TEACHING TRAUMA AFFECTED STUDENTS: INCREASING PROFESSIONAL AWARENESS AND RESPONSIVE EDUCATIONAL ENVIRONMENTS

A Project

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by
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Department of Graduate and Professional Studies in Education
Abstract

of

TEACHING TRAUMA AFFECTED STUDENTS: INCREASING PROFESSIONAL AWARENESS AND RESPONSIVE EDUCATIONAL ENVIRONMENTS

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Statement of Problem

The National Child Traumatic Stress Network (NCTSN) reports that up to 40% of students have experienced, or been witness to, traumatic stressors during their lifetime. According to the National Research Counsel Institute of Medicine, “the environment provided by the child’s first caregivers has profound effects on virtually every facet of early development, ranging from the health and integrity of the baby at birth to the child’s readiness to start school at age 5” (2000, p. 219). Not enough parents, teachers, therapists, judges or physicians have adequate knowledge about child development or brain organization and function (Dobson & Perry, 2010; Perry, 2009). This study aimed to build educator awareness of affects of trauma. The secondary purpose of the study was to cause reflection and challenge perspectives regarding where bad / challenging behavior comes from and how it should be dealt with.

Sources of Data

The project utilized the framework designed by the National Staff Development Council (NSDC) (2007), with specific focus on the context, content, and process of high-
quality teacher professional development. The aim of this project was to provide professional development for early childhood educators working in the preschool environment. Professional development conducted was concentrated at an Early Childhood Center in an urban, low-income neighborhood in Sacramento, California. The participants included 18 educators who participated in both workshops and coaching. Staff participating included six teachers, seven instructional assistants, one administrator, two operations staff, and two substitutes. For the purposes of this project professional development consisted of two all staff workshops, ongoing coaching over eight months for teaching and operations staff, and hard and soft copy resources.

Conclusions Reached

The project outcomes included a number of successes and opportunities for further revision. An optimal setting, with established relationships and content focused specifically on relationships contributed to a forum where educators could reflect on and challenge their perspectives regarding where challenging behavior comes from, which was the secondary purpose of this project. The specific context for this project included many components of high quality professional development. The specific content for this project was based on research, linked to standards for children birth through age five and provided tangible instructional strategies to address identified gaps in a specific demographic of student’s achievement. A key strength of the content for this project was that it was specifically formed to meet identified needs at the individual preschool site and included modeling for teachers within their classroom. The process was
implemented within the context where educators will utilize the practices (i.e. at the school site) and included the coaching component found to the 85% more effective that workshops alone (Gulamhussein, 2013). Beyond the school site who participated in professional development, this project has the potential for future use and impact across multiple disciplines.

__________________________, Committee Chair
Rachael A. Gonzáles, Ed.D.

__________________________
Date
ACKNOWLEDGEMENTS

It is with the support of many colleagues, mentors and family members that I contribute the success of this project. Just as it takes a village to raise a child, I truly believe that the work we do as students or professionals is best set in a community context. I’d like to acknowledge a few groups of people who played significant roles in the incredible learning experience I have had prior to and during the expanse of this project.

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philosophy and career. From your approach with families I have learned many strategies for how to advocate, but not overpower. I respect your knowledge of theory and law, yet continual value of keeping your feet wet in the field and work in the trenches. Thank you for walking beside me in many endeavors throughout this season. Also to Andrea Knowlton, Kathy Conover and the staff at Napa County Office of Education whom I had the privilege of working with for a short period of time that significantly impacted my personal philosophy and codified the research demonstrating that all children can be educated together.

To my staff at Triumph Center for Early Childhood Education, the incredibly hard work and investment that goes into serving all students well is a practice you take on daily. Thank you for willingly opening your mindsets to the concept of childhood trauma and investment in students to take on working toward implementation of evidence based practices.

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Chapter 1

INTRODUCTION

The National Child Traumatic Stress Network (NCTSN) reports that up to 40% of students have experienced, or been witness to, traumatic stressors during their lifetime. Up to 26% of those children have witnessed or experienced trauma prior to the age of four. Trauma can include any type of abuse or neglect, toxic stress, exposure to violence, medical procedures, home destabilization, substance abuse, or other adverse early childhood experiences (Bergin & Bergin, 2009; Brunzel, Waters & Stokes, 2015; Wolpow, Johnson, Hertel & Kincaid, 2009). Trauma can impact school performance, impair learning or cause physical and emotional distress for one in every four children in the classroom (NCTSN, 2015).

Setting children up for successful long-term outcomes starts early (American Institutes for Research, 2012). With 65% of brain development complete by the time children turn five-years-old, preschool teachers have a crucial role to play in the children’s lives they support each day. Unlike therapy for some students who face challenges or have a disability, weekly stand-alone services are not enough for children who struggle with symptoms from trauma on a daily basis. Trauma affected children also require varying levels of support to build effective relationships with teachers. Moving toward educator awareness and therapeutic, responsive classroom environments supports trauma-affected students, as well as students with secure attachment and typical brain development to reach optimal outcomes.
Background of Problem

According to the National Research Counsel Institute of Medicine, “the environment provided by the child’s first caregivers has profound effects on virtually every facet of early development, ranging from the health and integrity of the baby at birth to the child’s readiness to start school at age five” (2000, p. 219). Within the first year of life children develop a template for how they attach to adults in their world. Secure attachment, one of four types of attachment, is associated with a number of crucial positive school outcomes including higher grades, better scores on standardized tests and lower levels of attention deficit hyperactivity disorder (ADHD) and school delinquency (Bergin & Bergin, 2009). Children’s inability to access the support needed from an adult, during a stressful situation, can interrupt their ability to ‘process, integrate, and categorize’ what happened (Statman-Weil, 2015, p. 72). This leaves children who have experienced trauma vulnerable to a breach in healthy attachment and at-risk for trauma-affected symptoms.

In the late 1990’s a growing interest in investigating the long-term affects of child trauma emerged. A landmark study by authors Felitti et al. (1998), in partnership with Kaiser Permanente and the Center for Disease Control, was launched looking at the relationship between adult health risk behavior, proneness to disease and chronic illness in relationship to adverse childhood experiences. This Kaiser study and follow up sister studies (Briggs-Gowan, Ford, Fraleigh, McCarthy, & Carter, 2010; Burke, Hellman, Scott, Weems, & Carrion, 2011) have demonstrated astounding correlations between trauma experienced in childhood and health, behavior and learning risks throughout
childhood, adolescence and adulthood. Trauma survivors are also at risk for a number of mental illnesses including anxiety, depression, Oppositional Defiant Disorder (ODD), ADHD and Post Traumatic Stress Disorder (PTSD) (Dehon & Scheeringa, 2006; Drake, Belsky, & Pasco Fearson, 2014; Martel, Gremillion, & Roberts, 2012; Wichstrom, Belsky, & Berg-Nielsen, 2013).

According to the National Institute of Mental Health (2015), one in five children either currently have or will have a seriously debilitating mental disorder at some point in their life. The cost associated with serious mental illness exceeds $300 billion per year. In 2003, the President’s New Freedom Commission on Mental Health noted that early intervention is key to favorable long-term outcomes. In addition, children receive more services through schools than any other public entity, therefore it is paramount to address the mental health needs of children in the educational setting.

Unbeknown to many professionals, mental health begins in infancy. Not enough parents, teachers, therapists, judges or physicians have adequate knowledge about child development or brain organization and function (Dobson & Perry, 2010; Perry, 2009). As a result of lack of knowledge, this researcher has observed that many professionals address the behavioral situation, instead of the root trauma symptoms. Tactics often include using behavioral strategies recommended for challenging behavior to respond to trauma symptoms. Research suggests that a relational, rather than behavioral, framework for addressing children’s behavior is more effective in supporting children with attachment or trauma issues (Brunzell et al., 2015; Floyd, Hester, Griffin, Golden, & Canter, 2008; Wolpow et al., 2009). Increasing the knowledge that professionals,
specifically educators, function out of is essential to the identification of trauma
symptoms and development of effective clinical and classroom interventions.
Empowered and knowledgeable professionals will support appropriate interventions;
therefore, decreasing the risk of negative immediate and long-term outcomes.

Purpose of Study

This study aims to build educator awareness regarding affects of trauma. The
project is focused on one agency within one specific demographic of children. The
primary purpose is to utilize staff professional development, at the preschool level, to
increase awareness of attachment and trauma. Educators will also be provided with
resources on interventions and creating trauma supportive environments and coaching to
begin the implementation process.

The secondary purpose of this study is to cause reflection and challenge
perspectives regarding where bad / challenging behavior comes from and how it should
be dealt with. Many educators view behavior based on their experiences growing up or
the narrow range of functions and responses that they may have been trained on during
their professional career. It is uncommon to find professionals who possess the skill and
mindset in order to differentiate between functions of behavior and utilize that knowledge
to inform their practice.

Theoretical Framework

Professional development refers to the development of a person in his or her
professional role. The goal of teacher professional development is to empower and train
teachers in a way that improves student performance. The project at hand utilizes the
framework designed by the National Staff Development Council (NSDC) (2007), as illustrated in Figure 1, with specific focus on the context, content, and process of high-quality teacher professional development.

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<th>Process Standards</th>
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<td><strong>Data-Driven</strong></td>
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<td>Staff development that improves the learning of all students uses disaggregated student data to determine adult learning priorities, monitor progress, and help sustain continuous improvement.</td>
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<td><strong>Evaluation</strong></td>
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<td>Staff development that improves the learning of all students uses multiple sources of information to guide improvement and demonstrate its impact.</td>
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<td><strong>Research-Based</strong></td>
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<td>Staff development that improves the learning of all students prepares educators to apply research to decision making.</td>
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<td><strong>Design</strong></td>
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<tr>
<td>Staff development that improves the learning of all students uses learning strategies appropriate to the intended goal.</td>
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<td><strong>Learning</strong></td>
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<td>Staff development that improves the learning of all students applies knowledge about human learning and change.</td>
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<td><strong>Collaboration</strong></td>
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<td>Staff development that improves the learning of all students provides educators with the knowledge and skills to collaborate.</td>
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<th>Content Standards</th>
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<td><strong>Equity</strong></td>
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<td>Staff development that improves the learning of all students prepares educators to understand and appreciate all students; create safe, orderly and supportive learning environments; and hold high expectations for their academic achievement.</td>
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<td><strong>Quality Teaching</strong></td>
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<tr>
<td>Staff development that improves the learning of all students deepens educators’ content knowledge, provides them with research-based instructional strategies to assist students in meeting rigorous academic standards, and prepares them to use various types of classroom assessments appropriately.</td>
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<tr>
<td><strong>Family Involvement</strong></td>
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<td>Staff development that improves the learning of all students provides educators with knowledge and skills to involve families and other stakeholders appropriately.</td>
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Figure 1. NSDC standards for professional development.

**Context**

In education, and various other disciplines, the environment sets the stage for learning. In their book *Student Achievement Through Staff Development*, Joyce and Showers (2002) identify keys to supportive contexts as administrator support, educator
buy in, and optimal settings. Long-term change is not sustainable without administrator support. Ultimately, administrators have the power to leverage funding and capacity to sustain initiatives, especially when decisions are made based on data. When a shared sense of need among staff is present, change will be welcomed with less resistance and implementation will occur more rapidly. Just as we know that children’s environments matter to their outcomes, the setting in which staff professional development is presented matters. Teachers who experience learning as a communal activity, instead of a task specific to only their own growth, are more likely to show progress in changing their beliefs, collaborating with others and ultimately changing their practice.

Content

In an era of higher expectations, with seldom increased capacity, it is not uncommon to find professional development content that is designed based primarily on historical perspectives, policies or perceptions. High quality professional development content should be research-based and linked to the standards students are required to master in the classroom. A component of a research-base should include an element of evidence-based practices that provide teachers with instructional strategies to utilize in their teaching practice. In addition, Gulamhussein (2013) suggests that the content should be specific to the narrow discipline and grade-level.

Process

The traditional process, or format, for professional development has consisted of the workshop model; typically, two to eight hours of lecture style content where teachers are expected to take newly acquired knowledge and independently implement it the
following day or week. Through an analysis of recent research, Darling-Hammond, Chung Wei, Andree, and Richardson (2009) found that in all studies they reviewed stand alone workshop style professional development was found to be ineffective in changing teacher’s practices in a sustainable way. Although this format of training is ineffective, more than 90% of teachers, as illustrated in figure 2, participate in workshop-style training sessions during a school year.

Figure 2. Types of professional development provided to teachers over a year.

Unlike stand-alone workshops, instructional coaching has an effective positive track record in supporting teachers to implement sustained changes to their practice that positively affect student’s outcomes (Darling-Hammond, et al., 2009; Gulamhussein, 2013; Skiffington, Washburn, & Elliott, 2011). Workshop style professional development is not typically connected to instructional coaching addressing the
implementation gap. Gulamhussein (2013) conducted a literature review of research comparing the workshop model and instructional coaching. Her review found that 10% of knowledge is implemented into practice following a stand-alone workshop and 95% of knowledge is implemented following ongoing, intensive coaching and collaboration. In addition, for teachers implementing new strategies it takes an average of 20 instances of practice to master. Considering the large body of current research, it is vital for administrators who made decisions about professional development to consider moving beyond stand-alone workshops.

The framework of professional development, for this study, was established utilizing the NSDC (2007) standards for professional development, along with evidence based practices supporting effective contexts, content and formats for professional development.

Definition of Terms

Attachment

A framework, that starts at birth, for a human being’s understanding of interpersonal relationships and context through which they perceive the world (Bowlby, 1969).

Challenging Behavior

Any behavior that consistently interferes with children’s learning, development, or success at play. The behavior may be harmful to the child, other children, or adults and may put a child at higher risk for later social problems or school failure (Kaiser & Rasminsky, 2007).
**Early Childhood**

The time period from birth to age eight (United Nations Educational, Scientific and Cultural Organization, 2016).

**Instructional Coaching**

A type of professional development where teachers work with a master educator before, during and after a workshop, receiving feedback on their implementation of a pre-determined teaching skill. Coaching typically includes use of reflective practice strategies and in some cases videotaping teachers during an agreed upon portion of instruction. Coaches support teachers to analyze their teaching and its impact on children aiming to cultivating a habit of continually assessing and reflecting on their teaching practices (Skiffington et al., 2011).

**Internal Working Model**

A human being’s framework for relating to the world around them which is constructed during the first 12-months of life from their experiences and interaction patterns with their primary attachment figures (Bretherton & Munholland, 1999).

**Mental Health**

A person’s condition with regards to their psychological and emotional well being. Three primary indicators of mental health include emotional well-being, psychological well-being and social well-being (Centers for Disease Control and Prevention, 2011).
Preschool

Preschool is an early childhood program in which children combine learning with play in a program run by professionally trained adults. Children are most commonly enrolled in preschool between the ages of three and five, though those as young as two can attend some schools. Preschools are different from traditional day care in that their emphasis is learning and development rather than enabling parents to work or pursue other activities (Encyclopedia of Children’s Health, 2016).

Toxic Stress

Prolonged stress that occurs when children experience strong, frequent or prolonged adversity that activates children’s stress response system and can disrupt brain development and healthy functioning of internal organs (National Scientific Council on the Developing Child, 2014).

Trauma

Trauma can include any type of abuse or neglect, toxic stress, exposure to violence, medical procedures, home destabilization, substance abuse, or other adverse early childhood experiences (Bergin & Bergin, 2009; Brunzel et al., 2015; Wolpow et al., 2009).

Justification

In an era of high stakes testing in school systems, there remains a great need for balanced professional development and educational programs. Programs that do not only address the academic needs of children, but those which address the whole child.
Research indicates that early academic achievement and kindergarten readiness are strongly tied to children’s social-emotional skills (Eisenberg & Eggum, 2010; McClelland, Cameron, Connor, Farris, Jewkes, & Morrison, 2007). This research project will benefit the education profession by providing resources and professional development to teachers, instructional assistants, operations staff and administrators that address the whole child, specifically through the lenses of attachment, social-emotional competency and mental health. This project will also encourage community mental health awareness by endeavoring to cultivate a grass roots movement addressing mental health; specifically, the recognition that mental health is fostered from birth, adults have a powerful role in supporting children’s healthy outcomes and beginning to break down the barriers and stigmas attached to mental health and illness.

Limitations

This project is centered around one school, in one community and addresses one area of mental health (i.e. attachment and trauma). The project will span less than one school year and address a domain, trauma, in which there continues to exist considerable stigma.
Chapter 2
REVIEW OF LITERATURE

Introduction

The formation of professional development for the project at hand was based on a review of relevant literature, which is discussed in this chapter. Topics associated with trauma and education, consistently found in literature, include prevalence, long-term affects, and diagnoses associated with trauma. Attachment and brain development are also inexplicably linked with trauma. Finally, school interventions; the evidence based practice that flows out of the current base of research. During the development of the workshop modules and coaching for this project, the facts about attachment and trauma were the focal point during workshops and teacher perspectives and intervention the emphasis of coaching.

Prevalence and Long Term Effects of Trauma

*Adverse Childhood Experiences*

In the late 1990’s a growing interest in investigating the long term affects of childhood trauma emerged. The well-known Adverse Childhood Experiences (ACEs) study (Felitti et al., 1998) was based out of Kaiser Permanente’s San Diego Health Appraisal Clinic. Kaiser partnered with the Center for Disease Control in order to look at the relationship between health risk behavior, proneness to disease and other chronic illness in relationships to ACEs. They specifically looked at how adverse childhood experiences linked to health risk behaviors and adult diseases. ACEs were defined as adverse childhood experiences and for the purpose of the original ACEs study they fit
into seven categories. The seven categories included psychological, physical or sexual abuse, violence against the child’s mother, and living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned.

Although the ACEs study best applied to middle class, Caucasians it was groundbreaking due to the 9,508 adult sample size and its findings within a demographic thought to be less at risk. The study utilized a correlational design, specifically a prediction research design. The predictor variable was the number of ACEs. The criterion variable was health risks and the presence of adult diseases. Health risks included being a current smoker, severely obese, engaging in no physical activity, depressed mood, attempted suicide, self-proclaimed alcoholic, use of illicit or injected drugs, having intercourse with more than 50 partners and had or having a sexually transmitted disease. Diseases that lead to death included ischemic heart disease, cancer, stroke, chronic bronchitis or emphysema, diabetes, fair or poor self-rated health and ever having had a skeletal fracture, hepatitis or jaundice.

The ACEs study was a landmark study for its correlation between early experiences of children and their long term effects. There was a strong dose response relationship, the effect of differing levels of exposure, between the number of ACEs and the risk factors/adult disease. Over 50% of respondents reported experiencing one or more ACE. Less exposure to ACEs was found among older persons, white or Asian persons and college graduates. For all variables there was a significant correlation between the number of ACEs and risk/adult diseases. When it culminated in 1998, the
ACEs study led the way for many smaller studies that would be conducted looking at the affects of adverse childhood experiences.

Burke et al., (2011) utilized ACEs to investigate their correlation to increased risk for obesity and learning/behavior problems in primarily minority youth who lived in a low-income urban community. The authors hypothesized that many youths in the target population would have experienced one or more ACE. They also hypothesized that an ACE score of four or more would be associated with higher probability of childhood diagnoses of obesity and/or learning/behavior problems.

The authors findings aligned with both their number of ACEs hypothesis and their correlational hypothesis. Specifically, 67% of children had experienced at least one or more ACE and 12% experienced four or more ACEs. The authors also disseminated statistical analysis applying to what percent of children experienced an ACE from each each of the nine categories. As predicted with their second hypothesis, children with more adverse childhood experiences had more learning/behavior problems and/or were obese. Three percent of children with no ACEs had a learning/behavior problem, while 51.2% with four or more ACEs meant the same criteria. With a closer range, 45.2% with four or more ACEs in comparison with 31.3% with no ACEs.

Likewise, another sister study conducted by Briggs-Gowan et al., (2010) addressed the limited body of research on what they labeled ‘Potentially Traumatic Events’ (PTE). The researchers looked at infants and children across diverse socio-economic and race demographics and broke traumatic events into two categories, non-interpersonal and violence exposure. Non-interpersonal PTE included non-intention
incidents such as a car accident, natural disaster or attack by an animal. Violent exposure PTE included domestic violence, child abuse or other interpersonal trauma.

Briggs-Gowan et al., (2010) set out to estimate the lifetime prevalence and the correlation of potentially traumatic events in urban-suburban healthy birth cohort of healthy children. An ethnically and sociodemographically diverse stratified random sample of 1,788 children ages one to three years old was used. They hypothesized that about 20% of children would have experienced a PTE with boys being more vulnerable to noninterpersonal PTEs and girls vulnerable to witnessing violence. They also sought out to identify sociodemographic and parental factors associated with exposure.

Parents completed a number of scales, reporting their child’s history, parental mental health and social supports. Numerous statistically significant correlations were found, including an increased likelihood of exposure to PTEs associated with living in a single-parent home, high parenting stress, and clinically significant levels of parent mood and anxiety symptoms. Children living in poverty were two to five more times likely to experience violent exposure. Single parenting, outside of poverty, was also associated with violent exposure. In alignment with attachment theory, and its interdependence on relationships, violent exposure PTE specifically tended to have potentially detrimental effects on children’s functioning.

*Rhesus Monkeys*

At the same time that John Bowlby was exploring human attachment, Harvey Harlow was actively researching behaviors in animals (Suorni, 1999). After years working with mice, Harlow began watching the behaviors of monkeys at his local zoo.
He soon learned that they had a much greater mental capacity than mice and eventually began his own monkey colony. Initially, Harlow raised some monkeys in isolation due to their susceptibility to disease. His first inadvertent attachment observation was the social awkwardness of the monkeys raised in isolation. His ensuing study of attachment in rhesus monkeys was carried out over 30-years. Although the types of experiments Harlow conducted would not be considered humane today (i.e. separating babies from mothers until they died of psychological damage) the rhesus monkeys complimented the work of John Bowlby demonstrating how crucial attachment in infants is to development.

Harvey’s rhesus monkeys are also renown for demonstrating cross-generational consequences of early attachment relationships, also known as generational trauma. Several monkey studies demonstrated continuities between the type of attachment relationship developed across generations of monkeys. Although monkeys are not exclusively the same as humans, one may argue that they both have internal working models and exhibit similar attachment and trauma characteristics. Some of Harlow’s research demonstrated that it took at least five generations of intervening with monkeys to move from insecure, disorganized attachment to secure attachment not exhibiting pervasive trauma behaviors. Evidence used in monkey research should be considered as practitioners consider the impact of attachment and trauma in children and across generations in families.

Diagnoses Associated with Trauma

Children who have experienced traumatic events typically do not have a framework for secure attachment to adults in their life. Anxiety is one of the possibly
negative associations that children with insecure attachment may face. Anxiety, particularly in relation to parent and peer factors, is scarce in research. Wichstrom et al., (2013) uniquely looked at two community samples of four-year-olds living in Norway. The sample of 1,000 children over-represented kids with emotional and behavioral problems. Parent interview, assessment, observation and preschool teacher ratings were used to look at behavioral inhibition, ADHD, parental anxiety, peer victimization and social competence at age four and six.

![Figure 3. Theoretic model of factors affecting anxiety development in young children.](image)

The authors hypothesized that insecure attachment, negative life events, comorbid disorders, anxiety disorders, behavioral inhibition and parental factors (i.e. anxiety, socioeconomic status and divorce) at age four would be predictive of peer victimization, low social skills and overprotective or hostile parenting which would be predictive of anxiety disorders at age six, illustrated in Figure 3. Using a logistic-regression analyses, the authors found that ADHD, behavioral inhibition, parental anxiety and peer victimization at age four increased the risk of anxiety at age 6; with social skills as a
decreased risk factor. The other hypothesized effects on anxiety were not found to be statistically significant although discussion noted that the lack of correlation between insecure attachment and anxiety contrasts with other research and considers the possibility that age six may be too young for that prediction to be fulfilled.

Martel, Gremillion, and Roberts (2012) looked at research on Oppositional Defiant Disorder (ODD) and ADHD in correlation to temperament, which at that time had not been researched in preschool aged children. The authors hypothesized that specific aspects of temperament would be associated with preschool behavior disorders such as ODD and ADHD. Their sample included 109 children ages three to six and their families. Parents and teachers reported using the Disruptive Behavior Rating Scale, the Child Behavior Questionnaire and the California Q-sort. There were some validity issues noted by the authors, including inner rater reliability and survey return rates. The study results confirmed the authors’ hypothesis and correlations found with older children. Specific correlations included temperament characteristics inclusive of negative affect, surgency and lower levels of effortful control. Preschoolers with these characteristics were more likely to have a diagnosis of ODD or ADHD. Both temperament and self-control can affect student long-term outcomes. Temperament can be defined as the difference between individual’s reactivity and self-control.

Drake, Belsky, and Pasco Fearson (2014) set out to look at the role of mother-child attachment on self-regulation skills, test the role of children’s self-regulation skills to classroom engagement, and examine how self-regulation affected attachment security and self-regulation across time. In their study, they analyzed data from the National
Institute of Child Health and Human Development (NICHD) Study of Early Child Care and Youth Development. In order to test the association of attachment at 15 and 36 months and self regulation at grade one, the data from 51,149 children was examined. A strong association between secure attachment and greater self-regulation skills was found. Self-regulation is a pertinent skill in building relationships with both adults and peers. Children with a secure attachment may have greater capacity to get the most out of their school learning experiences which is a key determiner of long-term scholastic success. Children with an insecure attachment may benefit from direct support to build lacking self regulation skills. There is less known on the role early social experiences plays in later conscientiousness, specifically the growth of self-regulatory skills across time instead of measurement at one single point in time. The study suggested that the diagnosis of both ODD and ADHD take into account self-regulatory skills which translate to adolescent and adult conscientiousness.

In order to support appropriate diagnosis Dehon and Scheeringa (2006) studied 62 traumatized children examining whether a Child Behavior Checklist-Posttraumatic Stress Disorder can be used for accurately screening for Posttraumatic Stress Disorder (PTSD) in young children. The scale was modified, removing five measures that did not apply to preschool aged children. The researchers found that 75% of the time children who met nine of the 15 screening criteria also met clinical criteria for PTSD. Although PTSD is more typically diagnosed among adults, because they have the language to communicate what is going on internally, children can experience the same symptoms although their growing language skills may not be sufficient to articulate what is going on inside of
them. Although this screening tool is primarily used in the medical field, use by appropriate professionals in the education field, to support referrals to busy medical professionals who may not see a child in their natural setting, could be supportive in helping families navigating obtaining appropriate diagnosis and support. To parents and educators who are not aware of PTSD, symptoms can look like defiance, ADHD, illness, anxiety or depression instead of another early childhood trauma side effect.

Attachment

Evidence presented on the long-term affects and diagnosis associated with trauma commonly link back to early attachment patterns. Attachment theory originates from the work of John Bowlby (1969) and illustrates a framework, that starts at birth, for a human being’s understanding of interpersonal relationships and context through which they perceive the world. Attachment is a deep and enduring affectionate bond that connects one person to another over time. It starts in infancy with a process called ‘serve and return’ (National Scientific Council on the Developing Child, 2014). Serve and return is a key part of development where an infant and significant adult interact. It is one of the most essential experiences in shaping the architecture of children’s developing brain. Young children naturally reach out for interaction through babbling, facial expressions, and gestures. When adults respond back with the same behavior it illustrates the concept of serve and return. Serve and return is a key process in development, supporting acquisition of healthy, secure attachments.

According to the National Research Counsel Institute of Medicine, “the environment provided by the child’s first caregivers has profound effects on virtually
every facet of early development, ranging from the health and integrity of the baby at birth to the child’s readiness to start school at age five” (2000, p. 219). Within the first year of life children develop a template for how they attach to adults in their world. Although children can have different types of attachment with different caregivers, their type of attachment with their primary caregiver in their first year of life predicts their template for further attachment and interactions throughout life. This template is called an internal, or mental, working model (Bretherton & Munholland, 1999). For example, a child who has a primary caregiver who is emotionally available and supportive as the child explores the world through play will likely grow up seeing the world as a generally safe place where people are helpful and available to meet their needs. Based on their view of the world, their internal working model, they may be more apt to take risks because as a child they learned it was safe to explore. They also likely learned that if you fell or got hurt someone would be there to help you recover. A child who has a primary caregiver who is preoccupied or sees themselves as incompetent or devalued, may not be available while their child is playing or respond in a timely manner when they have needs. This child is liable to grow up seeing the world as a place where they have to fend for themselves because they never know if people are going to be there for them or not. Based on their view of the world, they may be more hesitant to take risks or rely on people because as a child they learned that people where not dependable. Humans internal working models create the template for how they view life and are used to regulate, interpret and predict attachment related behavior, thoughts, and feelings.
Internal working models are believed to reflect the repetitive interaction patterns between an individual and his/her attachment figure. Because of this, the development of internal working models and attachment styles can be seen as complimentary. There are four widely recognized types of attachment; one which is considered secure/healthy and three which are considered insecure. The attachment types include secure, insecure-avoidant, insecure-ambivalent and insecure-disorganized.

Secure attachment is associated with a number of crucial positive school outcomes including higher grades, better scores on standardized tests, lower levels of ADHD and school delinquency (Bergin & Bergin, 2009). Children with secure attachment are confident in forming meaningful relationships with others, engaging in productive activities and overall are resilient and emotionally healthy. They have experienced sensitive, attuned and responsive caregiving; including a primary caregiver with the ability to read and interpret their cues, engage in reciprocal attunement, frequent eye contact and the capacity for empathy. They are frequently talked to, touched, cuddled, and nurtured. As an adult they can integrate the good and bad and say things like, ‘my parents did the best they could and I have a great relationship with them today.’ They see the world as generally good and can trust people to provide for them.

Children with insecure–avoidant attachment may be easily consoled by a stranger. They may not prefer their parent and often internalize overwhelming experiences instead of acting out. Children with this type of attachment can be just as stressed but they do not show it because they have learned through experience it will not get them a reaction. They have experienced less attentive and responsive caregiving
where their parent likely minimized their distress (e.g. ‘your fine,’ ‘I’ll give you something to cry about’). In these cases, the primary caregiver may be withdrawn due to depression or grief; and therefore make eye contact less and provide limited physical nurturance. As an adult with an insecure – avoidant attachment pattern they typically do not recognize the negative experiences in their childhood, but instead act like it was great. They appear to be independent and typically avoid close relationships and refrain from asking for help.

Children with insecure – resistant attachment do not have effective coping strategies. They often create push and pull in relationships. They may display anger toward caregivers. They can present as clingy or rejecting, they would like to be comforted, but cannot process comforting appropriately. Words such as immature, fussy, hyperactive, passive, or angry may be used to describe them. They have experienced inconsistent, unpredictable, and unresponsive caregiving. Sometimes their attachment figure may be sensitive and responsive or harsh. The caregiver may experience substance abuse or mental illness. As an adult, children with this type of caregiving tend to focus on negative experiences when asked about their childhood. They do not easily recover from setbacks, create push and pull dynamics and may stay in relationships for unhealthy reasons. Much like their parents they have a heightened susceptibility for substance abuse.

Children with insecure – disorganized attachment typically do not have any type of coping strategies. This is the most detrimental attachment style and is typically only seen in children who have started life in orphanages, experienced extreme neglect or
abuse or have had significant disruptions in care. Insecure – disorganized attachment can sometimes manifest as oppositional defiant disorder or reactive attachment disorder. As an adult most children have pervasive mental illnesses.

In 1987, Hazen and Shaver conducted one of the first pieces of research looking at how children’s attachment may carry into adulthood. This was the cornerstone of greater research to come codifying the notion that children’s first 12-months sets a working attachment template that follows them through life. Hazen and Shaver (1987) utilized attachment theory, formed by researchers such as Bowlby (1969) and Mary Ainsworth (Ainsworth, Blehar, Waters, & Wall, 1978), in looking at attachment formed for the purpose of ‘romantic love’ in adulthood.

The study at hand had five hypotheses. One of the authors five hypotheses was that adult’s self report of their relationship with primary caregivers in childhood would predict their romantic love attachment. A survey was printed in a local newspaper and 620 responses were utilized. There were a large number of remaining responses that were not utilized due to stable findings based on the initial 620 processed questionnaires. Using a one-way ANOVA, with attachment style as the independent variable, statistically significant correlation between childhood reports of attachment and adult attachment in a romantic relationship were found.

With the knowledge that attachment plays a long-term role in all human life, there has been a growing body of research focused on attachment and its predictors in the early years. In 2005, Shamir-Essakow, Ungerer, and Rapee conducted a study on attachment, behavioral inhibition and anxiety in preschool children. They wanted to know the
concurrent and independent associations between insecure attachment, behavioral inhibition, and anxiety. The specific population of 104 at-risk preschool children and their mothers were assessed in a clinical setting on two different occasions. As hypothesized, behavioral inhibition and insecure attachment, independent of one another, were found to be associated with child anxiety. In addition, maternal anxiety was associated with child anxiety and insecure children exhibited higher levels of anxiety than children with secure attachment templates.

Attachment can be a protective factor or risk when trauma occurs. For example, a child who has a secure attachment and a caring, responsive primary care giver is more likely to be able to receive comfort and process and express emotions associated with the experience. As a result of their internal working model they see the world as a generally good and safe place, so once trauma has been processed they increasingly apt to be able to move forward productively than a peer who experienced the same type of trauma who has an insecure attachment.

The Developing Brain

Attachment and early childhood trauma go hand-in-hand when considering affected children, knowledge of educational professionals, and the possible educational challenges. Dr. Bruce Perry, a well-known clinician and researcher in the field of children’s mental health and neuroscience, created the ‘Neurosequential Model of Therapeutics’ (2009). The Neurosequential Model of Therapeutics (NMT) is an approach that integrates core principles of neurodevelopment and traumatology to inform work with children, families and the communities in which they live. Perry has studied,
in depth, the affect of traumatic experiences on brain development; acknowledging that the same traumatic events will impact a child differently based on their developmental stage and brain development at the time of the occurrence. For trauma-affected children, while many deficits may be present, the sequence in which deficits are addressed, based on brain development, is pertinent for the greatest outcomes. Figure 4, an illustration from the Child Trauma Academy (2015), shows basic brain organization. The brain develops from the bottom up. If impairment occurs in utero, infancy or early childhood, dysfunction can disrupt normal development unless intervention occurs targeted toward the original function developing in the brain when trauma occurred. Thus, it is imperative for professionals to know at what age the child experienced the trauma, so that appropriate strategies can be utilized to intervene.

Figure 4. Bruce Perry’s neurosequential model of therapeutics.
For example, figure 5 (Child Trauma Academy, 2015) illustrates a brain ‘map’ of a 14-year-old who experienced trauma early in brain development while the brainstem and dienceph were still developing. For this child, a traditionally thought of ‘age appropriate’ intervention, such as using linguistic skills to solve problems with another peer, would likely focus on development of skills targeting the cortex or the limbic system. The problem with a top down approach, based on the brain map in figure 5, is that the foundational systems, the brainstem and the dienceph, do not yet have capacity to maximally support a more sophisticated ‘age appropriate’ intervention. An age appropriate intervention would likely be frustrating and have a lower success rate for both the adolescent and teachers or clinicians supporting the intervention.

Figure 5. NMT functional brain ‘map’
Although the early experiences that children have are predictors, they are not necessarily permanent. The counterbalance to trauma is resiliency; the ability to withstand or rebound from stress (Wolpow et al., 2009). Resiliency can protect from the effects of trauma, or resiliency can be built, through intervention, to help combat the effects of trauma. Based on an attachment model, and teacher’s crucial role in building relationships with students and spending the majority of daily activity with students, they have an integral part in the role of recovery and building resiliency.

Working with children who present challenging behavior as a result of attachment and trauma can sometimes be overwhelming for teachers. It is not uncommon for teachers to receive guidance that includes using behavioral methods such as reinforcement, punishment or planned ignoring as a blanket recommendation for treating children with behavior challenges. Although these are valuable, research based strategies for some challenging behavior, they are not evidence based for responding to trauma and attachment initiated behavior. Research suggests that a relational, rather than behavioral, framework for addressing children’s behavior is more effective in supporting children with attachment or trauma issues (Brunzell et al., 2015; Floyd et al., 2008; Wolpow et al., 2009).

School Interventions

Teacher-child relationships are tied to each child’s internal working model based on their attachment template. Healthy attachment has at least two pertinent foundational functions in classrooms. First, it facilitates the notion of security so children and adolescents feel safe to explore and learn. Second, it is the basis for socialization and
formation of healthy relationships (Bergin & Bergin, 2009). Research has found that
teacher-child relationships can be one of the most influential factors and strongest
predictors of school success (Floyd et al., 2008).

Classroom Interventions

A young child’s classroom is where they spend the majority of their day at school.
Unlike elementary school children, preschoolers eat, sleep and even attend recess with
the teaching staff from their classroom. As a matter of fact, some young children with
working parents/guardians may be in care/school for eight to 12 hours each day.
Although there will likely be many adults involved for a child who requires specialized
support due to trauma, the classroom teacher is the starting place and the glue for any
provisions or services that will be deployed on a daily basis. Based on the attachment
model, relationship is the key foundation of a child’s success in the classroom.

It can be concluded that trauma-affected children, or those who do not have
healthy attachments, may be considered having ‘special needs’ in the educational setting
due to the additional provisions they require. In a comparison study examining the
student-teacher relationships of children both with and without special needs Demirkaya
and Bakkaloglu (2015) found that students with special needs have increased conflict and
less closeness with their teachers than peers without special needs. Their research, based
in Turkey, studied 40 teachers who were working in 33 mainstream schools. They
specifically focused on 54 children with special needs (SN) and 54 who had no identified
special needs (non-SN), the comparison groups were similar based on age, gender, family
income and parents level of education. The mean age of teachers was 35-years-old,
experience 11 years and mean classroom size 22 preschool children. There were 21 teachers who expressed that they receive no support from families or support providers and 19 who reported receiving support.

Although all children were found to be equally dependent on their teacher, SN students were found to engage in more conflict with their teacher and scored significantly lower for ‘closeness’ of relationship with teacher and peers. Regression analysis connected externalizing and self-centered behaviors with conflict (43.6%) and social interaction, social acceptance and independence explained closeness (51.1%) (p. 166).

Floyd et al., (2008) analyzed the evidence from 1994 to 2007 in peer reviewed articles on early childhood reactive attachment disorder; specifically measures and interventions. After review of 50 articles a common framework for intervention emerged and suggested

a) nurturing the child; b) understanding behaviors before punishing; c) interacting with children based on emotional age; d) being consistent, predictable, and repetitive; e) modeling and teaching appropriate play and social behaviors; f) maintaining realistic expectations; g) being patient with children and self; and using resources (2008, p. 52)

Likewise, Head Start, a federally funded preschool program for at-risk children ages three through five-years old, recognized a need for utilizing evidence based or evidence informed practices to intervene with trauma affected students in 2007 (Holmes, Levy, Smith, Pinne, & Neese, 2015). Communities, particularly in the Midwest, accepted that there was limited knowledge and recognition regarding the impact of
trauma on young children. Homes et al., (2015) described that, after extensive research, Head Start chose The Attachment, Self Regulation, and Competency (ARC) framework developed by Blaustein and Kinniburgh in the Trauma Center at the Justice Resource Institute in Brookline, Massachusetts. In addition to training on the ARC framework for all staff working with traumatized children, Head Start counties that employed Head Start Trauma Smart (HSTS) offered Intensive Individual Trauma-Focused Intervention to those children referred, and consultation by a trauma trained individual to the classroom staff at a minimum of 6 hours per month. The 81 children who received intensive services from Head Start, in this study, showed statistically significant (.05) decreases in attention problems, externalizing problems, ADHD problems and ODD problems.

Isolated or short-term services are not sufficient for children who struggle with symptoms from trauma on a daily basis. Trauma affected children require support to build effective relationships with adults and children alike. Moving toward creating therapeutic, responsive classroom environments supports trauma-affected students, as well as students with secure attachment and typical brain development.

Mental Health Consultation

Although there is little evidence linking mental health consultation in the school setting to children exposed to trauma, mental health consultation has been reported effective in supporting teachers increase in competency and effectiveness when educating children in the classroom.

Most recently, a three-year study in urban New Jersey (Ocasio, Van Alst, Koivunen, Huang & Allegra, 2014) examined the effects of mental health intervention on
challenging behavior. The mental health specialist spent two days per week at each school site facilitating implementation of a social skills curriculum, consulting with teachers and providing play therapy to children. Although authors did not have strategic controls for maturation, evidence supported positive outcomes in the form of decreased challenging behavior for children who participated in the interventions.

In 2010, a small study, based out of one Head Start center, looked at the effects of teacher relationship training, conducted by a mental health professional, on children’s behavioral problems (Morrison & Bratton). All Head Start staff participated in a two-and-a-half-day intensive training and received two phases of coaching by certified school counselors, who were also doctoral students. As a result, nine of the 15 children in the intervention group, who previously had clinically significant internalizing or externalizing behaviors, returned to no clinical concern for behaviors following the intervention. Although the study did not report the positive effects on teachers, one can presume that decreasing children with significantly challenging behavior by two-thirds based on new skills acquired increased teacher ability to teach skills in the classroom and feelings of success.

During a span of six-years Alkon, Ramler, and MacLennan (2003); Green, Everhart, Gordon and Gettman (2006); and Upshur, Wenz-Gross and Reed (2009) conducted studies looking at the effectiveness of mental health consultation in preschool settings. Commonalities included direct consultation with classroom staff and a focus on skill building for adults. Both Alkon et al., (2003) and Green et al., (2006) found that the frequency of mental health consultation related to the perceived effectiveness by teachers.
They also found that teachers who participated in mental health consultation had increased teaching skills in the classroom and self-efficacy in addressing children with mental health needs.

Mental health intervention in early childhood is not mandated and is often not made a priority by states, counties or districts. Discussion in many of the fore-mentioned studies noted that consistent implementation and lack of funding can be setbacks when looking at the feasibility of services for young children. Although many obstacles exist, there is a consistent base of evidence supporting the effectiveness of mental health consultation for teachers, classrooms and children.

Summary

Based on current data indicating the prevalence of children who have experienced trauma, one in four children’s learning or behavior will be affected (NCTSN, 2008). Children with trauma are also at increased risk for mental and physical health issues throughout their life span. With 25% of students at-risk to demonstrate trauma related symptoms, it is pertinent that the teaching field have educators who are equipped to effectively support all students. According to Wolpow, Johnson, and Kincaid, “the classroom can be positioned as a powerful place of intervention for posttraumatic healing both in the context of special education and in mainstream classrooms that contain trauma-affected students” (2015, p. 3). Educators supporting trauma affected students have an opportunity to play a powerful role in helping to ameliorate the long term negative effects of trauma.
Chapter 3

METHODOLOGY

Introduction

The aim of this project was to provide professional development for early childhood educators working in the preschool environment. Based on an informal needs assessment the topic of attachment and trauma was found to be appropriate. The participants included 18 early childhood educators from six different classrooms, located on the same site, at a charter school district’s preschool program. The professional development provided include two workshops with follow up weekly or bi-weekly instructional coaching. Staff were also provided a number of hard and soft copy resources.

Professional development conducted during this project was concentrated at an Early Childhood Center, also known as a preschool, in an urban, low income neighborhood in Sacramento, California. The school enrolls 92 children and 75% of those children qualify for free or reduced meals through the California Adult and Child Food Program. The school is racially and ethnically diverse, with families from various backgrounds. The prevalent first language at the preschool is English, the prevalent ethnicity is non-Hispanic and the prevalent race is African American. The researcher of this project is also the Director of Early Childhood Education for the school.

Needs Assessment

By design, the focus preschool for this project has a vision to serve every child and family who walks through their doors using evidence based practices. Over its nine
years of operation the school has been known locally as a preschool who will accept and serve children who have been dismissed from other preschools due to challenging behavior. The population of at-risk children being served has created a need for staff professional development in order to foster competency within staff to serve the diverse population.

The needs assessment for this project was based on informal and formal information collected over several years. Four years ago the Director of the preschool reached out to a local resource and referral agency after experiencing that existing behavioral techniques were not working for all children who had behavioral challenges. Through the Sacramento County Office of Education an informal partnership was established with a social worker who had a focus on early childhood, trauma and toxic stress. One of the key questions that the partnership posed was if the school may be serving any children who have experienced trauma.

During the 2014/15 school year a brief trauma overview workshop was presented to preschool staff by the aforementioned social worker. The workshop did not include instructional coaching. Subsequently, on a professional development needs survey, completed as part of the school’s regular process for reflection and forward planning, staff ranked trauma awareness and interventions as the number one topic they believed would support their professional growth and student outcomes during the coming school year. During the same time period, the researcher conducted a qualitative survey of individuals serving trauma affected children, see Appendix A, to collect information on the expanse of knowledge and types of professional development educators receive in
relation to early childhood trauma, toxic stress and attachment. The outcome of this survey suggested that educators, across disciplines, do not receive formal training or on the job professional development in regards to the topics at hand, although they frequently come in contact with trauma affected children throughout their careers.

The demographic of students being served at the preschool, buy-in from staff, and lack of implementation of evidence based practices created a critical need for professional development in order to strengthen the program and meet the needs of individual students and families. As a result of the collective informal and formal information collected the author made the decision to provide professional development in order to increase educator awareness to trauma affected students and responsive educational environments.

Participants

Many children spend up to 10 hours per day at preschool and have several different center staff who support in meeting their needs on a daily basis. For young children continuity of care is important to meeting their needs and creating a safe environment. Due to these factors it was determined that all staff, certificated and uncertificated, who worked at the preschool, including operations staff and substitutes, would be a part of professional development.

There were 18 educators who participated in both workshops and coaching. Staff participating included six teachers, seven instructional assistants, one administrator, two operations staff, and two substitutes. The education of staff included eight four-year degrees in early childhood education or child development, four four-year degrees in
psychology or a field not related to child development, three two-year degrees in early childhood education and three staff who had nine or more child development or early childhood education college units. Experience in the field of education ranged from one to more than ten years. Of the 18 staff members there were two who had been working for the specific school district for more than four years, ten who had been working there for two to three years and six who were first year employees. All educators attended workshops and participated in coaching willingly.

Professional Development

For the purposes of this project professional development consisted of two all staff workshops, ongoing coaching over eight months for teaching and operations staff, and hard and soft copy resources. Due to the sensitive nature of the topic, and research-based practices on the context of professional development, all workshops were conducted at the school site. In order to provide staff time to process and implement information workshops were conducted six weeks apart.

The titles / topics of the two workshops were Attachment: Early Brain Architecture (see Appendix B) and Creating Trauma Supportive Environments (see Appendix C). The content for each workshop was presented through a power point presentation. Both of the presentations included embedded media to provide examples (i.e. pictures and videos), talking points, and ‘real-life’ stories utilized throughout the workshop in order to tie research to practice.

The content for the two workshops was based on perceived and reported staff knowledge and research documented in the literature review of this project. In order to
understand the variety of ways that children may experience and process trauma educators must first have a concrete understanding of attachment and internal working models. The Attachment: Early Brain Architecture workshop included an overview of early development in infants and toddlers, in depth information on defining attachment, types of attachment and internal working models, and research on the long-term effects of attachment. Participants were encouraged, through various facilitation techniques, to reflect on attachment pertaining to their own upbringing as well as how specific attachment styles may impact their relationships with, and instruction of students and families.

The Creating Trauma Supportive Environments Workshop was considerably heavier than the first workshop. The workshop started with an overview of attachment, including more in depth stories and videos providing practical examples of how attachment templates, internal working models, manifest in day-to-day interactions. The remainder of the content focused on defining trauma, the prevalence and long term effects of trauma and interventions. Due to rich staff discussion throughout the workshop and constraints of allotted time, some of the interventions were not discussed as in depth as might be ideal; in addition, staff did not have ample opportunity to role play interventions or develop draft intervention plans. The workshop closed with a review of online resources where staff can find supplementary case studies, handouts for parents and evidence based practices.

Each staff member also received a folder of resources during the second workshop. The primary goal of the resource packet was to provide participants written
examples of trauma symptoms and interventions, talking points for opening conversations with families and respected websites participants could refer to in their journey to dig deeper into the topics at hand. The primary website provided to staff was the National Child Traumatic Stress Network (NCTSN). Participants received three resources retrieved from NCTSN and three resources published by other authors.

Each teacher received ongoing instructional coaching from August through mid-March as part of the schoolwide structure for professional development. Coaching included at least one classroom observation from an observation room adjoined to the classroom and a 45-minute feedback and coaching conversation. Coaching also intermittently included videotaping the classroom or the instructional coach modeling how to utilize specific strategies with students or the entire class. A portion of coaching for each teacher focused on supporting trauma affected students; this coaching varied based on the student needs in the teacher’s classroom. For example, coaching for a teacher new to the school, with only one student demonstrating trauma side affects, was focused primarily on building relationships with students and behavior management; while coaching for a more seasoned teacher with multiple students demonstrating trauma affected characteristics focused on supporting the teacher’s use of interactions and interventions based on the child’s emotional age by referencing the Neurosequential Model of Therapeutics (Perry, 2009). Coaching for five of six teachers additionally included supporting the planning and implementation of family conversations.
Conclusion

Based on the demographic of children and families the school serves, and the informal and formal needs assessment, the topic of teaching trauma affected students was found appropriate. Although the majority of staff, certificated and uncertificated early childhood educators, held a two or four-year college degree, most reported only briefly covering the topic of attachment during their formal education experience. No participant reported learning about trauma during their formal education experience. In order to fully understand the affects of trauma, staff first participated in a workshop on *Attachment: Early Brain Architecture*, prior to the second workshop on *Creating Trauma Supportive Environments*. Follow-up instructional coaching provided opportunities for educators to participate in reflective practice and receive feedback as they engaged in the process of putting research into practice.
Chapter 4

PROJECT SUMMARY

The project at hand, *Teaching Trauma Affected Students: Increasing Professional Awareness and Responsive Educational Environments*, consisted of gathering evidence on effective professional development and early childhood trauma, then subsequently creating and delivering professional development to a preschool site located in Sacramento, California.

Key findings during investigation were founded on evidence that one in four students demonstrate trauma affected symptoms in the educational environment (NCTSN, 2015). The expanding body of research on adverse childhood experiences (Briggs-Gowan et al., 2010; Burke et al., 2011; Felitti et al., 1998) clearly illustrates the detrimental affects of childhood trauma in the absence of intervention. Among the negative outcomes are obesity of childhood and adulthood, behavior and learning problems, and increases in both health risks and the presence of adult disease. In addition, children who do not have healthy attachments and experience trauma are at risk of stunted brain development (Perry, 2009). When a 14-year-old’s brainstem and dienceph, the earliest forming portions of the brain that support numerous foundational functions including reasoning, problem solving, and motor regulation, are not fully formed, teachers are less likely to have the same level of tolerance for lack of social-emotional skills as they might have with a four or five-year old who is facing similar challenges. Research based on Perry’s Neurosequential Model of Therapeutics (2009) recommends treatments that address the adolescent’s developmental age instead of their
chronological age. As children become older and their chronological and developmental ages span further apart this author has observed that the likelihood of receiving comprehensive, research-based interventions becomes increasingly dismal. The brain’s capacity for change also decreases with age as it becomes more specialized to perform complex functions and less capable of reorganizing and adapting to newly acquired skills (Center on the Developing Child, 2007). Although symptoms of trauma do not always include challenging behavior, as children grow up without fully developed lower brains they are likely to exhibit anti-social behavior. When anti-social or aggressive behavior has persisted past the age of 9-years-old, further intervention has a poor chance of success (Dodge, 1993).

Due to the over one quarter of students who demonstrate symptoms of trauma, early intervention is crucial to mitigate the risks of negative academic, social, behavioral, physical and mental health outcomes. Teachers, nor axillary school staff, are prepared to effectively support the internalizing or externalizing behavior and needs stemming from childhood traumatic experiences. Professional development typically offered to teachers weighs heavy on workshops and lacks necessary support educators require to effectively implement their newly acquired knowledge; resulting in sustained changes in practice that positively affect student’s outcomes (Darling-Hammond et al., 2009; Gulamhussein, 2013; Skiffington, Washburn, & Elliott, 2011). During eight months of the 2015-16 school year these key findings were utilized to create two professional development workshops that were proceeded and followed by extremely critical instructional coaching in order to support staff in closing the implementation gap of knowledge to practice.
Conclusions

This section will focus on conclusions and recommendations that address the context, content and process of the professional development created throughout this project.

Context

The context is the immediate and secondary environments in which the professional development occurred. The specific context for this project included many components of high quality professional development. The administrator, also the researcher, was fully supportive of the initiative. A shared sense of need was present among staff, the workshops were presented to all school staff by someone they had a relationship with, and the workshops and coaching occurred at their own school site. Coaching conducted by someone who has ample knowledge of the subject, relationships with teachers and students and is on campus frequently was found to be tremendously beneficial. Benefits reported by staff include having a coach to model in crisis situations with specific students, having students react naturally to the coach because a relationship has been previously formed and teachers trust to vulnerably discuss the challenges of supporting students and families who have experienced trauma due to their pre-existing relationship with the coach. The findings of this project align with research (Joyce & Showers, 2002) demonstrating the importance of administrator support, educator buy in, and optimal settings in creating effective contexts for professional development. It is also the authors observation that an optimal setting, with established relationships and context focused specifically on relationships contributed to a forum where educators could reflect
on and challenge their perspectives regarding where challenging behavior comes from, which was the secondary purpose of this project.

From an administrator and researcher standpoint there were several barriers faced during the course of the project. On the administration front, barriers included staff turnover, complex job descriptions of preschool administrators, lack of funding to hire stand alone coaches, and the complicated role of being an evaluating manager and a coach. An additional limitation included the vast expanse of topics that teachers are at demand to increase their skills in, some of which are directly monitored by state funding. These growth requirements and ever increasing job duties of teaching staff create difficulty in providing the intense and ongoing focus that teachers need to make gains in practices in one sector.

From a researcher standpoint, the investigator made several observations as well as collected anecdotal evidence from teachers throughout the project. One barrier observed was the structure of mental health services in the school’s county of residence. In addition, there is a lack of services provided to support willing, yet underserved families to navigate the medical system required to obtain mental health services. Likewise, teachers reported that the Special Education Local Planning Area (SELPA) serving the preschool does not willingly address behavioral or mental health issues affecting children’s educational progress, in turn hindering their ability to provide appropriate education and engage in multi-disciplinary collaboration. Teachers were also concerned about kindergarten and elementary school staff’s willingness to continue implementing the recommended evidence based practices once the students are no longer
in preschool. One teacher shared a story about extensive work she did to collaborate with elementary school staff and pass on materials during a child’s kindergarten transition last school year, only to find that the school was not implementing the practices that preschool staff had found effective. Instead, she found the staff in kindergarten were utilizing behavioral techniques found to exacerbate, instead of support, the healing of trauma.

A final, unexpected finding, affecting the context of this project was the number of families the preschool serves that demonstrate evidence of the presence of generational trauma. The researcher, and teaching staff, eventually recognized that due to the nature of working with young children, most of whom live with their biological families, there are many children in the midst of traumatic experiences and who may be living in a family with unrecognized generational trauma. Although the first workshop briefly discussed the Harlow’s monkey’s experiments (Suomi, 1999), illustrating the effects of generational trauma, this was found to be a concept that most teachers did not yet think about when working with families. The concept from the researcher’s perspective was not planned in the initial formation of the project. Although the notion of generational trauma and children who are going through trauma simultaneously to their preschool experience caused a challenge for teachers, the mere fact that teachers were beginning to recognize those possibilities, supported the primary purpose of the study which was to build educator awareness of the effect of trauma.
Content

Content is the material provided during professional development. The specific content for this project was based on research, linked to standards for children birth through age five and provided tangible instructional strategies to address identified gaps in a specific demographic of student’s achievement. A key strength of the content for this project was that it was specifically formed to meet identified needs at the individual preschool site and included modeling for teachers within their classroom.

Preschool staff reported that the information provided in the Attachment: Early Brain Architecture and Long Term Outcomes workshop provide a much more in depth perspective of how the work they do every day is affected by attachment than found in college courses they have taken. Attachment knowledge provided them a foundation for understating childhood trauma. Staff welcomed alternatives to behaviorally based strategies and reported that behaviorally based strategies had not been effective with children who may have experienced trauma in their past practice. They also noted that the component of modeling, within coaching, was highly effective.

Although the researcher experienced only positive feedback from site staff members, there were three key components of the content that in hindsight would be adjusted. First, when the workshop frameworks were fully formed there was enough content for three workshops. It is the researcher’s perspective that breaking down content into smaller units, especially with the sensitive nature of some of the content, would have been more effective in supporting teachers to internalize content aside from the coaching component. Second, the content could have been more effective if there was an added
component of case studies that were followed throughout the workshops, and additional staff opportunities in the form of hands-on activities during the workshops to support staff in putting newly learned information into theoretical practice. Lastly, there was mixed feedback on the effectiveness of coaching based on the content and process. Teachers found that it was difficult to have the same coach and evaluating supervisor for both academic and non-academic components of their performance. The consistency of coaching also varied based on staffing, school-wide needs and the needs of the classroom. Next steps for future coaching could include having a coach work with teachers who have trauma affected children in their class more intensively initially, phasing into extended intervals as they feel confident with implementation. Additionally, having a coach that does not function as staff’s evaluating manager support staff with facing the challenging realities of supporting children and families who have experienced trauma. Finally, coaching should include modeling and a component supporting family collaboration and procurement of external mental health resources for children and families.

Process

The process is the way in which professional development is implemented. The specific process for this project included two workshops and ongoing coaching. The process was implemented within the context where educators will utilize the practices (i.e. at the school site) and included the coaching component found to be 85% more effective that workshops alone (Gulamhussein, 2013).
Dealing with vicarious trauma and slow progress, due to re-working neural pathways and affecting internal working models that took years to form the way they are (Bretherton & Munholland, 1999; Center on the Developing Child, 2007), was difficult to staff because using evidence based practices to support the healing process rarely results in short term ‘fixes.’ Persevering over time in order to see change, while implementing newly learned skills, was reportedly challenging. Some staff were tested to conceptualize evidence based interventions that may not be perceived to match the child’s numerical age. Closing the implementation gap on these newly learned strategies was even more difficult. As noted during discussion about content, providing staff with opportunities to engage in case studies may support staff’s acquisition of skills. In addition, trauma affected students are far from one size fits all. An intervention that works for one child may not be effective for another child manifesting the same symptom. Interventions for children rarely look the same because the child’s temperament, age at the time of trauma, type of trauma, attachment relationships and internal working model all determine the child’s processing and trauma affected symptoms (Perry, 2007). Due to the complex nature of trauma, interventions cannot be unidimensional in nature, which posed a curve ball for staff working with this population of vulnerable children.

The process of pairing workshops and coaching was reported by staff to be effective in supporting changes in their teaching practices. A few of the changes included more successful strategies for supporting children to de-escalate when they are angry, sad or scared and implementation of strategies that met the child’s developmental age of trauma occurrence; resulting in increased problem solving and regulation skills
and increase in effective classroom management skills allowing more teaching to occur throughout the day. Due to the author of this project also functioning as the school administrator, wearing many hats and susceptible to ever changing time demands, coaching did not consistently occur on a weekly basis with a specific focus on the implementation of information learned during the two workshops. Additionally, workshops were held several months after the school year began, leaving a gap between when teachers started supporting students with trauma affected symptoms and the time they received additional knowledge, tools and coaching. Future replications of this project should consider the duration and intensity of coaching and the timing of workshops within the scope of coaching.

Recommendations

Beyond the school site who participated in professional development, this project has the potential for future use and impact across multiple disciplines. The ultimate goal of this project is to develop a variety of resources and professional development that is available to professionals and parents across disciplines. Awareness is a need on community and state wide levels; lack thereof can make concentrated work with only teachers difficult in terms of interdisciplinary and cross disciplinary collaboration. Recommendations for future expansion include:

• Integrate the constructive feedback noted in the conclusions and recommendations section of this project. One-way feedback will be implemented is by adjusting the workshop presentations to include more stories as examples that weave throughout
both workshops and add case studies where staff can begin to apply their newly acquired knowledge.

• Due to widely utilized Positive Behavioral Intervention Supports (PBIS) frameworks implemented state and nation-wide, consider adding cross references and support throughout coaching; making connections between the how the two frameworks, behavioral and trauma affected approach, can be implemented hand in hand. For example, while using rewards for children who demonstrate trauma affected symptoms are not recommended, utilizing positive descriptive acknowledgement aligns with both PBIS and supports children who are healing from traumatic experiences.

• Current teacher preparation programs do not address issues of mental health. Components of the workshop could be included in teacher preparation programs.

• Expand the preschool workshops to include three modules. The primer session, *Attachment: Early Brain Architecture & Long Term Outcomes* would remain the first of three modules. Due to the dense nature of content in *Creating Trauma Supportive Environments* this workshop would be divided into two sessions, separating out trauma characteristics and long term affects into the first and creating trauma supportive environments and interventions into the second.

• Adapt the three preschool modules content in order to use them to provide professional development to elementary school teachers and staff. Examples of adaptations could include shifting the illustrations to pertain specifically to elementary aged children, exploring mind sets and barriers more in depth based on
what kind of philosophy’s teachers view relationships and behavior from, or going
more in depth about how interventions may practically work in the elementary
school environment. Additionally, the author has observed that by the time
children are in elementary school the teacher – parent relationship becomes
primarily focused on academic and behavioral outcomes. For children who are
exhibiting trauma related symptoms it is vital for teachers to have as much
understanding as possible about the student and their families background,
sometimes even information about the parent’s pregnancy can provide a great deal
of insight into a child’s symptoms. Providing training and coaching to teachers
supporting these more in depth relationships and conversations with family
members may be an appropriate adaptation for the elementary school modules.

• Increase the number of ‘parent-friendly’ resources provided to educators during
workshops and coaching. As a component of coaching, the researcher had the
opportunity to participate in conversations with five families of children who
demonstrated symptoms of childhood trauma. Throughout the process of
introducing the concept, learning more about the families’ history and exploring
interventions, each of the teachers and the coach agreed that access to one to two
page materials that introduce the topic, talk about symptoms, long-term outcomes
and evidence based interventions would be helpful in supporting conversations
with families about a topic that remains at large a taboo subject.

• Adapt the three preschool modules content in order to use them to train and coach
foster parents. The nature of foster parent’s role is to serve children and/or
adolescents who have experienced trauma. Based on separation from their primary attachment caregiver, these children are also at risk for having an insecure attachment template. Examples of adaptations could include shifting the illustrations from the classroom environment to the home environment, supporting foster parents to advocate for their child within the educational system and providing case studies and illustrations that relate to the home and community environments.

• Consider adding an additional module on how the experiences individuals have growing up affect their world view and interactions with children. Throughout the research process, the author has become increasingly aware, personally and professionally, how the experiences that each individual has growing up creates their internal working model, which in turn affects the way we interact with children and view their behavior. It is the authors belief that leading educators and/or foster parents through self – reflection may support building awareness and creating trauma supportive environments.

• Continue to build collaborative relationships and partnerships with local organizations that will lead to continued dissemination of trauma resources and future uses of this project.

Due to the limited knowledge and recognition in today’s culture of how mental health impacts today’s children and tomorrow’s adults, there remains a great opportunity for increasing awareness of how trauma affects children and adults and building increasingly supportive environments.
Appendix A

QUALITATIVE SURVEY OF INDIVIDUALS SERVING TRAUMA AFFECTED CHILDREN
<table>
<thead>
<tr>
<th>Job Title</th>
<th>Briefly share your experience working with children affected by early childhood trauma.</th>
<th>In your experience what type of professional development or training do teachers typically receive on early childhood trauma, toxic stress, or attachment disorder?</th>
<th>What type(s) of professional development or training would be ideal for teachers to receive?</th>
<th>What are some of the negative outcomes children affected by early childhood trauma may demonstrate?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Worker</td>
<td>3 years as an Early Childhood Mental Health Therapist with Children's Hospital Oakland. 9-month training program from Child Trauma Institute, San Francisco with Alicia Lieberman. Currently consult early interventionist and child care programs working with children birth to three who have experienced trauma.</td>
<td>None. Sometimes newer teacher may learn about attachment but nothing on trauma.</td>
<td>I would like to see this be a mandated, integrated part of all teaching curriculums.</td>
<td>Behavioral problems, developmental delays, insecure attachments, health/medical problems, mental health problems such as anxiety and depression, poor relationships with peers, long-term issues such as substance abuse and poor health in adulthood. Higher rates of special education referral and incarceration. Negative imprint may even be passed onto the offspring through epigenetic modifications.</td>
</tr>
<tr>
<td>Former Elementary Teacher</td>
<td>Five years of teaching, five years and substitute teaching and observance of my nieces and nephew’s.</td>
<td>Little or none</td>
<td>At the very least teachers should receive training to recognize the signs of early signs of early childhood trauma, preschool, kindergarten and first grade teachers should receive training in how to best assist preschool, kindergarten and first grade teachers should receive training in how to best assist others.</td>
<td>Acting out, inability to adjust to the normal classroom setting so other students can learn.</td>
</tr>
<tr>
<td>Elementary Principal</td>
<td>In my experience I have experienced polar opposites with children who experienced childhood trauma. Some need a lot of physical contact, some children do not want to be touched. I have also had children who work hard and focus and I have had some (most) give up easily.</td>
<td>I have experienced none.</td>
<td>Signs of Early Childhood Trauma; How do You Help Children who Have Early Childhood Trauma</td>
<td>anger, loss of interest, self-hurting themselves, hurting others, quiet, lack of focus</td>
</tr>
<tr>
<td>Former Special Education Teacher and Program Coordinator</td>
<td>Home visitor for infants/toddlers with disabilities and their families. Consultation with preschool programs (special education, head start, state preschool)</td>
<td>ECSE credential addresses attachment disorder in depth, other trauma minimally. Conferences have workshops (i.e. IDA). In-service programs address attachment disorders (Prog Infant Toddler Caregivers, CSEFEL). Unfamiliar with early childhood/child development programs.</td>
<td>Preservice training should include as a component. Ongoing in-service with consultation/mentor support.</td>
<td>A lack of trust in adults impairs behavior and development. Challenging behaviors (aggressive or withdrawal), extreme fear.</td>
</tr>
<tr>
<td>Job Title</td>
<td>Briefly share your experience working with children affected by early childhood trauma.</td>
<td>In your experience what type of professional development or training do teachers typically receive on early childhood trauma, toxic stress, or attachment disorder?</td>
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<tr>
<td>-----------</td>
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<td>--------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Aunt of 2 children with attachment disorder</td>
<td>I have a nephew that suffers from attachment disorder and I worked with hundreds of children as a naturalist/educator. Some of these children showed signs of trauma.</td>
<td>Not much.</td>
<td>Conflict resolution, how to ID children with trauma, how to help children with trauma.</td>
<td>Inability to attach, lack of attention, inability to deal with uncomfortable situations, acute, depression, anxiety, bipolar disorder.</td>
</tr>
<tr>
<td>Pre-K Teacher</td>
<td>I have worked with one child who I know had experienced early childhood trauma. However, looking back now, I am sure I have actually worked with more. It was a lot of relationship building, earning this child's trust, following through, and open communication with the family that helped him be successful in the class.</td>
<td>I would say that a &quot;typical&quot; early childhood development center would not provide any professional development or training on early childhood trauma, toxic stress, or attachment disorder.</td>
<td>I think ANY training on childhood trauma would be beneficial especially if it included strategies to help in the classroom.</td>
<td>Unable to regulate, identify self when you are exposing yourself when you are exhausting so it's hard to deal with. It can also be difficult to build a trusting relationship with the family.</td>
</tr>
<tr>
<td>Inclusion Specialist (Elementary School)</td>
<td>My experience includes supporting a child who was six years old with reactive attachment disorder. At first, I tried to use the tools I had been taught through ABA to shape this student's behavior, which means examining the ABC of behavior. This also included creating a reinforcement schedule for paras to follow, as they reinforced the student's positive behavior. However, it became apparent fairly quickly that this student's behavior was unique in the sense that it did not respond to typical ABA techniques. The student didn't seem to care about reinforcement and would manipulate the environment to fit his own needs. His sense of fight or flight did not improve, even after a solid sense of rapport had been established. The school system also seemed at a loss for how to support this student and the process of providing him the right amount of support at school moved very slowly. It was also frustrating at times because his home life was in constant chaos and there was no sense of urgency to get a full psychological evaluation outside of the school system.</td>
<td>In my limited experience, there hasn't been any professional development on any of these issues and the credential program did not include very much useful information either.</td>
<td>Professional development which would be ideal for teachers includes understanding strategies how to make the system move faster and partnering with outside resources to offer families. Another training which would be helpful would be learning how to &quot;work&quot; with families who's lives are in chaos.</td>
<td>Aggression, emotional manipulation, hunger, extra bravado, social isolation, and a general detachment from others.</td>
</tr>
</tbody>
</table>

Note: All individuals completing the survey responded to the statement: "Early childhood trauma can include . . ." by marking all of the options.

"Early childhood trauma can include (please check all boxes that apply): Physical abuse, sexual abuse, emotional abuse, toxic stress, exposure to violence, medical procedures, neglect, home destabilization, substance abuse, . . ."
Appendix B

WORKSHOP I MATERIALS

Attachment: Early Brain Architecture & Long Term Outcomes
Attachment
Early Brain Architecture & Long Term Outcomes

[Signature]
K. Miller
Education M.A. Candidate
Notes / Talking Points:

1. (Statman-Weil, 2015, pp. 72)

2. (2000, pp. 219).

Talk about what can count as stressful for a baby

Talk about how even the food the mother is eating, and emotional state of the mother during the pre-natal period
Notes / Talking Points:

What are the things that directly impact a baby in the first year? These are big categories.
Notes / Talking Points:

We can think of how these look when we are adults.
Impacts on Early Development

- What does the infant bring to the relationship?
  - Temperament & social style
  - Emotional expression
  - Neurologic functioning
  - Physical health status
  - Cognitive level

Notes / Talking Points:

Bruce Perry story about the boy who was a rapist and murderer
Notes / Talking Points:

Talk about signaling behaviors (crying, calling, reaching out) vs attachment behaviors (ones that bring the baby to the adult) approaching, following, climbing up onto lap, clinging

Attachment parenting is different from attachment

Co-sleeping, breastfeeding, slings, stay at home mom’s – not always necessary for health attachment
Notes / Talking Points:

https://www.youtube.com/watch?v=m_5u8-QSh6A

Harvard Center on the Developing Child

One of the most essential experiences in shaping the architecture of the developing brain is “serve and return” interaction between children and significant adults in their lives. Young children naturally reach out for interaction through babbling, facial expressions, and gestures, and adults respond with the same kind of vocalizing and gesturing back at them. This back and forth process is fundamental to the wiring of the brain, especially in the earliest years.
What is Attachment?

- What are all the things that a baby needs a caregiver for in their 1st months of life?
- The earliest period of infancy lays out the foundation for future development
  - Trust and reliance on others
    - You are there when I need you
  - Emotional expression
    - Learning how to express need
    - Understanding that needs will get met
  - Beginning of regulation
    - Self-soothing
    - Calming
    - Learning what to expect of the world
    - Responding to calming influence of caregiver

Notes / Talking Points:

Example of attachment is a nursing mother hearing another baby cry and having her milk come in

Attachment is seen in every country & in all primates – may look different ways

Think of the movie Babies
Notes / Talking Points:

Talk about nature vs nurture first and development within the first 12 months of life

# per second being formed (700 per second)

What is engrained in a child’s pathways?

Disappointment, inconsistency, unpredictability

Notes / Talking Points:

https://www.youtube.com/watch?time_continue=52&v=VNNsN9IJkws

Emotional or cognitive structures that comprise attention, perception, memory, affect, fantasy and behavior

In short the child’s world view and guide to his/her responses to people
Notes / Talking Points:

Are all attachments the same?

Attachment hierarchy

Can there be different attachment styles?

There is typically a primary attachment
Notes / Talking Points:

Does not mean perfect parenting
Notes / Talking Points:

Does not mean perfect parenting
Types of Attachment

- Secure

  - As an adult . . .
    - Can integrate the good and the bad and say things like ‘my parents did the best they could and I have a great relationship with them today’
    - ‘I’m okay, you’re there for me’ or ‘the world is generally good, so I can trust you to provide for me.’
Types of Attachment

- Still Face Experiment

Notes / Talking Points:

https://www.youtube.com/watch?v=apzXGEbZht0

Mary Ainsworth’s Strange Situation
Notes / Talking Points:

Self sabotage to meet your internal working model

Cortisol levels are tested by a swab in the mouth
Notes / Talking Points:

Self sabotage to meet your internal working model

Cortisol levels are tested by a swab in the mouth
Types of Attachment

- Insecure - Avoidant
  - As an adult . . .
    - Don’t recognize the negative experiences in their childhood, act like it was great
    - Appear to be independent and self reliant and typically avoid close relationships
    - They refrain from asking for help, may lack creativity and have sudden outbursts
Types of Attachment

- Insecure - Resistant
  - Inconsistent and unresponsive care giving
  - Have learned adaptations for less than optimal care giving
  - Infants may initially seek proximity upon reunion but become rejecting by pushing away or squirming
  - Often create a push-n-pull in relationships
  - Do not have coping strategies
  - May display anger toward caregiver
  - Can present as clingy or rejecting, they would like to be comforted but cannot process comforting appropriately
  - Often words such as immature, fussy, hyperactive, passive or angry may be used to describe them
Types of Attachment

- Insecure - Resistant

  - Caregiver Characteristics
    - Inconsistent or unpredictable
    - May respond sensitively sometimes
    - Due to stress, mood changes or substance issues may be less available other times
Types of Attachment

- Insecure - Ambivalent
  - As an adult . . .
    - Tend to focus on the negative experiences in childhood
    - They do not easily recover from setbacks
    - Create a push and pull in relationships, may stay in relationships for unhealthy reasons
    - More likely to have an addiction

Notes / Talking Points:

Add health outcomes for this category
Types of Attachment

- Insecure - Disorganized
  - Very rare in the U.S.
  - Typically found in children who have started life in orphanages, children in many foster homes or extreme CPS cases, babies who have been shuffled around between many people
  - Have learned adaptations for less than optimal care giving
  - Do not have coping strategies

Notes / Talking Points:

Could look like they have signs of autism – sometimes with a change in caregiver

those signs can go away within months

Sometimes can manifest as oppositional defiant disorder or reactive attachment disorder in childhood
Notes / Talking Points:

Could look like they have signs of autism – sometimes with a change in caregiver

those signs can go away within months

Sometimes can manifest as oppositional defiant disorder or reactive attachment disorder in childhood
Critical Periods for Attachment

- Birth - 6 months
  - Primary caregiver development
  - Who do I attach to?
- 6 months
  - Begins to show a preference for caregiver
- 7-9 months
  - Stranger anxiety
- 8-9 months
  - Separation anxiety develops
- 9-12 months
  - Object/people permanence
  - “I know you are out there somewhere”

Notes / Talking Points:

Children’s growth is affected by attachment – child who had a teenage mother and the doctors tried everything – talk about her feeding habits, cuddling, etc.
Maternal Behaviors

- Maternal behaviors that predict attachment
  - Sensitivity vs insensitivity
  - Acceptance vs rejection
  - Accessibility vs being ignored and neglected
  - Cooperation vs interference
  - Comforting child when child needs comforting
  - Accepting child’s range of feelings
  - Sensitivity & responsiveness to child’s cues
  - Avoiding being intrusive or too directive
    - Not overwhelming the child
  - Showing positive feelings
  - Showing genuine love and joy
  - Allowing the child to be separate and autonomous while still keeping him/her safe
Notes / Talking Points:

Look up positive outcomes of secure attachment

3 Shamir-Essakow, Ungerer, and Rapee
Notes / Talking Points:

Baby monkeys did not have healthy maternal care, it took five generations to repair the damage.
Long Term Affects

- Adult Attachment Interview
  - Helps adults understand their interpersonal relationships

- Adult romantic love study
  - A questionnaire published in a local newspaper
  - Statistically significant correlation between childhood reports of attachment and adult attachment in a romantic relationship were found

Notes / Talking Points:

Hazen & Shaver (1987)
Reflection

Notes / Talking Points:


Think of your own upbringing

Think about parents whose children we are serving. What do we imagine their childhood was like? How might that affect how they parent their children?

Refer to Harlow’s monkeys
Appendix C

WORKSHOP II MATERIALS

Creating Trauma Supportive Environments
Creating Trauma Supportive Environments
The environment provided by the child’s first caregivers has profound effects on virtually every facet of early development, ranging from the health and integrity of the baby at birth to the child’s readiness to start school at age 5 (1).

<table>
<thead>
<tr>
<th>Attachment Style</th>
<th>% of Sample (also generalizable to U.S. population)</th>
<th>The Child’s General State of Being</th>
<th>Mother’s Responsiveness to Her Child’s Expressions of Need</th>
<th>Fulfillment of the Child’s Needs (Even if the Child Acts in Denial)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure Attachment</td>
<td>65%</td>
<td>Secure, explorative, happy</td>
<td>Quiet, sensitive, consistent</td>
<td>Enforces and dictates that her needs will be met.</td>
</tr>
<tr>
<td>Avoidant Attachment</td>
<td>10%</td>
<td>Not very explorative, emotionally distant</td>
<td>Distant, disengaged</td>
<td>Subconsciously believes that higher needs cannot be met or met.</td>
</tr>
<tr>
<td>Ambivalent Attachment</td>
<td>10-15%</td>
<td>Anxious, insecure, angry</td>
<td>Inconsistent; unresponsive</td>
<td>Cannot rely on mother needs being met.</td>
</tr>
<tr>
<td>Disorganized Attachment</td>
<td>10-15%</td>
<td>Depressed, angry, oppositional</td>
<td>Extroverted, enfractured or Disinhibited, passive or intrusive</td>
<td>Severely confused with no strategy to have mother needs met.</td>
</tr>
</tbody>
</table>

Notes / Talking Points:

Ambivalent also known as ANXIOUS or RESISTANT

(1) According to the National Research Counsel Institute of Medicine, “the environment provided by the child’s first caregivers has profound effects on virtually every facet of early development, ranging from the health and integrity of the baby at birth to the child’s readiness to start school at age 5” (2000, pp. 219).
Attachment Overview

Think back to the child or parent that you reflected on during the attachment workshop. What has changed in your perspective or practice in the past month?
Notes / Talking Points:

We know that children’s attachment / experiences during their first 12 months of life determines their internal working model.

Their internal working model determines what lens they see life through.
**Notes / Talking Points:**

Video walking through the forest with ‘happy’ music playing

Parallels to draw

- When we have healthy experiences we generally see the world as a positive place
- We expect good things out of people
- Our heart rate generally stays level and we know that life brings joys and challenges
Notes / Talking Points:

Video walking through the forest with ‘jaws’ music playing

Parallels to draw

• When we have traumatic experiences we generally see the world as a negative or unsafe place

• We do not easily trust and we are always on edge for something to happen

• Our heart rate may be elevated even at resting – we have jaws music constantly playing in our head
Notes / Talking Points:

When someone says, “love you”, there are accompanying non-verbal signals validating the verbal information, such as eye contact or facial expression. The same can be said of someone who is telling the truth.

Children raised with caregivers who "talk the talk" but don't "walk the walk" (e.g., those exposed to domestic violence or multiple foster homes) internalize patterns of communication and interaction that are distorted and often destructive. This is also how a child learns the mismatched association between intimacy, power, violence, and threat.
Why Be a Trauma Informed School?

- 40% of students have experienced, or been witness to, traumatic stressors during their lifetime, and up to 26% of those children have witnessed or experienced trauma before the age of 4.

- Trauma can impact school performance, impair learning and cause physical and emotional distress for 1 in every 4 children in a classroom.

National Child Traumatic Stress Network, 2015
Notes / Talking Points:

Empathize with staff in the room who may have experienced childhood trauma or may struggle with mental illness.
What is Childhood Trauma?

- Traumatic experience between the age of 0 - 6
- An event that threatens the child’s safety or the safety of their caregiver(s)
- The child may be unable to verbalize and process the trauma
- Trauma may be ‘held in the body’ (sensory impact)
- The child may blame themselves (magical thinking)

Notes / Talking Points:

Have participants generate types and write on chart paper
What is Childhood Trauma?

- Children’s inability to access the support needed from an adult, during a stressful situation, can interrupt their ability to ‘process, integrate, and categorize’ what happened (1).

- This leaves trauma survivors vulnerable to rupture in healthy attachment and at-risk for trauma-affected symptoms.

Notes / Talking Points:

(2) Statman-Weil, 2015, pp. 72
What is Childhood Trauma?

- Toxic Stress

**Three Levels of Stress Response**

- **Positive**
  Brief increases in heart rate, mild elevations in stress hormone levels.

- **Tolerable**
  Serious, temporary stress responses, buffered by supportive relationships.

- **Toxic**
  Prolonged activation of stress response systems in the absence of protective relationships.

**Notes / Talking Points:**

Constant stress makes it really hard to get information into long term memory.

Talk about how this can affect children in the classroom and learning.
Notes / Talking Points:

Have participants pull out the ‘Symptoms and Behaviors Associated with Exposure to Trauma’

Handout from NCTSN & ‘Possible Regulation and Stress Response Correlates ...’Handout

From personal knowledge and NCTSN Toolkit

On average children smile 400x per day – watch for children who do not smile as much, it can be an indicator
Notes / Talking Points:

Published in 1998, opened the door for many follow up studies

This is a population of people who we might think of as typically being less prone to trauma – remember that trauma occurs throughout income brackets and various ethnicities – it may look slightly different

Refer to Nadine Burk Harris TEDtalk for those who want 15-minute summary from a physician

https://www.youtube.com/watch?v=95ovlJ3dsNk
Trauma Long Term Affects

- Adverse Childhood Experiences (ACEs) (7 categories)
  - Psychological, physical or sexual abuse
  - Violence against the child’s mother
  - Living with household members who ...
    - Were substance abusers
    - Mentally ill or suicidal
    - Ever imprisoned
Trauma Long Term Affects

- Health Risks
  - Current smoker *(2x more likely)*
  - Severely obese
  - Engaging in no physical activity
  - Depressed mood
  - Attempted suicide *(30x more likely)*
  - Self proclaimed alcoholic *(7x more likely)*
  - Use of illicit or injected drugs *(46x more likely)*
  - Having intercourse with more than 50 partners
    - *(7x more likely to have had sex before age 15)*
  - Had or having a sexually transmitted disease
Trauma Long Term Affects

- Terminal Diseases
  - Ischemic heart disease (2x more likely)
  - Cancer (2x more likely)
  - Stroke
  - Chronic bronchitis or emphysema (4x more likely)
  - Diabetes
  - Fair or poor self-rated health
  - Ever having had a skeletal fracture, hepatitis or jaundice
Notes / Talking Points:

http://www.acestudy.org/
Notes / Talking Points:

FOLLOW UP STUDIES

Sister Study - Burke, Hellman, Scott, Weems and Carrion (2011) Three percent of children with no ACEs had a learning/behavior problem, while 51.2% with 4 or more ACEs meant the same criteria

Sister Study - Briggs-Gowan et al. (2010)

1,788 children age 1 – 3

Children living in poverty were 2 – 5 more times likely to experience violent exposure. Single parenting, outside of poverty, was also associated with violent exposure.
Notes / Talking Points:

This list is not exhaustive. Typically surrounds a lack of self-regulation skills which become internalizing or externalizing behavior.

A note about PTSD, symptoms can look like defiance, ADHD, illness, anxiety or depression instead of another early childhood trauma side effect.
Notes / Talking Points:

This list is not exhaustive. Typically surrounds a lack of self-regulation skills which become internalizing or externalizing behavior.
Notes / Talking Points:

All the causes can fall into the category of trauma
Notes / Talking Points:

The work of Bruce Perry - children’s mental health and neuroscience

Note: The neurosequential model of therapeutics (NMT) is an approach that integrates core principles of neurodevelopment and traumatology to inform work with children, families and the communities in which they live. The same traumatic events will impact a child differently based on their developmental stage and brain development at the time of the occurrence.

For trauma-affected children, while many deficits may be present, the sequence in which deficits are addressed, based on brain development, is pertinent for the greatest outcomes.

KEY TAKEAWAY – you can not address everything at once
Notes / Talking Points:

NOTE: an illustration from the Child Trauma Academy (2015) shows basic brain organization. The brain develops from the bottom up. If impairment occurs in utero, infancy or early childhood, dysfunction can disrupt normal development unless intervention occurs targeted toward the original function developing in the brain when trauma occurred.

Thus, it is imperative for professionals to know at what age the child experienced the trauma, so that appropriate strategies can be utilized to intervene.
### Notes / Talking Points:

**Graphic: NMT Functional brain map**

For example, figure 2 (Child Trauma Academy, 2015) illustrates a brain ‘map’ of a 14-year-old who experienced trauma early in brain development while the brainstem and dienceph were still developing. For this child, a traditionally thought of ‘age appropriate’ intervention, such as using linguistic skills to solve problems with another peer, would likely focus on development of skills targeting the cortex or the limbic system. The problem with a top down approach, based on the brain map in figure 1, is that the foundational systems, the brainstem and the dienceph, do not yet have capacity to maximally support a more sophisticated ‘age appropriate’ intervention. An age appropriate intervention would likely be frustrating and have a lower success rate for both the adolescent and teachers or clinicians supporting the intervention.
Notes / Talking Points:

The counterbalance to trauma is resiliency; the ability to withstand or rebound from stress (Wolpow et al., 2009). Resiliency can protect from the effects of trauma, or resiliency can be built, through intervention, to help combat the effects of trauma.

Based on an attachment model, and teacher’s crucial role in building relationships with students and spending the majority of daily activity with students, they have an integral role in the role of recovery and building resiliency.

Resilient people immediately look t he problem and say, What’s the solution to that? What is this trying to teach me.”
The Road to Healing

Working with traumatized children can be

for teachers and parents.

Notes / Talking Points:

Overwhelming

Vicarious trauma

Exhausting

Rewarding
Notes / Talking Points:

It is not uncommon for teachers to receive guidance that includes using behavioral methods such as reinforcement, punishment or planned ignoring as a blanket recommendation for treating children with behavior challenges.

Although these are valuable, research-based strategies for some challenging behavior, they are not evidence-based for responding to trauma and attachment initiated behavior.

(3) Brunzell, Waters, & Stokes, 2015; Floyd et al., 2008; Wolpow, Johnson, Hertel, & Kincaid, 2009
Notes / Talking Points:

(4) Floyd, Hester, Griffin, Golden and Canter (2008) analyzed the evidence from 1994 to 2007 on peer reviewed articles on early childhood reactive attachment disorder; specifically measures and interventions. After review of 50 articles a common framework for intervention emerged and suggested

a) nurturing the child; b) understanding behaviors before punishing; c) interacting with children based on emotional age; d) being consistent, predictable, and repetitive; e) modeling and teaching appropriate play and social behaviors; f) maintaining realistic expectations; g) being patient with children and self; and using resources (2008, pp. 52)
Classroom Interventions
Nurturing the Child

- Attachment
  - Healthy attachment has at least 2 pertinent foundational functions in classrooms.
    - First, it facilitates the notion of security so children and adolescents feel safe to explore and learn.
    - Second, it is the basis for socialization and formation of healthy relationships
  - Teacher-child relationships are tied to each child’s internal working model based on their attachment template. (5)

Notes / Talking Points:

(5) Bergin & Bergin, 2009
Notes / Talking Points:

Although there will likely be many adults involved for a child who has special needs due to trauma, the classroom teacher(s) are the starting place and the glue for any supports or services that will be deployed on a daily basis.

NOTE: Demirkaya and Bakkaloglu (2015) found that students with special needs have increased conflict and less closeness with their teachers than peers without special needs

(7) Floyd, Hester, Griffin, Golden & Canter, 2008
Notes / Talking Points:

It may seem like the child’s behavior is happening for ‘no reason’
Notes / Talking Points:

Rewiring the brain – children with trauma do not have left and right brains that are connected the same way ours is – when we learn to reinterpret we are helping to support rewiring of the child’s brain
Classroom Interventions
Understanding Behaviors

- Set clear, firm limits for challenging behavior and develop logical - rather than punitive - consequences
  - Strive to have a consistent person support the child
  - Be mindful of tone and body language
- During transitions and times of change
  - Provide plenty of warning
  - Narrate to the child what the expectations and routine is throughout the situation
  - Provide additional support preventively
Classroom Interventions
Interactions Based on Emotional Age

► Neuosequential Model of Therapeutics

► The developmental state of the child has a profound impact on how teachers will influence the child’s brain

► In order to influence higher parts of the brain, the lower parts must be intact first
**Notes / Talking Points:**

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Notes / Talking Points:

Neuosequential Model of Therapeutics

The importance of touch to infants

NOTE: using language too much is discouraged, often children in this phase will naturally do the opposite than we ask them to do, they may not be responsive to our prompts to calm

Think an infant / toddler

Model without words Comfort

Constantly ensure they feel safe

Distraction

Check your own emotions, body language
Notes / Talking Points:

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Classroom Interventions

Interactions Based on Emotional Age

- Limbic Interventions
  - Once there is an improvement in self-regulation... then interventions can move to more relational-language interventions
  - Play therapy (puppets, role play, symbolic play child-led play)
- CSEFEL Module 1 Interventions
  - PDA
  - Choices
  - Additional visuals
  - Friendship skills
  - Simple emotion regulation

Notes / Talking Points:

Neuosequential Model of Therapeutics
Notes / Talking Points:

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Notes / Talking Points:

Neurosequential Model of Therapeutics

Emotional Literacy

Talking through the problem as the primary intervention

May take years to get to this point although these are the most common interventions used
Notes / Talking Points:

(7) Brunzell, Waters & Stokes, 2015
Notes / Talking Points:

The foundation for learning to play as a child is having a safe base and mimicking our parents or things we see

Children who did not have an attachment figure or who had disruption during the first few years of life may not have basic play skills
Notes / Talking Points:

When a teacher is absent the child may be struggling all day wondering if the teacher is ever going to come back.

An extra loud day in the classroom may trigger memories of a time when there was domestic violence or prolonged arguing.
Notes / Talking Points:

Talk about children who have trauma that has not been recognized by family members yet or who are in the midst of trauma as we serve them HIGHLIGHT THE ‘ASSESSMENT CONSIDERATIONS …’ handout that has questions that can be asked of caregivers to open conversations

Often when a child gets a behavior plan we will see some quick wins and/or changes – it takes years

Talk about vicarious trauma
Notes / Talking Points:

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Resources

- The California Center for Early Childhood Mental Health
  - [www.cacenter-ecmh.org](http://www.cacenter-ecmh.org)

- The National Child Traumatic Stress Network
  - [www.nctsnet.org](http://www.nctsnet.org)

- The Center for Pediatric Traumatic Stress
  - [www.chop.edu](http://www.chop.edu)
  - [www.healthcaretoolbox.org](http://www.healthcaretoolbox.org)
  - [www.aftertheinjury.org](http://www.aftertheinjury.org)
Resources

- Bessel Van Der Kolk
  - www.traumacenter.org

- Child Trauma Academy
  - www.childtrauma.org

- Harvard
  - www.developingchild.harvard.edu
References


Child Trauma Academy (2015). Neurosequential Model of Therapeutics & NMT Functional brain ‘map’ [Figure 4 & 5]. Retrieved from http://www.childtrauma.org


