; rather, an individual's subjective emotional and psychological experience of that event governs the level of trauma experienced (Bath, 2008; Berson & Baggerly, 2009; Goodwin-Glick, 2017; Hernandez, 2014; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017). The evidence suggests that the more frightened and helpless an individual feels, the more likely that individual will be traumatized.

Trauma can be caused by one-time events such as an accident, injury, natural disaster, or violent attack (Bath, 2008; Berson & Baggerly, 2009; Goodwin-Glick, 2017;

Hernandez, 2014; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017). Trauma can also be caused by ongoing, relentless stress, such as living in crime-ridden neighborhoods or battling life-threatening illnesses (Bath, 2008; Berson & Baggerly, 2009; Goodwin-Glick, 2017; Hernandez, 2014; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017). Some of the commonly overlooked causes of trauma are things such as the sudden death of someone close to an individual, the loss of a significant relationship, or a general humiliating or deeply disappointing experience (Bath, 2008; Berson & Baggerly, 2009; Chiu, 2012; Goodwin-Glick, 2017; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017). Sudden and unexpected events that occur when the individual is unprepared and feels powerless, particularly during childhood, or when someone is intentionally cruel to an individual people can be traumatized (Bath, 2008; Berson & Baggerly, 2009; Goodwin-Glick, 2017; Hernandez, 2014; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017). Understanding what causes trauma can help identify the characteristics to look for to help detect individuals who have experienced trauma.

Characteristics

Traumatized individuals are often in a heightened state of anxiety that impacts how well they are able to learn, socialize and participate in everyday life (Bath, 2008;

Berson & Baggerly, 2009; Goodwin-Glick, 2017; Hernandez, 2014; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017). Knowing the behavioral characteristics that often accompany trauma helps parents, teachers, doctors, and other caregivers provide these children with the help they need to heal properly (Bath, 2008; Berson & Baggerly, 2009; Goodwin-Glick, 2017; Hernandez, 2014; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017).

According to Steinbrink (2013) initial characteristics and/or behaviors that immediately follow a traumatic event might portray a child as easily afraid and panicked. That child might also cry a lot, be unusually scared of things they weren't afraid of before, and may display increased signs of sadness and depression (Bath, 2008; Berson & Baggerly, 2009; Chiu, 2012; Goodwin-Glick, 2017; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017). Right after a traumatic event, a child can also be confused, angry and appear to be in a state of shock. In cases which might be considered more extreme, a child may have trouble sleeping, a decreased appetite, and physical complaints such as headaches, stomach aches and other body pains (Bath, 2008; Berson & Baggerly, 2009; Chiu, 2012; Goodwin-Glick, 2017; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright,

2017). Usually, these short-term characteristics are temporary and can gradually fade in a few days or weeks.

According to Sundborg (2017), long-term characteristics and/or behaviors can emerge after initial characteristics have faded and, in some cases, certain traumatic events, particularly events that occur repeatedly, like child abuse, can have life-long effects that impact behavior. For instance, many children who are abused have a difficult time making friends and their interactions with peers are awkward or inappropriate (Bath, 2008; Berson & Baggerly, 2009; Chiu, 2012; Goodwin-Glick, 2017; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017). Any kind of traumatic event can lead to mood disorders, depression, guilt, shame, and anxiety (Bath, 2008; Berson & Baggerly, 2009; Chiu, 2012; Goodwin-Glick, 2017; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017). Often, children who are the victims of a traumatic event will withdraw from friends and family as well. In more extreme cases, children might resort to alcohol or drug use to help them cope with their feelings and, as a final resort, children might also become aggressive or suicidal (Bath, 2008; Berson & Baggerly, 2009; Chiu, 2012; Goodwin-Glick, 2017; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017).

Children may reenact the traumatic event, by acting it out or drawing pictures of what happened. Overall, children suffering from traumatic stress symptoms generally have difficulty regulating their behaviors and emotions. This traumatic stress can be broken down into two types, physical and psychological/emotional trauma.

Physical and Psychological/Emotional Trauma

Physical trauma is best described as a physical injury. The injury can range from minor to life-threatening. Physical trauma can also refer to abuse, both physical and sexual, neglect, as well as violent acts (Berson & Baggerly, 2009; Chiu, 2012; Goodwin-Glick, 2017; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Pizzolongo & Hunter, 2011; Steinbrink, 2013; Sundborg, 2017; Wright, 2017). Where physical trauma is objective, there is another form of trauma that is subjective.

Emotional and psychological trauma is the result of extraordinarily stressful events that can affect your sense of security and make you feel powerless. Traumatic experiences often involve a threat to life or safety, however, any situation that leaves you feeling overwhelmed and isolated can be traumatic, even if it doesn't involve physical harm (Bath, 2008; Berson & Baggerly, 2009; Breidenstine, 2017; Chiu, 2012; Goodwin-Glick, 2017; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; Wright, 2017). It is not the objective facts that determine whether an event is traumatic, but your subjective emotional experience of the event (Killian-Farrell, 2016).

The more frightened and helpless you feel, the more likely you are to be traumatized. Being able to recognize certain traits or symptoms helps identify individuals who have experienced trauma.

Traits and Symptoms

According to Richardson (2010) there are common traits or conditions that may occur following a traumatic event. Sometimes these responses can be delayed, for months or even years after the event.

One of the physical traits associated with a traumatic event is eating disturbances. Things such as loss of appetite, or in more severe cases, anorexia or bulimia, sleep disturbances, sexual dysfunction, low energy, and unexplained chronic pain are all examples of physical traits associated with trauma (Bath, 2008; Berson & Baggerly, 2009; Chiu, 2012; Fecser, 2014; Goodwin-Glick, 2017; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; VanderWegen, 2013; Wright, 2017). Some other common physical signs of trauma include paleness, lethargy, fatigue, poor concentration, and a racing heartbeat (Bath, 2008; Berson & Baggerly, 2009; Chiu, 2012; Fecser, 2014; Goodwin-Glick, 2017; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Steinbrink, 2013; Sundborg, 2017; VanderWegen, 2013; Wright, 2017). The physical symptoms of trauma can be as real and alarming as those of physical injury or illness, and care should be taken to manage stress levels after a traumatic event.

According to Wright (2017) emotional traits associated with a traumatic event are depression, spontaneous crying, despair, feelings of hopelessness, anxiety, panic attacks, fearfulness, compulsive and obsessive behaviors, feelings of being out of control, irritability, anger and resentment, emotional numbness, and withdrawal from normal routine and relationships. Cognitive traits or symptoms associated with a traumatic event are memory lapses, especially about the trauma or traumatic experience, difficulty making decision, decreased ability to concentrate, feelings of being distracted, and ADHD symptoms (Berson & Baggerly, 2009; Chiu, 2012; Fecser, 2014; Goodwin-Glick, 2017; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Richardson, 2010; Steinbrink, 2013; Sundborg, 2017; VanderWegen, 2013; Wright, 2017).

Traits or symptoms such as intrusive thoughts, flashbacks or nightmares, sudden floods of emotions or images related to a traumatic event, amnesia, avoidance of certain situations that resemble the traumatic event, detachment, depression, feelings of guilt, reactions of grief, an altered sense of time, hyper-vigilance, jumpiness, and extreme guarded sense, overreactions, including unprovoked anger, general anxiety, insomnia, and obsessions with death are all traits or symptoms of emotional trauma associated with a more severe traumatic event (Berson & Baggerly, 2009; Chiu, 2012; Fecser, 2014; Goodwin-Glick, 2017; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Richardson, 2010; Steinbrink, 2013; Sundborg, 2017; VanderWegen, 2013; Wright, 2017).

Children and adolescents vary in the nature of their responses to traumatic experiences. According to Richardson (2010) and Wright (2017), reactions of individual youth may be influenced by their developmental level, ethnicity/cultural factors, previous trauma exposure, available resources, and preexisting child and family problems. However, nearly all children and adolescents express some kind of distress or behavioral change during the acute phase of recovery from a traumatic event (Berson & Baggerly, 2009; Chiu, 2012; Fecser, 2014; Goodwin-Glick, 2017; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Killian-Farrell, 2016; Oehlberg, 2014; Richardson, 2010; Steinbrink, 2013; Sundborg, 2017; VanderWegen, 2013; Wright, 2017). Not all short-term responses to trauma are problematic, and some behavioral changes may reflect adaptive attempts to cope with a difficult or challenging experience (Richardson, 2010). Short-term distress is almost universal and very common, where long-term distress seems to be less prevalent. There are some key connections and relationships to the type and level of trauma experienced, such as the economic link.

Socio-Economic Relationship to Trauma

Trauma experienced by an individual can be tied to many things. There are a few prevalent indicators that reflect the relationship between socio-economic status and the types and levels of trauma experienced. There have been studies that suggest some trauma is heavily influenced by social inequality and social status (Adams, 2010; Arnstein, 2014; Carello & Butler, 2015; Chiu, 2012; Goodwin-Glick, 2017; Hernandez, 2014; Horner, 2017; Locovino, Jackson & Oltmanns, 2014). Individuals from marginalized socioeconomic groups may experience chronic discrimination and

prejudice, leading them to become more suspicious, paranoid, and/or distrustful than those from more privileged socioeconomic groups (Adams, 2010; Arnstein, 2014; Carello & Butler, 2015; Chiu, 2012; Goodwin-Glick, 2017; Hernandez, 2014; Horner, 2017; Locovino, Jackson & Oltmanns, 2014; Killian-Farrell, 2016). Traumatic experiences early in life by individuals with lower socioeconomic standing make it difficult for individuals to see others as trustworthy and safe, leading to the development of symptoms related to trauma. Studies also show that there are prospective risk factors based on socioeconomic status that can lead to physical, emotional and sexual abuse among children continuing into adolescence (Adams, 2010; Arnstein, 2014; Carello & Butler, 2015; Chiu, 2012; Goodwin-Glick, 2017; Hernandez, 2014; Horner, 2017; Locovino, Jackson & Oltmanns, 2014; Killian-Farrell, 2016).

Lower socioeconomic status leaves individuals more susceptible to experiencing trauma, and continuing to experience trauma. In turn, the trauma experienced is passed on to the next generation, and a cycle continues. Lower socioeconomic status and prolonged trauma can also lead to substance abuse (Adams. 2010; Arnstein, 2014; Carello & Butler, 2015; Chiu, 2012; Goodwin-Glick, 2017; Hernandez, 2014; Horner, 2017; Locovino, Jackson & Oltmanns, 2014; Killian-Farrell, 2016).

Relationship of Substance Abuse to Trauma

There are many theories and proposals to explain the link between trauma and substance abuse in adolescents. The evidence is clear that there is an increased risk of developing substance abuse due to trauma, and conversely, substance abuse increases the likelihood that adolescents will experience further trauma (Adams. 2010; Arnstein, 2014;

Carello & Butler, 2015; Chiu, 2012; Goodwin-Glick, 2017; Halter, 2008; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Locovino, Jackson & Oltmanns, 2014; Killian-Farrell, 2016; Pizzolongo & Hunter, 2011).

According to Arnstein (2014), adolescents can develop substance abuse problems in an attempt to manage distress associated with the effects of trauma exposure and traumatic stress symptoms. Youth turn to alcohol and/or other drugs to manage the amount and intensity of emotions and traumatic reminders associated with traumatic stress in order to numb themselves to reduce the experience of intense emotions, whether positive or negative (Adams, 2010; Arnstein, 2014; Carello & Butler, 2015; Chiu, 2012; Goodwin-Glick, 2017; Halter, 2008; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Locovino, Jackson & Oltmanns, 2014; Killian-Farrell, 2016; Pizzolongo & Hunter, 2011). Exposures or reminders of a traumatic event have been shown to increase drug cravings in adolescents with co-occurring trauma and substance abuse. In fact, substance use is more likely to develop following trauma exposure than with others who have not experienced similar feelings (Adams, 2010; Arnstein, 2014; Carello & Butler, 2015; Chiu, 2012; Goodwin-Glick, 2017; Halter, 2008; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Locovino, Jackson & Oltmanns, 2014; Killian-Farrell, 2016; Pizzolongo & Hunter, 2011).

For many adolescents, substance use disorders precede the onset of trauma exposure. A direct link can develop between alcohol use and engagement in risky

behaviors in which adolescents may get hurt, such as hitchhiking, walking in unsafe neighborhoods, and driving after using alcohol and/or drugs (Adams, 2010; Arnstein, 2014; Carello & Butler, 2015; Chiu, 2012; Goodwin-Glick, 2017; Halter, 2008; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Locovino, Jackson & Oltmanns, 2014; Killian-Farrell, 2016; Pizzolongo & Hunter, 2011). Adolescents with substance abuse disorders are also significantly more likely than those with non-substance abusing peers to experience trauma that results from risky behavior, including harm to themselves or witnessing harm to others (Adams, 2010; Arnstein, 2014; Carello & Butler, 2015; Chiu, 2012; Goodwin-Glick, 2017; Halter, 2008; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Locovino, Jackson & Oltmanns, 2014; Killian-Farrell, 2016; Pizzolongo & Hunter, 2011). Youth who already are abusing substances may be less able to cope with traumatic events as a result of the functional impairments associated with problematic use:

> In one study, investigators found that even after controlling for exposure to trauma, adolescents with substance abuse disorders were two times more likely to develop PTSD following trauma than were their non-abusing peers. The research suggested that the extensive psychosocial impairments found in adolescents with substance abuse disorders occurred in part because they lacked the skills necessary to cope with trauma exposure ("National Child," 2008, p.2).

Regardless of how the onset of trauma exposure or PTSD and the development of substance abuse problems occurred, adolescents with this co-occurrence experience

difficulties with emotional and behavioral regulation that make it all the more difficult for them to stop using drugs and/or alcohol (Adams, 2010; Arnstein, 2014; Carello & Butler, 2015; Chiu, 2012; Halter, 2008; Hernandez, 2014; Horner, 2017; Juarez, 2014; Locovino, Jackson & Oltmanns, 2014; Pizzolongo & Hunter, 2011).

Conditions related to trauma, as well as levels and types of trauma, are identified through measurement and assessment tools designed specifically for that purpose (Adams, 2010; Arnstein, 2014; Carello & Butler, 2015; Chiu, 2012; Halter, 2008; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Locovino, Jackson & Oltmanns, 2014; Pizzolongo & Hunter, 2011). Understanding these tools is key to understanding trauma.

Measurement/Assessment Tools

General questions do not make an adolescent comfortable enough to disclose traumas like childhood physical or sexual abuse. Therefore researchers have developed several surveys and questionnaires designed to assess trauma and post-traumatic symptoms that have been tested and determined to be reliable (Adams, 2010; Arnstein, 2014; Carello & Butler, 2015; Chiu, 2012; Goodwin-Glick, 2017; Halter, 2008; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Locovino, Jackson & Oltmanns, 2014; Killian-Farrell, 2016; Pizzolongo & Hunter, 2011). The questions are designed to be neutral and specific, to make it more likely to produce a useful response. Many different screening instruments measuring trauma and traumatic history, as well as post-traumatic history are available to use. Some instruments are conducted in interview format and others in a self-reporting format. According to

Behavioral Health Evolution (2016), instruments appropriate to use are determined by the specific adolescent population and additional practical factors. In selecting a screening tool, one should determine the following: first, what types of traumas they are most interested in finding out about; second, do they want to survey a wide range of possible traumas or focus on a particular group of traumas such as physical and sexual assault; third, do they want a survey that simply screens for the presence of PTSD symptoms or one that also gives you information about frequency and intensity of symptoms; fourth, how much time do they have to assess for trauma, PTSD symptoms, and associated conditions; fifth, what is the privacy level of the setting for administering the surveys; sixth, what is the literacy level of the adolescent being assessed; seventh, what is the primary language of the adolescent being assessed; and finally, what is the cost of using the screening tool ("Behavioral Health," 2016)?

Some of the more well-known screening tools are recommended by Behavioral Health Evolution (2016), and are described below.

Adverse Childhood Experiences Score (ACES) measures stressful or traumatic events, including physical, sexual and emotional abuse, physical and emotional neglect, family member violence, substance use and misuse within the household, household mental illness, parental separation and/or divorce, and incarcerated household members. ACES has a scale that measures the amount of trauma a person has experienced, and also determines the level of trauma experienced based on the final score. The Brief Trauma Questionnaire (BTQ) is a ten-item self-report screening tool for trauma exposure that can

be quickly administered and is suitable for special populations, such as persons with mental illness, as well as for general population groups.

The Traumatic Life Events Questionnaire (TLEQ) effectively assesses trauma history of an individual. Child Post-Traumatic Symptoms Scale (CPSS) has been shown to be reliable and valid as a screening tool for use with children and adolescents. The CPSS assesses symptom criteria for PTSD, as well as whether the respondent is experiencing impairment in functioning.

The UCLA Reaction Index **(**UCLARI) is the most commonly used measurement tool for PTSD symptoms in children and adolescents. The UCLARI has two parts: The first part includes a brief screening of the respondent's trauma history, and the second part assesses the frequency with which post-traumatic stress symptoms were experienced over the past month ("Behavioral Health," 2016).

Without screening, individuals who have a history of trauma and related symptoms often go undetected. Screening, early identification, and intervention serve as a prevention strategy (Adams, 2010; Arnstein, 2014; Carello & Butler, 2015; Chiu, 2012; Goodwin-Glick, 2017; Halter, 2008; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Locovino, Jackson & Oltmanns, 2014; Killian-Farrell, 2016; Pizzolongo & Hunter, 2011).

Interventions and Techniques to Treat and Prevent Trauma

A successful treatment approach must be flexible enough to accommodate the multiple ways in which trauma may be regulated (Adams, 2010; Arnstein, 2014; Carello & Butler, 2015; Chiu, 2012; Goodwin-Glick, 2017; Halter, 2008; Hernandez, 2014;

Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Locovino, Jackson & Oltmanns, 2014; Perry & Szalavi; Pizzolongo & Hunter, 2011; Souers & Hall, 2016). Traumatic stress in children is treatable and there are highly effective methods available to help children through their experiences and trauma. The treatments have several layers related to support and relationships. First, the treatment needs to be able to provide support so the child feels safe and secure. Next, caregivers, as well as others, have to adhere to a supportive role in the treatment. Treatment must also provide an opportunity to maintain healthy relationships, reduce unnecessary secondary exposures, and help the child return to typical routines (Arnstein, 2014; Carello & Butler, 2015; Chiu, 2012; Goodwin-Glick, 2017; Halter, 2008; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Locovino, Jackson & Oltmanns, 2014; Perry & Szalavi; Pizzolongo & Hunter, 2011; Souers & Hall, 2016). In more serious cases, referring children for a clinical trauma evaluation may be necessary, and can provide children with more intensive approaches (Carello & Butler, 2015; Chiu, 2012; Goodwin-Glick, 2017; Halter, 2008; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Locovino, Jackson & Oltmanns, 2014; Perry & Szalavi; Pizzolongo & Hunter, 2011; Souers & Hall, 2016).

Some of the treatments that are available for children who have experienced trauma include the following therapies and approaches: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Trauma-Focused Cognitive Behavioral Therapy for Childhood Traumatic Grief (TG-CBT); The Child and Family Traumatic Stress Intervention (CFTSI); Modular Approach to Therapy for Children with Anxiety,

Depression, Trauma, or Conduct Problems (MATCH-ADTC); Dialectal Behavior Therapy (DBT); Eye Movement and Desensitization and Reprocessing (EMDR); and Child First ("Child Health," 2017).

Along with the models mentioned above, children can undergo other forms of therapy and counseling that address trauma (Carello & Butler, 2015; Chiu, 2012; Goodwin-Glick, 2017; Halter, 2008; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Locovino, Jackson & Oltmanns, 2014; Perry & Szalavi; Pizzolongo & Hunter, 2011; Souers & Hall, 2016). Treatment options for trauma exist in educational settings as well.

Interventions, Techniques, and Practices Utilized in Education

The educational field is one of many community organizations that must find a productive way to work with children who have experienced trauma, so it's only natural that educational organizations adopt trauma interventions, techniques and practices to aid them (Carello & Butler, 2015; Chiu, 2012; Crable, Underwood, Parks-Savage & Maclin 2013; Fecser, 2014; Hebert, 2013; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Locovino, Jackson & Oltmanns, 2014; Perry & Szalavi; Pizzolongo & Hunter, 2011; Souers & Hall, 2016).

Schools are increasingly viewed as a critical setting for the delivery of health and behavioral health services. (Carello & Butler, 2015; Chiu, 2012; Crable, Underwood, Parks-Savage & Maclin 2013; Fecser, 2014; Hebert, 2013; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Locovino, Jackson & Oltmanns, 2014; Perry & Szalavi; Pizzolongo & Hunter, 2011; Souers & Hall, 2016).

One of the trauma-informed-care interventions that schools can employ is the Cognitive Behavioral Intervention for Trauma in Schools (CBITS). The CBITS is a school-based group intervention that has been shown to reduce traumatic symptoms, depression symptoms, and psychosocial dysfunction ("Child Health," 2017). The linkages between trauma exposure, physical health, behavioral health and academic functioning underscore the importance of integrating trauma informed care within educational settings (Carello & Butler, 2015; Chiu, 2012; Crable, Underwood, Parks-Savage & Maclin 2013; Fecser, 2014; Hebert, 2013; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Locovino, Jackson & Oltmanns, 2014; Perry & Szalavi; Pizzolongo & Hunter, 2011; Souers & Hall, 2016).

Another approach is the Trauma Affect Regulation: Guide for Education and Therapy (TARGET). TARGET is an educational and therapeutic approach for the prevention and treatment of traumatic stress disorders. TARGET is based on a process that includes a sequence of skills that are designed to help youth understand and control their trauma and related reactions triggered by daily life stresses. The goal of TARGET is to help youth recognize their personal strengths utilizing the skills consistently and purposefully when they experience stress in their current lives ("Child Health," 2017).

Stress management and relaxation skills are also methods educational organizations employ. To implement these management techniques, some schools teach students breathing techniques, meditation, mindfulness, and other pertinent self-calming and soothing techniques (Carello & Butler, 2015; Chiu, 2012; Crable, Underwood, Parks-Savage & Maclin 2013; Fecser, 2014; Hernandez, 2014; Horner, 2017; Hummer, Dollard,

Robst & Armstrong, 2010; Juarez, 2014; Locovino, Jackson & Oltmanns, 2014; Perry & Szalavi; Pizzolongo & Hunter, 2011; Souers & Hall, 2016). Other institutions employ additional methods such as music, exercise and other movement techniques such as stretching, yoga or martial arts (Carello & Butler, 2015; Chiu, 2012; Crable, Underwood, Parks-Savage & Maclin 2013; Fecser, 2014; Hebert, 2013; Hernandez, 2014; Horner, 2017; Hummer, Dollard, Robst & Armstrong, 2010; Juarez, 2014; Locovino, Jackson & Oltmanns, 2014; Perry & Szalavi; Pizzolongo & Hunter, 2011; Souers & Hall, 2016).

Some of the most impactful strategies include teaching children how to express feelings and develop tools for coping. Utilizing scales to rate emotional intensity, or being able to identify and label emotions, is key for students to learn how to express their emotions properly (Crable, Underwood, Parks-Savage & Maclin 2013; Locovino, Jackson & Oltmanns, 2014; Perry & Szalavi; Pizzolongo & Hunter, 2011; Souers & Hall, 2016). Other interventions include connecting students to friends, peers and supportive adults, giving students ideas about participating in creative and positive social activities, and connecting students with available resources in the community (Locovino, Jackson & Oltmanns, 2014; Perry & Szalavi; Pizzolongo & Hunter, 2011; Souers & Hall, 2016).

Conclusion

Trauma is more prevalent today than ever before and is an especially serious issue in education. Trauma critically affects a child's life, particularly the capacity to cope with stress and the ability to learn. Childhood trauma can have a direct, immediate, and potentially overwhelming impact on a child. According to the research, the issue of trauma has been largely ignored by educational systems. Today there are a variety of

assessment tools for trauma, and some intervention techniques that can be applied. By adopting a trauma informed care approach, educators can begin to understand the role of trauma, its effect on children and learning, and how educators can change methods of interacting and responding to children impacted by trauma.

A trauma informed care approach can be implemented in many settings, and is distinct from trauma-specific interventions or treatments that are designed to address the consequences of specific trauma and facilitate healing.

Trauma is pervasive and can lead to many unwelcome outcomes. Building upon personal strengths and making needed adjustments can help those who have experienced trauma be more successful in their schooling. Educational systems need to incorporate accommodations that can address traumatic stresses and their effects. The trauma informed system also needs to promote wellness, resiliency, and protective practices. Best practices suggest the system should also incorporate positive principles of safety, trustworthiness, choice, collaboration and empowerment. Recognizing, addressing and understanding the issue of trauma and addressing the implications of traumatic experiences for students should become a focus for educational systems. Implementing trauma informed care has the potential for widespread positive effects, including more positive academic outcomes in education. Currently there are only a few validated interventions for educators to implement with individual students who have experienced trauma.

The goal of this study is to explore best practices available for implementing trauma informed care in an educational organization. Key elements and themes will be

identified in order to utilize the best practices available when addressing those elements. The question is what are the key themes to reference in order to identify and implement the best practices that exist for educators in a trauma informed care system in order to positively effect change.

METHODS

Introduction

This study was a qualitative study utilizing interviews and questionnaires to reveal trauma informed care best practices. Five participants with varying degrees of expertise in Trauma Informed Care were purposely chosen, with varying levels of experience, in order to investigate the best practices they utilize when implementing trauma informed care within a secondary educational setting.

Participants

Five participants were purposefully chosen with at least three years of experience in implementing trauma informed care. An online search was performed in order to create a list of secondary institutions to draw a sample list from. The sample was drawn from a list of secondary institutions within the western region employing trauma informed care, and volunteers were sought at said institutions. Volunteers were selected from Washington, Oregon, and California. Only those who hold positions within a secondary institution employing trauma informed care practices were asked to volunteer. Two participants were high school counselors in California. One has seven years of experience with trauma informed care, while the other participant has three years of experience. One participant is a Dean of Students in Washington who has five years of experience in trauma informed care. Two participants are high school principals, one from California who has four years of experience with trauma

informed care, and the other from Oregon has three years of experience with trauma informed care. All participants are over the age of 35, two are female and three are male.

Instrument

The interview schedule included 12 questions ranged from general knowledge and practice to experience, expertise and implementation. The questions examined attitudes and opinions toward the subject of trauma informed care, as well as evaluation techniques and staff involvement. The interview questions were derived from the literature, most notably from "Trauma-Informed Care in Behavioral Health Services," SAMHSA, 2014.

Procedure

After identifying the sample necessary for the study, emails were sent as invitations to participate. Follow-up phone contacts were made to those who responded via email. Phone calls were made to set up a time and a place to conduct the interview with each participant. Two days before the scheduled time, an email reminder was sent including a general overview of the interview process. Interview questions, time expectations, and a reiteration of confidentiality were discussed in the email reminder. On the day of the interview, I arrived fifteen minutes early to ensure everything was in place and ready for the interview. We found comfortable seating, in a comfortable area, and discussed the consent form and interview guidelines. After the participant signed the consent form, I asked a series of semi-structured questions following the interview schedule. Interviews

lasted 30 to 60 minutes, depending on the level of engagement from each participant. Two of the participants were too far for a face to face interview, so telephone interviews were conducted. The general format was followed for the telephone interview with the exceptions that consent forms were emailed prior to the interview, signed, and emailed back. I asked the same series of semi-structured interview questions via telephone that were audio recorded and then transcribed.

Each participant was also allowed to fill out the questionnaire following the interview and email it back to interviewer. The written portions were then compared to the audio recordings and transcribed. Thematic coding was used to identify key themes and elements that existed in the responses given by the interviewees. Some of the key codes looked at Physiological and physical elements, Environmental elements, background elements, and leadership elements.

Analysis

Once the interviews were complete, they were transcribed. Qualitative data was coded for the analysis of the interviews. The coding process was thematic, drawing on common themes around best practices in trauma informed care, as well as approaches and experience. A code book was created with the themes in mind (see appendix) in order to create consistency. Member checking was utilized for follow up questions and insight regarding questions that may have arisen during the transcription and coding process.

RESULTS

This study was a qualitative study utilizing interviews and questionnaires to reveal trauma informed care best practices. Five participants with varying degrees of expertise in Trauma Informed Care were chosen at random, with varying levels of experience, in order to investigate the best practices utilized when implementing trauma informed care within a secondary educational setting. The interviews were coded for common themes, in order to determine what best practices may exist when taking a Trauma Informed Care approach within a secondary setting. The themes that were found were brought up in all five interviews. Those themes are listed and discussed below. The table illustrates the number of occurrences the theme was detected in all of the interviews, as well as the percentage on the interviews that theme revolved around.

Table 1

THEME	**OCCURANCE**	**PERCENTAGE**
Physical & Psychological Safety	17 times	14%
Trustworthiness & Transparency	15 times	12%
Peer Support	12 times	9%
Collaboration & Mutuality	15 times	12%
Empowerment, Voice & Choice	22 times	17%
Cultural, Historical & Background	18 times	14%

THEME	OCCURANCE	PERCENTAGE
Environmental Effects	10 times	8%
Governance & Leadership	18 times	14%

Physical and Psychological Safety

The theme of safety was prominent in the interview responses. Both physical safety and psychological safety were key points within the theme of safety. One participant described it this way in explaining that safety was a matter of both environmental and sense of control.

> *"What we have noticed is that students want something soft and comfortable, something they can control and manipulate. Students tend to do better in place they can control, rather than a place that is unpredictable. This place needs to be less restrictive, more inviting, and help students feel safe."*

Throughout secondary education organizations, whether or not children and/or adults feel psychologically safe is addressed. The understanding of what is safe and what is not is defined by those served, the student and staff population.

Trustworthiness and Transparency

The theme of trust and transparency was a key component in all 5 interviews. The interviewees stressed that trust and transparency are of the utmost importance when taking a trauma informed care approach. Organizational operations and decisions around trauma informed care should be conducted with transparency.

> *"You want to make sure that there is a system in place that is consistent and students know what they are walking into every day, and they know what to expect. Anyone that is triggered by trauma will need clear expectations."*
> *"Authenticity, engagement, modeling, etc. are ways of really doing that, really being transparent. Transparency is key to building trust. In order to build trust, you have to be transparent."*

The ultimate goal is building and maintaining trust with students and staff, community members, family members, and other organizations that may be involved. Building trust is accomplished by creating relationships, consistency, and reducing factors that may result in aggravating trauma.

Peer Support

Peer support and mutual self-help and self-care is a theme that is common as well. These are key vehicles for establishing safety, hope, building trust, enhancing collaboration, and utilizing experience and past practice, as well as educational histories and lived experience, to promote recovery and healing within a trauma informed system.

> "*Self-care is important. Teaching self-care is important as well. There's something that is called compassion fatigue and a secondary trauma. I see it with the clinicians that are working with most impacted students. Some of the practices that exist that have worked in my experience are open and transparent communication, staff meetings, open door policy by administration, and the school website are the ones that come to mind when addressing staff needs and concerns, as well as communication between students, staff, administration and the public."*

In this instance, peer refers to individuals who have lived through experiences of trauma, or have experienced traumatic events and can be key

caregivers in recovery. In order to have peer support and self-help, self-care must be a focus. With that focus, it is easier to support those who are also dealing with trauma.

> *"Taking on trauma from another is not easy and neither is learning empathy. Learning ways to deal with trauma is important for those reasons. Whatever that may be to help deal and cope with issues is important."*

Collaboration and Mutuality

Importance was placed on partnering, and the leveling of power differences between staff, students and administration.

> *"The opportunity to have communication with each other and support each other is important because there is a lot of support that comes from within. a lot of the difficulty to deal with self-care is trying to do it all in isolation, and isolation is not what this whole movement is about. It's about forming community and healthy, safe environments for everybody, including staff. There isn't always a unified vision, but it's important to be really clear in that way, and embrace ideas the staff may have as well."*

This demonstrates that the trauma informed care approach needs relationships in order to facilitate healing from trauma. With meaningful sharing of power and decision-making, healing can take place and those involved will feel better, more accepted, and be able to develop the skills necessary to cope with current and past traumas. Organizations are able to recognize that everyone has a role to play in a trauma informed care approach.

Empowerment, Voice, and Choice

Secondary educational organizations recognize and build on individuals' strengths and experiences. Effective organizations foster a belief in the primacy of

the people served, the power of personal resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. Developing that ability is a challenge given the busy lives of educators. However, the common focus on trauma related needs can motivate staffs to engage in needed professional development.

> *"The thing that we've really found is critical is that communicating and educating staff is really important. Is it that we're wanting to be naïve or lesson planning, or we're looking at doing things differently when we are used to doing them a certain way? When we understand why, we're much more motivated to do it and make the change. And so trauma has been a really strong pathway for us to help understand why it is we're changing what."*

These organizations understand that the experience of trauma may be a unifying element in the lives of those who run the organization, provide the services, and/or come to the organization for assistance and support. As such, operations, workforce development and services are organized to foster empowerment for staff and clients alike.

> *"I know that some of the more productive work that has happened with students that have trauma is not sitting down at a table and having sort of transactional therapy or insight based therapy, but it's really taking a hike with them, moving with them, talking with them as they do something. Those are the types of opportunities that are gateways into repairing the neuro development and also putting the child at ease. Bringing them into a context where they feel calmer. This allows them to have control of the situation so they feel they have the power to make choices for themselves."*

Understanding the importance of power differentials and the ways in which students have often been the recipients of coercive treatment with a diminished voice and choice in decisions is important for setting the stage for an

effective approach. In TIC clients are supported in shared decision-making, making choices, and goal setting to determine the plan of action to heal and move forward. They are supported in cultivating self-advocacy skills. Staffs are facilitators of recovery rather than controllers of recovery. Staffs in turn, are empowered to do their work as well as possible by adequate organizational support. This is a parallel process as staff needs to feel safe as much as students receiving services.

Cultural, Historical and Background

This theme touched on secondary organizations actively moving past cultural stereotypes, and utilizing experience and background to help explain trauma related behaviors.

> *"Think about it, we teach our children at a young age, the things we want them to learn. In essence, if we teach them how to cope, and deal with trauma at a young age, then they are less likely to have issues as they continue their junior high and high school career."*

Secondary organizations leverage the healing power of culture and traditional cultural connections, and incorporate policies, protocols, and processes that are responsive to the students and their backgrounds. It also recognizes and addresses historical trauma that may exist.

> *"In my opinion, TIC also addresses the root of the issue as opposed to addressing the symptoms. That's whatever the root may be. It could be a past trauma, a present trauma. It could be anything to do with family, abuse, neglect. It could even be more complex such as family dynamic, family history, culture, religion, what-have-you. Finding and addressing the root allows for healing instead of just coping in the moment."*

Environmental Effects

The secondary organization should ensure that the physical environment promotes a sense of safety, wellness, calmness, and collaboration.

> *"Physical environment plays a big role in trauma, and how trauma is addressed."*
> *"Environments that are stable, allow for the student to control, that are quiet and calm in nature, and have manipulatives to distract behaviors seem to work the best."*

Staff and students should experience a setting that is safe, inviting, and not a risk to their physical or psychological safety and well-being. The physical setting should also provide collaborative spaces and promote a trauma informed care approach through openness, transparency and a systematic approach to healing from trauma.

Governance and Leadership

The theme of leadership was a key component in the interviews as well. One participant expressed it in this way:

> *"Physical environment plays a huge role in helping to address and deal with those who have suffered through trauma. This is not only important for students, but for staff as well. Physical environments that are calm, quiet, and can be controlled are crucial for healing, collaboration, and sustainability."*

Organizations that ensure the physical environment promotes a sense of safety and collaboration will be more successful in employing a trauma informed care approach. Another participant expressed it in this way:

> *"It really comes down to, if you want best practices for people with trauma, the relationships. Schools have become the community of care. Schools can no longer just be academic. Schools have to be working across the domains of academic, social, emotional and*

behavioral."

Committed leadership also promotes a systematic approach to addressing trauma and traumatic events with staff and students. Identifying a person with the specific responsibility for facilitating TIC is key within any organization to lead, oversee, promote and guide.

> *"I think a good place to start is having an administrator who wants to start and wants to understand what this is and support the students that are coming into their schools. I think another good place is start informing yourself and other staff members about how trauma impacts everybody, then getting people to realize that trauma affects everyone."*

Leadership is often needed to initiate and substantiate a system and process of change while creating an open environment for the inclusion and voice from students and staff.

DISCUSSION

When the interviews were concluded, the key issues that arose were centered around physical and psychological safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, cultural and historical backgrounds, environmental effects, and governance and leadership. Practice that centered around those themes were seen by the respondents to be practices that are most effective when taking a trauma informed care approach.

I found it interesting that the most common theme among the experts centered on empowerment, voice and choice. The fact that trauma informed care is knowledge-based, which means that the themes are founded on an accumulation of facts and/or information, makes it only fitting that the most common theme is centered on knowledge and education. I also found it interesting that the environmental effects were not mentioned frequently. I thought that environment would play a key role in a trauma informed care approach given the central role of a sense of safety. However, even though it is a theme amongst the responses, it is not a prominent one. This leads me to conclude that environment, although it may play a role, it is not as significant as other themes in having successful practices within a trauma informed care approach.

The themes identified in the study fit the literature well. Although the literature seemed to focus more on defining what trauma was, looking at traits,

and recognizing and diagnosing trauma, it also focused on intervention techniques that seemed to be most prevalent when adopting a trauma informed care approach. This relates directly to the interventions because the interventions described above reflected one or more of the themes identified through this study. However, even though they may relate, it's hard to decipher which interventions fall within which of the theme and which interventions would be most successful.

Further investigation is needed to see what specific practices work best within the themes acknowledged in this study. Some of the respondents alluded to a systematic approach, regardless of what specific techniques were used, centered around consistency and relationships. All of those practices are centered on the most common theme that was identified in this study. Further investigation is also needed to determine the validity these practices have when taking a trauma informed care approach, in order to provide quantitative data and provide more concrete information and results.

In summary, the themes of physical and psychological safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, cultural and historical backgrounds, environmental effects, and governance and leadership were found in conducting this study of trauma informed care. Respondents suggest that practices centered around these themes will be successful, especially practices centered around the theme of empowerment, voice and choice. Secondary institutions adopting a trauma informed care approach should focus on these themes in designing an

effective approach, and in order to develop a sustainable model in working with students and staff that have experienced trauma.

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APPENDIX

Interview Questionnaire

1. What is your definition of trauma and trauma informed care?

2. What would consider best practice(s) with the approach to trauma informed care?

3. How does leadership communicate its support and guidance for implementing a trauma informed approach?

4. How does written policies and procedures include a commitment to providing trauma-informed services and supports?

5. How does leadership demonstrate support for the voice and participation of people who have trauma histories?

6. What services/best practices are typically in place for trauma survivors/people receiving services and peer supports in meaningful and significant roles in agency planning, governance, policy-making, services, and evaluation?

7. How much does physical environment promote a sense of safety, calming, and de- escalation for students and staff?

8. In what ways do staff members recognize and address aspects of the physical environment that maybe re-traumatizing, and work with people on developing strategies to deal with this?

9. Would you consider self-care to be an important practice for trauma survivors? Why?

10. What practices are in place in order to keep staff members fully informed of rules, procedures, activities, and schedules, while being mindful that people who are frightened or overwhelmed may have a difficulty processing information?

11. Would you consider trust and transparency a key component? Why? How is transparency and trust among staff promoted?

12. Is trauma informed care something that you would promote for secondary institutions? Why or why not? What are the benefits and challenges?