Trauma Informed Care:

A Qualitative Study of Teacher's Effectiveness

in the Classroom

Alison Trimper

Baylor University

Paper presented at the annual meeting of the Southeastern Universities Graduate

Research Symposium, March 30, 2023.

Statement of the Problem

Adolescents' declining mental health impacts many aspects of their lives, particularly their ability to be successful in K-12 classroom spaces (Brunzell et al., 2015; Dutil, 2022; Ellis et al., 2020; McInerney & McKlindon, 2014; Smith, 2021, Wolpow et al., 2009). Adolescents are hurting, and evidence shows the measure of their mental health declined rapidly from 2005 to 2019 by 23.7% (Center for Disease Control, 2013, 2019). The onset of COVID-19 and the subsequent isolation that adolescents endured only worsened and compounded the negative effect on their mental health (Branquinho et al., 2020; Chen et al., 2020; Gussoum et al., 2020). Unfortunately, this impact is apparent in formal school spaces as students' behaviors, lack of interest, and the inability to pay attention are heightened concerns (Adubasim & Ugwu, 2019; Felitti et al., 1998; Frydman & Mayor, 2017; Perry, 2019; Wolpow et al., 2009). Adolescents' mental health impacts every facet of their lives, including their performance at school.

Fortunately, research shows there are ways to combat adolescents' declining mental health (Avery et al., 2020; Bath, 2008; Brunzell et al., 2015; Carello & Butler, 2015; Cole et al., 2013; Crandell et al., 2019; Doncliff, 2020; Keller-Dupree, 2013; Martin et al., 2017). Teachers who implement strategies to combat poor mental health see positive gains in the classroom when they create spaces where all students can learn and be successful (Avery et al., 2020; Bath, 2008; Brunzell et al., 2015; Carello & Butler, 2015; Cole et al., 2013; Crandell et al., 2019; Doncliff, 2020; Keller-Dupree, 2013; Martin et al., 2017).

Effects of Trauma and Poor Mental Health on Learning

Understanding trauma's impact on mental health is imperative, as the effects of trauma are cumulative. The more trauma a person experiences, the more significant its effect on psychological and physical health (Burke-Harris, 2019; Frenkel, 2010; Sweeney et al., 2018). The body begins to stockpile the memories of the trauma and the perceived threats the trauma has caused. The body adds to the stockpile with every perceived threat it encounters. When this occurs, even the most minor event can trigger a traumatic response since the body is already overloaded with the stressors of the previous trauma. As a result, the body becomes sensitized to new stressors and events (Eyerman, 2013; Perry, 2009; Sweeney et al., 2018). Because the body is sensitized, it is open to more trauma, and seemingly small events can trigger significant responses.

Effects of trauma and poor mental health on learning. Trauma and poor mental health can have a devastating effect on learning. As Wolpow et al. (2009) stated, "Focusing on academics while struggling with trauma is like 'trying to play chess in a hurricane'" (p. 3) because students' brains are so focused on the traumatic event they are unable to concentrate on anything else. Students experience trouble paying attention, lower IQs, lower motivation, lower standardized test scores, more referrals to special education classes, higher absences, and forming positive relationships (McInerney & McKlindon, 2014; Smith et al., 2021; Terrasi & Crain de Galarce, 2017; Wolpow et al., 2009). Trauma and its effect on the mental health impact students' ability to learn, process information, and choose appropriate behaviors.

Trauma negatively impacts how the brain receives, processes, and stores information. Because of this, students experiencing trauma have difficulty learning, remembering details, and displaying appropriate behaviors (Ko et al., 2008; McInerney &

McKlindon, 2014; Osher et al., 2018; Wolpow et al., 2009). In addition, the physical reactions to trauma and the increased cortisol in the brain impact the ability to remember and learn (Adubasim & Ugwu, 2019; Burke-Harris, 2019; Branquinho et al., 2020). Trauma can also affect the organizational language students need to succeed in the classroom (Osher et al., 2018). The physical changes to the brain caused by trauma make it extraordinarily difficult for an adolescent to maintain the mental stamina needed to succeed in the classroom.

In formal classroom spaces, the physical changes in the brain result in a profound shift in students' behavior. For example, a child with the limbic system affected by excess cortisol will have trouble behaving in the classroom and may also show signs of aggression or self-destruction (Terrasi & Crain de Galarce, 2017). In addition, adolescents may have extreme and exaggerated responses to acting out or withdrawing as they display similar symptoms to those of PTSD (Terrasi & Crain de Galarce, 2017; Wolpow et al., 2009). Adolescents suffering from trauma often present as students with anger or defiance issues (Terrasi & Crain de Galarce, 2017). The adolescents' brain, struggling with the fight or flight response, has difficulty focusing and behaving in the classroom.

COVID-19 Is a Traumatic Event for Many Adolescents

The COVID-19 pandemic has been a significant source of trauma for many adolescents. COVID-19 broadly impacted adolescents' mental health as it served as a primary traumatic event for some, whereas further traumas will compound the effects of previous traumas for others. In others who had previously experienced trauma, COVID-19 could result in an additive event or even an event that causes re-traumatization.

Whether it is a primary event or a secondary trauma, adolescents are at a higher risk for trauma symptoms than other populations (Gussoum et al., 2013).

Trauma's effects do not necessarily diminish once the traumatic event has ended. With COVID-19, the end of stay-at-home and mask orders did not mean every adolescent recovered from the trauma they experienced without intervention. The findings are comparable to those after the SARS/H1N1 outbreak of 2009, where researchers found instances of anxiety, depression, and PTSD in adolescents who were required to quarantine (Gussoum et al., 2020; Loades et al., 2020). In the case of the SARS/H1N1 outbreak, the effects of trauma had still not declined three and a half years after the outbreak ended (Pazderka, 2021). In addition, adolescents impacted by September 11, 2001, events suffered from long-lasting impacts five years later (Bath, 2008). As illustrated by these other traumatic events, these findings imply the effects of COVID-19 may persist for many years.

Teachers' effect on trauma.

Classrooms and teachers, often the first line of defense in adolescents' fight for good mental health, are woefully unprepared (Dutil, 2022; Ko et al., 2008). Although schools are often the entry point for referring students for mental health services as they are the professionals that see adolescents daily, they are often unprepared to deal with students' mental health (Dutil, 2022; Ko et al., 2008). Teachers and other professional staff have inadequate training to teach them how to identify or do with students who they suspect are suffering from mental health issues. In addition, many teachers are unaware of the adverse effects of mental health on students' academic success, so they do not feel monitoring students' mental health is their job.

Teachers and school systems are often the first line of defense in students' mental health. Therefore, teachers must build an environment that is a positive space where students feel safe, secure, and valued. As Crandell et al. (2019) found, positive relationships with teachers and other professionals in the school system can be powerful Counter-ACEs. Students' physical and emotional safety is the first and most crucial step in building a Counter-ACEs climate (O'Neil et al., 2010). Safe classrooms have several factors in common and includes attributes of honesty, boundary setting, protection, and security (Holley & Steiner, 2005). Creating a safe place does not mean the space is free from discomfort or struggle. It merely suggests that it is a place where a student can struggle with support (Holley & Steiner, 2005). Many students crave positive relationships with their teachers and flourish with constructive, precise interactions (Reed & Wexler, 2014). Positive, supportive relationships are not only beneficial to the student suffering from trauma, but those relationships are essential and beneficial to all students.

Social Emotional Learning in the classroom.

School systems have implemented Social Emotional Learning (SEL) in their classrooms (Cavanaugh, 2016; Herrenkol, 2019; Thomas, 2019; Pawlo et al., 2019). The SEL programs, however, are usually designed specifically for students experiencing traumas (Pawlo et al., 2019). Because most teachers are not certified mental health professionals and cannot diagnose students' mental health needs, many programs do not apply to them, leaving them without strategies to create safe spaces in the classroom.

Although researchers agree teachers need to build a safe space for children with trauma (Cantor, 2021; Cavanaugh, 2016; Cummings et al., 2017; 2016; Holley & Steiner, 2005; Leonard & Gudino, 2016; Reed & Wexler, 2014), synthesis of the literature shows

there is no one single framework that meets the needs of the classroom teacher (Herrenkol, 2019; Thomas, 2019). Without a proven framework, teachers need to balance their students' mental health and academic needs on their own. The lack of an established framework also indicates to some teachers that the mental health of their students is not a problem for them to solve. Many classroom teachers feel the delivery of information is their primary reason to be in the classroom and attending to students' mental health is a secondary or tertiary responsibility to which they do not need to attend.

While the literature is sufficient for building a case for the declining mental health of adolescents and the impact of trauma on their mental health, there are still holes in the literature. The most glaring example is the lack of data regarding programs for teachers to implement to yield positive effects for their all their students, but especially those impacted by trauma. Teachers need a proven structure that works for all students and can implement across all grades and subject matter.

In 2014, the Substance Abuse and Mental Health Services Administration (SAMHSA) introduced the Trauma Informed Care Framework, which outlines areas for all professionals who deal with people experiencing trauma to use, including teachers (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Although this framework was not designed explicitly for teachers, it contains aspects applicable to the classroom. In this study, I sought to discover how four teachers use the areas outlined in the Trauma Informed Care Framework to meet the social and emotional needs of their students.

Theoretical Framework

The theoretical framework that shapes this work is the Trauma Informed Care Framework. This framework, introduced by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2014, outlines six principles (See Figure 1) to be used address trauma (SAMHSA, 2014). The Substance Abuse and Mental Health Services Administration designed these principles for all sectors of professionals who treat people with trauma, not just teaching professionals. They are used to combat the effects of ACEs by helping build an environment that is safe for everyone.

The Trauma-Informed Care Framework outlines six components that professionals can utilize to build a protected space for students so their healing can begin. The six facets are safety, trustworthiness, cultural issues, peer support, collaboration and mutuality, and empowerment and voice (SAMHSA, 2014). Utilizing these tenets, teachers can modify their behaviors and teaching practices to build classrooms where all students social and emotional needs are met.

The first three components, safety, trustworthiness, and cultural issues, center around the idea that adolescents should have a safe space in which they are encouraged to thrive. School system safety indicates physical and psychological safety (SAMHSA, 2014). In addition, teachers who build a safe place of learning provide stability, routines, predictability, connections, and emotional regulation (Carello & Butler, 2015). Safety is the building block for the rest of the principles in the Trauma-Informed Care Framework.

Trust is also fundamental to building a safe learning environment. Professionals achieve trust by maintaining transparency and building connections (Reed & Wexler, 2014; SAMHSA, 2014). Adolescents who may not be able to rely on or trust other adults respond positively to adults they know they can trust. This relationship is important to

adolescents' success. Students need at least one adult in their lives who they can trust to be successful, and often this person is a teacher (Keller-Dupree, 2013; Loomis et al., 2018; West et al., 2014).

Although schools often provide the first line of mental health support, teachers and other professionals who work within the school system are frequently not equipped to identify and deal with students experiencing trauma (Cavanaugh, 2016; Dutil, 2022). Professionals often misidentify signs and symptoms of trauma as ADD and Oppositional Defiance, which leads to ineffective ways of dealing with traumatized students and often causes re-traumatization (Dutil, 2022). By utilizing this framework, professionals can build an atmosphere of trust and deeper learning.

Purpose of the Study and Research Questions

This qualitative, single case study aimed to shed light on how four teachers at a small regional middle school in Southeastern New Hampshire utilize the six trauma-informed approach principles in their classrooms to support students' mental health. The four teachers offer their perspectives on how they create safe classroom spaces for all students, especially those with poor mental health, so they can thrive in the classroom. My purpose for this study was to share four teachers' perspectives on how they differentiate themselves from other teachers who did not provide students with such safe classroom spaces. Expressly, I sought to uncover if the teachers' practices aligned with the six principles of the trauma-informed approach. Specifically, one primary research question guided this study: In what ways do teachers use the Trauma-Informed Care approach to support students' social and emotional well-being in the classroom?

This study is important to pinpoint teachers' successful skills to ensure all students, especially those who suffer from trauma, feel safe, connected and supported in their classrooms. This study will assist campus principals and administrators in identifying or building professional development to help all classroom teachers become trauma responsive. In addition, it will shape the way Social Emotional Learning curriculums are developed and presented to teachers. The following chapter details the research design and methodology of this study.

Methods and Procedures.

For this study, I will collect data in three ways. First, I will use classroom observations, conduct individual semi-structured interviews, and will hold a focus group interview with all four teachers to capture all relevant data. Data collection will begin in Fall 2022 after I receive IRB approval, and I set a timeline to ensure the data will be collected, analyzed, and written about in a thick, rich text by the fall of 2023.

Once all relevant parties give permission, I will begin the data collection procedures. Classroom observations will be the first data collection procedures that will take place. A protocol will be used for structure and to identify the things in the classroom that feel into the ideas outlined in the Traumatic Informed Care Framework. The Observation Protocol is a guide, so I will note everything representing a positive interaction between teacher and student. Observations will occur on the same day during periods 1, 2, 3, and 4. Each observation will last one class period, which is approximately 50 minutes.

Next, I will conduct semi-structured interviews with each participant. The semi-structured interviews allow me to delve deeper into teachers' perceptions about how they

understand their role in providing a learning space where all students experience a positive social and emotional well-being. In addition, the interview questions aligned with the Trauma-Informed Care Framework and highlighted teachers' actions in each of the six criteria. Finally, I will record the interviews to ensure accurate data collection and to allow me to go back to specific areas where I need more information.

Results and conclusions.

The qualitative data will be analyzed using seven steps: cleaning data, transcribing the semi-structured interviews and focus group interviews, entering data into NVivo to identify codes, reading and rereading transcripts to identify codes, clean codes, and combine them into themes, analyze the data, and report the findings. Each step of this process will be important to ensure the results are indicative of the data collected. These steps are also important to maintain the validity of the study. The conclusions will be draw through the thick, rich descriptions derived through the qualitive process.

*The educational importance of the stud*y.

The mental health of our children was declining even before the COVID-19 pandemic. Teachers are combating the effects of trauma and poor mental health on a daily basis in their classroom. This study will help to give teachers the tools they need to build classrooms where all students can be successful and thrive.

Bibliography

Adubasim, I., & Ugwu, C. (2019). Impact of trauma on neurodevelopement and learning. *Archives of Neurology*, *3*, 4. https://doi.org/10.33552/ANN

Avery, J. C., Morris, H., Galvin, E., Misso, M., Savaglio, M., & Skouteris, H. (2021). Systematic review of school-wide Trauma-Informed approaches. *Journal of Child & Adolescent Trauma*, *14*(3), 381–397. https://doi.org/10.1007/s40653-020-00321-1

Bath, H. (n.d.). *The three pillars of Trauma-Informed Care*. 5.

Branquinho, C., Kelly, C., Arevalo, L. C., Santos, A., & Gaspar de Matos, M. (2020). "Hey, we also have something to say": A qualitative study of Portuguese adolescents' and young people's experiences under COVID-19. *Journal of Community Psychology*, *48*(8), Article 8. https://doi.org/10.1002/jcop.22453

Burke-Harris, N. (2018). *The Deepest Well*. Houghton Mifflin Harcourt.

Cantor, P. (2021). All children thriving: A new purpose for education. *American Educator*, *Fall*, 14.

Cantor, P., Osher, D., Berg, J., Steyer, L., & Rose, T. (2019). Malleability, plasticity, and individuality: How children learn and develop in context. *Applied Developmental Science*, *23*(4), 307–337. https://doi.org/10.1080/10888691.2017.1398649

Carello, J., & Butler, L. D. (2015). Practicing what we teach: Trauma-Informed educational practice. *Journal of Teaching in Social Work*, *35*(3), 262–278. https://doi.org/10.1080/08841233.2015.1030059

Cavanaugh, B. (2016). Trauma-Informed classrooms and schools. *Beyond Behavior*, *25*(2), 41–46.

Center for Disease Control. (2013). *Mental health surveillance among children—United States, 2005-2011*.

Crandall, A., Miller, J. R., Cheung, A., Novilla, L. K., Glade, R., Novilla, M. L. B., Magnusson, B. M., Leavitt, B. L., Barnes, M. D., & Hanson, C. L. (2019). ACEs and counter-ACEs: How positive and negative childhood experiences influence adult health. *Child Abuse & Neglect*, *96*, 104089. https://doi.org/10.1016/j.chiabu.2019.104089

Cummings, K. P., Addante, S., Swindell, J., & Meadan, H. (2017). Creating supportive environments for children who have had exposure to traumatic events. *Journal of Child and Family Studies*, *26*(10), 2728–2741. https://doi.org/10.1007/s10826-017-0774-9

Eyerman, R. (2013). Social theory and trauma. *Acta Sociologica*, *56*(1), Article 1. https://doi.org/10.1177/0001699312461035

Frankel, J. B. (1998). Ferenczi's trauma theory. *The American Journal of Psychoanalysis*, *58*(1), Article 1. https://doi.org/10.1023/A:1022522031707

Guessoum, S. B., Lachal, J., Radjack, R., Carretier, E., Minassian, S., Benoit, L., & Moro, M. R. (2020). Adolescent psychiatric disorders during the COVID-19 pandemic and lockdown. *Psychiatry Research*, *291*, 113264. https://doi.org/10.1016/j.psychres.2020.113264

Herrenkohl, T. I., Hong, S., & Verbrugge, B. (2019). Trauma-Informed programs based in schools: Llnking concepts to practices and assessing the evidence. *American Journal of Community Psychology*, *64*(3–4), 373–388. https://doi.org/10.1002/ajcp.12362

Holley, L. C., & Steiner, S. (2005). Safe space: Student perspectives on classroom environment. *Journal of Social Work Education*, *41*(1), 49–65.

Keller-Dupree, E. (n.d.). *Understanding childhood trauma: Ten reminders for preventing retraumatization | The Practitioner Scholar: Journal of the International Trauma Training Institute*. Retrieved June 14, 2022, from https://www.thepractitionerscholar.com/article/view/10867

Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., Brymer, M. J., & Layne, C. M. (2008). Creating Trauma-Informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice*, *39*(4), 396–404. https://doi.org/10.1037/0735-7028.39.4.396

Leonard, S., & Gudiño, O. (2016). Academic and mental health outcomes of youth placed in out-of-home care: The role of school stability and engagement. *Child & Youth Care Forum*, *45*(6), 807–827. https://doi.org/10.1007/s10566-016-9357-y

Loades, M. E., Chatburn, E., Higson-Sweeney, N., Reynolds, S., Shafran, R., Brigden, A., Linney, C., McManus, M. N., Borwick, C., & Crawley, E. (2020). Rapid systematic review: The impact of social isolation and loneliness on the mental health of children and adolescents in the context of COVID-19. *Journal of the American Academy of Child and Adolescent Psychiatry*, *59*(11), Article 11. https://doi.org/10.1016/j.jaac.2020.05.009

Loomis, B., Epstein, K., Dauria, E. F., & Dolce, L. (2019). Implementing a Trauma-Informed public health system in San Francisco, California. *Health Education & Behavior*, *46*(2), 251–259. https://doi.org/10.1177/1090198118806942

McInerney, M., & McKlindon, A. (2016). Unlocking the door to learning: Trauma-Informed classrooms & transformational schools. *Education Law Center*, 24.

O'Neill, L., Guenette, F., & Kitchenham, A. (2010). "Am I safe here and do you like me?" Understanding complex trauma and attachment disruption in the classroom. *British*

Journal of Special Education, *37*(4), 190–197. https://doi.org/10.1111/j.1467-8578.2010.00477.x

Osher, D., Berg, J., & Jones, W. (2018). Trauma and learning policy inititive (TLPI): Trauma-Sensitive schools descriptive study. *American Institutes for RESEARCH*, 118.

Pawlo, E., Lorenzo, A., Eichert, B., & Elias, M. J. (2019). All SEL should be Trauma-Informed. *Phi Delta Kappan*, *101*(3), 37–41. https://doi.org/10.1177/0031721719885919

Pazderka, H., Brown, M. R. G., Agyapong, V. I. O., Greenshaw, A. J., McDonald-Harker, C. B., Noble, S., Mankowski, M., Lee, B., Drolet, J. L., Omeje, J., Brett-MacLean, P., Kitching, D. T., & Silverstone, P. H. (2021). Collective trauma and mental health in adolescents: A retrospective cohort study of the effects of retraumatization. *Frontiers in Psychiatry*, *12*, 682041. https://doi.org/10.3389/fpsyt.2021.682041

Perry, BruceD. (2009). Examining child maltreatment through a neurodevelopmental lens: Clinical applications of the neurosequential model of therapeutics. *Journal of Loss & Trauma*, *14*(4), 240–255. https://doi.org/10.1080/15325020903004350

Reed, D., & Wexler, J. (2014). "Our teachers … Don't give us no help, no nothin'": Juvenile offenders' perceptions of academic support. *Residential Treatment for Children & Youth*, *31*, 188–218. https://doi.org/10.1080/0886571X.2014.943568

Rosenberg, Jamie. (2019, March 19). *Mental health issues on the rise among adolescents, young adults*. AJMC. https://www.ajmc.com/view/mental-health-issues-on-the-rise-among-adolescents-young-adults

SAMHSA. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach. *U.S. Department of Health and Human Services*, 27.

Smith, J., Guimond, F.-A., Bergeron, J., St-Amand, J., Fitzpatrick, C., & Gagnon, M. (2021). Changes in students' achievement motivation in the context of the COVID-19 pandemic: A function of extraversion/introversion? *Education Sciences*, *11*(1), Article 1. https://doi.org/10.3390/educsci11010030

Smith, L., Jacob, L., Yakkundi, A., McDermott, D., Armstrong, N. C., Barnett, Y., López-Sánchez, G. F., Martin, S., Butler, L., & Tully, M. A. (2020). Correlates of symptoms of anxiety and depression and mental wellbeing associated with COVID-19: A cross-sectional study of UK-based respondents. *Psychiatry Research*, *291*, 113138. https://doi.org/10.1016/j.psychres.2020.113138

Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: Relationships in trauma-informed mental health services. *BJPsych Advances*, *24*(5), 319–333. https://doi.org/10.1192/bja.2018.29

Terrasi, S., & de Galarce, P. C. (2017). Trauma and learning in America's classrooms. *Phi Delta Kappan*, *98*(6), 35–41. https://doi.org/10.1177/0031721717696476

Thomas, M. S., Crosby, S., & Vanderhaar, J. (2019). Trauma-Informed practices in schools across two decades: An interdisciplinary review of research. *Review of Research in Education*, *43*(1), 422–452. https://doi.org/10.3102/0091732X18821123

West, S. D., Day, A. G., Somers, C. L., & Baroni, B. A. (2014). Student perspectives on how trauma experiences manifest in the classroom: Engaging court-involved youth in the development of a trauma-informed teaching curriculum. *Children and Youth Services Review*, *38*, 58–65. https://doi.org/10.1016/j.childyouth.2014.01.013

Wolpow, Ray, Johnson, Mona M., Hertel, Ron, & Kincaid, Susan O. (2009). *The heart of learning and teaching: Compassion, resiliency, and academic success*.

https://www.k12.wa.us/sites/default/files/public/compassionateschools/pubdocs/thehearto
flearningandteaching.pdf