

## Pre-Reading Homework

### From *Fostering Resilient Learners: Strategies for Creating a Trauma-Sensitive Classroom* (Souers and Hall, 2016)

#### **EXCERPTS FROM: "Chapter 1. Understanding Trauma and the Prevalence of the Not-OK"**

Educators have long known that what happens outside school can have a profound effect on what happens in school. A full library's worth of research explained why some students were successful in school and others weren't (see Hattie, 2009, for a meta-analysis of external factors affecting student achievement).

As an educator, you don't need a peer-edited research article to validate what your gut and your experience have already told you is true: a student's life outside school matters.

Trauma is an exceptional experience in which powerful and dangerous events overwhelm a person's capacity to cope. (Rice & Groves, 2005, p. 3)

The term *complex trauma* was first explored in 2003 by the National Child Traumatic Stress Network's Complex Trauma Task Force, a collective of professionals representing a dozen universities, hospitals, trauma centers, and health programs across the United States. This term emerged from the recognition that many people experience multiple adversities over the course of their lifetime.

Note that these definitions focus on the *impact* of the events, not the *nature* of the events. Although some events (the death of a parent or surviving the September 11, 2001, terrorist attacks on the World Trade Center, for example) may warrant a label of trauma in their own right, we all respond differently to trauma. Our own experiences and interpretations influence the degree of impact we feel following exposure to a traumatic event.

#### **More Than Their Story**

When schools first started integrating trauma awareness about 10 years ago, they tended to emphasize the events themselves and the details of those experiences. Educators and other professionals felt compelled to learn a student's "story" as a means of understanding his or her behavior. That approach often led to getting caught up in the trauma narrative rather than supporting and understanding the effect of that event on the young person. It's not that a person's story isn't important, but educators don't always have the luxury of knowing the story. We do, however, see the story's lingering effects.

For instance, let's say I work with two children who have had similar traumatic experiences: they both have a parent who has been incarcerated for the last two years, and they rarely get to see that parent. Although that life event is devastating for us to consider, the two young people have dramatically different responses: one is unable to process the reality and shuts down whenever something evokes a memory of his parent, while the other functions relatively well, compensating by building a stronger bond with the remaining parent. It is much more helpful for me to monitor the *effect* of the event on each individual, not to preoccupy myself with the details of the event itself.

This shift in perspective prompts us to be more sensitive to that effect and thus better foster healing and growth. Moreover, by altering our approach, we can begin to see students as more than their story. All too often, we reduce students to their experiences and make decisions about their capabilities based on those experiences. Changing our focus enables us to concentrate on nurturing the whole child and creating trauma-sensitive learning environments for all students.

## **ACEs Wild**

In the late 1990s, Dr. Robert Anda and Dr. Vincent Felitti led a collaborative project between the Centers for Disease Control and the Department of Preventive Medicine at Kaiser Permanente in San Diego, California, to explore the relationship between children's emotional experiences and their subsequent mental and physical health as adults. This groundbreaking research (Felitti et al., 1998) revealed a strong correlation between adverse childhood experiences and adult health and, perhaps more significantly, signaled that these ACEs were far more prevalent than previously thought.

What constitutes an ACE? Many of us can probably come up with some ideas, but the initial eight ACEs that Felitti and colleagues studied were

- Substance abuse in the home.
- Parental separation or divorce.
- Mental illness in the home.
- Witnessing domestic violence.
- Suicidal household member.
- Death of a parent or another loved one.
- Parental incarceration.
- Experience of abuse (psychological, physical, or sexual) or neglect (emotional or physical).

Many would argue now, and I would agree, that the list is not complete and should include other experiences, such as exposure to a natural disaster, criminal behavior in the home, terminal or chronic illness of a family member, military deployment of a family member, war exposure, homelessness, and victimization or bullying.

Despite this limitation, the details of the original ACE Study are fascinating. Anda and Felitti collected data from more than 17,000 adult patients who were insured by the major insurance provider in Southern California (Kaiser Permanente), tallying how many ACEs from the list each respondent had experienced. Each ACE listed was given a value of 1, so individuals reporting none of the above would have an ACE score of 0, whereas those who experienced all of the ACEs would have a score of 8. The researchers found that more than half of their subjects had experienced at least one ACE during their youth. Roughly 25 percent had experienced multiple ACEs, and 1 in 16 had an ACE score of 4 or above (Felitti et al., 1998).

Not only did this study's result shock the belief systems of many people working in the caregiving fields, but it also helped dispel the myth that trauma happens only in populations of poverty. Although living in poverty increases the likelihood of ACE exposure, poverty itself is not considered an adverse childhood experience. This study supported what many of us already knew: trauma does not discriminate. It happens everywhere—across all races, religions, socioeconomic levels, and family systems.

One of the more profound implications of this study was the acknowledgment of the prevalence of trauma in our society. One might even hypothesize that these numbers were low estimates of the actual occurrences, owing to social taboos against seeking or sharing this type of information and the fact that the traumatic experiences were self-reported. In fact, in two similar studies (Breslau, Kessler, & Chilcoat, 1998; Burns, 2005), more than 90 percent of respondents reported at least one lifetime traumatic event. These studies have been replicated with hundreds of thousands of subjects and across several arenas (including, for example, health care, education, and military), but the results remain consistent. These findings have been so powerful that many states are incorporating ACE awareness into their state studies and census data.

## **Effect of ACEs on Adult Health**

The original ACE Study investigated the relationship between ACEs and overall health and found, quite simply, that the higher an individual's ACE score was, the more likely it was that he or she would adopt or present with significant health-concerning outcomes, such as chronic obstructive pulmonary disease, hepatitis, sexually

transmitted disease, intravenous drug use, depression, obesity, attempted suicide, or early death. In fact, there is a clear "dose effect," meaning the likelihood of having physical or mental health issues later in life increases in direct correlation to an individual's ACE score (Felitti et al., 1998).

Those working in the medical and mental health fields have long known that trauma exposure is toxic to the human body, and the ACE Study gave health professionals permission to begin to significantly address this issue on a global level.

**Effect of ACEs on Children**

The ACE Study shows a remarkable link between not-OK childhood events and health issues later in life. What the original ACE research did not explore, however, was the immediate effect that these traumatic experiences had on children. This is crucial information that can inform educators' practice and the supports we offer to the young people under our care.

First, is childhood trauma as prevalent as the original ACE Study suggested? Sadly, yes. Recent research indicates that there are now more children affected by trauma than ever before:

- Nearly 35 million U.S. children have experienced at least one type of childhood trauma (National Survey of Children's Health, 2011/2012).
- One study (Egger & Angold, 2006) of young children ages 2–5 found that 52 percent had experienced a severe stressor in their lifetime.
- A report of child abuse is made every 10 seconds (ChildHelp, 2013).
- In 2010, suicide was the second leading cause of death among children ages 12–17 (Centers for Disease Control and Prevention, 2011).

Having established the continued prevalence of trauma, let's look at how these experiences affect children's educational outcomes. Inspired by the original ACE Study, Dr. Chris Blodgett and his research team (Blodgett, 2012) at Washington State University's Area Health Education Center conducted its own adverse childhood experiences study in 2011, investigating the effect of the same eight ACEs on the educational outcomes of elementary school students (ages 5–11) in Spokane County, Washington. The results confirmed the pervasiveness of ACEs:

- Forty-five percent of students had at least one ACE.
- Twenty-two percent of students had multiple ACEs.
- One in 16 students had an ACE score of 4 or higher.

Simultaneously, it emerged that ACEs have a powerful negative effect on students' readiness to learn, leading to the "triple whammy" of school troubles in attendance, behavior, and coursework (the ABCs). Students showed progressively higher incidents of scholastic struggles as their ACE scores rose, again revealing the "dose effect" suggesting that the number of traumatic occurrences matters even more than their severity. For example, a student with one adverse childhood experience was 2.2 times more likely than was a student with no ACEs to have serious attendance issues, a student with two ACEs was 2.6 times more likely to have these issues, and a student with three or more ACEs was 4.9 times more likely to have these issues. Figure 1.1 summarizes Blodgett's team's findings.

**Figure 1.1. Correlation Between Number of ACEs and Struggles with School and Health**

	<b>Attendance</b>	<b>Behavior</b>	<b>Coursework</b>	<b>Health</b>
<b>3+ ACEs</b>	4.9	6.1	2.9	3.9

<b>2 ACEs</b>	2.6	4.3	2.5	2.4
<b>1 ACE</b>	2.2	2.4	1.5	2.3
<b>No known ACEs</b>	1.0	1.0	1.0	1.0
The more ACEs a student experienced, the more likely he or she was to experience serious school and health issues.				

Note that there is a fourth column labeled "Health." Blodgett and his team found a direct link between childhood trauma and physical health, documenting higher rates of frequent illness, obesity, asthma, and speech problems in students with higher ACE scores. These results further support the original ACE Study's findings that ACEs are toxic to the body.

### How Trauma Affects the Brain

So how, exactly, does exposure to trauma affect educational outcomes? Simply put, trauma is toxic to the brain as well as to the body. There has been vast research conducted on the brain in the last two decades that challenges much of how we have historically interpreted the brain and its function. Scientists have discovered a new way of looking at the power of nurture in human development. Further, the increasing awareness of the effects of trauma on the brain has offered tremendous insight into the role trauma exposure plays in development, especially in childhood.

In the midst of extreme stress, our bodies are forced to respond via a heightened state of alert known as the *fight, flight, or freeze response*. Our bodies were designed to be in that state only for brief periods, and only in the face of extreme danger. But when children are exposed to complex or acute trauma, the brain shifts its operation from development to stress response, which can have lasting repercussions. According to Harvard University professor Jack Shonko (2009),

In contrast to normal or tolerable stress, which can build resilience and properly calibrate a child's stress-response system, toxic stress is caused by extreme, prolonged adversity in the absence of a supportive network of adults to help the child adapt. When it occurs, toxic stress can actually damage the architecture of the developing brain, leading to disrupted circuits and a weakened foundation for future learning and health.

When brains are triggered by threat or perception of threat, they release chemicals into the body to allow us to "survive" those states of stress. When released in large doses, these chemicals become toxic to the body and can create significant impairment in development. Because the fetal, infant, and early childhood brain is so sensitive, chronically elevated levels of stress hormones can significantly disrupt the development of the brain in a multitude of ways, affecting learning, memory, mood, relational skills, and aspects of executive functioning (Shonko & Garner, 2012)—all required for success in a classroom setting.

### Wrapping It Up

Exposure to multiple and severe stressors can profoundly affect how children interpret their world. The more ACEs a child is exposed to, the greater the likelihood that he or she will experience developmental delays and health problems down the line. Increasing our awareness of ACEs in children and looking at our students through

a trauma-sensitive lens open up an opportunity for us to approach teaching and learning in new ways.

Further, when we start to look at the prevalence of the adversity that many of us have faced in our own lives, we must also celebrate the power of resilience. Many of us have found a way to survive the not-OK. As professionals, how can we foster that same resilience in students that we were able to muster up to survive our own experiences?

We know that childhood trauma has become an epidemic. No one is immune: trauma occurs everywhere, in all populations and circumstances, at every socioeconomic level, across ethnic and cultural lines, within all religions, and at all levels of education (ChildHelp, 2013). Because trauma's effect often presents itself as a mental health issue, the need for services is growing substantially. Yet research reveals that only a minority of children receive services: according to the Surgeon General's Report, "about 75 to 80 percent of children with a serious emotional disturbance fail to receive specialty services, and, according to family members, the majority of these children fail to receive any services at all." According to Kutash, Duchnowski, and Lynn (2006), the vast majority of children receive no mental health services, and among those who do, most receive the services at school.

Children with mental health issues are not required to obtain professional mental health services, but they are legally obligated to attend school. Thus, school is the one place where we are guaranteed access to our trauma-affected children. Our students need us to create a trauma-sensitive learning environment for them.

## Reflective Questions

1. Exploration of trauma sometimes launches a "nature versus nurture" debate. Why do you suppose some children are more strongly affected by certain events than others are? What does this suggest for us as professionals?
2. What are your initial responses to the prevalence of trauma? Are you surprised? Why or why not?
3. Review the original ACE Study's list of stressors. What might you add to that list? What do you see significantly affecting our students?
4. Given the information above, how might you shift your approach in working with these vulnerable children?
5. What steps can you take to bring this important topic into your professional conversations? How might that provide an avenue to better support our students?

