

Contents

INTRODUCTION	3
CHAPTER 1	
What Is Trauma?.....	5
CHAPTER 2	
What Does Trauma Look Like?.....	18
CHAPTER 3	
What Are Trauma- and Stressor-Related Disorders?	30
CHAPTER 4	
Is It Misbehavior or Trauma-Related?.....	37
CHAPTER 5	
How Can Teachers Help Students Exposed to Trauma?.....	45
CHAPTER 6	
How Can School Mental Health Professionals Help Students Exposed to Trauma?	59
CHAPTER 7	
How Can Administrators Help Students Exposed to Trauma?	69
CHAPTER 8	
What If a Student Needs More Support?	78
CHAPTER 9	
How Can Schools Partner with Parents to Help Students Exposed to Trauma?	84
CONCLUDING THOUGHTS	92
RESOURCES	
Notes.....	94
Acknowledgements	95
Resources: Where Can I Find Out More About Trauma?	96
Appendix A	102
Appendix B	104

See page 101 for information about Downloadable Resources.

Introduction

Taylor is sitting in algebra class, focused on the equation her teacher has written on the board. Suddenly, she hears the sound of heavy footsteps outside the classroom door. Her body instantly reacts—her heart begins to race, her muscles grow tense then tremble, and one part of her brain feels frozen in thought while the other part of her brain says to run! Taylor’s teacher calls on her for the answer, but her mind suddenly goes blank. As Taylor stutters the wrong response, the sound of her teacher’s footsteps approaching her desk sends Taylor into defense mode. The lion’s roar of the teacher’s voice elicits an unconscious reaction as Taylor jumps out of the seat with fists clenched and yells, “Get away!” The teacher then yells back. . . .

Taylor is not alone. Thirty-five million school-age youth have been exposed to trauma, including acute traumatic events (single time-limited crises, such as car accidents, death, and natural disaster) or chronic traumatic events (multiple crises or adverse childhood experiences, such as poverty, violence, and child maltreatment).¹ To optimize our effectiveness as educators, we must acknowledge the impact of trauma exposure as a contributing factor to school challenges and better understand how to support students. Many students (and staff) have experiences like Taylor. They suffer in silence. Cognitive, social, and emotional development are interrupted. Trauma interferes with the executive functions required to be successful in the classroom, and it impacts our ability to trust our environment and others. For those with repeated trauma exposure, their life may feel like they are constantly walking on eggshells, waiting for the next trauma trigger to occur and never really knowing or trusting how their body and brain will respond. While this book will focus on students and their families, there are many educators who have trauma histories themselves. I hope the content provided in this book can also help educators who have been personally impacted.

As educators, we see the behaviors, but we don’t always consider or understand why these behaviors occur. I began my career as a special education teacher who specialized in working with students with emotional and behavioral challenges. I was trained primarily as a behaviorist. Most behaviors can be explained by analyzing the antecedents, behaviors, and consequences of observable behaviors. Thus, behaviors can then be modified or influenced if there are strong enough reinforcers or

punishment. What was missing over twenty years ago in my teacher training program was understanding and identifying trauma. As I reflect back to the students I worked with early in my career, it saddens me to think how many of those students had trauma histories that were never acknowledged, validated, or addressed through trauma-informed practices. No wonder so many only showed temporary gains (they were only responding to the immediate reinforcers) and minimal long-term progress. While strategies using behaviorist theories can be effective, they are insufficient for those with trauma histories. These students need and deserve more from us. What we can do does not require a lot of extra effort; it just requires patience, understanding, and a different approach to addressing behaviors.

In this book, I will identify the different types of stress and the symptoms that accompany trauma exposure. I will highlight the commonalities between externalizing disorders as well as trauma- and stressor-related disorders. Too often, trauma is confused with willful oppositional behaviors. We will also explore the overlap with anxiety. I strongly suggest you read another book in this series by Leigh Bagwell titled *Educator's Guide to Helping Students with Anxiety*. Leigh's book further describes anxiety that can underlie trauma exposure and provides great resources for anxiety management. I will provide practical strategies for school mental health professionals (school counselors, school psychologists, school social workers, and school nurses), along with strategies for administrators, teachers, and parents. It is also important to realize that some types of trauma exposure may require intensive services beyond what a school can provide. Thus, we will review effective school and research-based psychotherapeutic treatments. Lastly, I will provide additional resources to further your understanding of trauma identification and multitiered, trauma-informed interventions.

Most importantly, trauma is treatable!

Through trauma informed practices, educators and school mental health professionals can make positive impacts on the lives of those affected by trauma. As former president of the National Association of School Psychologists, my presidential theme was "Small Steps Change Lives." I hope this book will help you take the small steps needed to make a big difference in changing the lives of students, teachers, and parents. Increased understanding regarding trauma and effective interventions helps us to provide better supports that facilitate growth and achievement in all areas of life. We may truly be the lifeline that provides the hope and encouragement an individual needs to integrate the trauma experience into who they are, without letting it completely define what they become.



1

What Is Trauma?

The term “ACEs,” or Adverse Childhood Experiences, has received increased attention in education over the past decade. ACEs are defined as potentially traumatic events that occur in childhood (zero to seventeen years) to include the following: experiencing violence, abuse, or neglect; witnessing violence in the home or community; having a family member attempt suicide or die by suicide; being raised in an environment that undermines a sense of safety and stability; and exposure to traumatic events that impact a person’s ability to emotionally attach to others such as substance misuse/abuse, mental health problems, and/or instability due to parental separation or family members being incarcerated.

A hallmark study initiated in 1994 by Kaiser Permanente and the Center for Disease Control measured a variety of ACEs and their relationship to health and social problems.² What they discovered is ACEs are common and highly interrelated. Almost two-thirds of study participants reported at least one ACE, and nearly one in six reported they had experienced four or more types of ACEs. Women and several racial/ethnic minority groups were at higher risk for having experienced four or more types of ACEs, and some children were at greater risk than others.

This study also discovered how ACEs impact all aspects of a person’s life. The graphic below summarizes the cumulative negative effects of ongoing toxic stress and trauma exposure.



Sources: Center for Disease Control and Prevention (2020). In public domain.³

Current research supports a strong, predictive correlation between ACEs and negative outcomes. ACEs have a “dose-response” reaction, meaning as the number of adverse childhood experiences increases, the risk of developing significant health and mental problems gradually accumulates. For children, growing up in an environment with toxic stress can lead to difficulty forming healthy and stable relationships. This then leads to unstable work histories as adults, which can then lead to depression and limited educational and economic opportunities. The effects of the toxic stress can then be passed onto their own children (generational trauma). Toxic stress is often compounded by the historical and ongoing traumas due to systemic racism and poverty, which leads to living in under-resourced and/or racially segregated neighborhoods. These living conditions often lead to food insecurity and forced frequent moves. The cumulative effects of the toxic stress then lead to chronic health problems, substance misuse/abuse, and mental illness, including suicide. And to further compound development, ACEs also negatively impact brain development, academic achievement, and the ability to develop social-emotional competencies and executive

functions such as attention, decision-making, learning, and responding to stress— the exact skills needed for academic and occupational success. In summary, the academic, emotional, social, and economic costs to families, communities, and society is great. Are you feeling defeated yet?

On so many levels ACEs can seem impossible to overcome. However, trauma is treatable and ACEs are preventable! By acknowledging the impact of trauma and implementing trauma informed practices, we can create and sustain safe, stable, nurturing relationships and environments for all children and families. We can help to prevent and/or mitigate the negative impact of ACEs and help all children reach their full potential. Our small steps can change lives!

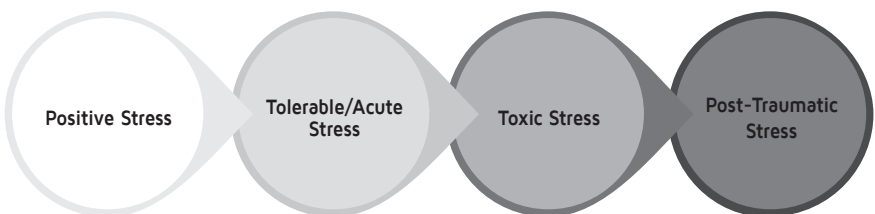
Science shows the effects of ACEs are not permanent.⁴

Stress vs. Crisis vs. Trauma

Humans experience different types of stress and trauma exposures, yet these experiences are highly interrelated as they determine how we cope and respond.

Stress

Stress can actually be a good thing! *Yeah right, you may be thinking. How can stress be good when we are more stressed now than we have ever been?* But it's true. At the same time, however, stress can also be toxic. Thus, it's important to distinguish among three kinds of stress responses: positive, tolerable, and toxic.



Positive stress helps us take action when we are uncomfortable and is essential for normal development. It is characterized by brief increases in heart rate and mild elevations in hormone levels. For example, positive stress might occur when a child begins their first day of school or is receiving an immunization shot. It may also be initiated by an impending deadline that motivates us to get the project done. Stress is experienced when you find yourself in an unsafe situation and your brain and body are told to take action to get to a safer location. Positive stress is a moderate, short-lived stress response, and when the stressor subsides, the body returns to a calm baseline.

Tolerable (acute) stress is potentially harmful, but relatively short-lived. For example, an acute stressor is the loss of a loved one, a natural disaster, or a frightening injury that activates the body's alert systems for a longer period of time than positive stress. It requires the use of coping strategies and can be buffered by supportive adult relationships that help the child to adapt, thus mitigating the potential damaging effects on the brain and body. The child learns to adapt and integrate the experience into their life narrative as they move forward, adjusting to the "new normal." Thus, not all stressful situations are a crisis.

Toxic stress is strong, frequent, prolonged activation of stress mechanisms that often occurs when a child experiences adverse childhood experiences without adequate adult support. When prolonged activation of the stress response systems occurs continuously, or is triggered by multiple stressors, the cumulative effects take a toll on an individual's physical and mental health and disrupt body and brain development. However, research also indicates that supportive, responsive relationships with caring adults, particularly if these relationships are available early in life, can help to prevent or reverse the damaging effects of toxic stress response.

Crisis

A *crisis* is perceived as extremely negative, can generate feelings of helplessness, powerlessness, and/or entrapment, and may occur suddenly, unexpectedly, and without warning. It leads to a temporary state of upset and disorganization that overwhelms an individual's ability to cope and has the potential for positive and/or negative outcomes. Thus, a crisis that is effectively managed can be considered tolerable (acute) stress. However, a crisis not effectively managed, or the continual accumulation of stressors, can lead to toxic stress.

When toxic stress is ongoing and is combined with ongoing chronic trauma, post-traumatic stress can develop. Post-traumatic stress often begins as a normal response to stress and trauma, but the reactions become prolonged and begin to impact physical and emotional health.

Thus, does exposure to a crisis mean an individual will develop toxic stress or post-traumatic stress? No. While this may be the case for some, this is not the case for all. While crisis exposure and trauma are correlational, the relationship is not necessarily causal. Resiliency and supports can mitigate the negative impacts of trauma exposure and help an individual adjust.

A crisis is the event, experience, or condition that leads to danger or the potential for danger.

Trauma is the result of an individual's reaction to the crisis event.

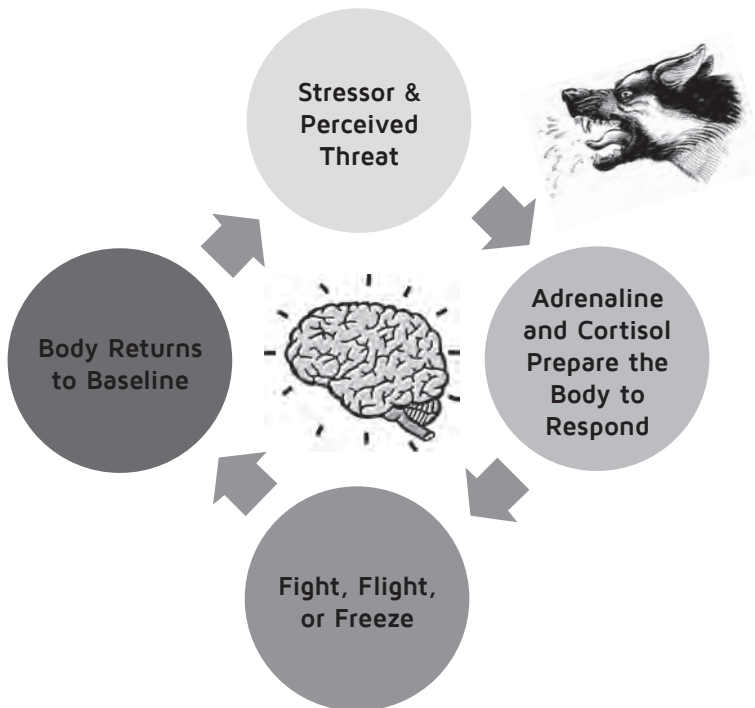
Acute vs. Chronic/Complex Trauma

Trauma reactions are the result of actual or perceived harm to one's physical, psychological, or emotional well-being. What makes the crisis experience traumatic is the individual's reaction, not just the experience itself. Cultural context also matters. For example, in cultures where women are viewed as inferior or keeping the family together avoids public shame, domestic violence may be

seen as more tolerable and disclosure and expression of traumatic stress may not occur. These individuals may not perceive this as trauma and/or will suffer in silence for fear of the consequences of disclosure, but their body and mind still feel the impact.

There is also a distinction regarding the different types of trauma experiences—acute versus chronic trauma. **Acute trauma** exposure is of time-limited duration (car accidents, natural disasters, loss of a family member, etc.). When a threatening acute stressor is perceived (i.e. scary dog), the body releases stress hormones (adrenaline and cortisol) that increase heart rate and blood pressure and prepare the body to either flight, fight, or freeze. When the threat is gone, the body returns to baseline. The brain becomes calm again and is available for learning and prosocial interactions. Supportive adults and social-emotional lessons (e.g. anxiety management) can help students learn how to do this.

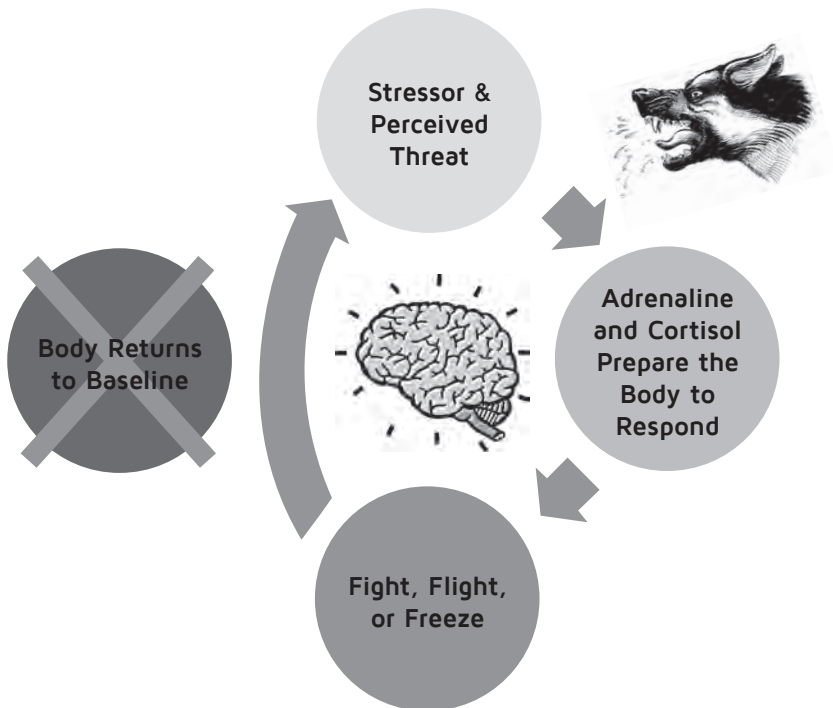
Acute Trauma:



Chronic/complex trauma is continual and ongoing exposure to toxic stress that continues or repeats for months or years at a time. It usually begins early in life, disrupts development including the formation of a self, and interferes with the child’s ability to form a secure attachment bond with caregivers (we will talk about this more in chapter 4.).

When the threatening stressor (i.e. scary dog) is perceived by an individual with a history of ongoing trauma exposure, the body responds; however, there is no complete return to baseline. The body and brain feels like it is living on pins and needles most of the time. A person can’t experience safety when the scary dog is constantly living in their brain (and maybe also in their house or neighborhood). The scary dog is always lurking around the corner or they “see the dog” everywhere, scared an attack could occur at any time. The brain is constantly interrupted which makes learning difficult, and emotional regulation and relationships are negatively impacted.

Complex/Chronic Trauma



For some, traumatic stress reactions may last several weeks or months but generally start to subside if a child experiences no other traumas and has resiliency and supports in place to help cope with the stress. For example, a child who witnessed her parent being killed as a result of domestic violence may initially be preoccupied with her own safety and criminal justice processes. Once she is reassured that she is safe and will be protected, and she has effective supports in place, she may not show further signs of traumatic stress. She may, however, begin to express her grief about the loss of her parent. Her traumatic stress reactions do not develop into toxic stress or post-traumatic stress. However, take this same situation with a child who does not have resiliency or supports, and there are ongoing secondary stressors such as the loss of a home, needing to relocate to live with relatives, changing schools, and losing peer support. This child is more likely to exhibit toxic or post-traumatic stress reactions.

Trauma Triggers

For those with a trauma history, there are often trauma triggers that activate the trauma reactions described above. Common triggers include:

- loud, chaotic environments
- threatening gestures
- certain odors (specifically those related to the trauma experience)
- physical touch
- sounds (fire alarm, sounds of emergency vehicles and emergency personnel, music that is connected to the event or loss)
- confinement or feeling trapped
- unclear/uncertain expectations
- change in routine (especially without notice)

- authority figures that try to set limits through demands (instead of providing choices)
- witnessing an altercation or violence between other individuals
- spaces that remind them of trauma experience (low lighting, bathrooms, unsupervised areas)
- feelings (anger, sadness, or fear) in response to common school conflicts (being approached by another student, getting in trouble, doing poorly on a test, being called stupid or unmotivated)

Impact on Brain Development

“We tend to divide the work of mental health separate from the world of physical health, but the body doesn’t do that.”

—Dr. Nadine Burke Harris⁵

Trauma can change the brain. There is much research that supports the idea that traumatized brains look different from non-traumatized brains, with three main areas of the brain being significantly impacted. The “thinking center” (prefrontal cortex, or PFC) and “emotion regulation center” (anterior cingulate cortex, or ACC) are underactivated; whereas the “fear center” (amygdala) is overactivated. The thinking center is most impacted by deprivation (neglect) due to lack of stimulation, and the emotional regulation center is most impacted by trauma and violence.

The Whole-Brain Child is a great book that describes the impact of trauma on the brain in a way that students, educators, and parents can understand.⁶ They use the analogy that our brains are like a house. The upstairs contains our prefrontal and neocortex, our “thinking brain.” Characters such as Calming Charlie, Problem Solving Paul, Creative Carrie, and Flexible Fred are the thinkers, problem solvers, planners, and emotion regulators who are creative, flexible, and empathic toward others. The downstairs is our limbic system (amygdala), our

“feeling brain,” which is very focused on keeping us safe and making sure our needs are met. This is where the instinct for survival originates. The characters that live downstairs, Alerting Alice, Frightened Freddie, and Big Boss Buddy, help us look out for danger and will sound the alarm when there is a threat and we need to fight, run, or hide.

Our brains work best, and we learn best, when the upstairs and the downstairs work together and can carry messages up and down the stairs to each other. This allows us to make good choices, maintain friendships, come up with exciting and creative games to play, problem solve when in an uncomfortable situation, and calm ourselves down when we are stressed or scared. When one of the characters in the downstairs brain spots some danger, the downstairs brain (“feeling brain”) takes over and “flips the lid” on the upstairs brain (“thinking brain”), which exposes our amygdala and emotions take over. The pathway that normally allows the upstairs and downstairs to work together is no longer connected, and our brains become overwhelmed with feelings such as fear, sadness, or anger.

What happens when YOU FLIP YOUR LID

PREFRONTAL CORTEX IS ENGAGED:

Calm, rational thought, mental flexibility. Able to make good decisions.

LID IS FLIPPED --> AMYGDALA IS ENGAGED

Big emotions arise—anger, fear, anxiety, sadness. Unable to make good decisions or calm down.

Source: The Whole-Brain Child

The infographic features a dark grey header with the title 'What happens when YOU FLIP YOUR LID' in white, flanked by two brain icons. Below the header, the text 'PREFRONTAL CORTEX IS ENGAGED:' is followed by a fist icon and a text box describing calm, rational thought. A double arrow points to the text 'LID IS FLIPPED --> AMYGDALA IS ENGAGED', which is followed by an open hand icon and a text box describing big emotions and inability to make good decisions. The source 'The Whole-Brain Child' is noted at the bottom.

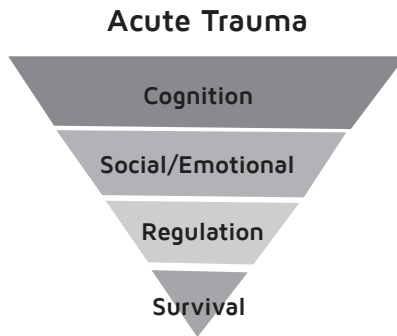
The upstairs brain (neocortex or “thinking brain”) can work properly again when we are out of danger. How long does it take to return to equilibrium and resume learning? That depends if exposure is a positive or tolerable/acute stressor or a toxic, chronic stressor. If an individual experiences toxic stress, they are at increased risk for their body not returning to baseline (the downstairs brain stays activated). They experience chronic stress, vigilance, fear, and irritation and also have a hard time feeling safe, calming down, managing emotions, or sleeping; all symptoms of a hyperactive amygdala. In addition, they experience more difficulties with concentration and attention and struggle more to think clearly—all symptoms of the thinking center being underactivated.

A Student’s Story

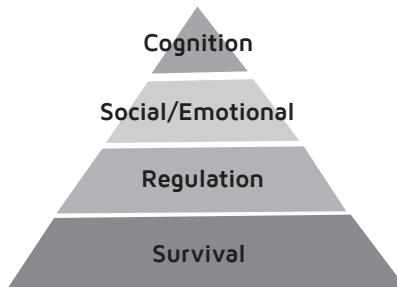
Taylor did not mean to jump out of her seat and yell at her teacher. She actually loves her algebra teacher. But due to being a victim of sexual abuse and hearing the sound of footsteps just before her uncle enters her room late at night to abuse her (trauma trigger), she “flipped her lid” and her emotional and physical responses took over. Due to the ongoing abuse, even when she wants to calm down and feel better, she can’t. There are just too many reminders, too many trauma triggers. Teachers and peers perceive her as a “loose cannon” who can’t control her temper. Now she is headed for her third out-of-school suspension this semester.

Taylor’s brain is also experiencing developmental trauma. Survival is her brain’s focus, with little energy left for social/emotional regulation and cognitive processing. Whereas the brain of a non-traumatized student can focus on cognition (learning) and social/emotional regulation, with little energy needed for survival and regulation.

Trauma & Brain Development



Developmental/Chronic Trauma



Adapted from Holt & Jordan, Ohio Dept. of Education

Source: <https://sharedparentinginfo.com/563/>

Taylor is not trying to be the “bad kid.” She just needs someone to understand. She needs someone to help her learn how to identify her trauma triggers so she can implement emotional regulation and anxiety management strategies. Her amazing teacher could benefit from staff development to better understand trauma.

???

**QUESTIONS
to
CONSIDER** ??

1. What is Taylor's trauma history?

2. What are her trauma triggers?

3. What parts of her brain are under- and overactivated?

4. How have her academics and relationships been impacted by trauma?

5. What resources are available to Taylor, her teachers, and her parents?

**KEY
POINTS**

- There are different types of stress and trauma exposure. Not all are bad. Resiliency and social supports make a difference in outcomes.
- Trauma impacts brain development. Behavior is not always a conscious choice but a trauma response to a perceived threat.
- Trauma is treatable!