Children Learn What They Live: Addressing Early Childhood Trauma Resulting in Toxic Stress in Schools

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Though there is extensive research on the health outcomes of individuals who have experienced adverse childhood experiences (ACEs), society at large has not embraced this ground-breaking research and many still believe that the use of harsh punishment for students provides the same intended result as a discipline approach that teaches coping skills and the management of emotions. These traumatic experiences can result in toxic stress and create long term effects on children's social-emotional and cognitive development that impair academic performance. This commentary will discuss trauma-informed educational practices have been developed to aid in recovery in the school environment.

Children Learn What They Live

A growing body of research on the effects of adverse childhood trauma on student learning and social-emotional development is becoming available. Unfortunately, trauma-informed educational practices have not become common practice in the classroom nor the overall school environment. Mallett (2016) claims that starting in the 1980s, driven by concerns with youth violence, the educational and juvenile justice response to children and adolescents shifted from rehabilitation to a focus on punitive responses, such as zero tolerance policies, with the intent of achieving safety and order. This shift was reinforced by highly publicized school violence incidents, like the Columbine school shooting in 1999.

Now, a generation later, the evidence seems to indicate that we have created schools that principally use punitive practices in response to a growing number of high needs children who pose generally low safety risks (Mallett, 2016) but who may behave in ways that challenge teachers and schools. Some of the possible reasons for the continued reliance on punishment through detention, suspension, or expulsion, at least in Illinois, are limited community resources and funds for implementation. Teacher resistance, and most recently, signals from the Trump administration in the wake of the passage of the Every Student Succeeds Act (ESSA) of 2015, as well as challenges to Obama-era discipline directives, are also obstacles.

In Illinois, where I work as the director of an educational family support program, efforts to provide ongoing training and technical assistance to educators have increased. The prevalence of traumatized students is acknowledged by the Illinois State Board of Education based on the feedback of school administrators and educators across the state, which is divided into regions overseen by Regional Offices of Education (ROE). Even for those schools that have embraced a trauma-informed lens, there is difficulty implementing extensive trauma-sensitive programs due to limited community resources and funding. Mental health services are sparse in rural areas, especially for children living in poverty (Andrilla, Patterson, Garberson, Coulthard, & Larson,

2018). In Illinois, more than 90% of Illinois counties have been designated mental health professional shortage areas by the federal Health Resources and Services Agency (Forrest, n.d.).

Because of the lack of funding during two years of a recent state budget impasse, 86% of the Community Behavioral Healthcare Association of Illinois membership had either reduced or eliminated psychiatric services (NAMI Illinois, 2015). The state had already slashed more than $113 million in general revenue funding for mental health services between fiscal years 2009 and 2012, according to research by the National Alliance on Mental Illness (NAMI) of Chicago (Progress Illinois, 2015). Many Illinois mental health providers took drastic measures to endure the budget impasse. The state's largest provider of social services, Lutheran Social Services of Illinois, laid off 750 staffers and closed over 30 programs (NAMI Illinois, 2015).

The current 2019 Illinois budget contains reductions in funding for addiction prevention and mental health grants for children and adolescents. The budget also eliminates certain after-school programs and school support services funding for the lowest performing students in Illinois (Gordon & Lifson, 2018).

Addressing the Problem

In 2016, state board officials reached out to collaborate with the ROEs to provide professional development in becoming trauma-sensitive. I was asked by the regional superintendent of schools in western Illinois to take part in a series of "train the trainer" workshops on early childhood trauma which began in July 2017. These workshops focused primarily on how trauma and toxic stress affects brain development, which in turn affects behavior and learning, and how to address these challenges. We were then asked to pass this content on to school districts at the school level. As I did this, many educators who participated requested more help on how to turn this knowledge into action that could change the school environment. They were seeking concrete guidance on how to implement trauma-informed practices in their schools, and this ultimately led to my developing a five-hour training for all school personnel, briefly discussed below.

As a result of these efforts, by the 2018-19 school year, districts in eight Illinois counties that participate in a professional development consortium through their Regional Education Offices now have the opportunity to receive ongoing training and technical assistance in developing a trauma-informed response in their schools. There are several trauma-informed practice trainings available for school administration to schedule for their districts. A presentation that provides an overview of toxic stress and how adverse childhood experiences affect learning and development is initially offered. This is followed by the trauma-informed lens training, which can range from two and one-half to five hours depending on time constraints. Further training in the following year, where schools can reflect and discuss how trauma-informed practices are being implemented and how they are benefiting students, is also offered. Schools that have participated in one of the trauma-informed practice trainings are also eligible to participate in a session called "Is It Teacher Burnout or the Effects of Vicarious Trauma?" which addresses the phenomenon of vicarious, or secondary, trauma and how it can affect those who work with students.

The Effects of Early Childhood Trauma on Brain Development

Exposure to traumatic events in childhood is widespread. According to the 2011-2012 National Survey of Children's Health through the Data Resource Center for Child and Adolescent Health, nearly 35 million U.S. children have experienced one or more types of childhood trauma (Data Resource Center for Child & Adolescent Health, 2018). Trauma can include physical and sexual abuse, abandonment, neglect, death of a loved one, a serious accident, witnessing violence, being bullied, incarceration of a loved one, fire, illness, traffic accidents, natural disasters, and life-threatening situations. In addition to trauma exposure in early childhood, there is growing evidence to suggest that children who live in extreme poverty are highly vulnerable to exposure to potentially traumatizing events and can often develop posttraumatic stress disorder (PTSD) based on such experiences (Costello, Erkanli, Fairbank, & Angold. 2002; Elklit & Petersen, 2008).

Child psychiatrist Dr. Bruce Perry has treated hundreds of children who have endured unimaginable trauma. In his book, *The Boy Who Was Raised as a Dog* (Perry & Szalavitz, 2006), Perry tells their stories, as well as their amazing transformation through a variety of support mechanisms. Dr. Perry also emphasizes how early experiences have a far greater impact on child development than later ones. He explains that babies are born with the core elements of the stress response already intact and centered in the lower, most primitive parts of their developing brains. When an infant's brain receives signals from inside the body and/or from external senses that something is not right, these signals register as distress. This distress can be hunger if calories are needed, thirst if dehydrated, or anxiety if there is a perceived external threat. When this distress is relieved, the infant feels pleasure because the stress-response is interconnected with the "pleasure/reward" areas in the brain. An infant's stress system continues to stay on high alert when they do not receive consistent relief from fear, loneliness, discomfort, and hunger because the stress-response is also connected to areas of the brain that represent pain, discomfort, and anxiety. If stress is relieved quickly and consistently in early childhood, children develop the neural connections to handle stress and trauma in the future (Perry & Szalavitz, 2006).

Patterned, repetitive, positive stimuli are necessary for the brain to develop properly and has the most effect on memory and brain development. The systems in the brain that are repeatedly activated will change for better or for worse (in cases where the stimuli are negative), and the systems that are not activated remain stagnant. If children are not given the opportunity to build healthy relationships and to cope with stress, those specific areas of the brain that are connected to the development of trust, for example, will be underdeveloped (Perry & Szalavitz, 2006).

When children who have not been helped to develop coping skills are exposed to certain "triggers" that activate their traumatic memories, they can respond with behaviors that mirror the symptoms of diagnosable mental health disorders. Triggers can be anything from an adult's raised voice, to being accidentally bumped into, to the anniversary of a loss. Traumatized children tend to have overactive stress responses, and these can cause them to be aggressive, impulsive, and needy. As a result, these children can seem difficult, easy to upset, and hard to calm, and may overreact to the slightest change (Perry & Szalavitz, 2006). When a child reacts to what they perceive as inescapable stress from trauma with *dissociation* (disruptions in aspects of consciousness, identity, memory, physical actions and/or the environment), their body prepares

them for that stress by slowing heart rate, breathing, and other functions. The freezing response the body makes when stressed is comparable to what is referred to as "a deer caught in the car headlights" moment. This behavior is also often misinterpreted as defiant refusal or, in school, the ignoring of teachers' requests, because the child literally cannot respond to requests at that moment.

Many post-traumatic psychiatric symptoms are related to either hyper-arousal or dissociative responses to memories of the trauma (Perry & Szalavitz, 2006). When a child is hyper-aroused, their body is activating a fight or flight response, which increases the heart rate. Aggression and impulsivity that can accompany the fight or flight response can also appear to be acts of defiance or opposition, when in fact they may be remnants of a response to some prior traumatic situation that the child has somehow been prompted to recall. According to Perry & Szalavitz (2006), "while not all attention deficit disorder, hyperactivity and oppositional-defiant disorder are trauma-related, it is likely that the symptoms that lead to these diagnoses are trauma-related more often than anyone has begun to suspect" (p. 51).

Initial Studies on Adverse Childhood Experiences

During the 1980s and early 1990s information about risk factors for disease had become widely researched. One finding was that risk factors were not randomly distributed in the population (Felitti et al, 1998). This suggests that the number of adverse childhood experiences suffered as a child is positively correlated with increased risk for health and mental health issues in adulthood. To reinforce this finding, replication studies have been conducted which have continued to provide evidence of the complex relationship between child development and long-term health outcomes.

The Original ACE Study. Between fall 1995 and winter 1996, 13,494 Kaiser Health Plan members completed standardized medical evaluations designed to examine the relationship of health risk behavior and adult disease to the breadth of exposure to childhood emotional, physical, or sexual abuse. This research, the original Adverse Childhood Experience (ACE) Study (Felitti et al., 1998), included seven categories of adverse experiences: psychological, physical, and sexual abuse; violence against mother; living with household members who were substance abusers, mentally ill or suicidal, and living with household members who had ever been imprisoned.

The ACE study findings suggested that adverse childhood experiences were major risk factors for the leading causes of physical illness and disability, mental health disorders such as depression and anxiety, early death, and a generally poor quality of life in the United States (Felitti et al., 1998). More specifically, adults with multiple categories of childhood exposure were likely to engage in alcohol abuse, smoking, or illicit drug use. These adults reported poorer health outcomes such as obesity, early mortality, chronic obstructive pulmonary disease, ischemic heart disease, liver disease, and lung cancer. Those with higher ACE scores also indicated a greater frequency of contracting a sexually transmitted disease, having an unintended pregnancy or a spontaneous abortion, or experiencing fetal death. Finally, an increase in incidence of suicide attempts and intimate partner violence was also indicated more often with

those with higher ACE scores (Felitti et al., 1998). This ground-breaking research paved the way for further studies across the United States.

The Family Map Inventory Study. Because the ACE questionnaire was originally structured for adult respondents, new approaches were needed for identifying ACEs in children. Leanne Whiteside-Mansell was the lead developer of the Family Map Inventories (FMI). Her initial research in 2004 involved close collaboration with families, classroom educators, home visitors, administrators, and other social service staff working with families (Whiteside-Mansell, Bradley, Conners, & Bokony, 2007). The FMI are family-centered assessment tools that are used to assess ACE risks, protective factors, and service needs in the family home and increase the quality of parent-teacher partnerships. They are divided into age-specific scripted interviews for prenatal families and families with children ages birth to three or three to five years. The inventory can be used upon enrollment in any home visiting program or during parent-teacher conferences for children three to five. A variety of programs, including state and federal home visiting programs, early childhood programs, and childcare centers, use this tool.

The FMI cover the following areas: self-support/routines, school readiness/early learning, environmental safety/family cohesion, discipline/health, home/car safety, social integration and parent-child warmth. FMI-ACEs were found to be associated with parenting beliefs and behaviors related to child abuse and neglect (e.g. corporal punishment and confinement). They also significantly predicted at-risk social-emotional development; children with four or more FMI-ACEs were over six times more likely than those with none to have scores that indicated significant risk factors in the home environment (Whiteside-Mansell et al., 2007).

The SAMHSA's Trauma-Informed Approach. The key in providing trauma recovery for effected children starts by creating an atmosphere of safety via predictable, respectful relationships. Some of the most therapeutic experiences for traumatized children do not take place in "therapy" but in naturally occurring healthy relationships, such as between school personnel and students Substance Abuse and Mental Health Services Administration (SAMHSA), 2014). The SAMHSA recommends a trauma-informed approach be implemented throughout the school day and embraced by all school staff (2014). Harris and Fallot (2001) describe this type of trauma-informed care as a universal precaution designed to be both preventative and rehabilitative in nature. This approach addresses the relationship between children's personal triggers and perception of danger and the neurobiological reaction that leads to distress and resulting problematic behavior. In addition, it acknowledges the significance of trauma and its profound impact on a person's perception of emotional and physical safety, behaviors, relationships, and medical status (Jennings, 2004).

SAMHSA's concept of a trauma-informed approach is grounded in six key principles developed from the original ACE study (Felitti et al.,1998). The approach guides schools in providing a physically and psychologically safe environment and seeks to limit re-traumatization of students. Through training in trauma-informed practices, school personnel are taught to recognize how the school environment may trigger painful memories and, as a result, provoke reactive behaviors or responses and/or re-traumatize students (SAMHSA, 2014).

Each principle that is listed below provides a mechanism for schools to use in order to develop a more tangible and emotionally supportive trauma-informed environment:

- **Safety.** Schools must assure that both students and staff feel physically and psychologically safe in both the physical environment and in their interpersonal interactions. To foster this, for example, schools might incorporate physical spaces in the school for both students and staff to practice self-care techniques such as deep breathing and stretching in a quiet, non-judgmental environment. Also, the level of noise and raised voices in the school environment should be maintained or reduced so to reduce the possibility of re-traumatization.

- **Trustworthiness and transparency.** Everyday operations and decision making should be done with transparency and involve students, families, and school staff as necessary to build and maintain trust. For example, trauma-informed rules and expectations should be readily available on the school website, classroom newsletters, and during parent/teacher conferences.

- **Peer support.** Schools should provide an opportunity for those who have endured trauma to share their lived experiences with peers with similar histories in order to aid in their healing. An example could be offering a support group after school that helps students express their feelings, support each other, and become connected to needed resources.

- **Collaboration and mutuality.** Collaborating and leveling power differences among school administration, educators, and families are necessary to ensure all individuals are important contributors in developing a trauma-informed environment. This can occur through having parents and students hold key positions on school improvement and school policy committees.

- **Empowerment, voice, and choice.** Throughout the school, individuals' strengths and experiences are acknowledged and built upon by educators and staff; there is shared decision-making and goal setting as well as a shared belief in building resiliency and facilitating recovery.

- **Cultural, historical, and gender issues.** The school offers access to gender responsive services that reflect understanding of the ways gender stereotyping can compound and constrain student growth and development. The school creates policies, protocols, and practices that are racially, ethnically, and culturally responsive to the needs of all individuals.

Trauma Recovery within a Trauma-Informed Approach

The training I have developed lasts approximately five hours, guided by a PowerPoint presentation (see Figure 1), group discussion, and self-reflection and disclosure, and employs a two-hour follow-up during the next school year. This two-part training is designed for all school personnel including administrators, educators, paraprofessionals, school social workers, counselors, psychologists, librarians, lunchroom workers, custodians, bus drivers, and monitors.

During the trainings, childhood trauma is defined and the concept of toxic stress through early childhood adverse experiences is identified. In addition, the impact of trauma on child development, learning, education, and relationships is explored, and information about how trauma affects brain development and the ability to learn is provided.

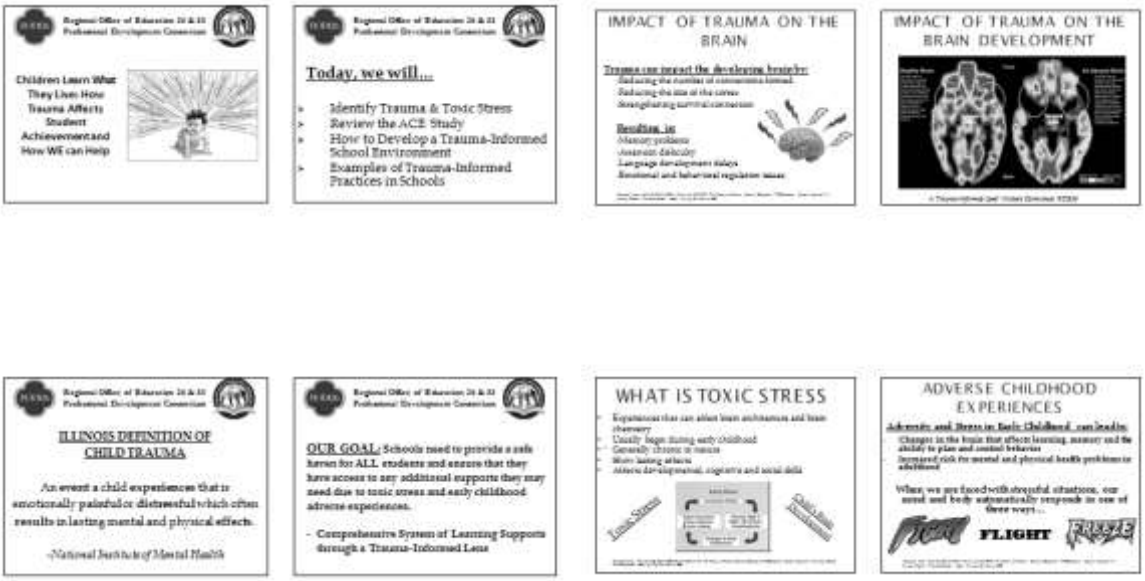

Figure 1. Example of PPT presentation slides.

Session Tools

Participants review the original ACE Study and have the choice to complete the ACE questionnaire, score their results, and report them anonymously using their cellular phone or laptop.[1] A resilience quiz that accompanies the ACE questionnaire, which identifies protective factors for individuals, schools, families and ultimately communities, is discussed as well.[2] Self-reflection on personal resilience and protective factors is encouraged during small group discussion.

The trauma-informed approach developed by SAMHSA and examples of trauma-informed practices in schools are presented, including emphasizing the importance of providing safe, stable, and nurturing relationships, the provision of wraparound services, and incorporating mindfulness activities throughout the school day.

The wraparound approach. Since most of the school districts where I provide this training are in rural areas, providing wraparound services and mental health supports can be challenging due to budget restraints. Schools are encouraged to reach out and collaborate with community providers for these supports. In one Illinois county I work with, for example, the community mental health center has begun allowing mental health counselors to meet with students during

[1] See questionnaire at https://www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf
[2] See quiz at https://www.aap.org/en-us/_layouts/15/WopiFrame.aspx?sourcedoc=/en-us/Documents/RESILIENCE_Questionnaire-1.docx&action=default

school hours, with parent approval, to help provide mental health supports within the school walls.

Through a wraparound process, the student, family members, and school staff collaboratively develop an individualized plan to meet the needs of the student. This plan addresses outcomes for the student and family at home as well as in school through one cohesive plan. The planning process along with the services and supports should be individualized, family driven, and strength-based through natural supports. "The values associated with wraparound specified that care was to be strengths based, culturally competent, and organized around family members' own perceptions of their needs and goals" (Walker & Burns, 2006, p 1580). Community resources can be limited in most of the rural school districts I work with. During the training, participants are encouraged to share how they face this hurdle, and together we brainstorm how to meet the needs of students when resources are scarce.

Mindfulness activities. Social-emotional learning has been defined as the process through which children and adults acquire and effectively apply the knowledge, attitudes, and skills necessary to understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions (CASEL, 2014). Mindfulness practices, which can help individuals reflect on their thoughts and feelings in a non-reactive way, can be practical, enjoyable, and effective ways to introduce social-emotional learning (Davidson & Begley, 2012).

When a child's brain is continually in a stressful state, memory and rational decision making is affected due to the preparation of the fight or flight response. Children in a high stress state can have very little energy for traditional academic learning in a classroom setting. Mindfulness techniques, such as breathing exercises, guided meditation, and various exercises (see Appendix A) can reduce stress, calm, and focus students.

According to Weare and Nind (2011), school is an appropriate setting for mindfulness-based interventions; children spent a good part of their day there, and interventions can be incorporated and directed to children in need as part of a preventive approach at little cost (p. 6). Teachers do not need to be specialists to incorporate these interventions in their classrooms. There are several websites and free resources that guide educators on how to incorporate mindfulness in the classroom.[3]

Since mindfulness activities do not require any specialized training by educators, examples of various mindfulness activities listed below are explored during the training and can be incorporated directly in the classroom. Some examples of these activities are provided in Appendix A. It is critical to note, however, that forcing or coercing a child to engage in mindfulness activities is not helpful and could actually serve to trigger a child further. Discomfort or resistance needs to be recognized (Schwartz, 2019) and explored in an appropriate and supportive way.

Participant reflection. The training then helps participants explore their perceptions of students' misbehavior in school, specifically their assumptions about this behavior, through a trauma-

[3] Websites cited include: http://www.mindfulteachers.org/ and https://www.mindfulschools.org/

informed lens, along with recognizing participants' own adverse childhood experiences and what mechanisms in their own lives allowed them to rise above these experiences. As a final activity, participants are asked to identify one or more of the trauma-informed educational practices introduced in the training that they plan to implement in either their own classroom or on a school-wide basis. For example, one example of a broad-based trauma-informed practice could be the principal deciding to welcome children by name as they enter the building each morning. On a classroom level, a teacher may develop a way he or she could promote a sense of safety, developing a "check in/checkout" system with students who show signs of stress. The teacher "checks in" with a student by meeting with them at the beginning of the school day and reviewing the goals they have set together for the student the day before. At the end of the day, the student and teacher "check out" to see how the day went and if goals were accomplished.

Follow-up training. As part of the agreement to work with a given school, I schedule a time for meeting and networking during the following school year. While the follow-up training is meant to be flexible and responsive to participants' particular needs, it is important to note that the initial five-hour training remains consistent so all participants will receive the same foundational training on trauma regardless of date of participation. This is meant to ensure a *shared understanding* of early childhood trauma and its effect on brain development among school staff.

As the facilitator, I make myself available between the initial and follow-up trainings to provide technical assistance by phone, email, and in-person when needed. At the follow-up session, returning participants are asked to report on the intervention they chose during the initial session. Feedback and suggestions from staff are encouraged, as is networking, and I provide updates on additional research and new programs being offered.

Evaluation. The effectiveness of the training is assessed through a written evaluation by participants upon completion of the initial 5-hour training, as well as verbal input during the follow-up training (see Appendix B). Participants are also asked to indicate areas where they feel they need further training. School teams are encouraged to attend training together, with a special emphasis on the inclusion of school administration.

Participating schools are encouraged, though not required, to provide statistics on the number of detentions, suspensions, and expulsions before and after the implementation of trauma-informed practices. Participants will also be asked to provide input from students and their families on their view of the changes in the school environment since the implementation of trauma-informed practices.

After the first two years of implementation, the ROE26 and ROE33 Professional Development Consortium will decide how to proceed with further training, perhaps considering extending the amount of training offered, and developing a webinar.

Emerging Obstacles

Despite these promising developments, non-punitive forms of discipline are not easily adopted by all school personnel, including school administration. The success of transforming the school

environment to be trauma-informed is dependent on educators accepting change. School leaders should consider the possibility of facing resistance.

Teacher Resistance

While a comprehensive overview of teacher responses to discipline reform is beyond the scope of this paper, it is worth noting that a significant reason why trauma-informed practices may not be heavily embedded in more schools across the nation is a "silent resistance" by educators who do not yet buy into alternative responses for classroom management.

According to the U.S. Government Accountability Office (GAO) (2018), during the 2013-2014 school year, 2.8 million K-12 students received one-or-more out of school suspensions nationwide (p. 71). African American K-12 students made up 15.5% of public school students but were approximately 39% of students suspended from school. They were also overrepresented in rates of in-school suspensions, referral to law enforcement, expulsions, school-related arrests, and corporal punishment (GAO, 2018, p. 14). American Indian or Alaska Native, Latino, Native Hawaiian or other Pacific Islander, and multiracial boys were also disproportionately suspended from school, representing 15% of K-12 students but 19% of K-12 students receiving one or more out-of-school suspensions. Finally, students with disabilities served by IDEA were more than twice as likely to receive one or more out-of-school suspensions as students without disabilities (GAO, 2018, p. 73).

While suspension rates in the United States have risen steadily since the 1970s, there remains little to no evidence that zero-tolerance discipline policies such as suspension and expulsion improve student achievement (Nussbaum, 2018). Punitive discipline does not teach new skills or behaviors; it is often based on removing children from the classroom through means such as detention, transfer to alternative education programs, suspension, and expulsion (Blodgett & Dorado, 2017). Evidence is now emerging that punishment (e.g. corporal, suspension, and expulsion) leveled at students makes it nearly impossible for them to learn and can actually intensify trauma (Nussbaum, 2018*).*

There is little empirical data on teacher attitudes about discipline reform, but there is anecdotal evidence that some teachers have become frustrated and resentful because they feel unable to address classroom management problems effectively. An article in the *Los Angeles Times* (Watanabe & Blume, 2015) reported on changes in the Los Angeles Unified School District (LAUSD), which was the first district in California to ban suspensions for "willful defiance" and as a result, saw a significant drop in suspensions. In 2013, the state's teacher unions had initially opposed the ban. Many teachers in the LAUSD reported that they felt their hands were tied in dealing with disruptive students who appeared to suffer little in the way of meaningful consequences. They blamed the district for failing to provide the training needed to effectively shift to the new approach. Surveys by the California Teachers Union in 2016 reported that 86% of the nearly 3,500 respondents needed help with alternative approaches to discipline as well as increased access to school mental health professionals (Adams, 2017); this concern about lack of training continued to be reflected in an April 2017 survey by the California Teachers Association (Adams, 2017, para. 2).

Similarly, Educators for Excellence, a national advocacy group, surveyed teachers and found that less than half believe that detentions, expulsions, and out-of-school suspensions are effective at improving student behavior. Seventy-four percent and 64%, respectively, prefer positive behavior reinforcement and restorative practices—but their top professional development need was additional training in these methods (Educators for Excellence, 2018).

A recent study by TeachPlus (2018) surveyed Illinois teachers for reactions to significant changes in school discipline policies. In 2015, the Illinois Legislature passed Senate Bill 100 (SB100), which calls for more effective student discipline practices in public schools as a means of reducing the wide racial disparities in suspension and expulsion rates. The bill eliminated zero tolerance policies and limited the use of exclusionary procedures. The vast majority of teachers felt that professional development in alternative strategies had been quite poor, and almost half of the participants felt that the changes had resulted in a negative impact on student behavior, frequently mentioning, for example, that students "got away" with more and teachers had little recourse.

These concerns underscore continuing tensions between proponents of the Obama-era guidelines, including civil rights advocates and school discipline researchers, and many educators and educational policymakers regarding how best to proceed, and have resulted in a shift in priorities (Green & Benner, 2018; Nussbaum, 2018).

Every Student Succeeds Act: Will It Succeed?

There are provisions in the Every Student Succeeds Act (2015), such as the reduction of testing and overuse of exclusionary discipline practices, which would qualify as trauma-informed. There also are provisions for trauma-informed practices. For example, Student Support and Academic Enrichment Grants (SSAE) provide formula funding to support students and schools in high needs districts with comprehensive school-based mental health services and staff development based on trauma-informed practices that are evidence-based for school and community personnel (see https://www2.ed.gov/programs/ssae/index.html). In addition, other grants are authorized for in-service training for school personnel in the techniques and supports needed to help educators understand when and how to refer students affected by trauma, and children with, or at risk of, mental illness (see https://www2.ed.gov/programs/projectprevent/index.html).

ESSA also reauthorizes a number of existing programs that address needs in high-poverty and low-performing schools, including Promise Neighborhoods, Full-Service Community Schools and 21st Century Learning Centers.[4] Another program that was reauthorized specifically for schools impacted by violent or traumatic crises is the Project School Emergency Response to Violence, which funds short- and long-term education-related services for local educational agencies to help them schools recover from a violent or traumatic event (see https://www2.ed.gov/programs/dvppserv/index.html).

[4] These programs all attempt to increase support for students and families in distressed neighborhoods (see https://innovation.ed.gov/what-we-do/parental-options/promise-neighborhoods-pn/applicant-info-and-eligibility/ for information about Promise Neighborhoods; https://innovation.ed.gov/what-we-do/parental-options/full-service-community-schools-program-fscs/ for information about Full Service Community Schools; and https://www2.ed.gov/programs/21stcclc/index.html for information about 2st Century Learning Centers.

ESSA has the potential to increase trauma-informed practices and programs in schools as long as states and local school districts build on trauma-informed principles, such as SAMHSA's, to guide reforms locally. The law also requires Congress to fund the reauthorized programs at sufficient levels. Unfortunately, this has not been a priority for the Trump administration, which on a national level has not embraced the importance of increasing funding in mental health services that are essential in a school's wraparound approach for trauma-informed services. *The Washington Post* reported the administration's 2019 budget proposal plans to cut more than $3 billion from the Education Department while investing $1.6 billion to support private school vouchers and other school choice programs (Balingit, et al., 2018). This budget also adds $5 billion over the next five years to combat the opioid epidemic, which is part of $10 billion in government funding for substance abuse and mental health requested in the budget. No additional funding for mental health services were proposed in the budget.

In addition, as long signaled, Department of Education Secretary Betsy DeVos is at the time of is writing poised to roll back the Obama-era school discipline policies based on her involvement with the Federal School Safety Commission formed after the Parkland, Florida school shooting in February 2018. This commission reflects the belief that the focus on decreasing punitive and disparate punishment, impacting students of color, has contributed to schools becoming less safe as teachers feel unprepared to address violence and disruption as it occurs. The argument is that educators need suspension and expulsion as tools to rid classrooms of disruptive and dangerous students who disrupt learning and endanger classmates. Not surprisingly, proponents of the Obama-era guidelines are alarmed, arguing that they "had been an invaluable resource for schools and districts that want to foster a positive school environment and had improved educational outcomes for minority children" (Green & Benner, 2018).

Conclusions and Recommendations

Schools are often the first to notice negative behavioral changes related to attention, abstract reasoning, memory, impulse control, and attendance issues, and it is critical for educators to understand these may be due to adverse childhood experiences and trauma. Once symptoms are assessed, trauma recovery can begin. A trauma-informed approach in the classroom and change in the overall school environment can empower students to develop skills that will enhance self-regulation, help in managing emotions, and strengthen self-control.

It is important to find the best, most efficient way to provide training that is trauma-informed to all school personnel. As the provider of professional development in this area, my mission is to inform school administrators and school superintendents about the importance and benefits of having a trauma-informed environment in their schools, as well as the importance of fostering awareness of vicarious trauma among school personnel.

There continues to be a need for much more research on trauma-informed approaches and educational practices in the school setting. The studies I found have mostly been conducted in medical settings (Oral et al., 2016) and inpatient mental health settings (Musket, 2013). Research studies need to be conducted at schools utilizing trauma-informed practices, such as the mindfulness activities at Robert W. Coleman Elementary in Baltimore, Maryland, (Brewington,

2011) and those implementing the wraparound approach with onsite mental health services at schools like Lincoln Alternative High School in Walla Walla, Washington (Longhi, 2015). These schools have seen benefits in student achievement but have not conducted formal research to show measurable positive outcomes, which could contribute to development of trauma-informed education practices that work best for particular students populations and a school environments. Only after a commitment to further research and continued development and implementation of trauma-informed education practices will we see lasting change for those who have experienced toxic stress through adverse childhood experiences, and perhaps more effectively prevent the ongoing cycle of trauma.

Author Notes

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Appendix A

Mindfulness and Meditation Exercises

Deep Breathing

- **Deep Belly Breathing (aka Balloon Breath):** Stand up tall, sit up straight in a chair or lie flat on the floor. Bring all of your attention to your belly. Place your hands on your belly. Breathe in through your nose, all the way down to your belly and let it puff out. Then breathe out through your nose and gently pull your belly back in. Without making any judgements, notice how your belly moves with the breath. Do this slowly. Repeat 3 times.
- **Finger Breathing:** In time with the breath, gently take the index finger of the right hand up and run it up the outside of the left thumb on the in breath and the inside of the thumb on the out breath. Carry on up and down the next finger…. and so on. When you finish one hand, stop there and just breathe gently or swap hands. The finger simply follows the breath, not the other way around. You are not trying to change the breath, just to get in contact with it.
- **Somatic Holds:** Stand up tall or sit up straight in a chair. Keep your feet hip distance apart. Place one hand on your heart and one on your belly. Press yourself into your hands and your hands into your body. Do 3 rounds of Belly Breath.

Guided Meditation

- **Special Place Visualization:** Stand up tall, sit up straight in a chair or lie flat on the floor. Close your eyes are let them be soft. Breathe through the nostrils for a few moments until you feel calm. Imagine a very pleasant place, inside or outside, wherever you feel good. See a path that leads to a door. Follow the path and see there is a sign on the door with your name on it. This is your Special Place. Open the door and go inside. You can do whatever you want in your Special Place. Decorate it with your mind. Invite whomever you like to come to visit you in this place, or simply enjoy being alone. You are safe, happy, healthy and loved.

Compassion Exercise

- **Share the Light:** Sitting, lying down or standing, close your eyes and take a few deep inhales through the nose and a few audible exhales through the mouth. On your next inhale, image a warm golden glow at your chest (heart center). As you exhale, push the glow slowly out toward the extremities of your body. On each inhale the light gets stronger and on each exhale the light extends further. Eventually, you will extend the light out toward someone in particular or toward the whole world.
- 20 min. Koru Loving-Kindness Meditation

Gratitude Exercises

- **Gratitude List:** Upon waking or just before bed, bring to mind all of the things that you are grateful for. It doesn't matter if you do not feel particularly grateful. Say it out loud, if you can: "I am grateful for…" Start with something simple, like being alive another day, having a bed to sleep in, seeing the sun. Next, move on to the people in your life; you might include your pets. Then think of the opportunities that you have. To make this more automatic or if you are having a hard time, make a list of things you are grateful for and put it somewhere where you will see it every day. Feeling grateful will boost your mood and direct your attention toward more positive thinking.
- **List of accomplishments**: Before going to sleep, list all of things that you did in the day. It doesn't matter how small or insignificant your mind judges these things to be. Example: "I got up, had breakfast, showered, fed my cats, made my bed, etc." This will reduce your tendency to review your "to do" list and make you feel calmer and more confident.

Positive Affirmations

- I am strong
- I am calm
- I am healthy
- I am lovable
- Look in the mirror and smile at yourself
- Say your name, "_____, I love you." Using the 3rd person is sometimes more effective, especially if you have a hard time loving yourself. In times of suffering, place your hands at your heart and say, "_____, I love you and I'm going to take care of you."

Mindful Movement

- **Shoulder Rolls:** Stand up tall or sit up straight in a chair. Move your shoulders forward, up, back, and down. Repeat 3 times. Then reverse: back, up, forward, and down. Breath comfortably as you move.
- **Spinal Extension & Flexion:** Stand up tall or sit up straight in a chair. Inhale and move your chest forward and your shoulders back, opening your heart area. Then, exhale and curl (tuck and round) your back, stretching between your shoulder blades. Repeat 3 times.
- **Twists:** Stand up tall or sit up straight in a chair. Keeping your feet planted and knees gently bent, raise your arms out slightly from your body and gently swing your arms from side to side. Try to keep your hips facing forward. Repeat 3 sets.
- **Neck Stretches:** Stand up tall or sit up straight in a chair. Inhale. Exhale and gently move your right ear to your right shoulder. Then release. Inhale. Exhale and gently move your left ear to your left shoulder. Release. Repeat 3 sets.
- **Side Stretches:** Stand up tall or sit up straight in a chair. Inhale and raise your right arm.

Exhale and gently stretch your right arm up and over, across the midline of your body. Inhale up. Then exhale and release. Inhale and raise your left arm. Exhale and gently stretch your left arm up and over, across the midline of your body. Inhale up. Then exhale and release. Repeat 3 sets.

- **Mountain:** Stand up tall or sit up straight in a chair. Keep your feet hip distance apart. Keep your knees soft and draw in your belly. Inhale and raise your arm up and pull your shoulders down. Exhale and let your arms float down to your sides. Stand (or sit) in mountain and breath smoothly and slowing through your nostrils for 3 rounds of breath.
- **Tree:** Stand up tall or sit up straight in a chair. Transfer your weight to one foot and bring your other foot to your ankle, calf or thigh. Draw in your belly and reach your head to the sky. Use your eyes to balance by looking at a spot on the floor in front of you that doesn't move. Stand (or sit) in tree and breath smoothly and slowing through your nostrils for 3 rounds of breath. Repeat on the other side.
- **Chair:** Stand up tall. Inhale and lift your arms up. Exhale and lower your arms out in front of you and bend your knees to sit back into an imaginary chair. Draw in your belly and tuck your tailbone. Stand in chair and breathe smoothly and slowing through your nostrils for 3 rounds of breath. (If seated, take turn raising and holding one leg and then the other.)
- **Forward Fold:** Stand up tall or sit up straight in a chair. Keep your feet hip distance apart. Keep your knees soft and draw in your belly. Inhale and raise your arm up and pull your shoulders down. Exhale and hinge your body from the hips. Let your head hang and your shoulders and neck release. Stand (or sit) in forward fold and breath smoothly and slowing through your nostrils for 3 rounds

Appendix B

Training evaluation

Training Title: Children Learn What They Live: How Trauma Affects Student Achievement and How WE Can Help!

Date Attended: _____

Please select the rating for each section based on the following criteria:

5 = excellent 4 = good 3 = average 2 = fair 1 = poor

Please rate the trainer(s) on the following:

1. Knowledge of the subject matter.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
2. Ability to explain and illustrate concepts.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
3. Ability to answer questions completely.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

4. What specifically did the trainer do well?

5. What recommendations do you have for the trainer to improve?

Please rate the content and structure of the training:

6. The usefulness of the information received in training.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
7. The structure of the training session(s).	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
8. The pace of the training session(s).	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
9. The convenience of the training schedule.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
10. The usefulness of the training materials.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Open-ended comments (use the back if you need more space):

11. What did you most like about the training?

12. What can be improved with regard to the structure, format, and/or materials?

Your Name (Optional): _____