Trauma-Informed Care for Educators

Indiana Department of Child Services, Permanency and Practice Support

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Learning Objectives

• Define Trauma
• Understand child/adolescent traumatic stress and the effects trauma has on development
• Define trauma-informed care
• Recognize trauma symptoms in students
• Recognize and address Secondary Traumatic Stress
• Create classroom resources for trauma-informed instruction
What is Trauma?

• A traumatic experience is an event that threatens someone’s life, safety, or well-being.
• Trauma overwhelms one’s capacity to cope.
• Trauma has not been recognized as part of the daily experience of many children and adolescents, nor has the profound effect of trauma been recognized.
• A child does not have to be the direct victim to be traumatized by the occurrence – witnessing the event(s) can be traumatizing.
Categories of Trauma

• **Acute Trauma**: A single traumatic event limited in time. Examples: Death of a family member, single incident of violence, serious accident or disaster.

• **Chronic or Complex Trauma**: Multiple, consistent, or varied exposure to traumatic events. Examples: Repeated abuse/neglect, ongoing domestic violence, multiple instances of loss.
Types of Traumatic Experiences

• Community Violence
• Early Childhood Trauma
• Terrorism/War
• Medical Trauma
• Natural Disasters
• Neglect and/or Physical or Sexual Abuse
• School Violence
Community Violence

- Includes predatory violence (robbery, for example) and violence that comes from personal conflicts between people who are not family members. May include brutal acts such as shootings, rapes, stabbings, and beatings. Gang activity would fall under this category. Children may experience trauma as victims, witnesses, or perpetrators.
Early Childhood Trauma

• Children 0-6, can be the result of **intentional** violence – such as child physical or sexual abuse or domestic violence, or the result of natural disaster or accidents. Can include painful medical procedures or loss of parent/caregiver.
Terrorism/War

- Witnessing bombing, looting, shooting activities as a result of war. Includes displacement or homelessness for political reasons. Some youth have served as soldiers, guerillas, or other combatants in their home countries. Similar symptoms as combat veterans.
Medical Trauma

• Reactions to pain, injury, or serious illness and their associated invasive medical procedures or treatments. Experienced as frightening and reactions can affect the mind as well as the body. Children are anxious, irritable, “on edge”, and may have unwanted thoughts or nightmares about the illness, injury, or the hospital.
Natural Disasters

• Any natural catastrophe (tornadoes, hurricanes, earthquakes, fire, flood, explosion) that causes enough damage that local or federal disaster relief agencies are called into action.
Neglect

• Defined as when a parent or caregiver fails to provide care a child needs when they are capable of doing so – food, clothing, shelter, medical or mental health treatment, education, exposure to dangerous environments, poor supervision, abandonment.
Physical Abuse

- Causing or attempting to cause physical pain or injury. Single act or several acts: punching, beating, kicking, burning, shaking, striking with objects, inappropriate punishment. In extreme cases can result in death.
Sexual Abuse

• Range of sexual behaviors between child and older person, or child and another child. Involves bodily contact or verbal or visual sexual behavior. Includes sexual exploitation for purposes of child pornography or prostitution.
School Violence

• Fatal or non-fatal student or teacher victimization, threats, fights, extreme bullying, and students carrying weapons to school.

• Defined by the Center for Prevention of School Violence as “any behavior that violates a school’s educational mission or climate of respect or jeopardizes the intent of the school to be free of aggression against persons or property, drugs, weapons, disruptions, and disorder” (NCTSN).
Responses to Trauma

- Post-Traumatic Stress Disorder (PTSD)
- Biopsychosocial Impact
- Neurodevelopment
- Social Development
- Mental Health Effects
- Effect on Learning
- Strengths
Past Exposure to Trauma

• The effects of trauma are cumulative. The child who has had prior, or chronic, trauma exposure is at the greatest risk of developing symptoms.
PTSD

- DSM-IV
- Avoidance – Avoid traumatic reminders
- Re-experiencing – Nightmares, intrusive memories
- Hyperarousal – Abnormally increased arousal, responsiveness to stimuli, and scanning for threats
PTSD

• Post Traumatic Stress is responding to normal stressors and life events as if they are threats to your survival.
• Often distrust people in authority and see them as threats because of being abused or harmed by adults that are supposed to protect them.
• Abuse perpetrated by adults violates our social contract with children.
• Police, Teachers, Principals, bosses, etc. can be perceived as threats.
• As a result, there are situations where using a forceful or intimidating or authoritative manner might evoke stronger violence or increased resistance (FEAR)
Shaping of Beliefs

• Trauma shapes the survivor’s basic beliefs about identity, world view, and spirituality
  – Why did this happen? (Abuse is inevitable)
  – Why to me? (It was my fault)
  – What does this mean? (Nothing I do will make any difference)
Common Observations
Age 5 and under

- Greatest potential for impact. Fundamental neurochemical processes are altered, affecting growth, structure, and functioning of the brain.
- Crying, whimpering, screaming, trembling, tantrums, frightened facial expressions.
- Immobility or aimless motion.
- Regressive behaviors, such as thumb sucking, bedwetting, fear of darkness.
Observations: Age 6-11

• Internalizing symptoms: withdrawal, emotional numbing, irrational fears, somatic complaints, depression, anxiety, guilt, inability to pay attention, sleep problems, nightmares.

• Externalizing symptoms: irritability, outbursts of anger, fighting, school refusal.
Observations: Age 12-17

- **Internalizing symptoms**: emotional numbing, flashbacks, nightmares, confusion, depression, withdrawal and isolation, somatic complaints, sleep disturbances, suicidal thoughts, guilt, revenge fantasies.

- **Externalizing symptoms**: substance use, antisocial behavior, aggression, interpersonal conflicts.
More Observations

- Males may withdraw and become depressed, but rarely will acknowledge depression. More likely to use active emergency response, become hyper-aroused.
- Girls may have overly sexualized behaviors and lack of interpersonal boundaries. Internalized symptoms such as dissociation, and the surrender response in the presence of an offending adult.
- The child seems to make the same mistakes over and over, and does not appear to learn from experience.
- Child appears guarded, defensive, and angry.
- Child has great reactivity. Emotional outbursts may have no immediately identifiable antecedent.
More Observations (continued)

• When there is a meltdown, behaviors are offensive and inappropriate, include hurtful comments, sexual comments, threats of harm, and actual physical aggression.
• Slow recovery from outbursts.
• Child tends to hold grudges.
• Child blames others, no insight or remorse
• Dissociative reactions are common
• Extreme attempts to control others
• May appear to be manipulative, but actually is not
• Self-stimulation as a form of self-soothing
Neurological Effects

• Trauma changes our biology, including brain development. This can result in very well-developed emergency response systems in the brain, at a cost to the executive functions of our brain that enhance learning and self-regulation.

• Traumatized children can also demonstrate
  – Movement and sensation issues
  – Hypersensitivity to physical contact
  – Insensitivity to pain
  – Coordination and balance challenges
  – Unexplained medical/physical symptoms
Brain Development

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Brain Development—Cognition

- Difficulty learning and processing verbal information
- Difficulty using language to communicate
- Difficulty organizing and retrieving information
- Difficulty understanding cause and effect
- Difficulty focusing on and completing tasks
- Disrupted orientation in time and space
- Poor problem-solving skills
- Difficulty planning and anticipating
Trauma and Behavior

“It must be realized that every behavior has an anatomy.”
– Norman Geschwind

- The behavior of traumatized children is an insight into the responses of their brain-body system. Behavior represents a complex interplay of past experiences, reactions to the present, and the cumulative impact of relational exchanges over time. Australian Childhood Foundation, 2010

1. Child is startled by event or Trigger
2. Child subcortical right hemisphere enacts response
3. Behavior provokes a reaction in others
4. This reaction is perceived as an additional threat
5. Child is in a state of heightened arousal/stress
Trauma and Behavior (continued)

1. **Child startled by event/trigger:** the lack of explicit, logical memory means the child does not know what started the trigger behavior.

2. **Subcortical right hemisphere (processing emotions, feelings, intuition) enacts response:** child’s developing brain imprints the emotions felt at the core of the trauma, as well as the defense used against it.

3. **Behavior provokes a reaction in others:** Children’s behavior pushes adults’ buttons.

4. **This reaction perceived as additional threat:** Child is still in their right hemisphere and so is not using their cortex to read or interpret adult response. Primed to perceive ongoing threat.

5. **State of heightened arousal and stress:** most likely the defense state they used at the time of the initial trauma.
Social Development

• Recurring trauma associated with abuse and neglect increases the circulation of cortisol and its levels within the brain. These elevated levels kill neurons in the critical regions of the brain. Because of the loss of neurons, traumatized children develop problems with emotional regulation, impulsivity, logical thinking, and social behavior (Putnam, 2006).

• Social Development can be exhibited by problems with:
  – Boundaries
  – Trust/Distrust
  – Paranoia
  – Social Isolation
  – Understanding/identifying feelings of self
  – Difficulty with empathizing with others
  – Coping skills
Mental Health

• Depression and/or anxiety
• Drug and alcohol abuse
• Self-harm
Strengths of Traumatized Children

- They are very aware of how they are treated
- Typically responsive to respectful adults
- Recognize sincerity, easily distinguish insincerity
- Concerned about concepts of fairness and justice
- They are capable of great loyalty
- Actively seek personal control and mastery
- Possess strong survival skills
- They may be open to change, so long as they are offered an option that does not threaten their safety or subject them to humiliation
Assessment of Trauma

• Children who have experienced trauma may be diagnosed with a range of disorders and treated with multiple medications and therapies that are ultimately ineffective because the underlying need is not being addressed and these treatments do not reflect a trauma-informed approach.

» NCTSN

• In addition to assessment in the Emergency Room, Provider’s Office, School, or Family Therapist, there are other tools to assist in assessment of trauma:
  – Adverse Childhood Experiences (ACE) Study
  – Child and Adolescent Needs and Strengths (CANS)
Adverse Childhood Experiences (ACE) Study

- Ongoing collaborative research between Centers for Disease Control and Prevention in Atlanta, GA, and Kaiser Permanente in San Diego, CA.
  - Study includes over 17,000 Kaiser patient volunteers participating in routine health screening, and data resulting from their participation (which continues to be analyzed) reveals overwhelming proof of the health, social, and economic risks that result from childhood trauma.

Acestudy.org (Felliti et al, 1998 Centers for Disease Control and Prevention, 2005)
ACE Study (continued)

• Adverse childhood experiences (traumatic experiences) are the most basic cause of health risk behaviors, mortality, disability, and healthcare costs.

• Study found that the more categories of trauma experienced in childhood, the greater the likelihood of experiencing alcohol addiction, heart and liver diseases, depression, obesity, suicide attempts, domestic violence, unintended pregnancies and fetal death, etc. (See ACE Score sheet)
Child and Adolescent Needs and Strengths (CANS-Trauma Module)

• Comprehensive assessment of the factors that impact treatment decisions and outcomes.

• Used by clinicians and DCS Family Case Managers as a screening tool as well as ongoing assessment to decide the intensity of treatment indicated by the number of risk factors.

• 4 Point Scale used to rate all sections
Treatment of Trauma

Clinicians provide therapy, but trauma-informed youth workers also directly support how successfully these treatments are implemented at home and in the community.

- Evidence Based Practices:
  - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
  - Eye Movement Desensitization and Reprocessing (EMDR)
  - Dialectical Behavior Therapy (DBT)
TF-CBT Model

- **Trauma-Focused Cognitive Behavioral Therapy** (TF-CBT) for children is considered one of the best treatments for traumatized children and their non-offending parents. It is typically used with children who have issues due to trauma from physical abuse, sexual abuse, or witnessing domestic violence.

- TF-CBT components (PRACTICE) of therapy are covered over a series of sessions (Rubin, 2012):
  
  - **P** – psychoeducation and parenting skills,
  - **R** – relaxation
  - **A** – affective expression and regulation
  - **C** – cognitive coping and processing
  - **T** – trauma narrative development and process
  - **I** – in vivo gradual exposure
  - **C** – conjoint child-parent sessions
  - **E** – enhancing safety and future development

» Free resources for implementing TF-CBT can be obtained at www.NCTSN.org
EMDR

• **Eye Movement Desensitization and Reprocessing** (EMDR) therapy is a known as an all-inclusive psycho-therapy approach and successful form of treatment of trauma in many best practice models around the world.

• It is conducted through eight phases (Rubin, 2012)
  – client history and treatment planning
  – Preparation
  – Assessment
  – Desensitization
  – Installation
  – body scan
  – Closure
  – re-evaluation
DBT

- **Dialectical Behavior Therapy (DBT)** was originally developed for treatment of Borderline Personality Disorder, but is also effective for individuals with dual diagnoses (mental illnesses and developmental disabilities).
- Treats emotional instability and dysregulation, inability to tolerate distress, and interpersonal difficulties.
- Uses skill-building techniques coupled with mindfulness training (Dykstra, 2003).
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DBT Visual example

- Visual presentation handout for use in DBT skills modules.
- Components are illustrated with different shapes to help make them easier to remember. “Choice” is a main concept taught in this module (Dykstra, 2003).
Trauma-Informed Care

• Trauma-informed care is a “core competency” in working with DCS-involved youth, and other agencies in Indiana have taken the trauma-informed approach as well.

• Trauma-Informed System of Care
  1. Routinely screen for trauma
  2. Use culturally appropriate evidence-based assessment and treatment
  3. Make resources available to children, families, and providers on trauma exposure, its impact, and treatment
  4. Engage in efforts to strengthen resilience and protective factors
  5. Address parent and caregiver trauma and its impact on the family system
  6. Emphasize continuity of care and collaboration across child-service systems
  7. Address, minimize, and treat secondary traumatic stress among employees.
Trauma-Informed Care (continued)

• The provision of trauma informed care is a seminal concept in emerging efforts to address trauma in the lives of children as well as adults. It attempts to understand the connection between presenting symptoms/behaviors, and the individual’s past trauma history.

  – The key question to ask is not “What is wrong with you?”, but instead to ask “What happened to you?” (Wise, 2014).
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Effects of Trauma on Learning

For traumatized children, new experiences and new information carry elements of threat and uncertainty

• Toxic stress causes memory system failure
• Limited attention span and difficulties with concentration
• Can result in difficulties in logic and sequence tasks and/or processing language acquisition and comprehension
  » Australian Childhood Foundation

• Poor school performance
  – Lower GPA
  – Higher rate of school absences
  – Increased drop-out
  – More suspensions and expulsions
  – Decreased reading ability

» NCTSN

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Trauma-Informed Care in Schools

• Research shows that trauma can undermine children’s ability to learn, form relationships, and function appropriately in the classroom.

• Schools must be trauma-informed to ensure a greater understanding and a better school experience for children, young people, parents and staff.

• Trauma-sensitive school environments benefit all children—those with known trauma history, those whose trauma will never be identified, and those who are impacted by their traumatized classmates (Cole, 2009).
Trauma-Informed Care in Schools (continued)

• Children and young people who have experienced trauma face unique challenges in school.
  – Their experiences have left them little space for learning.
  – Constant state of tension and arousal can leave them unable to concentrate, pay attention, retain and recall new information.
  – Their behavior is often challenging in school.
  – They struggle to build positive peer relationships, and education staff can struggle to know how to best support them and make a difference. (Australian Childhood Foundation, 2010)
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Signs of Trauma in School Setting

• Self imposed isolation
• Aggression
• Lack of focus/attention
• Unexplained severe mood changes
• Extreme reaction to physical touch
• Low ability to make and keep friends
• Changes to academic performance
  – Unexplained drop in grades
  – Poor attendance
  – Homework incomplete or not turned in
Psychological and Behavioral Impacts of Trauma

Be aware of sudden changes in behavior as this can be a sign of trauma exposure.

- **Preschool Children**: clinginess, regression in previously mastered stages of development or lack of developmental progress, over- or under-reacting to physical contact, recreating the traumatic event.
- **Elementary School Students**: anxiety about safety, nightmares or disturbing memories during the day, hyperarousal, avoidance, emotional numbing.
- **Middle School Students**: worry about recurrence of trauma, increased somatic complaints, discomfort with feelings, repeated discussion of event and focus on specific details.
- **High School Students**: withdrawal from others or activities, angry outbursts and increased difficulty with authority, absenteeism, increased risk for substance abuse, negative impact on issues of trust and perceptions of others.
Manifestations of Trauma in the School Setting

• Children may repeatedly talk about, “play” out, or draw the traumatic event which can be shocking to other children or caregivers and teachers, but be aware that this a common symptom of trauma.
  
  – Ex: a sexually traumatized child may self-stimulate, or a child exposed to community or domestic violence may create drawings of violent scenarios.
  
  – Ex: Traumatized children may “over-share” and lack social boundaries—sharing with other students exactly what has happened to them.
SPACE Principals of Trauma-Informed Practice in Schools

• Research into the neurobiology of trauma suggests that when children are experiencing symptoms of trauma, the most complex functions of the brain are switched off.

• Acronym SPACE represents 5 key dimensions that can be incorporated into strategies for schools to respond to the needs of traumatized children.

(Australian Childhood Foundation, 2010)
SPACE

• **Staged**—Brain development is sequential, so instructional strategies should follow a staged pattern of conceptualization and implementation.

• **Predictable**—Strategies which promote stability and familiarity reduce the need for the stress system to engage. Children can then tolerate small degrees of change in their environment.

• **Adaptive**—instead of focusing on discipline and behavior management and excluding these children from activities, strategies should promote adaptability and multiple options for intervention.

• **Connected**—trauma results in distorted or confusing internal maps to navigate appropriate relationships. Strategies should emphasize relationships with safe, consistent adults and peers. Connected children are calmer and more able to learn.

• **Enabled**—Traumatized children have difficulty understanding themselves, and feel a disconnect between their past, present and future. Strategies for responding to these children will enable and empower them to realize their qualities, attributes and talents.
The Nurtured Heart Approach

• A relationship-focused methodology founded on “The 3 Stands” for helping children build their inner wealth and use their intensity in successful ways. Core methodologies originally developed for working with the most difficult children but has a proven impact on every child, including those challenged behaviorally, socially and academically (Glasser, 2008).
The Nurtured Heart Approach (continued)

Core Methodologies: The 3 Stands

• Stand One: Absolutely No!
  I refuse to energize negative behavior.

• Stand Two: Absolutely Yes!
  I will relentlessly energize the positive.

• Stand Three: Absolute Clarity!
  I will maintain total clarity about rules that demonstrate fair and consistent boundaries.
The Nurtured Heart Approach from a Teacher

_The Teacher_ by Haim Ginott

I’ve come to the frightening conclusion that I am the decisive element in the classroom.

It’s my personal approach that creates the climate.

It’s my daily mood that makes the weather.

As a teacher, I posses a tremendous power to make a child’s life miserable or joyous.

I can be a tool of torture or an instrument of inspiration.

I can humiliate or humor, hurt or heal.

In all situations it is my response that decides whether a crisis will be escalated or de-escalated and a child humanized or dehumanized.

» Children’s Success Foundation
Secondary Traumatic Stress

“...We are stewards not just of those who allow us into their lives but of our own capacity to be helpful.”

– Trauma Stewardship

• **Secondary traumatic stress** (STS) can result from empathetic engagement with children and families who have been traumatized.

• It is “the stress resulting from helping or wanting to help a traumatized or suffering person” (Secondary Trauma, 2010).

  – Anyone who works directly with traumatized children and adolescents is vulnerable to the effects of trauma (NCTSN).
**STS and Related Conditions**

**Secondary Traumatic Stress and Related Conditions: Sorting One from Another**

**Secondary Traumatic Stress** refers to the presence of PTSD symptoms caused by at least one indirect exposure to traumatic material. Several other terms capture elements of this definition but are not all interchangeable with it.

**Compassion fatigue**, a less stigmatizing way to describe secondary traumatic stress, has been used interchangeably with the term.

**Vicarious trauma** refers to changes in the inner experience of the therapist resulting from empathic engagement with a traumatized client. It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes that occur following cumulative exposure to another person’s traumatic material.

**Compassion satisfaction** refers to the positive feelings derived from competent performance as a trauma professional. It is characterized by positive relationships with colleagues, and the conviction that one’s work makes a meaningful contribution to clients and society.

**Burnout** is characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops as a result of general occupational stress; the term is not used to describe the effects of indirect trauma exposure specifically.
Symptoms of STS

• Symptoms mimic those of PTSD. Those affected may find themselves re-experiencing personal trauma or notice an increase in arousal and avoidance reactions related to the indirect trauma exposure. They may also experience:
  – Intrusive thoughts
  – Emotional exhaustion
  – Chronic fatigue
  – Physical illness
  – Sadness/Hopelessness
  – Poor concentration
  – Altered self-efficacy
  – Detachment
  – Fearfulness
  – Shame or Guilt
  – Hypervigilance

  » Conrad, 2010
Self Care for Youth Workers

• Be aware that STS is often an occupational hazard—it is the cost of caring—and it is not weakness or incompetence.
• Seek help for personal trauma, as those with their own trauma histories are at a higher risk of STS
• If symptoms persist, seek counseling with a professional who is trauma-informed.
• Avoid the tendency to allow work to be the sole source of personal identity. Maintain perspective by:
  – Drinking well
  – Exercising
  – Engaging in fun activities
  – Taking a break during the workday
  – Finding time to self-reflect
  – Avoiding tendency to bury feelings with substances or other excessive activities

» NCTSN

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Protecting Against STS

• Factors that protect against the development of secondary traumatic stress are
  – longer duration of professional experience
  – the use of evidence-based practices in providing care for traumatized children
  – developing the capacity to translate trauma-related knowledge into direct services, programs, policies and procedures, staff development and training, and other activities.
Project—Learning Centers

• Create resources for your trauma-sensitive classroom/office
Resources

• National Child Traumatic Stress Network [www.nctsnet.org](http://www.nctsnet.org)
• The Adverse Childhood Experiences Study (ACE) [www.acestudy.org](http://www.acestudy.org)
• Child Trauma Toolkit for Educators (NCTSN)
• “Optimizing Learning Environments for Traumatized Children: How Abused Children Learn Best in School” by Dave Siegler, Ph.D.
• *Transforming the Difficult Child: The Nurtured Heart Approach* by Howard Glasser and Jennifer Easley [www.difficultchild.com](http://www.difficultchild.com)
• *Making Space for Learning: Trauma Informed Practice in Schools* by the Australian Childhood Foundation
• *Helping Traumatized Children Learn* (Massachusetts Advocates for Children)
• Effects of Traumatic Events on Children from the ChildTrauma Academy [www.childtrauma.org](http://www.childtrauma.org)
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