TEACHERS’ EXPERIENCES WITH AND PERCEIVED ABILITY TO SERVE
STUDENTS EXPOSED TO TRAUMA

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TEACHERS’ EXPERIENCES WITH AND PERCEIVED ABILITY TO SERVE
STUDENTS EXPOSED TO TRAUMA

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ABSTRACT

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Children exposed to trauma may go on to experience chronic psychologic symptoms. There is an increasing need for general education teachers to recognize the signs of trauma exposure and be able to support traumatized students in the classroom. Few studies have examined the relationship between these perceptions and teachers’ previous experiences, training, and education on trauma exposure in adolescence. This study examined teachers’ experiences with and perceived ability to serve students exposed to trauma. One-hundred and fourteen general education teachers from the Midwest completed an internet survey on their experiences and perceptions; four teachers were interviewed about their experiences and perceptions. Results indicate an overall desire to aid students, and a positive relationship between pre-service trauma training and higher perceived ability to aid students exposed to trauma. There was no relationship between professional development and/or prior experience with students exposed to trauma and the teachers’ perceived ability to provide supports. Implications for school professionals when serving this population are discussed.
Dedicated to my mother, father, and two sisters. Thank you for supporting me in all I do.
ACKNOWLEDGEMENTS

I would like to acknowledge my thesis committee for providing input and support throughout the process of writing this thesis. I appreciate the anonymous general education teachers who took the time to participate in this study.
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CHAPTER I

INTRODUCTION

Trauma is an emotion-based response to a distressing event such as an accident, natural disaster, terrorism, exposure to domestic or community violence, maltreatment, severe bullying, or loss of a loved one (APA, 2016). When experiencing a traumatic event, an individual perceives a threat to either themselves or others and experiences distress such as feelings of horror, fear, or helplessness (Kataoka, Langley, Wong, Baweja, & Stein, 2012). After a traumatic event it is not uncommon for individuals to express shock or denial; some may struggle to move on with their lives and experience long-term reactions such as unpredictable emotions, flashbacks, strained relationships, and even somatic symptoms (APA, 2016). When a traumatic event causes long-term stress symptoms which interfere with daily life, then the symptoms become a disorder (Kataoka et al., 2012).

In today’s world it is likely that children will experience some form of trauma; in fact, 38.5% of adults in the United States report having experienced a traumatic event before they turned 13 (Gerson & Rappaport, 2013). Gerson and Rappaport (2013) further report that close to one-third of individuals will go on to develop post-traumatic symptoms. Given that childhood development has a significant impact on adult
functioning, anything that derails the process may produce long-term negative effects. Ippen, Harris, Van Horn, and Lieberman (2011) report that trauma symptoms in infants can manifest as disruptions in sleep and feeding patterns along with difficulties establishing secure attachments; preschoolers may present regulatory and social difficulties (Loeb, Stettler, Gavila, Stein, & Chinitz, 2011). Therefore, early identification and intervention are essential to help negate adverse long-term effects of exposure to trauma.

According to Loeb et al. (2011), it is difficult to assess for trauma exposure in children because young children may be unable to express themselves verbally, or they may just not want to speak of the traumatic event. Parent reports may not solve this problem because parents tend to underreport the post-traumatic stress symptoms, particularly if parents have experienced trauma themselves (Loeb et al., 2011). However, because children spend a majority of their day at school, teachers and mental health counselors are in an excellent position to notice abnormal behaviors and provide early support.

Currently, there is limited research on teachers’ experiences and their perceived ability to support these students. Such information is important to inform training and professional development initiatives. Thus, the present study sought to examine teachers’ experiences with and perceived ability to serve students exposed to trauma.
CHAPTER II
LITERATURE REVIEW

This literature review examines previous research on the difficulties of identifying and providing support to students exposed to traumatic experiences. The review begins with a definition of how trauma presents in students, the challenges that post-traumatic symptoms can pose, and the difficulties in identifying at-risk students. In addition, school-based interventions, and teacher experiences and perceptions of this population are examined.

Trauma in Children and Adolescents

Exposure to trauma is a growing issue for adolescents, with reports of one out of every four young people affected by some sort of trauma (Jaycox et al., 2009). Prolonged exposure of children and adolescents to traumatic events that may have an extended impact on the individual’s livelihood is also referred to as an adverse childhood experience or ACEs (Blodgett & Lanigan, 2018). Traumatic events can occur at the individual, family, or community level (Soeurs, 2017) and according to the Substance Abuse and Mental Health Services Administration (2018) it can include a negative life-altering event such as child maltreatment (ie. abuse or neglect), family stress or dysfunction (domestic violence, death or separation of a parent, substance misuse within household, incarcerated family member, and a family member that is mentally or
physically ill), community violence, and natural disasters. Further research from Little and Akin-Little (2013) reported that death of a sibling or friend is one of the most common forms of trauma for today’s youth. According to research by Bethell, Newacheck, Hawes, and Halfon (2014), adolescents with higher exposure to trauma was linked with an increased risk of repeating a grade, absenteeism, and lower overall school engagement. In addition, research by Burke, Hellman, Scott, Weems, and Carrion (2011) reported that as traumatic events increased learning and behavior problems at school were also increased. Therefore, knowledge of trauma and post-traumatic symptoms are important for teachers and for school staff to aid in recognition of those possibly affected.

**Trauma vs. PTSD.** Exposure to trauma is difficult for any individual and can be especially difficult for children who are still developing. Each child will differ in his or her ability to cope with trauma (Little & Akin-Little, 2013). Some students may be more resilient in their ability to circumvent the negative symptomology and instead experience posttraumatic growth. Posttraumatic growth includes the discovery of personal strength, new possibilities, relating to others, appreciation for life, and spiritual change (Calhoun & Tedeschi, 2014). However, not every child may be able to cope with trauma; many are at risk of developing more severe negative symptomology, such as post-traumatic stress disorder (PTSD, American Psychiatric Association, 2013).

Approximately 10-30% of adolescents exposed to trauma experience chronic psychological symptoms, resulting in a diagnosis of PTSD (Alsic, 2012). It is estimated that approximately 4-6% of youth in the general population qualify for a diagnosis of PTSD (Kataoka et al., 2012). Kataoka et al. (2012) explain that to be diagnosed with
PTSD the individual must experience a traumatic event, “in which he/she perceives a threat to either self or others and must experience distress (horror, fear, helplessness)” (p. 2). The primary symptoms associated with PTSD include flashbacks, numbing and avoidance, and hyperarousal. Flashbacks occur when an individual re-experiences the trauma; for example, in children this may be through repetitive play or re-enacting the trauma while they play. Numbing and avoidance is when the child avoids reminders of their trauma, and then withdraws or isolates themselves, avoiding activities they previously enjoyed. Lastly, hyperarousal is a heightened anxiety, experienced as being constantly “on edge” and can result in irritability, anger, and/or difficulty sleeping.

There are several risk factors for PTSD, including: characteristics of the trauma (severity, how long said trauma occurred and proximity to the event), individual factors (history of psychopathology, female gender), and characteristics of the parents (parental psychopathology, lack of parental support). In 75% of youth PTSD cases, the post-traumatic stress can also be comorbid with other diagnoses such as anxiety disorders, depressive symptoms, dissociation, substance abuse, and then aggressive and delinquent behaviors (Kataoka et al., 2012). Gutermann et al. (2016) report that symptoms used to diagnose PTSD do not accurately encompass all posttraumatic symptoms in children, and that this has led to an underestimation of young people with PTSD due to ongoing research about how symptoms in young people differ. Furthermore, because post-traumatic stress symptoms can be detrimental to a young person personally and socially, Gutermann et al. (2016) call for further research on the effects of subclinical and differing forms of PTSD, along with post-traumatic symptoms, because without early and
effective treatment recovery rates are poor. D’Andrea et al. (2012) also report that a diagnosis of PTSD as currently defined does not fully capture the range of post-traumatic symptoms, because less than one fourth of children in treatment for a traumatic event meet the criteria for PTSD. Furthermore, D’Andrea et al. (2012) explained that when children are diagnosed with PTSD, 40% have at least one other disorder diagnosis (i.e. mood, anxiety, and/or disruptive behavior). In some cases, the PTSD is only discovered after the child is referred to mental health services for the initial issues associated with another disorder. For example, a child may be therapy for depressed or anxious mood, but her psychologist may uncover a previous underlying trauma that warrants a PTSD diagnosis. This is further supported by research according to Copeland, Keeler, Angold, and Costello (2007), who found that PTSD is the 10th most common disorder initially diagnosed in adolescence following trauma exposure.

Prevalence. Research shows that trauma exposure among adolescents is very common, with two-thirds of youth having been exposed to some sort of trauma by the age of seventeen (Gonzalez, Monzon, Solis, Jaycox, & Langley, 2015). There are many different types of trauma that affect youth, including, but not limited to: abuse (sexual, physical, and emotional), loss of a loved one, exposure to domestic and community violence, natural disasters, or a combination of these. Trauma from abuse, as reported by the U.S. Department of Health and Human Services, is unfortunately common; 702,000 children were maltreated in the United States in 2014, with a victim rate of 9.4 per 1,000 children (U.S. Department of Human Services, 2016). Of the abuse reported, 75% were neglected, 17% physically abused, 8.3% sexually abused, and 6.8% experienced “other”
types of maltreatment—i.e., threats of abuse, parental drug/alcohol abuse, or parents giving up custody of a newborn (U.S. Department of Health and Human Services, 2016). It should be noted that these percentages accumulate to more than one hundred percent due to instances where abuse qualifies under multiple categories; the definition of “other” also differs across states.

Children are also exposed to trauma through domestic or community violence. Malik (2008) defined domestic violence as aggressive behavior that occurs at a child’s home, including physical altercations between parents or community violence. Community violence includes the child witnessing intentional aggressive behavior outside the home, such as hearing gunshots or witnessing a mugging. Malik (2008) further reports that both domestic and community violence have equally negative effects on the individual’s development, due to the witness becoming traumatized and losing a sense of safety and security, which may halt their emotional and behavioral development. In 2014, an estimated 1,165,383 violent crimes occurred in the U.S., at a rate of 365.5 crimes per 100,000 inhabitants (Federal Bureau of Investigation, 2016). In a study of a nationally representative sample of 4,459 children ages 0-17, conducted by The National Survey of Children’s Exposure to Violence, 25.3% of children had witnessed domestic or community violence (Hamblen, & Barnett, 2016).

One of the most common forms of trauma for adolescents is loss of a loved one. According to Morrow (2008), the death of a loved one can be one of the worst types of trauma an adolescent may experience. Unfortunately, according to the Children’s Grief Awareness Day campaign, approximately 1.5 million children live in a single family
household due to the loss of one or both parents (Schwartz, 2016) and each year 7,000 to 12,000 children in the U.S. have a parent commit suicide (Little, & Akin-Little, 2013). Furthermore, the national death rate for children ages 1-14 in 2014 was 9,080 children; in children ages five to fourteen there was an incidence rate of 12.7 per100,000 (CDC, 2016). Thus, it is likely that many children will somehow be affected by a traumatic event, either personally or through a peer during childhood.

**Signs and symptoms.** Not every child exposed to a traumatic event will experience negative effects, but it is not uncommon for any individual to experience some symptoms after trauma. In the weeks following a traumatic event, adolescents may experience various degrees of distress, including: feeling scared, having difficulty concentrating, avoiding reminders of the event, showcasing aggressive behavior or acting out, or losing interest in social activities or activities that once interested them (Alisic, 2012). According to research by De Young, Kenardy, and Cobham (2011) infants, toddlers, and preschoolers’ typically display post-traumatic symptoms as re-experiencing, avoidance/numbing, and/or hyperarousal. In reexperiencing, young children may engage in posttraumatic play where they continuously reenact themes from the trauma, draw pictures or repeatedly talk about the event, and an increase in distressing nightmares. Young children may also socially withdraw from family members and friends, and display restricted exploratory behavior. Lastly, after a traumatic event young children may demonstrate hyperarousal such as disturbed sleep, increased irritability, temper tantrums, constant state of alertness, difficulty concentrating, exaggerated startle response, loss of previously acquired skills, increased clingingness or increased separation
anxiety, and new fears that develop with no obvious links to the trauma (De Young et al. 2011).

Trauma symptoms are grouped into four domains: 1) affective, 2) behavioral, 3) cognitive, and 4) physical. Affective symptoms include frequent mood changes, depression, anger, fear, and/or feelings of being alone. Behavioral symptoms typically manifest as avoiding reminders of the trauma, but can also include withdrawal and isolation from peers or activities that were once of interest. Cognitive symptoms include distorted thoughts or beliefs about oneself, others, the event, and or the world. Children may also experience shame after trauma, believing that the event is somehow their fault. Finally, physical symptoms most commonly include elevated heart rates and blood pressure, increased muscle tension, and hypervigilance (Little & Akin-Little, 2013).

The School’s Response to Trauma

Mental health professionals, including school counselors and school psychologists, contend that schools are a logical place for provision of mental health services because every community has a school and every state mandates that children attend school (Little & Akin-Little, 2013). Children spend much of their time in school, thus it is a convenient place to not only identify children who may have been exposed to trauma, but also a logical place to deliver interventions. Little and Akin-Little (2013) further reported that in schools where mental health programs were present, school staff were more likely to refer students to mental health services and those students who received services showed improvements in behavior, emotional functioning, and academics.
Teachers are in an ideal position to recognize if a student may be struggling with exposure to trauma because students spend much of their time in school. Likewise, because students spend most of their time in the classroom, teachers are in a unique position where they can help to not only identify a student struggling but also use classroom accommodations to help the student learn to cope. Teachers can then serve as role models, providing emotional support and serving as a link between families, students, and mental health care by helping to monitor and support student’s recovery (Alisic, Bus, Dulack, Pennings, & Splinter, 2012). According to Anderson, Blitz, and Saastamoinen (2015) school staff members should work from a trauma-informed perspective to best help this population; they need to understand the causes of behaviors. For example, an individual with a trauma-informed perspective understands that a child’s outbursts are not acts of rebellion, but a reaction to overwhelming stress and/or anxiety (Anderson et al., 2015). Furthermore, receiving mental health care at school is especially important for students from lower socio-economic backgrounds, as school may be the only place they have access to intervention and support (Anderson et al., 2015).

**Impact of trauma on school performance.** Early life exposure to trauma can develop into more severe or chronic problems over time if symptoms are not identified early. Childhood trauma can interfere with development; psychological functioning in as early as first grade is linked to academic achievement years later (Gonzalez et al., 2015). It is during the elementary years that children are facing critical educational milestones that will build the foundation needed for future learning and school endeavors.
Further, new research has revealed that some students previously referred to special education due to behavioral or emotional problems were actually suffering from untreated PTSD symptoms (Ray, 2014). For example, behaviors children may display that are also symptoms of a trauma exposed adolescent include: poor concentration or attention difficulties, increased distress/worry, irritability and angry outbursts, jumpiness and increased alertness to environment, misbehavior uncommon to the child, physical complaints (stomach ache, headache, dizziness) without apparent cause, withdrawal from peers and activities that once held interest, listlessness, lack of responsiveness, and sudden and extreme emotional reactions. Likewise, research by Alat (2002) found that other social-emotional/behavioral symptoms include a shift in temperament (loud and outgoing to shy, confident to afraid) and a refusal or fear of going to school. All of these symptoms may lead to poor productivity and difficulties in the classroom. The student may fall behind academically and/or socially.

**Impact on development and long-term consequences.** If a child experiences trauma before the age of eleven he or she is more likely to display psychological symptoms than those who experience trauma at a later age (Little & Akin-Little, 2013). Trauma may manifest in adolescents as behavioral or learning problems. In fact, prolonged exposure to trauma can result in decreased brain size and functioning (Little & Akin-Little, 2013). Developmental ramifications may include returning to earlier stages and/or behaviors such as bed-wetting, finger-sucking, and loss of previously learned academic or social skills (Alat, 2002). Some older children develop self-destructive behaviors such as self-abuse/self-destruction (i.e. negative self-talk, cutting, eating
disorders, etc.), drug and alcohol abuse, and unhealthy behavior patterns that reflect anxious and avoidant or anxious and resistant attachments. These negative behaviors can be compounding, and adolescents may need help learning the necessary coping skills (Alat, 2002).

**Early Identification of Trauma Exposure**

According to Gerson and Rappaport (2013) childhood trauma is a “hidden epidemic” due to its ability to cause both immediate and long-term consequences (p. 137), with the ability to cause detrimental long-term effects when not identified early. Gerson and Rappaport (2013) further note that post-traumatic symptoms are often missed in children, so it is crucial that personnel working with youth receive the necessary training to recognize risk factors.

**School-based identification.** In the U.S., children are required to go to school, making it the ideal setting to identify setting to recognize at risk individuals (Gonzalez et al., 2016). According to Overstreet and Chafouleas (2016) schools can reach at-risk students more effectively by implementing a universal screener for trauma exposure or traumatic stress reactions. Universal screeners allow school staff to identify students who are at risk and to discern issues the general population may be struggling with that could be addressed with school-wide interventions. Overstreet and Chafouleas (2016) further report that once school staff understand their school’s climate, they can estimate the extent of services both the individual and entire school will need to ensure each student has a better chance of success. However, due to the many possible post-traumatic
symptoms, assessing for traumatic stress is difficult for clinicians as well as school staff. Screeners and interviews can be used to help further identify those at risk.

**Screening tools.** Universal screeners can provide school staff an initial identification of at-risk students (Overstreet & Chafouleas, 2016). Tools that Gerson and Rappaport (2013) mention that may be helpful for school staff to use are post-traumatic stress symptoms checklists or behavior indices to determine if the student presents with any risk factors. The National Center for PTSD (http://ptsd.va.gov/) and the National Child Traumatic Stress Network (http://NCTSN.org) offers free, brief risk assessment and evaluation tools to screen for childhood trauma and adolescent PTSD. Tools offered include the Traumatic Event Screening Inventory (assessing for trauma experiences), the UCLA Child/Adolescent PTSD Reaction Index for DSM-5, the Child Posttraumatic Stress Index, The Trauma Symptom Checklist for Children, and the Parent Report of Child’s Reaction to Stress. The UCLA Child/Adolescent PTSD Reaction Index for DSM-5 is also available in Spanish and German (http://www.ptsd.va.gov/PTSD). While these measures are all screening tools, they should not be used to diagnose. These tools are also limited because they are behavior checklists, which may be confusing for an individual who does not have prior training in assessing for PTSD symptoms. Also, these tools cannot be used alone to assess for symptoms; for example, the parent report may not be reliable because parents tend to underreport their child’s symptoms potentially because of their own previous trauma experiences (Loeb et al., 2011). Lastly, if an adolescent has a history of trauma, it is important to screen for suicidality, as this population may be at an increased risk (Gerson & Rappaport, 2013).
Furthermore, school-based screenings can pose additional challenges, such as: limited staff and funding to conduct screenings, limited developmentally appropriate measures available, and difficulties to following-up with all students (Overstreet & Chafouleas, 2016). Even though self-reports are typically the easiest screeners to use, they may not be appropriate for use with young children because they may be unable to comprehend and respond accurately to some questions (Gonzalez et al., 2015). Effective screeners for preschoolers can use tools such as puppets, stories, and play narrative techniques to determine if there is underlying trauma; however, they lack feasibility because of the time and energy for administration (Gonzales et al., 2015). Large scale implementation is impractical.

Despite the issues universal screening, Eklund and Rossen (2016) argue that it is the most effective way to identify students exposed to trauma early on. The authors provided the following guidelines for universal screening for trauma exposures in schools: obtaining parental consent, choosing developmentally appropriate screening methods (may include making developmentally appropriate modifications to measure), and ensuring that both group and individual screening does not require an extensive amount of time. Schools should also consider the time and expertise needed to analyze and interpret any findings. Eklund and Rossen (2016) also note that there is limited research on school-based screening for trauma exposure given that is a “relatively new” practice, but initial data supports screeners’ psychometric properties.

**Interviews.** When screening for post-traumatic symptoms many clinicians prefer interviews, as they can help identify hidden symptoms of post-traumatic stress.
Interviews allow establishment of rapport between the interviewer and interviewee, clarification of unclear responses, and addressing of sensitive issues (Loeb et al., 2011). However, while asking specific questions about trauma and PTSD symptoms may seem like the easiest option, traumatized children are not known to freely volunteer this information. Further, even with trained clinicians, PTSD symptoms are often missed in routine examinations (Gerson & Rappaport, 2013).

**School-Based Interventions for Trauma**

Children exposed to trauma are at an increased risk for physical, emotional, and behavioral difficulties in the classroom; they may be difficult students due to their challenging behaviors. In order to help these students, school staff need to employ a trauma-informed approach; they need to view the student’s outbursts and withdrawals not as acts of rebellion but as a way of coping with the overwhelming stress and anxiety from trauma exposure (Anderson et. al, 2015). Fortunately, there are several interventions for students who are struggling with post-traumatic symptoms.

**Cognitive-behavioral intervention for trauma in schools (CBITS).** CBITS was designed to be delivered by school mental health clinicians and targets the general education students ranging from ten to fifteen years old (Jaycox et al., 2009). The goal of this program is to reduce students’ symptoms related to trauma exposure and to increase coping and cognitive skills to handle future stressors. School mental health clinicians deliver CBITS over ten weekly group sessions, one to three individual student sessions, one teacher-education session, and two to four optional parent sessions (Jaycox et al., 2009). Akin and Akin-Little (2013) reported that CBITS would be beneficial for various
types of traumatic exposures, such as individuals who had witnessed or were the victim of violent acts, lived through a natural disaster, a house fire, or were physically injured or abused. Furthermore, the participants Akin and Akin-Little’s study included children from multiple locations across the U.S. and from several ethnic backgrounds, including Hispanic, Native Americans, and African Americans (Little & Akin-Little, 2013). Thus, CBITS is an example of an effective intervention that school counselors can utilize after a student has been exposed to trauma.

**Support for students exposed to trauma (SSET).** Not all schools have direct access to mental health clinicians, so CBITS was adapted into a new program called Support for Students Exposed to Trauma (SSET), which can be delivered by general school staff with no previous mental health training (Jaycox et al., 2009). One benefit of SSET is that it can be implemented in the classroom for all students regardless of previous exposure to trauma. This updated program targets students in fifth through ninth grade who were exposed to trauma and are experiencing elevated symptoms of PTSD, depression, and anxiety. The program is delivered by school counselors and teachers who first receive a two-day training session on their roles in the intervention. The teacher delivers this tier two intervention to the classroom over ten weekly small group sessions. In SSET there are no individual or parent sessions that are one-on-one with a counselor, instead the teacher and counselor work with a group of students. Intervention strategies in SSET include having students process traumatic experience through writing and drawing, social problem solving, relaxation training, psycho-education about common reactions to stress or trauma, cognitive coping (including thoughts and feelings about trauma and
helpful thinking), and controlling trauma reminders and general anxiety. The program was pilot-tested for two years with a group of 76 participants in which 58% met the initial study criteria of having experienced severe violence in the past year and had moderately severe symptoms of post-traumatic exposure (Jaycox, et al., 2009). The results of the study indicated that the SSET program could be implemented successfully by teachers and school counselors with students and parents reporting “good” to “high satisfaction” with the program. Furthermore, students demonstrated reductions in trauma symptoms and those who had reported a high level of symptoms experienced the most significant benefits.

According to Kataoka et al. (2012) there are several individual intervention strategies school staff and mental health professionals can employ at schools to help students exposed to trauma, including: relaxation training, cognitive restructuring, trauma narrative, in vivo gradual exposure to trauma reminders, and teaching problem solving. Kataoka et al. (2012) adds that in order for supports to be effective and lasting for the student, school staff will need to work with the parents so that supports provided in the school setting will be reinforced when the child is home.

**Teacher Training on Trauma**

Teachers are in the ideal position to help students exposed to trauma because they work with them every day. Ray (2014) notes five important things teachers can do to support students who have experienced trauma, including: 1) seeking outside help (school nurse, school psychologist or counselor, social worker, or principal); 2) creating a safe classroom atmosphere that offers acceptance and safety for all students (consistency in
class rules, routines, and no bullying policy); 3) letting the child speak, write, or draw about the events if they want to; 4) empowering students (trauma involves the loss of control so provide them with choices); and 5) considering best strategies to promote their academic success (shortened assignments to aid in focus, additional time to decrease anxiety and stress).

Many teachers feel ill-equipped or do not have the right knowledge set to know when and how to implement trauma-informed practices (Alisic, 2012). Research on teachers’ perspectives about providing support to students who have been exposed to trauma is limited. There are several studies on the perspectives of traumatic stress from the viewpoint of the child and their parents, but not specifically from the perspective of the teacher (Alisic, 2012).

**Teachers’ experiences with and perceptions of trauma-informed practices.**

Though there are school-based interventions for teachers to use with students exposed to trauma, teachers may struggle with how to identify at-risk students and how to provide the best care (Alisic, 2012). Alisic (2012) conducted a qualitative interview study in the Netherlands in which 21 teachers were asked open-ended questions about their perspectives regarding providing support to children after trauma. Alisic (2012) found that teachers struggled with how to provide the best care to students dealing with trauma, including knowing what their role should be, balancing the student’s needs with the rest of the classrooms, needing more professional knowledge, and knowing how to address the emotional toll trauma can have on support providers. Teachers questioned what their role was in supporting students who were exposed to trauma. They wondered where their
job as a teacher ended and when the social worker or psychologist should take over. They reported feeling that teaching did not just include academics, but now also includes helping children to grow socially and emotionally. Some teachers interviewed in the study conducted by Alisic (2012) believed that teachers should only teach what they were trained in which was academic subjects. Teachers also struggled with how to balance the needs of a child exposed to trauma and the needs of the classroom. Withdrawn children required extra attention, but the teachers also did not want to place too much focus on the traumatic event and make the student feel like an outcast or make the event something that was overly important. Teachers reported knowing that a normal routine was helpful to recovery and did not want to give the traumatic event so much focus that the child became stuck in that mindset. Teachers also doubted whether they had enough knowledge of how to help students cope with trauma, and many were not sure what or if their school had any protocols or guidelines for these situations. A majority of the teachers questioned if they should talk to the parents or children about the trauma, when it was appropriate to refer to more professional or specialized care, and who they should refer them to. They also struggled with the personal emotional toll, especially when some teachers had similar past traumatic experiences. In general teachers expressed concern with taking the problems home with them and did not feel like they were able to be as available to the students as they felt they should. However, teachers mentioned that they were able to find support among colleagues and reported that they felt reduction in their levels of stress when they could “vent” to colleagues (Alisic, 2012).
The Present Study

Previous research on post-traumatic stress symptoms, assessment and available interventions focuses more on practitioners in the clinical setting. Currently, research on teachers’ perceptions of their skills in working with students exposed to trauma and post-traumatic symptoms is somewhat limited. The study used as a basis for the present research was by Alisic (2012), who conducted a qualitative examination about teacher’s perspectives on providing services to children who experienced trauma. The current study expanded on Alisic (2012) by using mixed methods, including a quantitative survey and qualitative follow-up interview. This helped the researcher examine teachers’ experiences and perceived ability to serve students exposed to trauma.
CHAPTER III

METHOD

This chapter presents the research questions posed in the current study, along with the planned research design to collect data and answer the proposed questions. Materials, participants, and the procedure are also described.

Research Questions

The purpose of this study was to explore teachers’ experiences with and perceived ability to serve students exposed to trauma. The study also examined the relationship between the teachers on the job training such as professional development about trauma exposure, educational exposure to trauma informed teaching in graduate or undergraduate courses, and previous experiences of working students exposed to trauma and how each of these factors affected the teachers’ perceptions of not only the students but also their own ability to work with that population. As such, the following research questions were posed: (1) What are teachers’ past experiences working with students exposed to trauma? and (2) What is the relationship between amount of training, education, or previous experience in the area of trauma exposed students and teachers’ perceptions of their skills in providing support for these students?
Hypothesis

Research question 1 was answered with qualitative methods. Due to the exploratory nature of qualitative research, there was no hypothesis. For Research question 2, it was hypothesized that teachers would perceive themselves as generally unskilled in providing services to students exposed to trauma. This hypothesis was based on the study by Alisic (2012), which found that teachers struggled with what their role was as the teacher, how to accommodate the needs of all students, a desire for more knowledge on working with students exposed to trauma, and how to not take the work home with them. However, it was hypothesized that teachers who have more prior training in trauma from education or professional development will have more confidence in providing services than those teachers without previous experiences.

Research Design

This study employed a mixed methods design, with a quantitative survey and qualitative interviews as the data collection methods. The survey examined teacher perceptions and the relationship between these perceptions and teacher training, education, and previous experiences with students exposed to trauma. An electronic survey design was selected because it allowed for a quicker collection of data from a large group of people from different populations, reduced cost, ease of data entry, and flexibility of survey formatting (Granello & Wheaton, 2004). The qualitative data were used to further explore and understand the quantitative evidence and gave supplemental meaning to test the hypothesis (Morse & Niehuas, 2009).
The predictor variables included: (1) perceived amount of training on students exposed to trauma, which included professional development or other employment-based trainings on or including the topic of students and trauma, (2) perceived amount of education in the area of trauma exposed students, which was measured by undergraduate or graduate level sessions or courses that covered students exposed to trauma, and (3) previous experiences educating or working with students who had been exposed to trauma, which was measured by if the teacher had previously encountered a student exposed to trauma and if the teacher’s perceptions of these experiences were positive or negative. The criterion variable was the perceptions held by teachers about working with students exposed to trauma; this was measured by the number of survey questions answered with favorable perceptions of students exposed to trauma.

**Participants and Setting**

**Teachers.** Participants in the current study included \( n = 114 \) general education school teachers working in the Midwest region of the Unitec States in public, charter, rural, suburban, low socioeconomic, middle socioeconomic, and high socioeconomic status schools. Teachers were recruited through their school systems as well as via recommendation of local school principals. To be eligible for participation, all participants needed at least two years of prior general education teaching experience. Online surveys were administered by recruiting school principals and superintendents to email them to their staff. At the end of the survey, participants were asked if they would be willing to participate in a follow-up interview with the researcher. Participants for interviews were chosen based on willingness to participate and location to the researcher.
Any responses received that did not meet the eligibility criteria were excluded. Surveys with more than two questions left blank were excluded from analyses.

Of the 114 general education teachers who completed surveys, 71.93% reported teaching for more than ten years. Sixty percent reported teaching in a suburban school; 21.9% in an urban school; and 7% in a rural school setting. Approximately half of teachers reported teaching at the 6th grade or above. For complete demographic statistics on participants, see Table 1. At the end of the survey, 26 teachers left their email and contact information to be contacted for a phone interview. The researcher emailed all 26 volunteers to set up an interview (22.3% of teachers surveyed volunteered to be interviewed), and interviewed five teachers (4/4 of teachers surveyed were interviewed). Due to poor recording quality one of the five phone interviews was unable to be transcribed and analyzed.

Four general education teachers were interviewed via phone call, and each was given a pseudonym to protect their identity. Each teacher could identify at least one student that they had taught who had been exposed to trauma, and each teacher currently taught at a public school in the Midwest region of the U.S.

“Jess” is a kindergarten teacher who had been teaching for seventeen years, and teaching was her first career. Previously she had taught at a private school for two years, and then in her current district for eight years. In her interview Jess mentioned that the community has issues with drugs. She also shared that she has been CPI certified for at least five years.
“Susie” is a middle school music teacher who has been teaching for four years at her current district, which is the only district she had worked for since earning her license.

“Patty” is a high school math teacher who has worked at her current building for four years, previously she had taught at another district’s high school for three years. Patty is a second career teacher and previously worked in a corporate job. She described her district as having a strong Appalachian influence.

“Leann” teaches English Language Arts and Social Studies for sixth through eighth grade students. She has been teaching for twenty-one years at her building and said that she initially subbed for a year with the district before being hired on as a teacher.

Table 1. Demographics of Participants

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Years Teaching</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-10 years</td>
<td>32</td>
<td>28.1%</td>
</tr>
<tr>
<td>11-20 years</td>
<td>53</td>
<td>46.5%</td>
</tr>
<tr>
<td>21+ years</td>
<td>29</td>
<td>25.4%</td>
</tr>
<tr>
<td>Grade Level Currently Teaching</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preschool</td>
<td>5</td>
<td>4.4%</td>
</tr>
<tr>
<td>Elementary (K-5th grade)</td>
<td>53</td>
<td>46.5%</td>
</tr>
<tr>
<td>Middle School (6-8th grade)</td>
<td>27</td>
<td>23.7%</td>
</tr>
<tr>
<td>High School (9th-12th grade)</td>
<td>28</td>
<td>24.6%</td>
</tr>
</tbody>
</table>
Location and Type of School*

<table>
<thead>
<tr>
<th>Location</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>25</td>
<td>21.9%</td>
</tr>
<tr>
<td>Suburban</td>
<td>69</td>
<td>60.5%</td>
</tr>
<tr>
<td>Rural</td>
<td>10</td>
<td>8.8%</td>
</tr>
<tr>
<td>Charter</td>
<td>3</td>
<td>2.6%</td>
</tr>
<tr>
<td>Public</td>
<td>65</td>
<td>57%</td>
</tr>
<tr>
<td>Private</td>
<td>0</td>
<td>-</td>
</tr>
</tbody>
</table>

Socioeconomic Status*

<table>
<thead>
<tr>
<th>SES</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>High SES</td>
<td>1</td>
<td>0.9%</td>
</tr>
<tr>
<td>Middle SES</td>
<td>14</td>
<td>12.3%</td>
</tr>
<tr>
<td>Low SES</td>
<td>80</td>
<td>70.2%</td>
</tr>
</tbody>
</table>

*Participants were asked to select all options that apply.

Measures

The survey and interview question’s general topics were created by the researcher and based on current research from a 2012 study done by Alisic (see Appendices A & B).

**Quantitative survey.** The survey contained 17 items. The items were piloted and reviewed by a second-year school psychology cohort, two school psychology professors, and one school psychologist currently working in a public school system. The survey was then finalized according to feedback received. Survey questions were condensed and reworded for clarity, and the survey was then emailed to the cohort for additional feedback to ensure previous issues with the survey had been corrected. The survey asked teachers about their educational history, work setting, if they’ve worked with students
exposed to trauma and what types, and then if teachers have received any sort of trauma-related training (such as pre-service training in undergraduate or graduate course work, professional development, and a blank option to write in other training).

**Qualitative interview.** The semi-structured interview was initially designed to take 30-45 minutes and when conducted ranged in length from 16-33 minutes. This interview was piloted with a general education teacher who had worked in the field for 12 years, and then reviewed by a second-year school psychology cohort, two school psychology professors, and one school psychologist currently working in a public-school system. The interview questions were finalized according to feedback received. Interview questions were reworded for clarity and a definition of what trauma is was added to the introduction. The questions were then emailed to the cohort for additional feedback to ensure that previous issues had been corrected. Topics included past education and work history, such as what they felt their role was when working with students exposed to trauma, how this knowledge affected their practice, knowledge of school protocol, whether they received support from colleagues, and if there are any supports or information they wish they had as teachers to assist students exposed to trauma.

**Procedures**

The study was approved by the University of Dayton’s Institutional Review Board (IRB) prior to data collection. Descriptive data were collected from the survey to represent teachers’ overall perceptions of their training, and further descriptive data was collected in the semi-structured interviews. The purpose for using a mixed methods design was to gain a general perspective of teachers’ experiences and perceived ability to
serve students exposed to trauma, and then follow up with one-on-one interviews where these experiences can be discussed more in-depth. The interviews allowed the researcher to organize the experiences and perceptions of the participants into common themes and begin to generate theories (Morse & Niehuas, 2009).

**Phase I: Recruitment and consent.** The researcher sent email requests to principals and superintendents of school districts throughout the Dayton area region to obtain permission to survey teachers. If permission was obtained from the principal or superintendent, the researcher emailed the survey link to the principal or superintendent who then emailed the link to the teaching staff. The last question of the survey asked teachers if they were willing to participate in a follow-up phone interview. The question included an explanation of the study, explanation of the interview, and an area for them to provide consent should they agree. Participation was voluntary. The researcher emailed 31 districts and received consent from three districts; additional surveys were received from teachers who asked to send the survey to their friends who worked at other school districts and wanted to participate.

**Phase II: Survey administration.** The researcher administered the online survey through Google forms, which could be opened via an online link provided in an email (see Appendix A). The survey included an area where the teacher could provide contact information if they desired to participate in the follow-up interview. Teachers who agreed to participate were told that they will be contacted in the future for an interview. One-hundred fourteen surveys were collected.
**Phase III: Interviews.** Twenty-six participants volunteered to be interviewed through the survey, and after contacting all of them, five volunteers set up and completed phone interviews. Participants were interviewed individually by the researcher using a semi-structured format (see Appendix B). Participant interviews were conducted by phone and audio recorded for future transcription. Participants were notified that their identities would be kept confidential by using a pseudonym, that the interviews would be audio-recorded, and that the researcher would take notes of what was said during the interview. Interviews lasted from 17 minutes to 34 minutes. Participants were emailed a five-dollar Starbucks gift card after the interview to compensate them for their time. Of the five interviews completed, only four interviews were coded due to poor audio quality of the fifth interview; it could not be transcribed.

**Phase IV: Post-interview data analysis.** Recorded interviews were transcribed in full, coded, and analyzed.

**Data Analyses**

**Survey.** The survey results yielded nominal, ordinal, and interval data. Mean scores and percentages were used to summarize participant background and demographic information. Descriptive and parametric statistics (two sample t-test assuming unequal variances) were used to analyze the data.

**Interview.** The follow-up interview yielded qualitative data. The researcher’s notes and audio recordings were analyzed, and data were coded. Names were changed to pseudonyms, and identifying titles stricken in order to ensure anonymity. Following the
coding, the researcher used a content analysis process according Powell and Renner (2003) to condense the codes into themes from the transcription.

**Trustworthiness**

Steps were taken to ensure validity and reliability of the data. The researcher previously mentored college students, some of whom struggled with traumatic experiences, therefore in order to address potential bias, the researcher had a colleague familiar with the design check the identified themes. The colleague was given two transcribed interviews at random, and asked to identify the main ideas expressed by teachers throughout the interviews. The interviews coded by the colleague were then compared to the author’s coded version.
CHAPTER IV

RESULTS

Research Question 1

Quantitative data from the survey revealed that overall, 97.4% of teachers reported that they were aware of teaching a student who was exposed to trauma. Teachers reported that their students were exposed to various types of trauma. The most prevalent types of trauma types reported included neglect, domestic violence, and physical abuse. There were some discrepancies in the data. For example, one-third of the teachers indicated that their school had a protocol for recognizing and providing supports for students who had been exposed to trauma. However, when later asked if they felt confident they could follow their school’s protocol in order to aid students exposed to trauma, almost half responded that they felt confident implementing their school’s protocol. For complete demographic statistics on teachers’ past and present experiences, see Table 2.

Table 2. Demographics of Teachers’ Past & Present Experiences

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently Teaching/Have Taught a Student Exposed to Trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>111</td>
<td>97.4%</td>
</tr>
<tr>
<td>Number of Students Taught Who Were Trauma Exposed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>0 Students</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1 Student</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2 Students</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3 Students</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4 Students</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>5 or More Students</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Unsure</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Types of Trauma Students Were Exposed To*</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Violence</td>
<td>52</td>
</tr>
<tr>
<td>Complex Trauma (prolonged traumatic events)</td>
<td>52</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>96</td>
</tr>
<tr>
<td>Early Childhood Trauma</td>
<td>73</td>
</tr>
<tr>
<td>Medical Trauma</td>
<td>67</td>
</tr>
<tr>
<td>Natural Disasters</td>
<td>18</td>
</tr>
<tr>
<td>Neglect</td>
<td>97</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>88</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>75</td>
</tr>
<tr>
<td>Refugee Trauma</td>
<td>12</td>
</tr>
<tr>
<td>School Violence</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Terrorism</td>
<td>1</td>
</tr>
<tr>
<td>Traumatic Grief (severe grief symptoms)</td>
<td>57</td>
</tr>
</tbody>
</table>

Current School Has a Protocol for Recognizing and Providing Support to Students Exposed to Trauma

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>37</td>
<td>32.7%</td>
</tr>
<tr>
<td>No</td>
<td>31</td>
<td>27.4%</td>
</tr>
<tr>
<td>Unsure</td>
<td>45</td>
<td>39.8%</td>
</tr>
</tbody>
</table>

Teacher Felt Confident in Following School’s Protocol to Aid Students Exposed to Trauma

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>54</td>
<td>47.4%</td>
</tr>
<tr>
<td>Disagree</td>
<td>1</td>
<td>0.9%</td>
</tr>
<tr>
<td>Unsure</td>
<td>27</td>
<td>23.7%</td>
</tr>
<tr>
<td>My School Does Not Have a Protocol</td>
<td>32</td>
<td>28.1%</td>
</tr>
</tbody>
</table>

Teachers’ Sources of Training on Trauma*

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Undergraduate Class</td>
<td>22</td>
<td>19.3%</td>
</tr>
<tr>
<td>Graduate Class</td>
<td>19</td>
<td>16.7%</td>
</tr>
<tr>
<td>Professional Development</td>
<td>76</td>
<td>66.7%</td>
</tr>
<tr>
<td>None</td>
<td>29</td>
<td>25.4%</td>
</tr>
</tbody>
</table>

Number of Trauma Focused Trainings Attended as Part of School District

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Trainings</td>
<td>35</td>
<td>30.7%</td>
</tr>
<tr>
<td>1-2 Trainings</td>
<td>54</td>
<td>47.4%</td>
</tr>
<tr>
<td>3-4 Trainings</td>
<td>18</td>
<td>15.8%</td>
</tr>
</tbody>
</table>
Descriptive data were also obtained from semi-structured interviews done over the phone with four volunteers. Teachers cited current and past pupils they had encountered and worked with, and students demonstrated a range of post-trauma behavior from emotional, violent outbursts to isolation. However, according to teacher reports classmates were not judgmental and rather wanted to check in that the peer was alright. Teachers expressed varying degrees of confidence in working with trauma-exposed students, but each was adamant that they were there to help and often cited the school’s counselor, guidance counselor, and administration teams as a necessary resource. Each teacher shared a desire to help their students, but many were unsure how to help them best. Core themes identified are described to follow, and include: 1) the diverse and crucial role of communication, 2) the need for solution-based and relevant knowledge, 3) the availability of the school counselor, and 4) stereotyping students exposed to trauma.

The diverse and crucial role of communication. The diverse and important role of communication in the educational setting was discussed by each teacher interviewed. A majority of teachers shared that they often learned that the student had gone through a trauma from another source such as counselor, community person, or the student’s friends. In instances where teachers needed more information or more knowledge about a subject they often went to the school counselor or principal for insight. Several teachers said that they found out about her school’s available resources was by talking to people, and “Leann” said that she gained much of her knowledge from professional development
days at the start of the school year where staff were introduced to each other and told what personnel were in charge of specific areas. However, there were mixed responses when teachers were asked if their school had a protocol for reporting or working with colleagues to aid students. Each teacher mentioned working with other teachers to find ways to aid their at-risk students in the classroom, but “Patty” admitted that this communication was “informal” and that there was no protocol or tracking process in place. Means of communication teachers used to discuss potential tools for students in crisis included verbal communication face to face, phone calls, and through email.

Another role communication served among the teachers was that they often would confide in each other and use this as a means of decompressing. “Jess” referred to this trusted confidant as her “ear,” and was a specific individual she could talk with to decompress and relax from a hectic day. Several teachers said that lunch time was when they could just relax with their peers as it gave them a chance to talk, joke around, and decompress from any stressors that had occurred in the classroom. “Leann” shared that at her school there is a group of teachers that eat lunch together every day and talk, and she added that, “we’re all there for each other which is really great.”

The need for solution-based and relevant knowledge. Every teacher interviewed expressed a desire to help students, and that they often chose the field because they loved children and felt that their field was personally fulfilling. However, teachers expressed varying degrees of experience in working with students exposed to trauma and described varying confidence levels in knowing what to do to help these students. Teachers expressed the desire for more specific training and solution-based
resources. Teachers desired relevant knowledge that did not solely admire a problem, but that gave them a specific course of action or resources for the student. As Leann stated, “I don’t think teachers nowadays [are] trained well enough in de-escalation.” Jess reported that she was not instructed in CPI training until after a student had an emotional and physical meltdown in her classroom. Susie expressed that she did not feel like she knew how to make a connection when students were struggling in the classroom post-trauma. She said that she understands that students may be caught “in their own minds” or dealing with the “fight or flight” response, but she wants to know more about how she could, “reach the students that nothing is going to make a connection with them, just [to] try and open up the option of talking or having conversation with them…how do I break that barrier?”. Patty reported that she wished she had more about specific resources that she could direct families to in the community. Overall, teachers would like more specific knowledge and informational materials about trauma recovery. Susie cited a specific area she saw as a need was making sure that teachers understand the importance of one’s initial reaction to a student who has gone through a trauma. Susie mentioned an example where a student returned to school after a crisis, and another teacher greeted her in a dramatic fashion that brought unwanted attention to the student’s delicate situation in front of fellow staff and peers- some of whom Susie believed were not even aware of the situation initially. Also, several teachers expressed that the most rewarding information they received was through professional training focused on trauma recovery. Furthermore, when groups were kept smaller participants had the opportunity to ask questions and receive more immediate, specific feedback. As Jess shared:
I will be honest. I’ve taught for seventeen years. Sitting in a PD that has a big group 95% of the time teachers are playing on their phones, are playing on their computers, they’re not listening. Because it’s a big group and all of that information becomes just garbled, and it’s just like the kids. You put us in small groups, you teach us in small groups- we’re going to listen.

**The availability of the school counselor.** Each teacher interviewed mentioned working closely with a counselor concerning at-risk students on various occasions during their teaching careers. The school counselor served a variety of vital roles, including notifying teachers and staff of a student’s needs, communicating between staff and student’s parents about student’s needs, checking up individually with students, and providing training and resources to teachers when more information or knowledge was needed. Many teachers stated that the counselor was the first person they went to when they had concerns about a student, and Susie shared that the school counselor, “deals with a majority of students if they have issues in class or are not disciplined or focused for the most part. It is natural that we would speak to [them]”. The majority of teachers reported having a counselor in the building as vital to receiving immediate aid for students, especially when students were in crisis or teachers needed help in de-escalating the student. One school had a plan in place where if a student was having a crisis and needed to get out of the room to talk to the counselor, they could set up an appointment on Google classroom to meet with the counselor. A hall pass was then sent to the classroom, and the student could leave the classroom without drawing any unwanted attention from their classmates. However, Jess reported that her building did not always have a counselor available. At her building counselors were contracted through a private firm. While this created the opportunity for students who were eligible through the county to
continue their counseling sessions throughout the summer and school breaks, it also meant that several school buildings had to share a counselor. Since the counselor had to split her time, she was not always in building when she was needed. Jess spoke specifically of one event when a student had escalated in her classroom and the counselor was not available till an hour after the student’s episode. Jess added that:

"Unfortunately, by the time she got there the child had already reached the point where he would have to go home, but she was able to get there in time to talk to him to help him realize what was going on. And in leaving the school, be the least traumatic as we could possibly make it."

**Stereotyping students exposed to trauma.** The question of misconceptions of these students was posed, and each teacher agreed stereotyping students was a major issue in their buildings and districts. A majority of teachers interviewed reported that students exposed to trauma are often stereotyped and even labeled as “bad kids.” There was a general consensus that these students were misunderstood, as Patty stated, “I think that there is a typical reaction that they need to get over it or get tough without acknowledging the actual physical effect a trauma can have on a student.” Susie reported that people often falsely believe that these students just don’t care and that’s why they may display those problem behaviors, but in reality they are going through something that is mentally and emotionally trialing and are not in a place where they can be their best self. Susie further shared that sometimes in these situations teachers must remind themselves that it is not the student’s intent to cause issues in the classroom:

"There are some situations where you would think, okay I really tried a lot of things…or I’m really trying to reach out to this student. This is just not working, and I sometimes have to remind myself that that’s not necessarily true. It’s not that they don’t like the class or that they don’t like what’s going on, they just aren’t there. [They] aren’t in a place where [they] can be involved or as involved"
as they could be. That’s something I necessarily, I honestly have to remind myself.

Teachers touched on the idea that many of these students are not able to express themselves, and often do not understand what has gone on and are often just trying to regain “control.” In addition, teachers mentioned that these students are not any different from their peers in their basic needs. All children and adolescents crave attention and relationships, as Leann stated, “kids just want to be liked. They want to be loved. They want to be a part of something, so if you can do that with kids and just show them that you’re there—that relationship. Well I think you can turn a kid’s life around amazingly.”

Research Question 2

Parametrical statistical analyses were used to examine the relationship between teachers’ training, education, and previous experiences in working with trauma-exposed students and their perceptions of their skills in being able to work with and provide supports for those students in the classroom. A two-sample t-test was used to analyze the mean percentage of perceptions based on the percent responses consistent with favorable perceptions of working with students exposed to trauma on the Likert-scale survey (1=disagree, 2=slightly disagree, 3=neutral, 4=neutral, and 5=agree); this was adjusted for questions that had only three or four possible responses.

**Training.** An independent samples t-test was conducted to evaluate the relationship between teachers who obtained training on trauma-exposed students in their district, and their perceived ability to work with and provide support to the student. Analyses were run to determine if there was a relationship between professional
development (PD) trainings on trauma and teachers’ confidence in their abilities to work with students who experienced trauma. A total of 66.7% of teachers reported attending PD on students and trauma, while 33.3% reported that they did not receive PD training on trauma. However, when asked how many sessions of training teachers had completed, 69.3% of respondents said they had previous PD training on trauma; this second measure was used to run the statistical analyses. The teachers with prior PDs on trauma reported on average that they perceived their ability to serve students exposed to trauma in the range of _hesitant but willing to provide supports_ (ranked as a 3) to _optimistic about providing supports_ range (ranked as a 4) (average= 3.67); teachers without previous PDs on trauma also perceived their abilities to serve students exposed to trauma in the _hesitant but willing to provide supports_ (ranked as a 3) to _optimistic about providing supports_ range (ranked as a 4) (average= 3.60). Teachers’ responses on their perceived ability to serve students exposed to trauma without having previous education on trauma displayed a greater range in answers (variance = 0.42), than those who had received education on trauma (variance = 0.35). Results t-test were not significant, t (114)= -0.55, p=0.29. This suggests that there is not a significant relationship between receiving information on trauma exposed students in professional development and the teachers’ perceptions on working with and providing supports to those students in the classroom.

**Education.** An independent samples t-test evaluated the relationship between teachers who obtained information on trauma exposed students in their undergraduate or graduate level education, and their perception of being able to work with and provide support to the student. A total of 25.5% teachers reported taking undergraduate or
graduate level courses that included information on trauma exposure in students, while 74.5% of teachers reported they had not or were unsure of whether they had received education regarding trauma exposure and students. Teachers with pre-service training in trauma had a perceived ability to serve students exposed to trauma mean score of 3.79 (3=hesitant but willing to provide supports & 4= optimistic about providing supports) and teachers without previous education on trauma had a mean score of 3.6. Teachers’ perceived ability to serve students exposed to trauma who did not have previous education on trauma displayed a greater range in answers (variance = 0.43), than those who had received education on trauma (variance = 0.17). The t-test was significant, t (114)= 1.84, p=0.03. This suggests that there is a significant relationship between receiving information on trauma exposed students in undergraduate or graduate level courses and the teachers’ perceived ability to work with and provide support to those students in the classroom. This supports the prior hypothesis that teachers with previous trauma training will feel more confident about supporting trauma exposed students.

**Previous experience.** An independent samples t-test was conducted to evaluate the relationship between teachers’ current or past experiences in working with students exposed to trauma, and their perceived ability to work with and provide support to those students. A total of 97.4% teachers reported that they had or currently had a student in their classroom who had been exposed to trauma, where 2.6% of teachers reported they either had not or were unsure if they’d had a student who was exposed to trauma. Teachers who had previous experience with teaching a student who had been exposed to trauma reported a mean of 2.45 (3=more confident and optimistic about providing
supports, and 2=indifferent/no change in confidence/unsure about providing supports) and teachers without previous experience of having trauma exposed students reported a mean of 2.5 and no variance. The mean score of perceived abilities for teachers who had experience with trauma exposed students there was a variance of .33. The t-test was not significant, t (114)= 0.91, p=0.18. This result does not support a relationship between teachers’ past experiences with trauma exposed students, and their perception or confidence in their abilities to provide support.
CHAPTER V
DISCUSSION

Review of Purpose and Major Findings

Previous research indicates that teachers hold mixed perceptions regarding their confidence in and ability to provide supports to students exposed to trauma in the classroom (Alisic 2012). This study explored general education teachers’ perceptions of teaching and working with students who were exposed to trauma, and the relationships between these perceptions and the teachers’ prior training on trauma support, prior education on trauma support, and prior experience in working with students exposed to trauma.

Research question 1. The first research question asked about teachers’ previous experiences in working with students exposed to trauma. Due to the exploratory nature of this question, no a hypothesis was made. However, according to the survey results a majority of teachers previously taught students who were exposed to trauma, and the most common types of trauma reported were neglect, domestic violence, and physical abuse. This supports the most recent Child Maltreatment Report by the U.S. Department of Health and Human Services (2016) which indicated the top three types of adolescent trauma reported included neglect, physical abuse, and sexual abuse. However, close to
one-third of teachers surveyed reported that their school did have a protocol for responding to students exposed to trauma, and the majority of teachers expressed a desire to aid this student in the classroom. This desire to help was further supported by qualitative interview data.

Teachers voiced a desire to aid students, and an overall concern for ensuring that these students gain access to the resources or aid they need to be successful. Important themes identified in the interviews included: 1) the diverse and crucial role of communication, 2) the need for solution-based and relevant knowledge, 3) the availability of the school counselor, and 4) stereotyping students exposed to trauma.

By interviewing different teachers about their experiences in working with students exposed to trauma, schools may better understand teachers current level of experience with these students and build on the teacher’s trauma response knowledge and increase teacher confidence when working with this population. According to findings from this study, teachers desire to attend PDs on the topic of trauma response, but they want it to be relevant and applicable to their current situation(s). Teachers asked for trauma trainings that would increase their knowledge of solutions and not just admire the problem. Teachers are interested in specific resources they can use to help students exposed to trauma, and smaller settings for those trainings so that teachers can ask specific questions and get immediate feedback. This supports a study by Alisic (2012) which found that teachers wanted more knowledge of what resources were available for trauma-exposed students, like a “map of available services” for example. Alisic’s (2012) study also found that teachers could name an internal resource (such as school
psychologist or school counselor) that they could go to for guidance and could contact them also when in doubt. However, Alisic (2012) found that some of the participants felt hesitant to contact the internal resource, and some individuals had not contacted them immediately after suspecting a student had undergone a trauma. The current study did not support Alisic’s (2012) finding about teachers being hesitant to reach out to the internal resource, each teacher interviewed in this study could name the internal resource at their building and each teacher shared that they had worked with that person. However, according to one teacher interviewed, the ability to provide immediate counseling services to an at-risk student in her building is stunted due having to share a counselor with multiple buildings.

New themes found from teachers’ interviews that add to the previous research done on this topic include the diverse and crucial role of communication, and stereotyping of students exposed to trauma. The majority of participants interviewed shared that they learned of student trauma from another person; communication also served as a way to check in with peers and decompress from a difficult day. Teachers also reported that they were bothered by the stereotyping of students exposed to trauma as they were often seen as the “bad kid” due to negative behaviors displayed. There is no current research on these last two themes, however this opens the door to possible topics for future research in the area of serving trauma-exposed students.

**Research question 2.** The second research question asked about the relationship between the amount of training, education, or previous experience in the area of trauma exposed students and teachers’ perceptions of their skills in providing support for these
students? The initial hypothesis stated that teachers would perceive themselves as generally unskilled in providing services to trauma exposed students, and that teachers with more experience would display a higher confidence in their skills and abilities. This hypothesis was rejected based on findings in the current study. Results indicated that while general education teachers held *hesitant but willing to optimistic* perceptions of working with students exposed to trauma, there was not a significant relationship between these perceptions and a teacher’s prior training on trauma support or previous experience on working with students exposed to trauma. The results do indicate a significant relationship between pre-service (undergraduate or graduate level) training on trauma support and higher teacher perceptions in their ability to provide support to trauma-exposed students.

Additional data in this study suggests that teachers desire more resources on providing support to students after trauma. In addition, according to results from the semi-structured interviews, teachers prefer that this information be provided in a small group format that allows the opportunities to ask specific questions and receive immediate, applicable feedback. These findings were consistent with an article by Souers (2018) which expressed that teachers have an innate desire to care for and aid their students, but that teachers can become “mired down” by the problem behaviors of a child and can result in teachers “losing sight” of the student they are working with and the goals that they had for that student. The current findings about teachers desiring solution-based and relevant knowledge were consistent with findings by a 2012 qualitative study by Alisc, where researchers found that teachers desired more knowledge and information
on how to provide support to students exposed to trauma while they were in the classroom. However, whereas the study from Alisic (2012) had mixed findings as to a teacher’s perceptions of working with this population, the present findings demonstrate that teachers range from hesitant but willing to provide supports to feeling optimistic and confident about providing supports.

**Limitations**

While recruitment of survey participants yielded a greater number of participants than initially proposed (initial proposal=50; final count=114), fewer interviews were scheduled than initially proposed (initial proposal=10, final count=4). Also, the response rate was low (e.g. the researcher, contacted administrators at different buildings in 31 school districts, but only received consent from three for the surveys- 9% response rate; she contacted 26 people for the interview, but only five participated- 19% response rate, and one of the five interviews was not useable in the analysis). Thus, the final sample of participants may be skewed and may not represent typical teachers. While the sample size was adequate for data analysis, results are also not geographically diverse. Responses were limited to the Midwestern regional area and the majority of responses for surveys and interviews were retrieved from only three school districts. In addition, recruitment of participation for surveys was done through email; the validity of responses relies heavily on the respondent’s honesty and self-perceptions.

Another limitation was the use of the survey itself; it was created by the researcher and does not have established reliability or validity. As mentioned, there were certain discrepancies among the responses. In one instance, one-third answered that their
school had a protocol for recognizing and providing supports for students who had been exposed to trauma. However, when later asked if they felt confident they could follow their school’s protocol in order to aid students exposed to trauma, almost half responded that they felt confident implementing their school’s protocol. The answers to these two questions are contradicting, and seventeen teachers felt confident in something that they had previously answered they were either unsure of or did not believe the protocol existed. The second discrepancy was that when asked what types of previous trauma training teachers had, 76 (66.7%) responded they had attended professional development. However, when later asked how many professional development trainings at current or prior districts they had attended that specifically focused on working with students exposed to trauma, only 79 (69%) responded that they had attended one. Thus, it is possible that the researcher did not word all questions clearly. It is also possible that respondents did not read the entire question before choosing an answer.

The final limitation is that the semi-structured interview was completed over the phone; the researcher could not observe nonverbal behaviors, or establish in-person rapport. The interviews were also audio-recorded with the phone on speaker phone, and the researcher had some difficulty transcribing the interviews word for word due to the poor quality of the audio-recording in this type of setting. In addition, it is possible that interviewees withheld information during the interview, or misunderstood questions asked, which could affect information obtained.
Implications for Future Research

Future studies might sample from a broader geographical range. This may yield an increased number of participants, and an increased number of interviewees. Researchers may consider handing out surveys by recruiting teachers at a national teacher conference, or somewhere that large numbers of teachers are present from different locations. Conducting research at a conference may also make it easier to obtain teacher buy-in to participate if that initial face to face rapport is established from the start, which could potentially lead to more qualitative data from the interview being able to be obtained. It would be helpful to more closely examine pre-service teachers to gain their perspective on what skills and abilities they believe they have to work with students exposed to trauma, and then compare these perceptions with the perceptions of skills among teachers already in the work field say is needed.

Conclusion

Results of the current study indicate that general education teachers reported hesitant to optimistic experiences and perceptions of working with students exposed to trauma. There was no significant relationship between a teacher’s perceptions and the teacher’s prior training on trauma support and teacher’s previous experiences. There was a significant relationship between teachers’ pre-service educational experience and receiving trauma information in undergraduate and/or graduate level classes and an increased positive view of their abilities to work with and supply supports to trauma exposed students in the classroom. School psychologists and school counselors could serve as communication partners and trainers in providing support and information to
general education teachers on recognizing the signs of trauma and then how to aid the student in the classroom. In addition, the school psychologist and counselor could serve as a liaison between school staff and the trauma-exposed student’s parents in order to aid in creating a safe, empowering environment for the student at-risk and to ensure that the team is co in their actions to support the student. A greater focus on students preparing pre-service teachers to work with trauma-exposed students might be considered in future research. In addition, the survey pool could be expanded upon to include more teachers who do not have experience teaching students exposed to trauma in order to provide a more comparative analysis.
REFERENCES


http://dx.doi.org/10.1377/hlthaff.2014.0914


APPENDIX A

IRB Materials and Consent/Assent Letters

UNIVERSITY OF DAYTON- CONSENT TO PARTICIPATE IN RESEARCH

Teachers’ Experiences With and Perceived Ability to Serve Students Exposed to Trauma

Principal Consent Form

Dear Principal,

My name is Megan Stasiak and I am a graduate student in the School Psychology program at the University of Dayton. I am writing to invite you to participate in a research project that explores teachers’ experiences and perceived ability to serve students exposed to trauma; this could include death of a loved one, witnessing an accident/crime, etc.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to examine the experiences and perceptions of teachers working with students who have been exposed to some sort of trauma. The teachers will be administered an online survey to share their experiences and perceptions of working with these students, and whether they had any prior training in this area.

WHAT WILL BE DONE IN THIS STUDY?

Participants in the current study will include general education teachers. If you agree to have your teachers participate in this project, they will complete an online survey containing questions about their experiences and perceptions of their abilities to work with students exposed to trauma. I will email the link for the survey to you, and ask that you email it to your teaching staff.
At the end of the survey, there will be a volunteer question about consent for teachers who would be open to doing an in-person interview to discuss their specific experiences in working with these students and how it shaped their current perception.

**POTENTIAL RISKS AND DISCOMFORTS**

A possible risk is that teachers may become mildly distressed when recalling working with students who experienced trauma, particularly if they experienced trauma themselves. Participants will be informed that they can take a break or stop answering questions at any time.

**ANTICIPATED BENEFITS TO PARTICIPANTS**

There are several potential benefits related to participation in my study. The answers students provide could help guide future studies or interventions to accommodate students who have been exposed to trauma.

**CONFIDENTIALITY**

If results from this study are published or discussed in conferences, no identifying information will be included. Your district and individual teacher’s identities will be protected through replacing their names with pseudonyms. Only my direct supervisor and I will have access to identifying information.

**PARTICIPATION AND WITHDRAWAL**

Your teachers’ participation in this study is voluntary. If they decide to participate, they can withdraw consent and cease participation in the study at any time without discrimination or penalization. Also, the principal investigator may withdraw participants from this study if necessary circumstances develop.

**IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about this study you may contact: Megan Stasiak, M.S., researcher, University of Dayton, 937-846-5613, stasiakm1@udayton.edu or the Principal Investigator, Dr. Susan Davies, University of Dayton, sdavies1@udayton.edu.

**RIGHTS OF RESEARCH PARTICIPANTS**

If you have questions regarding your rights as a research participant, you may contact the Chair of the Institutional Review Board (IRB), Candise Powell, J.D., at the University of Dayton at IRB@udayton.edu.
SIGNATURE OF PRINCIPAL

I have read the information provided above. I have been given an opportunity to ask questions and all of my questions have been answered to my satisfaction. I have been given a copy of this form.

Name of Principal (please print) __________________________________________

School District________________________________________________________

Signature of Principle_________________________________________ Date_______

SIGNATURE OF WITNESS

My signature as witness certifies that the Principal signed this consent form in my presence.

Name of Witness (please print)

_____________________________________________________________

Signature of Witness _____________________________________________

Date__________

(Must be same as participant signature date)
Teachers’ Experiences With and Perceived Ability to Serve Students Exposed to Trauma

Teacher Consent Form

Dear Teacher,

My name is Megan Stasiak and I am a graduate student in the School Psychology program at the University of Dayton. I am writing to invite you to participate in a research project that explores teachers’ experiences and perceived ability to serve students exposed to trauma; this could include death of a loved one, witnessing an accident/crime, etc.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to examine the experiences and perceptions of teachers working with students who have been exposed to some sort of trauma. The teachers will be administered an online survey to share their experiences and perceptions of working with these students, and whether they had any prior training in this area.

WHAT WILL BE DONE IN THIS STUDY?

Participants in the current study will include general education teachers. If you agree to participate in this project, you will complete an online survey containing questions about your experiences and perceptions of your ability to work with students exposed to trauma.

At the end of the survey, there will be a volunteer question about consent for teachers who would be open to doing an in-person interview to discuss their specific experiences in working with these students and how it shaped their current perception.

POTENTIAL RISKS AND DISCOMFORTS

A possible risk is that teachers may become mildly distressed when recalling working with students who experienced trauma, particularly if they experienced trauma themselves. Participants will be informed that they can take a break or stop answering questions at any time.

ANTICIPATED BENEFITS TO PARTICIPANTS
There are several potential benefits related to participation in my study. The answers students provide could help guide future studies or interventions to accommodate students who have been exposed to trauma.

**CONFIDENTIALITY**

If results from this study are published or discussed in conferences, no identifying information will be included. Your district and individual teacher’s identities will be protected through replacing their names with pseudonyms. Only my direct supervisor and I will have access to identifying information.

**PARTICIPATION AND WITHDRAWAL**

Your participation in this study is voluntary. If you decide to participate, you can withdraw consent and cease participation in the study at any time without discrimination or penalization. Also, the principal investigator may withdraw participants from this study if necessary circumstances develop.

**IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about this study you may contact: Megan Stasiak, M.S., researcher, University of Dayton, 937-846-5613, stasiakm1@udayton.edu or the Principal Investigator, Dr. Susan Davies, University of Dayton, sdavies1@udayton.edu.

**RIGHTS OF RESEARCH PARTICIPANTS**

If you have questions regarding your rights as a research participant, you may contact the Chair of the Institutional Review Board (IRB), Candise Powell, J.D., at the University of Dayton at IRB@udayton.edu.
APPENDIX B

Survey

Please complete this survey and return it to the interviewer, if you have any questions please ask the interviewer. All information provided will be kept confidential. Please only fill out if you have at least 2 years of teaching experience.

1. Please indicate which grade level(s) you currently teach:
   _____Pre-school  _____K  _____1  _____2  _____3  _____4  _____5
   _____6  _____7  _____8  _____9  _____10  _____11  _____12

2. Years of Teaching Experience
   _____ Years teaching
   _____ Years in current position

3. Select the appropriate choice for type and location of your school, select all that apply.
   _____Urban  _____Suburban  _____Rural  _____Charter  _____Public  _____Private
   _____Other:__________________________________________________________

5. Select highest level of education attained:
   _____Bachelor’s degree  _____Some post-graduate classes  _____Master’s degree
   _____Additional courses taken after completing Master’s
6. Are you currently or have you previously taught a student who has been exposed to trauma? (Instances of trauma may include: death of a loved one, witnessing an accident/crime, experiencing or witnessing abuse, etc.)

____Yes
____No
____Unsure

7. How many students have you worked with who you knew had been exposed to trauma?

____0   ____1   ____2   ____3   ____4   ____5 or more
____Unsure

8. What types of trauma have your students been exposed to, experienced and/or witnessed: (check all that apply)

____Community Violence
____Complex Trauma
  -prolonged traumatic events
____Domestic Violence
____Early Childhood Trauma
____Medical Trauma
____Natural Disasters
____Neglect
____Physical Abuse
____Sexual Abuse
____Refugee Trauma
____School Violence
____Terrorism
____Traumatic Grief
  -severe grief symptoms

9. Has your confidence about teaching a student who has been exposed to trauma changed since working with him/her in your classroom?

____No
____Yes, I feel more confident about teaching students exposed to trauma

63
___Yes, I do not feel confident about teaching students exposed to trauma
___Unsure
___Not applicable

10. If you learn that a student in your class was exposed to trauma how would you feel (select the answer that best describes you):

_____Optimistic about supporting this student
_____Pessimistic about supporting this student
_____Hesitant, but willing to support the student
_____Indifferent

11. My school has a protocol for recognizing and providing support to students exposed to trauma?

_____Yes
_____No
_____Unsure

12. I feel confident that I could follow my school’s protocol and aid students exposed to trauma (select the answer that best applies to you):

_____Agree
_____Disagree
_____Unsure
_____My school does not have a protocol

13. What type of previous training have you had regarding students exposed to trauma? (select all that apply)

_____Undergraduate class
14. For undergraduate or graduate level classes- the information on working with students exposed to trauma was included in:

___Part of one class session
___One class session
___Multiple class sessions
___An entire course
___Not applicable

15. I have attended ____ trainings focused on working with students exposed to trauma at my place of employment? (current/past school districts)

___0
___1-2
___3-4
___5+

16. I have attended ____ trainings focused on working with students exposed to trauma outside of my place of employment.

___0
___1-2
___3-4
___5+
17. If a session/course was taken please give the name of the course and a brief discussion of material covered:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
If you would be interested in being contacted for a one on one interview that will delve deeper into the topics of this survey please provide the following information. Interviews will be 30-45 minutes at your convenience, all information will be kept confidential, and volunteers will receive a $5 Starbucks gift card to thank them for their time.

Name:_______________________________________________________

Email:_______________________________________________________

Phone Number:_______________________________________________
**APPENDIX C**

**Interview Protocol**

<table>
<thead>
<tr>
<th>Category</th>
<th>Questions</th>
</tr>
</thead>
</table>
| **Introduction** | “Thank you for participating in this interview with me. My name is Megan and I am a school psychology graduate student from the University of Dayton. As we talked about previously, I am working on a thesis project that is exploring teacher’s experiences and perceptions of working with students who have been exposed to trauma (give examples of trauma if needed) and then their perceptions of their abilities to provide support. Your participation is completely voluntary and you may stop the interview at any time. I look forward to hearing about your experiences, and ask that you answer as openly as you can. Do you have any questions before we start?”  
(Trauma could include death of a loved one, witnessing an accident/crime, etc.; Individual perceives a threat to themselves or others, experiences feelings like horror, fear, helplessness and has difficulty moving on and resuming their typical activities post trauma) |
| **Confidentiality** | “To ensure confidentiality we will use a pseudonym for this interview which you may pick at this time.”                                                                                                                                                                                                                                         |
| **Rapport**   | “How many years have you worked as a teacher at your current school?”  
“What made you decide to be a teacher?”                                                                                                                                                                                                                                       |
| **Opening**   | “To the best of your knowledge, do you currently have a child who has been exposed to trauma in your class?”  
No-“Have you had a student in the past who has been exposed to trauma?”                                                                                                                                                                                                         |
| **Experience/Strategies** | Think of one specific student to answer the following questions:  
“How did you know/learn that this student had been exposed to trauma?”  
“What did you do in this situation?”                                                                                                                                                                                                                                        |
| School protocols | “Did you provide any supports for the student in the classroom?”  
|                  | Yes—Ask to elaborate  
|                  | “Does your school have any sort of protocol for these situations, and if so please describe?”  
|                  | “Do you guide families to mental health care, and who do you refer them to?” |
| Colleagues       | “Do you and your colleagues talk about the topic of children and trauma?”  
|                  | “How do you support each other?” |
| Needs            | “What information do you wish you knew about working with students exposed to trauma?”  
|                  | “What supports would you like to have in these situations?” |