

10 Steps to Create a Trauma-Informed School



Caelan Soma, PsyD, LMSW
Derek Allen, MA



©2019 Starr Commonwealth
The unauthorized reproduction or distribution
of this copyrighted work is illegal.



13725 Starr Commonwealth Rd., Albion, MI 49224
800.837.5591 | info@starr.org | www.starr.org

Starr Commonwealth is a nonprofit organization serving children and families regardless of race, religion, color, national origin, or sexuality. Starr Commonwealth is accredited by the Council on Accreditation. Founded in 1913, Starr Commonwealth is licensed by the state of Michigan. Starr Commonwealth's Albion campus is a Michigan Historic Site. Starr Commonwealth receives funds from social agencies, foundations, corporations, and individuals.



Table of Contents

Introduction	A
Step 1	1
Provide School-Wide Childhood Trauma Awareness and Understanding of How Trauma Impacts Children’s Learning and Behavior	
Step 2	19
View Trauma as an Experience Rather than an Incident or a Diagnostic Category	

Learn Steps 3-10 at Starr.org/10steps

Conclusion	35
Resources	36
References	38

About the Authors



Dr. Caelan Soma, PsyD, LMSW, Starr Chief Clinical Officer, provides trauma assessment and short-term trauma intervention for students utilizing trauma-informed and evidence-based practices, including Starr's SITCAP® model.

Dr. Soma has been involved in helping with the aftermath of disasters such as Sandy Hook, Hurricanes Katrina and Rita, 9/11 and more. She has authored several books, the most recent titled *Working with Grieving and Traumatized Children and Adolescents*.

She is an internationally acclaimed speaker and trainer, and is the instructor for many Starr courses, including *Children of Trauma and Resilience and Structured Sensory Interventions II*. She received her doctorate in clinical psychology at California Southern University, where she also received the 2013 CalSouthern President's Award.



Derek Allen, MA, CTP-E, Starr's Chief Clinical Officer, trains professionals throughout North America in use of the Circle of Courage model, leads adults through complex discussions related to diversity and racial healing, and provides practical, evidence-based training in trauma-informed care. He also provides "thought-leadership" to the Starr Commonwealth organization in the areas of strength-based approaches in education and treatment and building resilience in children and families.

Derek is currently pursuing a doctoral degree from The Chicago School of Professional Psychology.

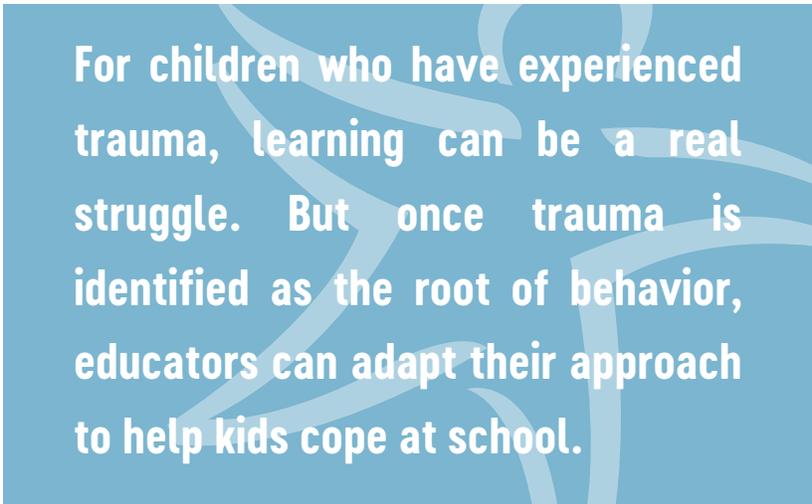
Starr Professional Training and Coaching

The Starr Professional Training and Coaching emerges from the vision that: knowledge + empowerment = impact.

Starr provides guidance and expertise to educators, clinicians, and many others who care for children from around the world in the form of research, publications, e-learning courses, in-person trainings, conferences and events, professional certifications, as well as school/organization-wide accreditation. These products and services have been developed through our three key legacy training programs: The National Institute for Trauma and Loss in Children (TLC), Reclaiming Youth International (RYI), and Glasswing (GW).

Introduction

This resource provides all school professionals with an understanding of childhood trauma and how it impacts learning and behavior. Included are 10 concrete steps to guide both the creation and implementation of a trauma-informed school. Actual scenarios, expert answers to tough questions from real teachers, and practical activity worksheets bring *10 Steps to Creating Trauma-informed Schools* to life.



For children who have experienced trauma, learning can be a real struggle. But once trauma is identified as the root of behavior, educators can adapt their approach to help kids cope at school.

Childhood trauma refers to any experience in a child's life between the ages of 0-17 that leaves them feeling hopeless, helpless and stuck, or fearing for their life, safety or survival - or for the life, safety or survival of a loved one. Examples include neglect, physical and sexual abuse, domestic violence, natural disasters, incarceration of a loved one, accidents and war. Childhood trauma also comes in the form of toxic stress experiences like homelessness, chronic bullying, living with parents, caregivers or siblings who have mental and physical health challenges or are struggling with addiction.

SAMHSA's (2014) concept of trauma is defined as follows:

Individual trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threaten-

ing and having lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being (p. 7, 2014).

The definition is expanded upon through the use of the three “E’s” of trauma: event, experience, and effect.

The Event

The event may be a single occurrence or be repeated over time and may include actual or extreme threat of harm. While there are many events that may be potentially traumatizing, we can't assume that exposure to them leads to post-traumatic stress symptoms and reactions. There are children exposed to similar events who will respond very differently from one another. Why is this? The answer is in the experience.

The Experience

It is the experience or perception of the event by the child that determines whether it is a traumatic event – to them. For example, we may view parent incarceration as a potentially traumatizing event. However, if the child of that parent experiences this event as one that provides them with relief, it is not then traumatic.

CASE EXAMPLE: Megan

Megan was referred when she was in 4th grade by her school principal who found out that Megan's father was recently incarcerated. Megan was having difficulty paying attention in class and seemed to be withdrawing from her peers. Upon meeting Megan, she was asked to tell a little bit about herself. She readily explained that she just moved in with her grandfather because her father was “locked up.” She went on

quickly to say, “I am so happy my Daddy is in jail – now we don’t have to worry about him getting killed on the streets by the other gang.” Later, during the sessions, it was learned that Megan’s grandfather suffered from diabetes and had recently started dialysis. When asked about her biggest worry she said, “If my grand-daddy dies, my mom and I will be homeless.”

This example shows us how adults may assume that a specific event is traumatic when in fact an alternate experience is causing a stress response. We can’t assume that certain events are traumatic until we understand how a child experiences that event.

The Effect

The experience then influences the effect of the event, over the short to long term. When a child has a prolonged and exaggerated stress response to the experience of any event, that is when we will observe post-traumatic stress symptoms and reactions.

While specific events are important to identify, we must not forget how those events are experienced. In many cases there is not just one thing that has happened but a constant experience of stress related to multiple exposures. It is often the day-to-day traumatic experiences impacting so many children that are forgotten, as attention is drawn to more critical events that receive the attention of adults and even gain media coverage. Chronic experiences such as living at or below the poverty line aren’t specific events but rather ongoing circumstances. An estimated 15.7 million children lived in poverty in the United States in 2015. Approximately 5.9 million of those children were under the age of 6. Research has clearly demonstrated that living in poverty has a wide range of negative effects on the physical and mental health of children. Poverty is a traumatic experience – it includes hunger, lack of adequate medical treatment, worry and a multitude of other stressors.



1 out of every 4 children attending school has been exposed to traumatic stress



14% of children have experienced abuse by a caregiver



Over 1/3 of students have been bullied in school

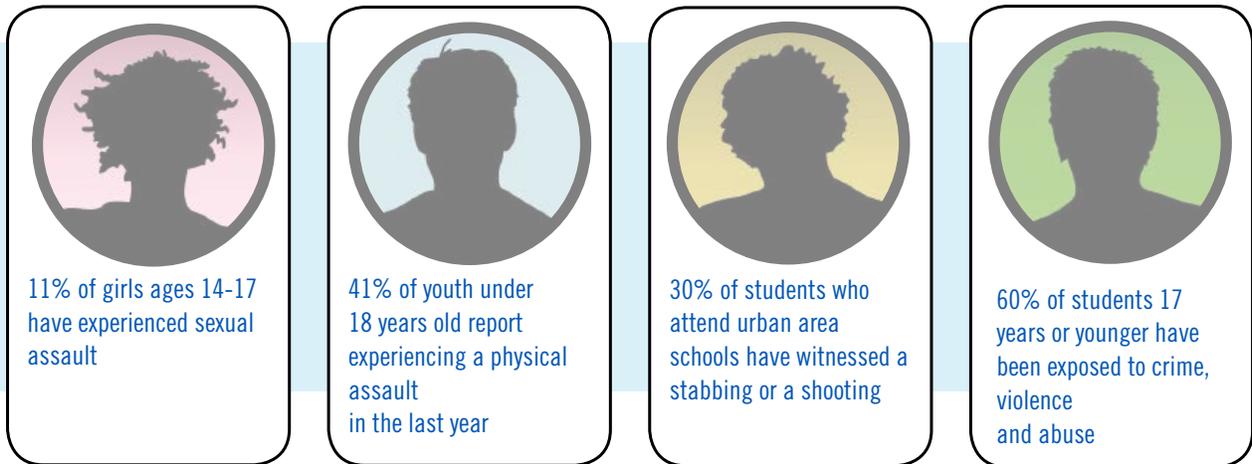


70% of children living in inner city neighborhoods are exposed to chronic toxic stress

Trauma isn't always associated with violence. Divorce, a move, chronic worry and health issues can all cause exaggerated and prolonged stress.

Traumatic events and toxic stress experiences negatively impact children and lead to changes in how they feel, behave, learn, interact with others and view themselves. How students perceive their stress and trauma is essential to understand as we implement the steps to creating a trauma-informed school.

Schools represent an opportune system for prevention and early intervention across multiple domains related to positive childhood outcomes. As the prevalence and impact of trauma and traumatic stress become increasingly understood, the push for schools to become trauma-informed has also increased (SAMHSA, 2014). The National Center for Traumatic Stress Network (NCTSN) has issued a call to action for schools to play a key role in addressing the needs of traumatized children. Because such a large number of students are impacted by trauma, school professionals are



acutely aware of the challenges students face as a result of toxic stress and traumatic experiences. The creation of trauma-informed schools must be a priority to support children’s social, academic and emotional development.

Since 1990, Starr Commonwealth has worked with thousands of professionals in both school and clinical settings who have taught us what matters most when working with stressed and traumatized children. This resource provides a comprehensive discussion along with action steps to implement with individuals throughout the school system to most effectively answer NCTSN’s call to action.

It is well documented that trauma can interfere with brain development, learning and behavior – all of which have a negative impact on a child’s school success. By understanding the impact of trauma, educators can respond to youth in ways that reduce and even interrupt trauma’s impact, support learning and create positive school opportunities where students can thrive.

When school professionals see students through a “trauma lens” and recognize the impact of trauma – hidden risk factors, the role of fear in behaviors and the unique physical needs of their students – they are able to approach students in ways that improve their ability to learn and connect with others. At the heart of trauma-informed approaches in the school setting is the belief that student actions are the direct result of their experiences, and when students act out or disengage, the question we should ask is not, “what is wrong with you,” but rather, “what has happened or what is happening to you?” By being informed about students’ current and past experiences, educators can promote school engagement and success.



Research indicates the following outcomes when schools are trauma-informed (Chafouleas et al, 2016):



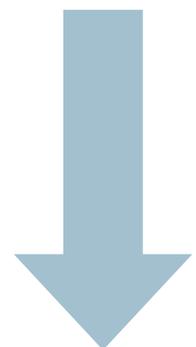
Improved

- Academic achievement and test scores
- School climate
- Teacher sense of satisfaction and retention
- Graduation rates
- Community and family collaboration with school



Reduced

- Student behavioral outbursts and referrals
- Stress for staff and students
- Absences, detentions and suspensions
- Student bullying, harassment and fights
- Need for special education, services and classes
- Drop-out rates



10 Steps to Create a Trauma-Informed School

1. Provide school-wide childhood trauma awareness and understanding of how trauma impacts children’s learning and behavior
2. View trauma as an experience rather than an incident or a diagnostic category

LEARN STEPS 3-10 at [Starr.org/10steps](https://www.starr.org/10steps)

About This Book

This resource is divided into 10 steps for school professionals to follow as they work towards the creation of trauma-informed schools and classrooms. The steps start by sharing a description of how trauma impacts children and their school experience. From there, each step provides detailed information and concrete actions that answer not just the “why” but also the “how” to create the best classroom and school supports for traumatized students and the school professionals who serve them.

The steps create a blueprint for trauma-informed school implementation and success. It is impossible to select which one of the ten steps is most important. As you explore each of them, you will learn that parts of each step overlap. The steps are not linear or sequential, but instead they fit together like puzzle pieces. While creating a trauma-informed school requires patience, with each small implementation you will see how each step complements another and you will experience significant benefits in the overall school climate. You may even see that parts of a step or even an entire step may already be in place in your classroom or school. If that is the case, celebrate and move on to the next step!

Q How can I support a high school student whose mother has terminal cancer and is in hospice care? What is the right thing to say to him? How can I accommodate him?

Your student is lucky to have a compassionate teacher who wants to say the right thing. You can let the student know you understand his mom is sick and you are available to talk. Ask if there is someone to support him at home. Sometimes all the focus shifts to the sick person, but others in the family suffer. Pay attention to changes in academics or behavior and make accommodations if needed.



STEP 1

Provide School-Wide Childhood Trauma Awareness and Understanding of How Trauma Impacts Children’s Learning and Behavior

Every person who works in a school setting should have knowledge about childhood trauma and the impact it has on learning and behavior. Trauma-informed professionals view others from a place of curiosity and are always wondering “What has happened or what is currently happening in a person’s life that is impacting how they think, behave and interact with others?” Instead of focusing on behavior as a problem or diagnosis, understanding trauma encourages the exploration of what might be driving behavior, providing a better understanding of what that person needs most. In the school setting, trauma-informed professionals don’t only view students in this way, but approach all staff, parents, and volunteers with curiosity.

CASE EXAMPLE: Ed

A third grade teacher was teaching a lesson on conjugating verbs into the past tense. Each student was expected to come to the front of the class and make the necessary changes to their assigned word. One student, seated in the back of the classroom, was assigned a word that needed “-ed” added to the end of it in order for it to be conjugated

properly. When it was his turn to approach the board and write these two letters next to the word he froze and refused to come forward. After some coaxing from his teacher and stares from the rest of the class, he walked to the board and picked up a marker. Just as he was about to write, he started yelling, crying, and flipped over a nearby table. The teacher immediately removed the rest of the students from the classroom and an administrator came down to the room to calm the student down.

What would be learned later is that the name of the man molesting the young boy was Ed.

Educators who witness outbursts like this often jump to attaching labels to the behavior and ultimately the student: aggressive, violent, emotionally-disturbed, oppositional and defiant. To them, the behavior does not make sense and is irrational. Therefore, it must be controlled, extinguished, medicated or punished. As one can see in the “Ed” example though, the behavior made more sense than anyone expected. In that young man’s brain an alarm was sounding; “ed” meant danger. The first warning sign of this was his “frozen” state in the back of the room. However, once pressured to come forward his brain selected a “fight” response. Obviously, this teacher had no way of knowing in the moment why her student was reacting the way he was, but trauma sensitivity doesn’t require that we know who is traumatized or in what way they were traumatized. Instead, it is how we react to behavior that matters most. Thankfully, somewhere along the way in this case someone asked the right questions to find out the truth, but how often does that fail to happen? How often do we label and punish these kids, focusing on what’s wrong with them rather than what they are experiencing and what has happened to them?

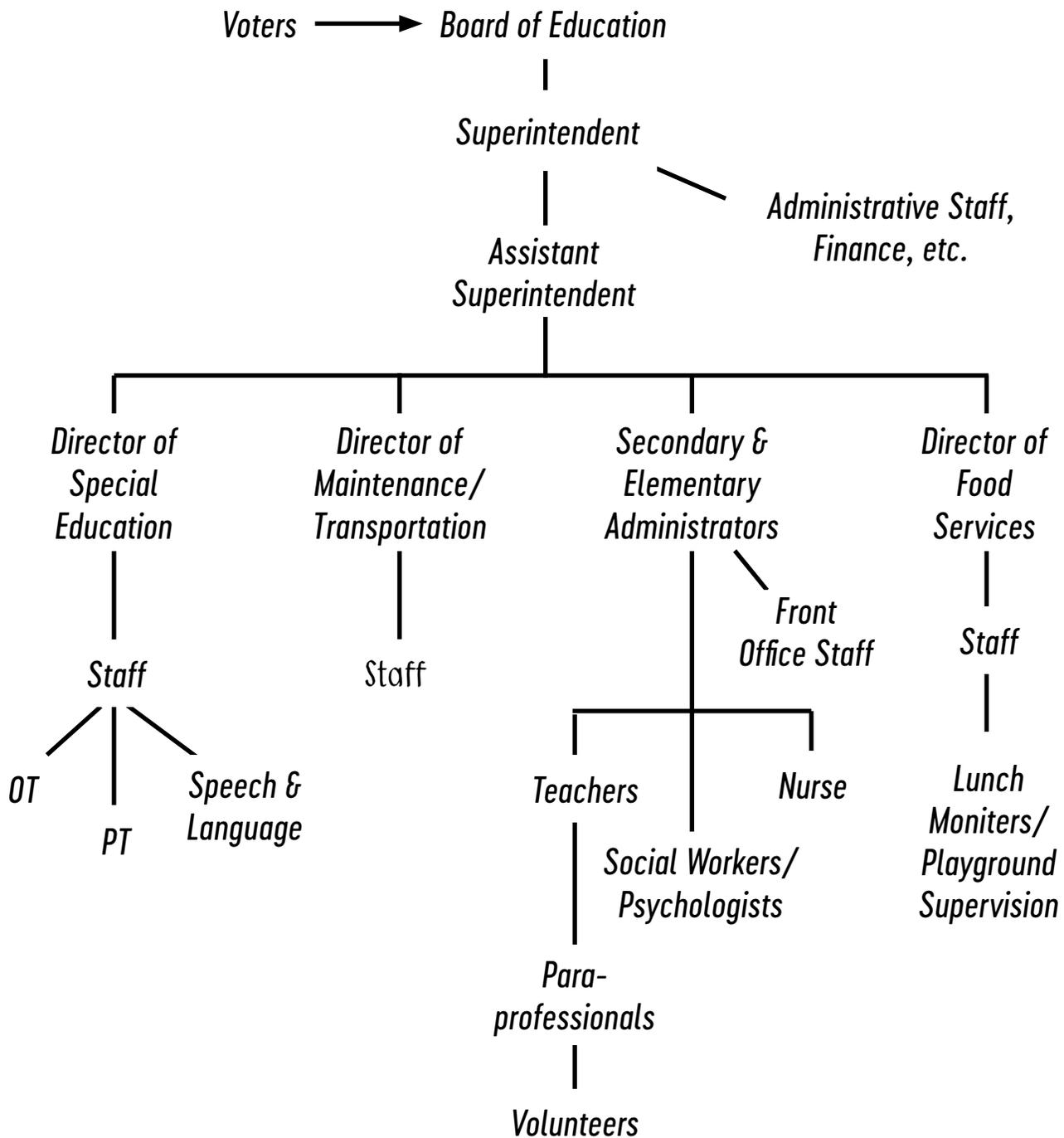
Contrary to what many school professionals think, you do not have to be a school social worker, counselor or psychologist to provide trauma-informed care and practice. Any person, regardless of

their own background and role in the school setting, can help students thrive academically, behaviorally, socially and emotionally when they understand how stress and trauma impact students. Many educators have concerns about becoming trauma-informed. Some fear any involvement with their students' traumatic and stressful experiences. Others feel overwhelmed with the demands of curriculum and behavior management and worry about adding another responsibility to their workloads. Others, upon hearing the word "trauma," immediately imagine something far too painful to witness. These responses are common and they are normal. Trauma is terrorizing not just for the victims but also for those who witness events and hear about the experiences. These feelings must be acknowledged and then followed with a discussion about what being trauma-informed really means.

It may come as a pleasant surprise for school professionals that being trauma-informed and providing trauma-informed care doesn't require knowing the details of a child's traumatic experience(s). Trauma-informed care doesn't dictate that traumatic experiences have to be discussed or processed. Instead, being trauma-informed means that professionals learn how to view all students through a curious lens that helps them explore how students view themselves, others and the world around them as a result of their unique experiences. With this knowledge, school professionals can create a school climate that provides traumatized children with what they need most to best develop. Providing students with opportunities to experience safety, consistency, understanding, connections and support is the true definition of being trauma-informed. Every person in every position who makes a decision that impacts students or who works directly or indirectly with children in a school system needs to learn about childhood trauma.

A generic school district organizational chart is located on the next page. As you implement step 1, find your own school or district organizational chart. This can be used to identify each person, group or department who will need to receive training about childhood trauma.

Who Needs to Receive Childhood Trauma Training?



You don't need to know exactly what caused or is causing the trauma to help. Instead of focusing on the specifics of a traumatic experience, educators can support children by concentrating on a student's worry, hurt or anger. You don't have to dig deep to be able to effectively respond with flexibility and empathy.

Understanding Trauma

Acute Trauma

A single time limited event. i.e. witness an accident, medical or dental procedure, death, move.

Acute Stress

Normal response to stress and trauma that lasts for 4-6 weeks.

Chronic Trauma

Multiple traumatic exposures and/or events over extended periods of time i.e. bullying, domestic violence.

Toxic Stress

Adverse experiences that lead to strong, frequent, or prolonged activation of the body's stress response system in the absence of the buffering protection of a supportive adult relationship* i.e. neglect, abuse, poverty, homeless-ness, community violence, war.

Post-Traumatic Stress

(Chronic Trauma and Toxic Stress)

This is also a normal response to stress and trauma, but because it is prolonged and exaggerated and lasts much longer than acute stress, the result is significant dysregulation of a person's central nervous system.

Trauma activates the body's stress response system, and when this happens heart rate, respiration, muscle tension and blood flow increases because of the body's cortisol and adrenalin surge.

When this activation, which is only meant to be short term, is prolonged, there is a compromise to the functions of the brain.

*Shonkoff et al, 2012

Exposure & Experiences

Children and adolescents are in a constant state of development and their life experiences can influence their physical and emotional growth in both positive and negative ways. Physiological changes to developing brains and their emotional and behavioral responses to trauma have the potential to significantly interfere with their school life. While brain development occurs mostly during the first years of life and then again during adolescence, the brain develops well into early adulthood (Anderson & Teicher, 2008). This means that early traumatic experiences as well as those happening during adolescence can profoundly impact and limit brain development in negative ways. The impact can result in the loss of cognitive function; physical, emotional and social delays; and problems with memory and problem solving, all of which undermine learning and compromise a child's school experience.

Spectrum of Trauma

Traumatic experiences change the structure and functioning of a child's brain when the activation of the stress response system is long lasting. When exposed to a stressor, everyone's body responds through either one or more fight, flight or freeze responses. When this happens, activated systems throughout the body release stress hormones that are designed to be protective for survival. However, these responses are supposed to be short term. When exaggerated and prolonged, rather than protective responses, they become dangerous to the brain and lead to negative implications for brain development and social functioning.

The American Academy of Pediatrics (AAP) warns that extended exposure to toxic stress can lead to functional changes in several regions of the brain involved in learning and behavior, including the amygdala, hippocampus, and prefrontal cortex (Shonkoff et al, 2012). Neuroimaging techniques show that brain regions actually reduce in size as a result of childhood maltreatment. This clearly indicates the brain structure and chemistry is affected for students who are stressed, anxious or insecure. A study conducted with at-risk children during the summer months and then again during the early weeks of school showed a dramatic 53% increase when school started in the stress chemical adrenalin, which activates our bodies. In addition, there was a 13% decrease

at the start of the school year compared with the summer months in brain chemicals that have a calming effect. These shifts were associated with an increase in anxiety, withdrawal, thinking and learning problems during the initial weeks of school. This type of stress reactivity is all too common in children with histories of trauma and exposure to chronic stress and results in academic, behavioral and relational challenges (Call, Purvis, Parris & Cross, 2014).

Changes in the brain are the reason why there is a significant correlation between trauma and low academic achievement. Children who have experienced trauma often find it more difficult than their peers to pay attention, process and recall new information heard during classroom instruction. In a sample of high-risk children who were exposed to more than four negative childhood experiences, all were more likely to have learning and behavior problems than their peers without adverse experiences. Other studies show children exposed to violence score lower on IQ and reading ability tests than their peers. Maltreated children are more likely than their peers to be retained in a grade, miss school, and be placed in special education classes. Children with more exposure to violence also have lower grade point averages than children with less exposure to violence (Center on the Developing Child at Harvard University, 2007).

Stress and trauma impact learning because of the effects on the functions of the brain. Let's take a closer look at the primary functions of the brain impacted by trauma.

Functions of the Brain

Brain Stem Functions

The brain stem is responsible for body functions that are involuntary and automatic, such as the regulation of breathing, heart rate and body temperature. The important thing to remember about the brain stem is that it works without us thinking about it. When we are exposed to intense stress or trauma, the brain stem is activated. This is the part of the brain that is responsible for the fight, flight and freeze survival responses that happen during stress and trauma.

Imagine what happens in your own body during intense fear or stress. Think about how your body

responds. Does your heart start to beat faster? Does your breathing become more rapid or shallow? Do you get hot or sweaty? Do your muscles become tense? The answer to each question is “yes”. These reactions happen because your brain stem becomes activated when you are faced with something that requires your attention and survival. All of the responses are automatic and occur without thought or intention.

The brain stem is the deepest part of the brain and sits at the top of our spinal cord. Keep in mind that the brain stem is intimately connected with the sensory part of our brain. You will see how the brain stem activates certain responses in our bodies depending upon our sensory experiences. Let’s discuss that now.

Sensory Brain Functions

This part of the brain is responsible for many things, but the main functions to highlight here are related to sensation, self-regulation and memory. As mentioned, the parts of the brain responsible for these functions are located in close proximity to the brain stem. The brain stem plays a key role with sensory brain functions and regulation of emotions and behavior. When exposed to stress, trauma, or body memories prompted by things we see, smell, hear or feel, our brain stem will either activate or remain calm. For example, when we smell or taste sour milk, our body responds. When we touch a hot pan, our body responds. When we hear a loud noise, our body responds. Almost immediately, we respond to sensory inputs, especially those that make us suspicious about our safety or the safety of others. If something doesn’t look, smell, taste or feel right, we experience a body response alerting us to the potential harm. Overall, these negative experiences or memories of them make us dysregulated (our brain stem will make our heart beat faster and our breathing shallower). In comparison, when we smell something soothing like lavender or smell something such as homemade cookies that reminds us of a good time in our life, we feel calm and content because our brain stem is not triggered to activate or engage in a survival response.

Senses

Identification of sensations is one of the main functions of the deep, sensory part of the brain. At birth, the brain functions responsible for sensation are working. While our senses become more refined as we develop, it is interesting to know and remember that they are all functioning imme-

diately at birth and are responsible for how we experience ourselves, others and the environment around us.

An infant can see. Visual acuity improves as the infant develops, but an infant can see contrasting patterns and shapes, especially the facial features of a caregiver. An infant can hear. We know that infants startle when they hear loud noises and calm to the sound of a caregiver's voice. An infant can taste. This is why infant formula is created to resemble the taste of sweet, fatty breast milk. An infant can smell. In fact, there have been studies that show infants can pick out the scent of their mother from several other mothers. Infants can feel senses of touch. We know what happens when their diapers are wet or when they receive one of their first immunizations – they cry! Disruption of any one of an infant's sensations creates stress and activates their brain stem and, as a result, an infant's heart rate, respiration and muscle tension will increase. This is visible when an infant is crying or when a toddler is having a tantrum. Sensations are disrupted, there is stress, the brain stem is activated, and we see dysregulation.

While these examples are related to infants, keep in mind everyone becomes dysregulated to some extent when their senses are disrupted. Imagine what happens in your body when you hear a loud noise, smell smoke, taste spoiled milk or feel a needle on your skin. You startle, pupils dilate – your body reacts, your brain stem is activated, it causes some degree of stress and without even thinking about it, you respond. You become acutely attuned to the sensations and you will often try to get away from the situation (flight), fight it off, or stay very still (freeze) in the first moments after you experience the sensation.

Self-Regulation

When one of our senses is activated, we have either a pleasant or an unpleasant experience. For example, if an infant can't see their primary caregiver, if their diaper is wet or if they are hungry, they become dysregulated. If they are fed, warm and dry, then they are likely to be content. Imagine for a minute how a parent or caregiver responds when they are with an infant who is crying. Likely, through another sensory input like holding, rocking or singing softly, we try to calm down the reaction of the stress system (activated by the brain stem) that exposure to that sensation has caused. This is accomplished by engaging in an activity that helps reduce the over-activation of the

brain stem. Rocking actually helps to rest the heart rate to the optimal 60-80 beats per minute and is why it is such a successful activity for children who are upset, and for adults who enjoy rocking on their porch swing for relaxation.

Senses ↔ Affect/Stress Regulation ↔ Memory

Memory

When an infant is picked up, rocked, comforted, changed, fed or burped in response to their dysregulation, they likely calm down. We respond to their dysregulation by trying to reconcile the disruption of their senses. When an infant's needs are met in this way over and over again during the first weeks and months of their life, memories are created. Memories of trust, consistency and an implicit knowing that, "when I signal discomfort, someone is going to help me feel better" are formed. Now imagine for a minute an infant who is crying and dysregulated. This time there is not a parent or caregiver who responds consistently to their needs. For example, the parent or caregiver has mental health challenges, abuses drugs or neglects the infant. In this case, the infant isn't re-regulated with the help of a caregiving relationship, or maybe sometimes they are attended to and sometimes they aren't. In this case, the infant doesn't create a memory that is rooted in trust. Instead, the memories created are those of distrust, inconsistency and fear.

In a perfect world, there is a beautiful dance going on between the main brain functions driving our sensations, stress-regulation and memory. However, when there is stress or trauma – especially when prolonged – these brain functions become dysregulated and don't work well together because there is disruption of sensations, dysregulation and no memories to draw upon to signal to that person how to help themselves regain a balanced state.

In trauma, the functions of the sensory brain are working overtime.

Symptoms of trauma resulting from the stress impact on the sensory brain:

- Sensory input disruption and overwhelm (sights, sounds, smells)
- Dysregulated central nervous system
- Difficulty managing emotions and behavior
- Hyperactive, jumpy, nervous

In the classroom, when the sensory brain is working overtime, educators see:

- Students easily triggered by what they hear, see or smell
- Reactive students
- Students who can't sit still, stay seated or listen

Thinking Brain Functions

This part of the brain is responsible for many things, but its main functions are language, learning, cognition, problem solving, decision making and impulse control.

Language

The Broca's area of the brain is the part of the brain responsible for language. This part of the brain is compromised during stress and trauma. An example of this is when a person is upset or angry and they can't find the words to speak. Or, when they remember something that happened but they can't find the words to describe what they experienced. This is why children of trauma not only don't want to talk about things that happened, but actually can't – this is why when we ask, "What happened or why did you do that?" we hear responses like "I don't know." Often there aren't even words, only shrugged shoulders or a blank stare. There is little access to words to describe their experience.

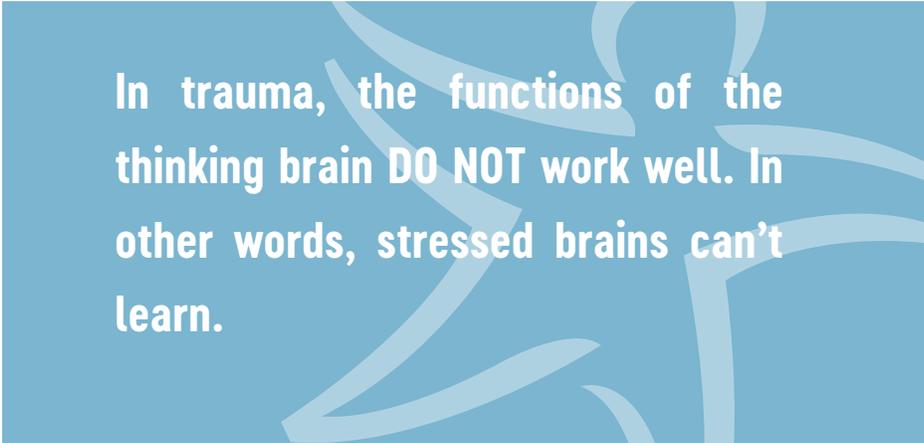
Learning & Cognition

The hippocampus, the part of the brain involved in learning and cognition, is compromised by the stress response. The hippocampus becomes damaged when stress and trauma experiences are prolonged and the damage actually leads to a decrease in the hippocampal volume of this structure.

Not only does this compromise a student's ability to remember what was learned in the past, it makes it difficult for students to learn new information (Saigh & Bremner, 1999).

Problem Solving, Decision Making & Impulse Control

The prefrontal cortex helps us to plan and control impulses, become mentally attuned to others, empathize with them, and provides us with a moral awareness. It also provides us with insight and logic allowing us to problem solve and make decisions. Like the hippocampus, the prefrontal cortex is impacted by stress and may not physically develop to its usual size and be of a smaller volume than average following trauma experiences that are exaggerated or prolonged. This can inhibit the functions to varying degrees.



In trauma, the functions of the thinking brain DO NOT work well. In other words, stressed brains can't learn.

Understand Trauma's Impact

Use the activity on page 15 with staff, parents or students to teach them how trauma impacts the brain.

Screening Students for Toxic Stress and Trauma

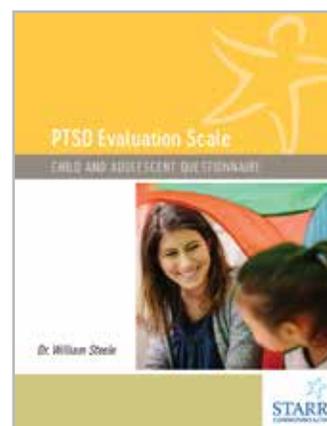
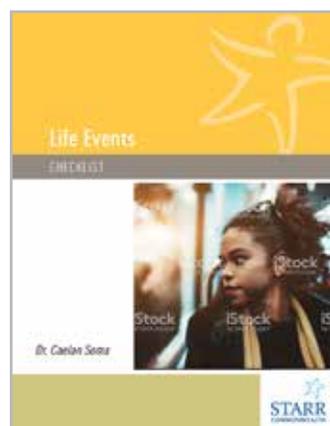
According a survey by The National Child and Traumatic Stress Network, few schools have protocols in place to obtain trauma histories for students. This becomes especially problematic for students who transfer from another school or district. Children often transfer schools because of potentially traumatizing or stressful events such as a change in living situation. By creating a

standardized protocol to assess exposure to potentially traumatizing incidents in the past or present among students, the school can immediately understand how they can best meet a student's unique behavior and learning needs. Starr recommends completing a Life Events Checklist (page 15) for each student in your building.

Starr's Life Events Checklist and PTSD Child and Adolescent Questionnaire

If a child has experienced one of the life events on the checklist, it doesn't mean the student is experiencing trauma. As discussed earlier, perhaps the experience of the event isn't traumatic. The checklist presents life events that may lead to post-traumatic stress when they are experienced by the child as things they have no control over and/or the experience or the response to the experience(s) lasts for longer than 4–6 weeks. This is a good screening tool. If any of the events on the checklist are checked, it is encouraged to explore that incident more in depth for intensity, frequency and/or duration. Then, Starr's PTSD Child and Adolescent Questionnaire (CAQ) can be used as an evaluation tool to explore trauma exposure more in depth.

The CAQ measures the frequency of common post-traumatic stress symptoms and reactions within the four clusters of trauma as indicated by the DSM-5 (APA, 2013), including re-experiencing, avoidance, negative cognitions and mood and arousal. The CAQ will provide a score for each cluster to identify if the child falls within the mild, moderate or severe range for each of the four categories. Just as a wide range of experiences can result in childhood trauma, a child's response to these potentially traumatizing events will vary depending on the characteristics of the child (i.e. age, personality, stage in development, prior trauma history, characteristics of resilience).



Potential Signs and Symptoms That May Indicate Trauma

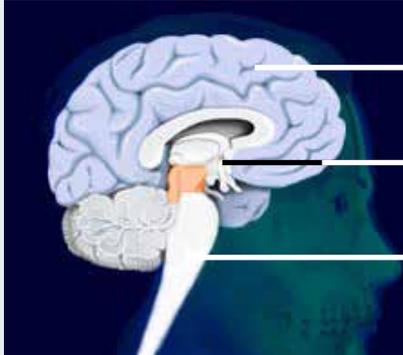


- ↗ Loss of appetite
- ↗ Easily startled
- ↗ Difficulty concentrating or remembering
- ↗ Frequent headaches or stomachaches
- ↗ Constant state of alert
- ↗ Diminished interest in school and activities
- ↗ Inability to experience joy or pleasure
- ↗ Self-blame or shame
- ↗ Feeling of detachment from others
- ↗ Recurrent conflicts with peers
- ↗ Irritability
- ↗ Outbursts of anger
- ↗ Trouble focusing on classwork
- ↗ Acting as if the traumatic event were recurring

Traumatized children may experience both physical and emotional distress. Educators must not assume a child showing signs of trauma will just “get over it”. Being an advocate for the child is vital. Without treatment, the damage done by childhood trauma can last a lifetime – with consequences as serious as a risk of suicide that is 15 times higher than the general population. But, with trauma-informed information and interventions, educators can interrupt this impact. The goal is to help move the children who have experienced trauma from victim thinking to survivor thinking which leads to empowerment, choice, active involvement in their own healing process and a renewed sense of safety and hope. Educators and school professionals are encouraged to learn about how trauma impacts children so that they are able to provide supports and intervention. This will help minimize the learning and behavioral difficulties that can result when the needs of trauma victims go unrecognized or unnoticed.

Understand Trauma's Impact Activity

TRAUMA activates the stress response. When the brain stem is activated, do the following physical symptoms increase (▲) or decrease (▼)? Circle the arrow below that applies.



thinking brain

sensory brain

brain stem

- ▲ Heart rate ▼
- ▲ Respiration ▼
- ▲ Muscle Tension ▼
- ▲ Blood flow ▼
- ▲ Cortisol ▼
- ▲ Adrenalin ▼

When this activation lasts for LESS than four weeks it is called **acute stress**.

When this activation lasts for MORE than four weeks it is called **postraumatic stress**.

When stressed, the Thinking Brain:

WORKS WELL or DOES NOT WORK WELL

Name or describe three symptoms of trauma as a result of the stress impact on the Thinking Brain:

1. _____
2. _____
3. _____

When stressed, the Sensory Brain:

WORKS WELL or WORKS OVERTIME

Name or describe three symptoms of trauma as a result of the stress impact on the Sensory Brain:

1. _____
2. _____
3. _____

Students in trauma often react by engaging in fight, flight, or freeze responses. Describe a student experience for each of the responses in the appropriate boxes below.

FIGHT

FLIGHT

FREEZE

Life Events Checklist

Name _____ Date _____

Instructions: Check all of the following life events that your child/adolescent has experienced. Write any other incidents that are not on the list that might have been traumatic for your child/adolescent.

Home

- Death of a family member
 - Domestic violence
 - Abuse
 - Neglect
 - Separation/divorce
 - Incarceration of a parent or sibling
 - Neighborhood violence
 - Robbery or theft
 - Abuse of drugs/alcohol by parent/guardian/sibling
 - Illness of family member
 - Fight with parent/guardian/sibling
 - Utilities turned off
 - Other:
-

School

- Behavior problem
 - Failing grade
 - Fight/bullying
 - Victim of bullying
 - Use of drugs or alcohol
 - Skipped school or a class
 - Death of a teacher or classmate
 - Illness of a teacher or classmate
 - Conflict with a teacher
 - Conflict with a classmate
 - Other:
-

Personal

- Family treatment
 - Psychotropic medication
 - Illness
 - Cutting/self abuse
 - Use of drugs or alcohol
 - Eating disordered behavior
 - Suicidal ideation
 - Intense sadness
 - Intense hopelessness
 - Intense anger leading to harming someone else
 - Other:
-

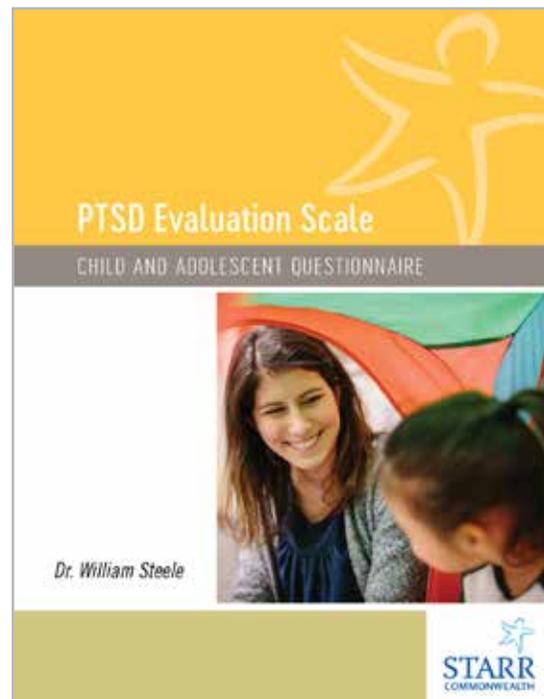
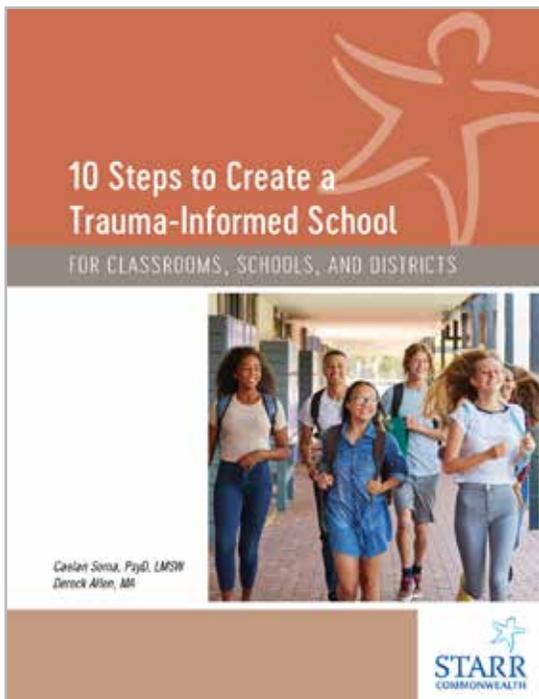
Social

- Argument with friend
 - Use of drugs or alcohol
 - Car accident
 - Witness to fight
 - Witness to violence
 - Trouble making friends
 - Does not get along well with others
 - Other:
-

Life Events Checklist is a screening tool designed to identify potentially traumatizing events that have occurred in a child or adolescent's lifetime. This tool does not diagnosis PTSD, however, it does identify incidents and events a child or adolescent has experienced that may lead to PTSD. Pack of 50 checklists. Available at <https://www.starr.org/store>.

VISIT Starr.org/10steps

**To Purchase 10 STEPS TO CREATE A TRAUMA-INFORMED SCHOOL
which includes the PTSD CHILD AND ADOLESCENT QUESTIONNAIRE**



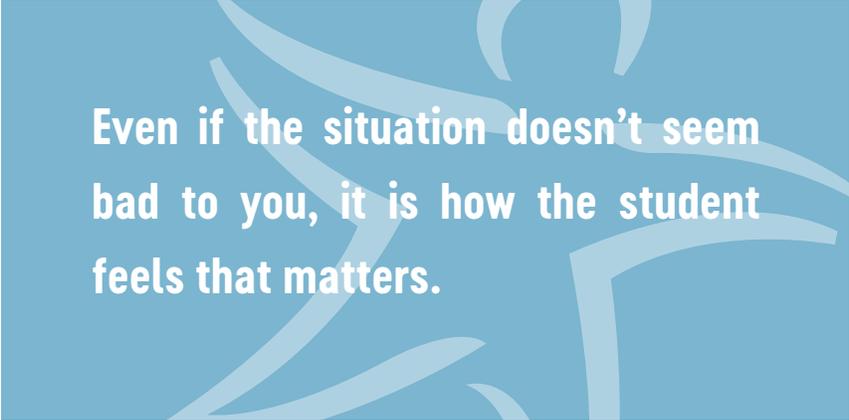
STEP 1 HIGHLIGHTS

- Don't assume – be curious.
- Always wonder what is driving the behavior you see.
- Screen for trauma exposure (past and current).
- Trauma is something we experience at a sensory, not a cognitive level.
- Trauma-informed interventions can interrupt the impact trauma has on children.

STEP 2

View Trauma as an Experience Rather than an Incident or a Diagnostic Category

Trauma is not just the incident itself but rather how the person experiences what happened or what is happening. Every person will have a unique response to life based upon their past experiences, coping skills, characteristics of resilience and protective factors. The perception of what has happened or what is happening is more important than the actual event. Adults often assume certain events are more traumatic than others. Adults may also assume that some events are just normal things every kids needs to learn how to “get through”. For example, many adults think that teasing from peers is a normal “rite of passage” instead of bullying. Remember, we can’t assume we know what is traumatizing or not traumatizing to a student. Instead, we need to be curious and ask how that particular event is impacting them.



Even if the situation doesn't seem bad to you, it is how the student feels that matters.

Try not to judge the trauma. Educators may unintentionally project that a situation isn't really that bad, but how the child feels about the stress is what matters most. Remember, the perception of the child is what matters most. For example, a child who lives in poverty may worry about the family being able to pay rent, find a job and have enough food to eat. Ongoing stressors can cause trauma reactions – any stress that lasts for longer than 4-6 weeks is post-traumatic stress.

ACTIVITY: Other Disorders

When you look at the most common signs and symptoms of post-traumatic stress, what other disorders would you suspect if you just saw symptoms and reactions and didn't know there was a history of or exposure to trauma? See the examples below and then fill in your answers on the next page.

Examples:

➤ Re-experiencing the trauma even though it is over
Psychosis: people don't see or hear the same things I do

➤ Marked loss of interest in or participation in significant activities
Depression

➤ Hyper-vigilance
ADHD

➤ Avoidance of traumatic triggers, memories or reminders of the trauma

➤ Negative beliefs about oneself and the world arising from the event

➤ Negative emotional state or inability to experience positive emotions

➤ Feelings of detachment from people

➤ Sleep problems

➤ Over-use of alcohol or substance abuse

➤ Over or undereating

➤ Irritability and angry outbursts

➤ Reckless or self-destructive behavior

➤ Exaggerated startle responses

➤ Concentration problems

If you mentioned that some of the symptoms look like anxiety, depression, substance abuse, eating disorders, bipolar disorder, ADHD and ODD, you are correct. In fact, because of the overlap in

symptomology between trauma and so many other disorders, two experts in the field of childhood trauma have proposed that there be a new diagnosis in for children of trauma called Developmental Trauma Disorder.

Developmental Trauma Disorder

Because of the abundant research that found traumatized children today are going undiagnosed and misdiagnosed, two leading childhood trauma experts Robert Pynoos and Bessel van der Kolk proposed a more relevant trauma category, Developmental Trauma Disorder (DTD). DTD was proposed because it reflects how traumatized children present as well as the abundant documentation neuroscience has provided regarding trauma's impact on the brain, the body, behavior, learning and emotions. Although not included in the DSM-5, the proposed DTD category presents a much more comprehensive, representative and descriptive view of how traumatized children experience themselves, others and the world around them as a result of their chronic, intensely stressful lives. DTD remains under consideration, but its contents are relevant to anyone who works with children of trauma. The focus on the subjective experience of trauma is critical to appreciating what matters most in our efforts to best understand and respond to traumatized children.

Differential Diagnosis between Trauma, ADHD & ODD

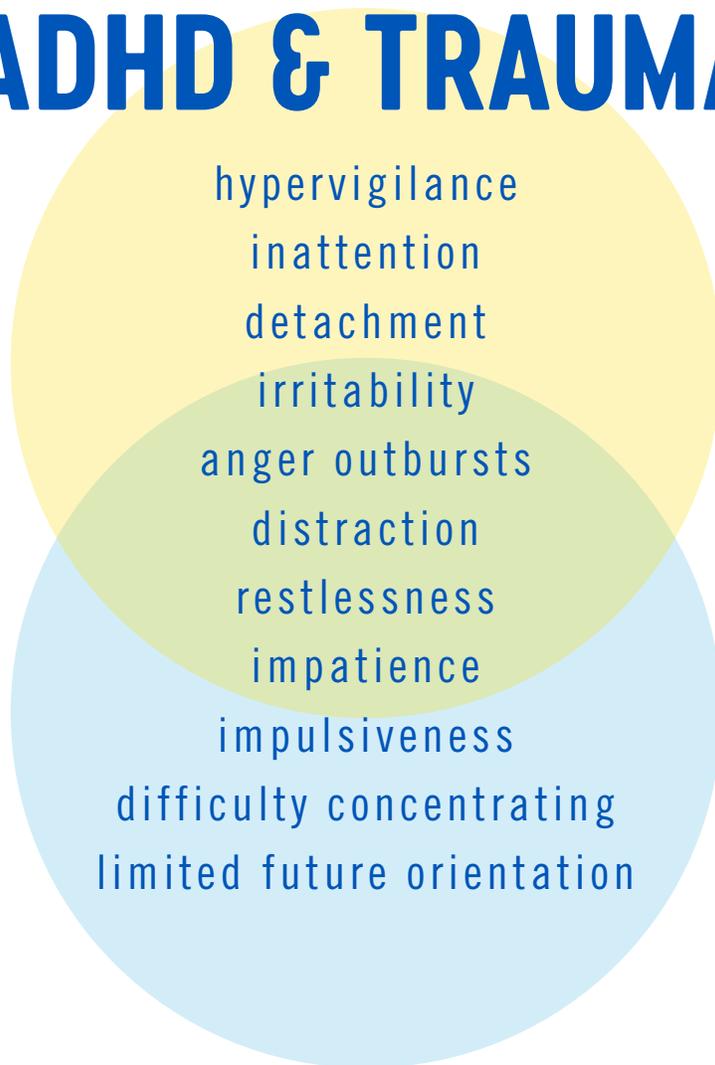
As indicated in the previous activity, the symptoms and responses following trauma or during chronic exposure to stress can look like many other disorders. Two of the most common diagnoses in the school setting for children of all ages are Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD). It is very common for trauma to be mistaken as ADHD or ODD, even by the most well respected and experienced educators. The differential diagnoses isn't easy but it is helpful to understand how and why this common mistake is made.

The differential diagnoses between trauma, ADHD and ODD present significant challenges. First, there are several overlapping symptoms of PTSD, ADHD and ODD. The diagnoses are not mutually exclusive, and there are currently significant assessment limitations.

This reality is terrifying and convicting for many educators. Often times it is the classroom teacher who first suggests the idea that a child may "be ADHD", and this suggestion typically results from

Overlapping symptoms of both trauma and ADHD include:

ADHD & TRAUMA



the child not “fitting into the box” of behavior expected of students in traditional learning environments. Uninformed educators, social workers, parents, and even medical professionals can quickly turn this suggestion into a misdiagnosis if they are not asking the right questions. In the end, a child who has experienced trauma and needs therapy may instead receive medication to treat a condition they do not have. Once professionals see the salient symptoms that PTSD and ADHD share, their common question becomes: “Is it PTSD or ADHD? Both?” Unfortunately, this question is not an easy one to answer.

For example:

- Abused children often exhibit high levels of hyperactivity.
- Inattention is one of the cardinal symptoms of ADHD, but inattention may also be the result of re-experiencing trauma, hypervigilance and/or the avoidance of stimuli as a result of trauma.
- Research tells us that a history of abuse/early childhood stress are risk factors for future psychopathology, including ADHD, and there is significant research showing a high overlap between ADHD and PTSD in populations of abused children.
- ADHD symptoms occur in 25-45 percent of severely maltreated children (This is well above the 9 percent rate of ADHD in the general population).
- ADHD is significantly more common among abused children with PTSD (37 percent) than in children without PTSD (17 percent) and physical and sexual abuse is more common in 6-12-year-old girls with ADHD than without ADHD.

It could be trauma and it could be ADHD, or it could be both. This research is why the need of providing a thorough and well-informed assessment before labeling or diagnosing a child is necessary, and is why routine inquiries about trauma histories are strongly recommended (Wilmott, 2008; Briscoe & Hinshaw, 2006; Weinstein, Staffelback & Biassio, 2000).

There are also many overlapping symptoms between trauma and ODD. Children with a history of traumatic experiences exhibit greater oppositional defiant behaviors than children without exposure to trauma. This is most likely the result of the negative physiological impact trauma has on core regulatory systems, compromising a child's ability to regulate and process sensory inputs. Changes in the body's critical stress response system prevent the modulation of sensory deregulation, making the child incapable of self-regulating their emotions and behavior. The experience of trauma increases vulnerability to stressors - even mild stressors that healthy individuals are able to handle. For example, simple problem solving becomes difficult, causing anger and confusion in a child that simply "does not know what to do" about a situation, ultimately resulting in rage, aggression and other oppositional defiant-like disorders.

Under stress, traumatized children’s analytical capacities are limited and behaviorally react with confusion, withdrawal and/or rage. Rather than making a gradual shift from right brain hemisphere dominance (feeling and sensory) to dominance of the left hemisphere (language, reasoning, problem solving) resulting in an integration of neural communication between hemispheres, they react only from their “sensory” or right brain, often lacking the “thought” or planning before action is taken.

Interestingly, many of the symptoms and reactions present in ODD are parallel to the symptoms and reactions in children post-trauma. More than 800,000 children are exposed to trauma annually from abuse and neglect alone. Twenty percent of those children are observed to have dramatic changes in behavior consistent with ODD following a traumatic event. It would be beneficial to develop guidelines helping pediatricians and other early childhood professionals routinely screen for the presence of trauma-related symptoms and impairments even in very young children. This would prevent the mislabeling of ODD in later years. As one of the top diagnoses given to children today, it is certainly important to understand both the etiology and intervention options proposed for ODD. When ODD is viewed from a biological and trauma-informed perspective, compassion from parents, caregivers, and teachers often follows.

If you look at just the symptoms and the reactions without viewing a student through a trauma-informed lens, it would be easy for even a well-intentioned professional to suspect and misdiagnose a traumatized child as having ADHD or ODD.

ACTIVITY: Symptoms & Reactions

➡ How many students in your school building are diagnosed with ADHD? ODD?

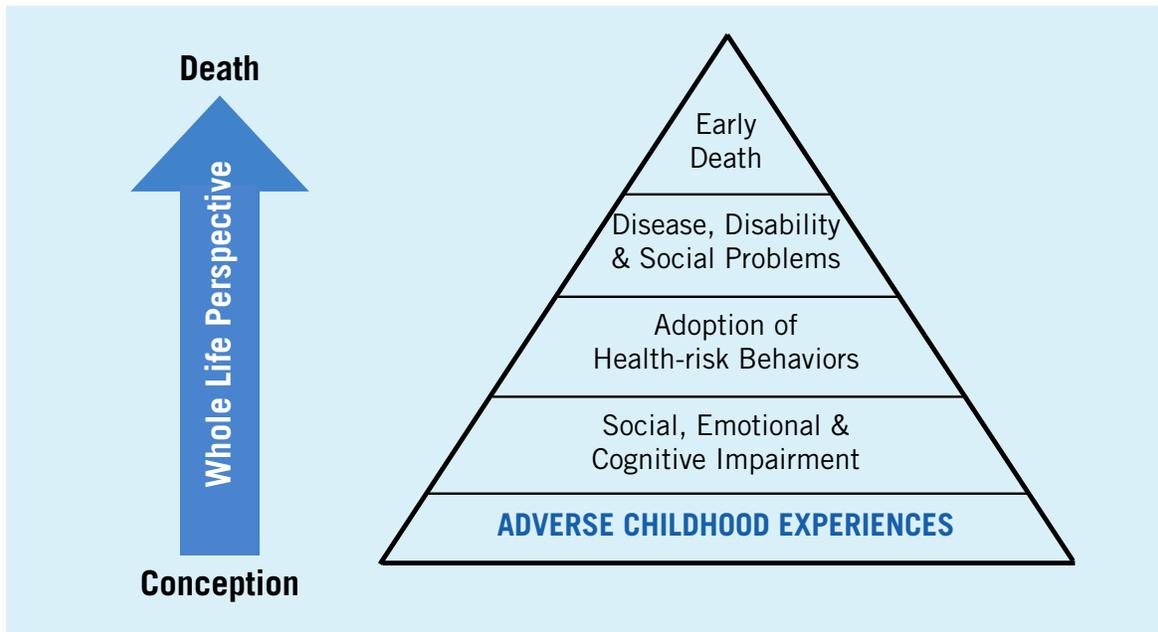
➡ How many of those students also have traumatic history or are experiencing traumatic or toxic stress currently?

➔ How will what you have learned in Step 2 change your view of these children?

➔ What will you do about this new knowledge you have related to these students?

Q How can I support one of my 6th grade students whose grandmother just died? They were very close, and he just can't seem to focus and is so withdrawn that I am worried about him. How should I react?

What might look like inattention and withdrawal are actually normal grief and trauma reactions. Normalize the reactions by saying, "I get it, it is hard to pay attention with so many other things on your mind. And, you probably don't even feel like socializing or having fun because you feel sad." Give the student permission to put their head down or go into the hallway for a drink of water during the day if they need a break. Let them know that even though they feel sad, it might help to do something with a friend that they enjoy. Referring the child to a counselor in or outside of the school setting might be helpful if you still see the student struggling at the 2-month mark after the death.



The Adverse Childhood Experiences Study

The Adverse Childhood Experiences (ACE) study (Felitti, 2009) is one of the largest investigations ever conducted to assess the associations between adverse childhood experiences and later life health and well-being. More than 17,000 participants were part of this study. The participants were mostly white, college-educated, employed adults who were screened for 10 prominent childhood traumatic experiences as part of their routine healthcare protocol. Each type of trauma was given one point. **70% of participants experienced at least one type of trauma.**

ACE scores of 4 or more resulted in four times the risk of emphysema or chronic bronchitis; over four times the likelihood of depression; and 12 times the risk of suicide. ACE scores were directly related with early initiation of smoking, sexual activity, adolescent pregnancy, and risk for intimate partner violence. Findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States.

ACTIVITY: Adverse Childhood Experiences

Questionnaire & Reflection

There are 10 types of childhood trauma measured in the ACE Study. Five are personal — physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect. Five are related to other family members: a parent who's an alcoholic, a mother who's a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce, death or abandonment. Each type of trauma counts as one. So a person who's been physically abused, with one alcoholic parent, and a mother who was beaten up has an ACE score of three.

There are, of course, many other types of childhood trauma — watching a sibling being abused, losing a caregiver (grandmother, mother, grandfather, etc.), homelessness, surviving and recovering from a severe accident, witnessing a father being abused by a mother, witnessing a grandmother abusing a father, etc.

The most important thing to remember is that the ACE score is meant as a guideline: If you experienced other types of toxic stress over months or years, then those would likely increase your risk of health consequences.

ACE QUESTIONNAIRE

Prior to your 18th birthday:

No Yes Did a parent or other adult in the household often or very often... swear at you, insult you, put you down, or humiliate you? or act in a way that made you afraid that you might be physically hurt?

No Yes Did a parent or other adult in the household often or very often... push, grab, slap, or throw something at you? or ever hit you so hard that you had marks or were injured?

No Yes Did an adult or person at least 5 years older than you ever... touch or fondle you or have you touch their body in a sexual way? or attempt or actually have oral, anal, or vaginal intercourse with you?

No Yes Did you often or very often feel that ... no one in your family loved you or thought you were important or special? or your family didn't look out for each other, feel close to each other, or support each other?

No Yes Did you often or very often feel that ... you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

No Yes Were your parents ever separated or divorced?

No Yes Was your mother or stepmother often or very often pushed, grabbed, slapped, or had something thrown at her? or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

No Yes Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

No Yes Was a household member depressed or mentally ill, or did a household member attempt suicide?

No Yes Did a household member go to prison?

_____ Add up your "Yes" answers. This is your ACE Score.

Now that you've got your ACE score, what does it mean?

The CDC's Adverse Childhood Experiences Study (ACE Study) uncovered a stunning link between childhood trauma and the chronic diseases people develop as adults, as well as social and emotional problems. This includes heart disease, lung cancer, diabetes and many autoimmune diseases, as well as depression, violence, being a victim of violence, and suicide.

The study's researchers came up with an ACE score to explain a person's risk for chronic disease. Think of it as a cholesterol score for childhood toxic stress. You get one point for each type of trauma. The higher your ACE score, the higher your risk of health and social problems.

As your ACE score increases, so does the risk of disease, social and emotional problems. With an ACE score of 4 or more, things start getting serious. The likelihood of chronic pulmonary lung disease increases 390 percent; hepatitis, 240 percent; depression 460 percent; suicide, 1,220 percent.

Reflection questions about your ACE Questionnaire:

Does anything surprise you about your ACE quiz?

Did any specific emotion or body sensation come up as you answered the ACE quiz questions?

When you think about the students in your school, how do you think they would score on the ACE quiz?

Resilience and Strengths

We can't talk about trauma without talking about resilience. First, ask yourself the question, "What is it about some students that do better than other students despite similar or even more significant exposure to traumatic and toxic stress?"

The answer is found in characteristics of resilience and strengths. The term "resilience" is borrowed from the physics field and refers to the ability of an object or substance to "spring back" into shape (elasticity). When applied to people, resilience refers to one's ability to "bounce back" from adversity. Resilience characteristics have been reported to exist in children prior to trauma experiences (Bonanno, 2004). Children who demonstrate most of the psychological and emotional attributes associated with resilience and whose social and family environment supports resiliency may experience trauma symptoms after exposure to traumatic events; however, only a small number will develop posttraumatic stress disorder (PTSD).

Psychological and emotional attributes associated with resilience in children include: above average verbal skills, cognitive and problem solving abilities, positive self-esteem, ability to self-regulate behavior, positive expectations about the future, and the ability to ask for help and use social support (Cloitre, Martin & Linares, 2005; Rice & Groves, 2005).

Family and social environmental processes associated with resiliency include: a stable, nurturing parent/caregiver, a connection to an adult in the extended family, and consistent family processes such as rituals, routines, traditions and structure (Cloitre, et al, 2005; Rice & Groves, 2005). In describing their Connections, Continuity, Dignity, Opportunity (CCDO) model, Seita, Mitchell, and Tobin (1996) wrote that resilience was the outcome of environments that promote connections, continuity, dignity and opportunity. Connections refer to supportive, guiding, positive relationships. Continuity refers to events that shape one's life. Dignity refers to value for self (self-worth) and others, and opportunity refers to environments that foster growth and change.

The power and influence of positive human relationships in fostering resilience cannot be understated. Urie Bronfenbrenner, a developmental psychologist renowned for his ecological systems theory of child development, once stated that "every child needs at least one adult who is irrationally crazy

about him or her.” Bronfenbrenner believed this was the greatest factor contributing to one’s healthy well-being later in life. Emmy Werner, also a developmental psychologist and a recipient of the Circle of Courage® award, conducted a ground-breaking 40-year longitudinal study on all 698 children born on the island of Kauai in 1955. The results of her study were consistent with the ACE study in that she was able to establish that certain risk factors during childhood correlated with later life health and emotional well-being outcomes. However, in addition to these risk factors, her work also identified certain “protective factors” that predicted one’s ability to overcome adversity (resilience). Chief among these protective factors was the presence of one caring adult who loved and supported the child unconditionally. Step 5: Foster Connections will further discuss this protective factor.

SPOTLIGHT: Dr. Rita Pierson, Educator

Dr. Rita Pierson was an educator for more than 40 years, serving as a teacher, special education teacher, counselor, assistant principal, director, testing coordinator, and consultant. She is probably best remembered for her inspirational advocacy that positive human connection [relationship] is the key to education.

Her famous quotes: “Kids don’t learn from people they don’t like” and “Every child deserves a champion; an adult who will never give up on them, who understands the power of connection and insists that they become the best they can possibly be” have been used as rallying cries for those in the education field who understand that building caring relationships with students and fostering resilience are the most important things a teacher can do, and that learning will not take place unless this is happening.

Of course, not all resilient children possess all of these attributes, nor do all of these characteristics exist to the same degree in children. It is therefore reasonable to hypothesize that factors of resilience exist in several combinations, and psychological and emotional traits exist to a greater or lesser extent in children. Family and social environmental supports range from many to modest, and it is reasonable to assume that a child with several psychological, emotional, family and social characteristics associated with resilience may be most resilient. Children with fewer psychological, emotional, family and social attributes may be less resilient. Consequently, exposure to traumatic events may result in fairly rapid return to pre-trauma functioning for children at the high end of the continuum of resilience and more prolonged struggle with posttraumatic symptoms for less resilient children. Being trauma-informed means that we need to look for hallmarks of resilience that students possess, and it means that we must help children build characteristics of resilience and draw upon their strengths through the interactions and opportunities we provide to them in the classroom and school setting (Steele, Raider & Kuban, 2007).



BLUEPRINT FOR RESILIENCE: The Circle of Courage® Model

The Circle of Courage® is a model of positive youth development based on the universal principle that to be emotionally healthy, all youth need a sense of belonging, mastery, independence, and generosity. This unique model integrates the cultural wisdom of tribal peoples, the practical wisdom of professional pioneers with troubled youth, and findings of modern youth development research.

Since its introduction in 1988 at an international conference of the Child Welfare League, The Circle of Courage® model has been depicted as a medicine wheel with the four universal needs of belonging, mastery, independence, and generosity arranged around it. The medicine wheel is a sacred image to many North American indigenous communities, often used to represent healing work or other important cultural concepts.

When these universal needs go unmet, the child's Circle is broken. But there is good news! All Circles can be mended. Based on findings in resilience theory and neuroscience, we know that human beings are biologically equipped to overcome adversity. Using strength-based approaches based on the Circle of Courage® model and sensory-based trauma intervention strategies based on Starr's SITCAP® model, we can help these young people mend their Circles and transition from being victims to survivors.

MORE STEP 2 ACTIVITIES AND REFLECTIONS AVAILABLE AT
[Starr.org/10steps](https://starr.org/10steps)

STEP 2 HIGHLIGHTS

- Trauma symptoms and reactions can be easily mistaken for other disorders – especially ADHD and ODD.
- Before you diagnose, make sure to screen for trauma exposure and assess for post-traumatic stress symptoms and reactions.
- As ACEs increase, so do health risk behaviors and physical and mental health problems.
- Being trauma-informed means that you are resilience-focused. Look for strengths, not just deficits.

Conclusion

We hope this resource provided you with not only an understanding of childhood trauma and how trauma can adversely influence learning, behavior and relationships but also specific tools you and your school will use to become a trauma-informed environment. All students need safe and supportive schools that can respond to an enormous body of research about how children's brains adapt to complex trauma and toxic stress.

Follow and use *10 Steps to Create a Trauma-Informed School* along with its accompanying activities, worksheets and evaluation tools with leadership, staff, students, parents and even your Board of Education to guide both the creation and implementation of a trauma-informed school. Regardless of your role in education, you can help with the process of creating a trauma-informed classroom, school and/or district. Educators can interrupt the impact of trauma and build resilience by creating a culture of awareness and sensitivity to each student's unique needs.

For more information on how we can help your school with training, consultation or accreditation email info@starr.org or call 800-837-5591.

THANK YOU FOR DOWNLOADING!
COMPLETE YOUR TRAUMA-INFORMED
TRANSFORMATION AT [Starr.org/10steps](https://starr.org/10steps)

Resources

- Show this video clip at your next Professional Development:
<https://vimeo.com/181823590>
- Take a Starr online course:
<https://starr.org/courses>
- Schedule a Starr Trauma-Informed Schools training at your school or district:
Email info@starr.org or call 800-837-5591
- Purchase the *Life Events Checklist*:
<https://store.starr.org/Course/view/life-events-checklist-1>
- Purchase the *PTSD Evaluation Scale: Child and Adolescent Questionnaire*:
<https://store.starr.org/Course/view/ptsd-evaluation-scale-child-and-adolescent-questionnaire-1>

Learn more about school violence prevention

- CDC Division of Violence Prevention
www.cdc.gov/violenceprevention
- CDC Division of Adolescent and School Health
www.cdc.gov/healthyyouth/
- STRYVE
www.cdc.gov/violenceprevention/stryve/
- Stop Bullying
www.stopbullying.gov

- Surgeon General's Report on Youth Violence
<http://www.ncbi.nlm.nih.gov/books/NBK44294/>
- Compliance with the Consumer Product Safety Commission's Playground Safety Handbook
<http://www.cpsc.gov/CPSCPUB/PUBS/325.pdf>
- Guide to Community Preventative Services
www.thecommunityguide.org/

References

American Academy of Pediatrics (2013). The crucial role of recess in school. *Pediatrics*, 131(1), 183-188.

Andersen, S., & Teicher, M. (2008). Stress, periods and maturational events in adolescent depression. *Trends in Neurosciences*, 31(4), 183-191.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, D.C: American Psychiatric Association.

Bonanno G.A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events. *American Psychologist*, 59, 20–28.

Baroni, B., Day, A., Somers, C., Crosby, S & Pennefather, M. (2016). Use of the monarch room as an alternative to suspension in addressing school discipline issues among court-involved youth. *Urban Education*, 1-21.

Barr, J & Saltmarsh, S. (2014). It all comes down to leadership: The role of the school principal in fostering parent-school engagement. *Educational Management Administration & Leadership* 42(4):491-505

Beltman, S., Mansfield, C., & Price, A. (2011). Thriving not just surviving: a review of research on teacher resilience. *Educator Research Review*, 6, 185-207.

Briscoe-Smith, A & Hinshaw, S. (2006). Linkages between child abuse and attention deficit hyperactivity disorder in girls: Behavioral and social correlates. *Child Abuse and Neglect*, 30(11), 1239-1255.

Call, C., Purvis, K., Parris, S. & Cross, D. (2014). Creating trauma-informed classrooms. *Adoption Advocate*, 75.

Campbell, C., & Schwartz, D. (1996). Prevalence and impact of exposure to interpersonal violence among suburban and urban middle school students. *Pediatrics*, 98(3), 396-402.

Casella, R. (2003). Zero tolerance policy in schools: Rationale, consequences and alternatives. *Teachers College Record*, 105, 872-892.

Castro, M., Exposito-Casas, E. & Lopez-Martin, E. (2015). Parental involvement on student academic achievement: A meta-analysis. *Educational Research Review*, 14, 33-46.

Center on the Developing Child at Harvard University. (2007). A science-based framework for early childhood policy: Using evidence to improve outcomes in learning, behavior, and health for vulnerable children. Retrieved from http://developingchild.harvard.edu/index.php/resources/reports_and_working_papers/policy_framework/

Chafouleas, S, Johnson, A., Overstreet, S. & Santos, N. (2016). Toward a blueprint for trauma-informed service delivery in schools. *School Mental Health*, 8:144-162.

Cole, S., O'Brien, J, Gadd, M. Ristuccia, J. Wallace, D. & Gregory, M. (2005). *Helping traumatized children learn*. Boston, MA: Advocates for Children.

Felitti, V. (2009) Adverse Childhood Experiences and Adult Health. *Academic Pediatrics*, 9 (3), 131 - 132

Fox, D. & Olsen, L. (2014). *Home-School Relations*. Allyn & Bacon

Jones, S. M., & Bouffard, S. M. (2012). *Social and emotional learning in schools: From programs to strategies*. Social Policy Report, 26(4), Society for Research in Child Development.

Kyriacou, C. (2011). Teacher stress: Directions for future research. *Educational Review*, 53, 27-35.

Lobo, R., G. Brown, B. Maycock., A. McManus. 2010. Development of an evaluation framework

and evaluation approaches for peer-based youth programs – Interim Report. Perth: Western Australian Centre for Health Promotion Research, Curtin Health Innovation Research Institute.

Mansfield, C., Beltman, S., Broadley, T., & Weatherby-Fell, N. (2016) Building resilience in teacher education: An evidenced informed framework. *Teacher and Teacher Education*, 54, 77-87.

National Child Traumatic Stress Network Schools Committee. (October 2008). Child Trauma Toolkit for Educators. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

Prilleltensky, I., Neff, M. & Bessell, A. (2016). Teacher stress: what it is, why it's important, how it can be alleviated. *Theory into Practice*, 55: 104-111.

Ramstetter, C., Murray, R. & Garner, A. (2010). The crucial role of recess in schools. *Journal of School Health*. 80(11): 517-526.

Rice, K. F., & Groves, B. M. (2005). *Hope and healing: A caregiver's guide to helping your children affected by trauma*. Washington DC: Zero to Three Press.

Robert Wood Johnson Foundation (2007). *Recess Rules: Why the Undervalued Playtime May be America's Best Investment for Healthy Kids and Healthy Schools Report*. Princeton, NJ: Robert Wood Johnson Foundation. www.rwjf.org/files/research/sports4kidsrecessreport.pdf.

Saigh, P. & J. Bremner (Eds.) (1999). *Post-traumatic stress disorder: A comprehensive text*, Allyn & Bacon: New York.

Shonkoff, et al. (2012) Center on the Developing Child at Harvard University. Key concepts: toxic stress. http://developingchild.harvard.edu/topics/science_of_early_childhood/toxic_stress_response.

Steele W., Raider, M. & Kuban, C. (2007) Connections, Continuity, Dignity, Opportunities: What allowed some to do better than others despite similar traumatic experiences. *School Social Work Journal*.

Stevenson, H. & Lee, S. Contexts of achievement: a study of American, Chinese, and Japanese children. *Monogr Soc Res Child Development*, 55(1-2): 1 – 123.

Substance Abuse and Mental Health Services Administration (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration.

U.S. Department of Education, Office for Civil Rights. (2014a, March). *Civil rights data collection data snapshot: Early childhood education* (Issue Brief No. 2). Retrieved from <http://www2.ed.gov/about/offices/list/ocr/docs/crdc-early-learning-snapshot.pdf>

Weinstein, D., Steffelbach, D. & Biassio, M. (2000). ADHD and PTSD Differential Diagnosis in sexually abused children. *Clinical Psych Review*, 20(3), 359-379.

Wilmott, R. (2008). The link between ADHD and child abuse. *Journal of Pediatrics*, 153(6), A3.

Wolpow, R., Johnson, M, Hertel, R. & Kincaid, S. (2009). *The heart of learning and teaching: Compassion, resiliency, and academic success*. Olympia, WA: Washington State Office of Superintendent of Public Instruction Compassionate Schools.

Zhang, A., Musu-Gillette, L., & Oudekerk, B., *Indicators of School Crime and Safety; 2015 (NCES 2016-079/NCJ 249758)*. National Center for Education Statistics, U.S. Department of Education, and Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice. Washington, DC; 2016.

Zins, J., Weissberg, R., Wang, M., & Walberg, H. (2004). *Building academic success on social and emotional learning: What does the research say?* : Teachers College Pr.

#DriventoHeal



 starr1913

 starrcommonwealth

 starrcommon