Rutgers Center for Law, Inequality and Metropolitan Equity (CLiME)
Trauma, Schools and Poverty Project

Conference Brief

Psychological Trauma and Schools: How Systems Respond to the Traumas of Young Lives

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Conference Highlights

- Decades of research have provided consistent, strong evidence that while the brain is "made for change," extreme childhood trauma changes neurobiological functioning in ways that lead to maladaptive socioemotional functioning.
- Prominent definitions of trauma fail to include other life events that, while not necessarily life-threatening or injury inducing, are subjectively experienced as highly stressful and traumatic.
- National estimates of the epidemiology of trauma mask the fact that childhood trauma and its consequences disproportionally affect people living in poverty and people from ethnic-racial marginalized backgrounds.
- Intergenerational or historical trauma, concentrated poverty, discrimination experiences and, in some cases, undocumented immigration status, present additional sources of chronic stress for oppressed children already at disparate risk for experiencing complex trauma and undermine their capacity for resilience.
- We should not be asking what is 'wrong' with a person who presents with potentially trauma-related symptoms, but rather what happened to that person.
- Children's early life experiences, including trauma, have major implications for their school-based learning that cannot be captured by high stakes assessments.
- Given that power and politics are embedded in every learning context, teachers must keep an open mind to what is traumatic, remain aware of the ways power and privilege operate in the classroom, and shape their pedagogy to allow children to share their traumatic experiences in different ways (e.g., writing).
- We cannot expect educators to play a role in breaking the school to prison pipeline until they are provided the training they need to serve students from marginalized backgrounds.
- Children's response to the same potentially traumatic event is dependent on numerous factors including their age, race, and epigenetics and therefore requires a complex solution.
- Adult misunderstandings of child trauma reactions can lead to a self-fulfilling prophecy, such that the adults' response to the child elicits behavior that ultimately confirms their incorrect assessment and fails to address the child's underlying needs.
- Schools have the potential to offer a safe and supportive community environment for children, and research has demonstrated that community support reduces trauma symptom severity.
- Effective trauma-sensitive practices should create a shared understanding of trauma's impact on learning and the need for a school-wide approach, support all students to feel safe, explicitly connect students to the school community, embrace teamwork and a sense of shared responsibility for students among staff, and anticipate and adapt to the dynamic needs of students.
- Approximately 70-90% of youth involved in the criminal justice system have experienced at least one trauma, with many having experienced complex trauma, or chronic exposure to multiple traumatic events early in life.
- Reversing the school to prison pipeline requires commitment to change, prevention and intervention across systems.
- Trauma deeply affects students, and it is the school's moral *and* legal obligation to provide systems of support for traumatized students so that they too have a chance to succeed.
- Creating a shared definition of trauma provides the basis for identifying a legally recognized status that can be used to legally obligate system-level responses.
- When we impose rigid definitions of trauma uniformly we fail to listen to children's own understanding of their traumatic experience.

Psychological Trauma and Schools:
How Systems Respond to the Traumas of Young Lives

By Alexandra K. Margevich, Ph.D.

On May 5, 2017, the Rutgers Center on Law, Inequality and Metropolitan Equity (CLiME) hosted an interdisciplinary all-day conference on the institutional responsibility of schools in responding to childhood psychological trauma, particularly in low-SES communities where early life trauma exposure is disturbingly ubiquitous. The conference brought together a group of panelists and audience members from diverse fields related to childhood trauma.

David D. Troutt, Professor of Law and founding Director of CLiME at Rutgers Law School–Newark, welcomed attendees and briefly described the genesis of this multi-stakeholder conference, which was borne out of his own research and conversations with colleagues who work with children at-risk for trauma exposure outside of law and policy. Professor Troutt, himself an experienced civil rights attorney with expertise in systemic causes of concentrated poverty in metropolitan areas, realized that lawyers and policy-makers often narrowly focus on targeting rules and structures as sources of widespread disparities we see too frequently in cities like Newark, New Jersey, without fully understanding or engaging with the very people those systems impact. Indeed, "[structural inequalities] manifest in the most personal possible ways, through people's psychology, physical well-being and relationships." In turn, these extensively documented individual and group-level effects critically contribute to issues that draw the attention of social justice advocates across disciplines and sectors, notably among them the **school to prison pipeline**. This inspired Professor Troutt to draw from the wealth of knowledge on childhood psychological trauma from a breadth of fields in addition to law and policy, from psychology to social work to education, to best understand and ultimately combat this incontrovertible social justice issue.

Transitioning into opening remarks, Professor Troutt humbly acknowledged the incredible support he received in building capacity to get CLiME's Trauma, Schools and Poverty project off the ground from then recently appointed RU-N Chancellor, Dr. Nancy Cantor. In fact, it was her support for publically engaged scholarship that partly made possible Professor Troutt's attainment of a Chancellor's Seed grant that eventually enabled this conference's occurrence.

OPENING REMARKS

Chancellor Nancy Cantor, a social psychologist who brought with her to RU-N an anti-ivory tower mentality and a passion for community engagement, commenced by emphasizing the need for action-oriented collaborations of this sort across both disciplines (e.g., law, psychology, public health) and systems (e.g., K-12, law enforcement, housing services) in cities like Newark, where the "sequela of poverty and racism haunt the halls of education, derailing genuine effort in heartbreaking ways." These collaborations further recognize the potential for spaces and places, such as neighborhood centers, hospitals and schools, to either cultivate or railroad young talent based on their responses to the diverse manifestations of childhood trauma (e.g., hyperarousal, aggression, depression). Critically, **anchor institutions** like RU-N can play a major role in spurring these collaborations to create well-informed, sustainable interventions and preventions that ultimately address what Newark Mayor Ras J. Baraka refers to as *the* public health crisis: the derailment of youth from schools to the criminal justice system.

Throughout her opening remarks, Chancellor Cantor argued that if we do not address childhood trauma at all levels, the efforts of one or more systems may be undone by the ambivalence or animosity of others. To highlight the need to address childhood trauma at all levels, Chancellor Cantor provided examples of RU-N cross-sector collaborations, including the Newark City of Learning Collaborative, which aims to increase post-secondary attainment of Newark residents from 18.1% to 25%, and the Safer Newark Council, which aims to reduce community violence concentrated on 20% of Newark streets. Importantly, neither of these initiatives can be sustained if high rates of childhood trauma exposure derail children from classrooms to jail cells, and if institutions (e.g., law enforcement, schools) fail to collectively mobilize in adopting and promoting trauma-sensitive practices.

To end, Chancellor Cantor reminded the audience that the legacy of systemic racism is one for which we must all take responsibility and pool our resources and expertise to help "pave a fairer path for opportunity for more children in more places like Newark."

PANEL ONE

The Making of Trauma: Definitions and Genealogies

CLiME psychology research associate, Dr. Alexandra Margevich (moderator), introduced the first panel of three experts from the fields of psychiatry, social epidemiology and clinical psychology, who explained the sources of psychological trauma and its widespread effects throughout the life course to set the stage for informing systems' responses to trauma.

The Neurobiology of Childhood Trauma

Dr. Royce Lee, Associate Professor of Psychiatry and Behavioral Neuroscience at the University of Chicago, explained two broad mechanisms by which trauma exposure at critical developmental junctures fundamentally changes neurobiological functioning in ways that ultimately lead to maladaptive socioemotional functioning: (1) neuroplasticity and (2) epigenetics. Both human and non-human primate research has revealed that while we are born with attachment systems that drive us to seek healthy, safe and supportive social relationships, when these systems are undermined by early life trauma, they can produce harmful consequences (e.g., mistrust, maternal abuse and neglect).

One of the critical neurobiological mechanisms through which trauma interrupts the development of effective social and emotional functioning is **neuroplasticity**, which broadly refers to the brain's ability to change in response to new information and experiences throughout the life course. Put more technically, different experiences trigger neurons, or brain cells, to release neurotransmitters (e.g., adrenaline) into the synapse, or gap between adjacent neurons. Neurotransmitters then bind to the receptors of a nearby neuron, triggering the release of even more neurotransmitters in the cell. When this process repeats in close temporal proximity, that neural connection becomes strengthened; that is, the neural response will be amplified in each subsequent encounter with related experiences close in time to the initial exposure, but will weaken or extinguish when enough time has elapsed without exposure. In his psychiatric work with seriously emotionally disturbed adults with histories of childhood trauma, Dr. Lee has gleaned three broad neurological systems that may be disrupted through neuroplastic processes following chronic childhood trauma that are associated with different patterns of atypical affect, cognition and behavior:

- Disruptions of the representation system, or working memory, are associated with, at the extreme end, psychotic symptoms such as delusions, hallucinations and loss of touch with reality.
- Disruptions of the emotional (or stress) system are associated with many of the clinical disorders most stereotypically linked with childhood trauma, including anxiety, depression, and post-traumatic stress syndrome (PTSD).
- Disruptions of the empathy system may result in problems of emotional empathy, which is associated with an inability to imitate and sympathize, and/or cognitive empathy, which is associated with difficulties in perspective-taking (i.e., motivated mental effort to think about what another person is thinking).

When a child's physiological and psychological needs are met during development, these three systems adaptively process information; however, children experiencing chronic trauma receive and process skewed social information that undercuts healthy functioning. Importantly, these children are by no means less intelligent. Indeed, an analysis of two large datasets finding a relation between single event trauma and multiple indicators of adult IQ found that this relation disappeared after accounting for baseline differences in cognitive functioning. Thus, traumatized children are still capable of focusing and processing information through these systems—tragically, they are chronically receiving incorrect information that ultimately warps their understanding of themselves and others in damaging ways. Twin studies have revealed that genetics, shared environment and non-shared environment approximately equally contribute to children's subjective reports of trauma—neither biology nor experience alone can predict a child's trauma response. It is therefore critical that health practitioners attend to not only the outcome of trauma, but also what caused the child to process and interpret that event as traumatic.

A second and less well understood neurobiological pathway through which childhood trauma detrimentally impacts children is through **epigenetics**, or altered gene expression resulting from early life experiences via methylation (i.e., carbon atoms binding to a gene). Importantly, cortisol, the body's main stress hormone that is produced through cascading events in the hypothalamic-pituitary-adrenal (HPA) axis, is one driver of post-trauma epigenetic effects. For example, seminal research using a rodent animal model of the stress response, which has since been replicated in both rodents and humans, has

revealed that disrupted rodent parental care "silences" the genes that control stress reactivity. Additionally, the relation between cortisol and post-traumatic symptom severity changes with longer periods of time between childhood trauma and the cortisol measure, suggesting a lasting neurobiological effect of early traumatic experiences. Specifically, in early childhood, *higher* cortisol in response to trauma predicts greater post-traumatic symptom severity; however, when measuring cortisol in adult survivors of childhood trauma, *lower* cortisol predicts greater symptom severity. Thus, childhood trauma impacts multiple cortisol-related processes such as inflammation, which in turn has implications for disease susceptibility and premature mortality.

Dr. Lee's research has provided further support for the relation between trauma and cortisol. Specifically, he found that when stress hormones are injected into primates' brains (mimicking a typical post-trauma cortisol spike), they become extremely socially anxious. In humans, he has observed a parallel yet often neglected trauma-related outcome termed paranoid personality disorder (PPD), which is characterized by high levels of social mistrust. Thus, the key to both findings is that childhood trauma produces epigenetic changes in the body's stress reactivity, which in turn affects how safe people feel in *social* contexts. From an intervention standpoint, although relatively stable, Dr. Lee optimistically (but cautiously) noted that even epigenetic processes can be reversed.

Decades of research have provided consistent, strong evidence that while the brain is "made for change," extreme childhood trauma affects the *way* the brain changes. While further research is needed to fully understand the mechanisms by which this occurs, the effect itself is undeniable—early childhood trauma alters one of the things that makes us most human: our mind.

Childhood Trauma: Epidemiology, Health Consequences, and Possibilities for Interventions

Dr. Natalie Slopen, Assistant Professor of Epidemiology and Biostatistics at the University of Maryland School of Public Health, began by problematizing the current dominant definition of trauma. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), a traumatic event involves exposure to actual or threatened death, serious injury, or sexual violation. This definition fails to include other life events that, while not necessarily life-threatening or injury inducing, are subjectively experienced as highly stressful and traumatic. In response to this critique, Dr. Jack Shonkoff, Director at Harvard's Center on the Developing Child, and colleagues have developed a taxonomy of stress to supplement the above definitions, including three categories of stress: (1) **positive stress**, or normal day-to-day stressors; (2) **tolerable stress**, or difficult events that we are able to move past with supportive relationships; and (3) **toxic stress**, or serious events that lead to a sustained stress response *in absence* of support and alternative coping mechanisms.

Having defined the problem, Dr. Slopen noted that childhood trauma and adversity are common among children in America. Indeed, data from the 2011-2012 National Survey of Children's Health revealed that among children 0 to 17 years, 3% had experienced the death of a parent, 7% had a parent incarcerated, and 20% experienced divorce or parental separation. Additionally, data from the 2013-2014 National Survey of Children's Exposure to Violence revealed that in the past year, 37% of children from this age group had experienced any physical assault, 15% had experienced any maltreatment and 25% had witnessed any violence. Critically, these national estimates mask the fact that childhood trauma and its consequences are disparately felt by marginalized populations and communities. For example, compared to U.S.-born white children, black and Hispanic children are approximately 2 times as likely to have a parent incarcerated. Moreover, whereas 1% of U.S.-born children from high income families have had a parent incarcerated, this percentage steadily increases as family income declines, with 17% of children living below the federal poverty line having this adverse experience.

Given the pervasiveness of childhood trauma, particularly among children from marginalized communities, it is essential to understand its impact on health (and education) across the life course. The **Adverse Childhood Experiences** (ACE) study represents a cross-sector collaboration aimed at documenting the link between experiences of childhood abuse, neglect and household dysfunction, and physical and mental health, high-risk behaviors and chronic disease. Across health indicators, a reliable **dose-response relationship** emerged such that more frequent and diverse experiences of childhood trauma were related to increasingly poor health outcomes. That is, controlling for age, gender, race and educational attainment, compared to adults

reporting no ACEs, experiencing 4 or more ACEs predicted 1.6 times increased odds of severe obesity (>35 BMI), 12.2 times increased odds of ever attempting suicide, 4.7 times increased odds of ever using illicit drugs, and 2.2 times increased odds of ischemic heart disease. Since the original ACE report, accumulating evidence supports inflammation as a major mechanism by which trauma affects adult health. While adaptive in the short-term, the chronic inflammation resulting from chronic childhood stress breaks down the body to produce negative health behaviors and outcomes.

While the epidemiology of childhood trauma makes it a major public health issue, there are viable social interventions that can stop the consequences of trauma. In a systematic review of quasi-experimental or randomized control trial research aimed at improving children's psychosocial well-being to improve post-trauma stress physiology, Dr. Slopen found that among children who experienced childhood trauma, those who received a social intervention displayed cortisol levels similar to a comparison group of children who had never experienced trauma. Similarly encouraging, a recently released report demonstrated that a family-centered prevention intervention program administered to African American families from rural Georgia at age 11 eliminated the association between ACEs and increased risk of pre-diabetes measured at 25 years. Evidence suggesting that childhood trauma's effects can be interrupted create an urgent need to better understand the importance of the developmental period during which trauma exposure occurs, the mechanisms underlying trauma's effects on physiological functioning, and the individual and structural factors that increase relative risk for childhood trauma exposure.

Psychological Trauma in a Social Context

Finally, Dr. Susan Esquilin, licensed clinical psychologist with expertise on child abuse, raised the critical issue of merely gaining recognition for the pervasiveness of childhood trauma in schools and other developmentally critical contexts. Unlike acute traumas, which often lead to anxious behaviors that easily garner sympathy, **continuous traumatic stress** produces a range of effects from problems with affect regulation (e.g., easily irritated) to recurrent fight or flight reactions (e.g., leaving the classroom). Problematic to clinicians, people experiencing chronic trauma or stress often present with externalizing behaviors (e.g., aggression) that are misinterpreted as indicators of attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder (CD), and bipolar disorder. The latter diagnosis is particularly troubling as there is no supported link between childhood aggression and adult manic behavior, yet these diagnoses are often accompanied by strong neuropharmacological drug prescriptions whose long-term effects we do not yet fully understand. Importantly, we should not be asking what is wrong with a person who presents with externalizing (or any) potentially trauma-related symptoms, but rather what happened to that person.

Returning to the fact that trauma disparately impacts non-dominant, marginalized group members, Dr. Esquilin noted the important role of four other chronic sources of stress endemic to membership in certain social groups that interrupt children's ability to recover from any one traumatic event. **Intergenerational** or **historical trauma** refers to the impact of previous generations' trauma response on subsequent generations who have not necessarily experienced that trauma themselves. Originally developed to describe the seeming impact of parents' Holocaust experiences on their children's trauma symptoms in absence of their fully understanding what happened to their parents, intergenerational trauma has more recently been extended to African Americans and Native Americans, whose predecessors were enslaved and stripped of their culture and social status. **Concentrated poverty** represents another chronic stressor these children may face and refers to a community where at least 30% of the population lives at or below the federal poverty line. Unfortunately, the legacy of place-based racial segregation in the form of housing policy situates those same children facing historical trauma at greater risk of experiencing concentrated poverty. This is evidenced by the fact that black people experience significantly higher rates of concentrated poverty than white people across metropolitan areas.

Finally, **discrimination experiences** and, in some cases, **undocumented immigration status**, present additional sources of chronic stress for oppressed children and undermine their capacity for resilience. Kent Hardy, for example, described the legacy of racial trauma as producing a "wound of rage" characterized by three elements: (1) internalized devaluation; (2) hypervigilance toward signs of disrespect; and (3) internalized voicelessness or feeling that one's experience is invalid and should not be expressed. Importantly, African Americans and other oppressed social groups have developed coping

mechanisms (e.g., keeping a child physically close and limiting exploration in public spaces) that may look inappropriate to "white influence professionals" who fail to consider the central role of social group membership, here race, in people's trauma response. It is therefore critical that people doing work with traumatized youth remain cognizant of the fact that "trauma and chronic stress impact poor people and people of color more than they do economically comfortable people and white people," and that poverty and non-dominant racial group membership too frequently (and by design) intersect. Professionals will only be able to effectively provide services to members of marginalized communities if they engage them in conversations aimed at better understanding the coping mechanisms that certain groups have developed to simply ensure their survival, which has been threatened realistically (e.g., police homicides of young black males) and symbolically (e.g., disparagement and dismissal of non-Western traditions) both historically and in contemporary society.

PANEL TWO

Trauma in Schools: The Politics of Labeling

Esther Canty-Barnes (moderator), Clinical Professor of Law and Director of the Education and Health Law Clinic at Rutgers School of Law-Newark, introduced the second panel, which included speakers with a broad array of experiences in the educational system, psychology, children in juvenile justice and literacy.

The Perilous Potential of Trauma in Classroom Practice and Pedagogy

Dr. Elizabeth Dutro, Professor and Program Chair at the University of Colorado-Boulder School of Education, began by discussing the important consequences of children's early life experiences, including trauma, for their school-based learning that cannot be captured by high stakes assessments. Education involves the integration of information students receive in school and their lived experiences—the two are inherently interconnect ed. Notwithstanding the importance of neurobiological effects of trauma, her research focuses on the critical role of how children represent their suffering through stories. Critically, trauma-informed practices centered on neuro-biological arguments risk pathologizing children and families, and fail to recognize students' humanity and validate their lived experiences. Given that power and politics are embedded in every learning context, teachers must keep an open mind to what is traumatic, remain aware of the ways power and privilege operate in the classroom, and shape their pedagogy to allow children to share their traumatic experiences in different ways.

Dr. Dutro has collaborated with teachers to develop a method for integrating trauma into practice called **pedagogies of testimony and critical witness.** This approach requires reciprocity in student-teacher interactions, such that teachers must first invite children to witness their own expression or testimony of a personally difficult experience to demonstrate that all lived experiences are valued resources in the classroom. Witnessing their teacher's vulnerability in response to adversity encourages children to become more comfortable disclosing challenging times in their own lives during literacy exercises. Importantly, children's trauma-imbued narratives also tend to reveal sources of healing and support, such as turning to their connections with family and friends. Importantly, teachers must acknowledge the shared human experience of risk and vulnerability while simultaneously recognizing the implications of historical inequalities for children's different life narratives. Unfortunately, children from disenfranchised backgrounds are positioned to experience more early life trauma and this will be reflected in their testimonies.

Through this approach, teachers and facilitators can analyze the changing ways in which children integrate childhood trauma into their school literacies in response to teachers' efforts to model and reinforce a trauma-sensitive classroom. For example, across the school year, one student, Enrique, went from merely mentioning his deceased cousin's name on a topic list to writing a personal narrative about playing video games with his cousin that included death-related metaphors to writing poetry explicitly detailing the violent loss of his cousin. Given the potential success of this approach, Dr. Dutro ended by emphasizing the importance of including trauma-sensitive practices and "anti-oppressive frameworks" early on and throughout teacher education. In the context of a safe and supportive classroom environment, students can learn that sharing one's difficult experiences is a critical component of both learning and connecting.

Barriers to Trauma-Informed Teaching Practices

Trevor Melton, Education Specialist in the Division of Academic Standards at the New Jersey Department of Education (NJDOE) and

Governor-appointed head of the NJ Department of Education's Juvenile Justice and Delinquency Prevention Committee, drew attention to the fundamental need for educators to pay attention to the lives of students *outside* of schools to best respond to their educational needs. Certain classroom exercises, such as being asked to fill out a family tree, provide information about parent demographics (e.g., address, occupation), and share about summer vacations, can be damaging for children living in contexts of chronic poverty and trauma exposure who may not even have a home or family to return to when the school day ends. Indeed, in his own experience working in the Abbott school office as interim coordinator for 31 school districts, Professor Melton noticed that although educators express wanting students to learn, they often fail to remove barriers that inhibit this very process.

A major barrier to trauma-informed teaching practices lies in education programs, as aspiring teachers are trained to implement practices year after year that may be culturally inappropriate and traumatizing without being taught to re-evaluate their efficacy in specific contexts. Professor Melton also noted that the majority of universities do not require education students to complete a social work course or other training that would make them better equipped to deal with children coming from difficult life circumstances. Additionally, many teachers simply fail to make themselves aware of the harsh realities their students face in their communities, such as housing instability, food insecurity, domestic violence and community violence. Unfortunately, when students living in adverse circumstances fail to submit homework assignments or react aggressively toward other students or teachers, educators respond punitively rather than compassionately thereby maintaining the school to prison pipeline.

Another barrier is the lack of communication between different systems following a child's traumatic experience. Although there are legal reasons why law enforcement, for example, is unable to contact a school to report that a child has just witnessed his mother's murder, this creates a barrier in educators' ability to understand the events that led to that child's inability to hand in homework or react aggressively. Thus, it is critical for people in all systems to acknowledge that trauma is a major part of many children's lives and to recognize (and actively look for) its signs. Fortunately, certain New Jersey districts like Pemberton Township have implemented trauma-sensitive training for teachers and other school employees to help them identify trauma and make referrals as appropriate. We cannot expect educators to play a role in breaking the school to prison pipeline until they are provided the training they need to serve students from marginalized backgrounds.

Advancing Trauma-Informed Care: Creating Trauma-Informed Schools

Dr. Kelly Moore, Director of the Rutgers' Children's Center for Resilience and Trauma Recovery, discussed her recent work on integrating trauma-informed practices into schools. Given that teachers and school staff spend large amounts of time with students during critical developmental periods, it is imperative that they (a) learn how to identify trauma and (b) receive on-site support to respond to and manage trauma symptoms without unnecessarily cutting into children's learning time or imposing damaging and lasting labels. Specifically, Dr. Moore's program sought to provide school staff with "turn-key skills" that they could immediately implement in their own classroom. The program involved four pieces:

1) Professional development: Critical to this program is that teachers and staff learn about defining trauma and toxic stress, identifying trauma-related behaviors, acknowledging the biases they bring into the classroom, assessing their own stress-related burnout, creating corrective experiences that make children feel safe amidst an otherwise unpredictable environment, and developing a collaborative plan to sustain a trauma-informed school culture.

2) Screening and assessment: Teachers and staff also need to ensure they are asking the right questions when trying to understand the source of a child's withdrawn, distracted or disruptive behavior; that is, they must replace the question "What is WRONG with you?" with "What HAPPENED to you?". While the former places the blame exclusively within the child, the latter acknowledges the important role of external circumstances in shaping children's classroom behaviors. Unfortunately, the misidentification of trauma leads to the harmful application of labels like ADHD, ODD and CD, which

are linked to these children's greater risk for criminal justice involvement. Importantly, incorrect diagnoses lead to incorrect (and sometimes dangerous) treatments.

3) Triage and intervention: When teachers or staff suspect a child has been traumatized, they are asked to complete a checklist about the frequency and severity of trauma symptoms and submit this form to the triage team who ultimately decides the best course of action. If necessary, the family will be contacted, the child will complete a more extensive testing battery, and the team will provide the family with options for school or community based care. Importantly, there are also many ways in which teachers and staff can intervene within the classroom, such as by creating **corrective experiences** that re-establish children's sense of the world as safe and predictable. Teachers and staff must also engage in **reframing behavior** by focusing on *why* a child behaved a certain way, which will in turn help them better understand that child's triggers.

4) Evaluation: Survey data from teachers suggests that while they are generally high in compassion and job satisfaction they often bring their work home; it is therefore critical that self-care training be incorporated into professional development programs. Preliminary data from the screening triage tool has revealed that 83% of children met clinically significant levels of one trauma-related symptom cluster, and this was primarily driven by anxious symptoms rather than aggressive ones. This suggests that acting out behavior in traumatized children stems from anxiety and not aggression or violence. Thus, anxiety must be the target of any intervention.

In conclusion, Dr. Moore noted that it is our responsibility to dig deeper with children to understand the source of their classroom behaviors rather than settle on the easy answer. Only then can we respond to their needs effectively and compassionately.

KEYNOTE: *Trauma Sensitive Schools*

Dr. Susan F. Cole, Director of the Trauma and Learning Policy Initiative at Harvard Law School, provided guidelines for transforming knowledge into policy using the example of her successful initiative in Massachusetts. In developing any policy agenda related to childhood trauma and schools, it is critical to engage both schools and families in conversations so that policies reflect their lived experiences and local expertise. Her model focuses on five core ideas for a trauma-sensitive policy.

The problem

1) We know from the ACE studies and other research that nearly two-thirds of children have experienced at least one traumatic event; however, educators are unlikely to know which students in their classroom have had a traumatic experience. It is therefore essential to create a learning environment that meets the needs of *all* students and has the potential to interrupt the consequences of childhood trauma. Trauma sensitive practices benefit both traumatized and non-traumatized children.

2) Children's response to the same potentially traumatic event is dependent on numerous factors including their age, race, and epigenetics and therefore requires a complex solution. Depending on the child, a traumatic experience can detrimentally impact academic performance (e.g., learning skills, ability to complete work), classroom behavior (e.g., withdrawal, perfectionism) and relationships (e.g., lack of trust, difficulty interpreting verbal/nonverbal information). Collectively, the difficulty in predicting any one child's traumatic reaction creates an issue of misunderstanding between children and adults. For example, a child may think that behaving perfectly will protect themselves and their family, but an adult might misinterpret this traumatic reaction as an indication that this child is thriving. Another student may be hypervigilant in his constant expectation of danger, but an adult might misinterpret this reaction as an inability to focus or lack of interest. Sadly, such misinterpretations and their implications for student-teacher interactions have devastating consequences for children, from academic disengagement to juvenile justice system involvement. A critical means of improving school responses to children's traumatic reactions is by including children and their families in conversations about trauma-sensitive practices in schools.

The solution

1) Dr. Cole defined trauma-sensitive schools as an environment in which "all students feel safe, welcomed, and supported and where addressing trauma's impact on learning on a school-wide basis is at the center of its educational mission." The process of developing a school-based solution to the pervasive problem of childhood trauma

first requires gathering and evaluating information from different disciplines to determine the most effective trauma-informed practices available. Once we have established a clear stance on the most viable solutions, but not before reaching consensus, we can look to social justice advocates like lawyers and policy-makers to help transform these ideas into actionable policy. Schools have the potential to offer a safe and supportive community environment for children, and research has demonstrated that community support reduces trauma symptom severity. While teachers are at the front line of education, they will not be able to single-handedly create a safe and cohesive environment for children without an infrastructure that provides support at all levels of schools.

Through her work in Massachusetts, Dr. Cole and her team have identified six key attributes of trauma-informed schools that can be used to evaluate the potential of new actions to cultivate a trauma-sensitive school culture. Effective trauma-sensitive practices should create a shared understanding of trauma's impact on learning and the need for a school-wide approach, support all students to feel safe, explicitly connect students to the school community, embrace teamwork and a sense of shared responsibility for students among staff, and anticipate and adapt to the dynamic needs of students. Additionally, her team has found that educators are better able to integrate trauma-sensitive practices into schools if they have a framework organized by school operations (i.e., leadership, professional development, access to resources and services, academic and nonacademic strategies, policies, procedures, and protocols, collaboration with families) that allow them to assess need at each level.

How we get there

1) Trauma sensitivity requires a *process* of culture change, not a one-size-fits-all program that fails to consider the school's extant norms and values. As such, it is critical to assess the school's concerns using an inquiry-based process that addresses the urgency of the problem, the school's readiness to embrace trauma sensitivity, the development of a sustainable action plan, and the selection of indicators that allow for reflection and evaluation.

2) Helping traumatized children learn should be a major focus of education reform, and we should be cautious about proposing solutions prior to engaging with the specific community. Several guiding principles from the case of Massachusetts include schools identifying urgent priorities, aligning multiple mandates/initiatives (e.g., truancy laws), allowing for locally tailored solutions, involving all stakeholders, and needing the time and resources for schools to engage in the process of culture change.

To end, Dr. Cole provided an overview of her team's successful policy initiative for creating trauma-sensitive schools, the 2014 Massachusetts Safe and Supportive Schools Statue, which seeks to "foster a safe, positive, healthy and inclusive whole-school learning environment." The initiative provides a framework and online self-assessment tool that educators can pick and choose from to best meet the needs of their school, including a statewide infrastructure to support schools in developing trauma-sensitive practices. The statute encourages the development of coalitions between schools and states to "foster a community of practice." Since its inception, the state has set up a Safe and Supportive Schools Commission to continually evaluate and make recommendations on the capacity needed at the state level to help schools achieve trauma-sensitive cultures. It is also important to incorporate the voices and expertise of those affected by these policies, namely teachers and parents, who best know the needs of children from their classrooms and communities. While the case of Massachusetts provides an encouraging framework for the state-wide adoption of trauma-sensitive practices, Dr. Cole ended by emphasizing a point made throughout her talk: we need to develop solutions that work for each community, and this is unlikely to look the same in any two places.

PANEL THREE:
How Systems Can Respond to Systemic Trauma

Solangel Maldonado, Joseph M. Lynch Professor of Law at Seton Hall Law School, moderated the final panel on how systems can respond to the epidemic of childhood trauma that is unequally distributed across groups of people and places.

Stop the Violence, Start the Healing: Schools Responding to Trauma in and Out of Schools

Dr. Lovie Jackson Foster, Assistant Professor at University of Pittsburgh School of Social Work, asserted that the need is more urgent than ever to bring trauma survivors, who disproportionately come from disenfranchised backgrounds and communities "consumed by terror," out of the streets and jails and back into environments that recognize and cultivate their

talent. As part of an arts based focus group study investigating the sources of children's traumatic experiences in Pittsburgh, Pennsylvania involving 99 youth divided into 21 groups, students were asked to create drawings in response to the following question: What factors in your community affect the emotional health and stress of young people in your community? Focusing on the subsample of 65 African Americans, children consistently drew pictures that captured elements of community violence, mistrust in authority, sense of imprisonment elicited by housing structures, and the lack of recreational spaces—all indicators of spatial inequality. Word clouds created from focus group discussions similarly revealed how trauma was deeply embedded in these children's lives, with several of the most frequently mentioned words being violence, crime, drugs and bullying. Most surprising was that all focus groups discussed schools positively; however, many of these children did not have operating schools in their communities.

Central to her discussion, Dr. Foster urged us to look, not only within schools but outside of schools, as systemic trauma intersects with every aspect of children's lives. Because children living with chronic stress are constantly in survival mode, they lack the cognitive resources to recruit the skills needed for classroom-based learning. To reduce the chronic activation of traumatized children's fight or flight response, Dr. Foster and her collaborators designed the Relationship Boundaries Behavior Model as a set of guidelines for the development of healthy, responsive relationships that allow children to know people are there for them while maintaining appropriate space (too close as abusive, too distant as neglectful) and boundaries. Given that African American children start to express a desire to drop out of school as early as 2nd grade, it is critical that teachers receive education about how to create responsive relationships with students from the moment they first enter the classroom.

Another critical area for intervention involves changing the curriculum to reflect honest, complete accounts of the historical and contemporary oppression of African Americans, Native Americans and other marginalized groups that allow educators and children to better understand the roots of social inequalities. Additionally, children will be more likely to engage with the material to the extent that it accurately reflects the plight of their people, rather than perpetuating lies that hinder their opportunity to fully understand and appreciate their cultural legacy. Youth and educators also need to be informed about necessary ingredients for a learning-conducive environment. The **S.C.A.R.F. model of behavior** proposes five components that must be cultivated to make children feel safe, secure and empowered in any social context, including: **S**tatus, **C**ertainty, **A**utonomy, **R**elatedness and **F**airness. For example, one way to build students' perceived social status is to introduce team activities where everyone has the opportunity to serve as a leader. Finally, Dr. Foster noted the critical need to reduce spatial inequalities by advocating for and developing youth-engaged communities that seek to understand what makes these children feel safe and supported, connecting children with elders to create intergenerational communities, and making these programs monetizable. In sum, youth and educators must collaboratively identify the threats to and sources of S.C.A.R.F present in the classroom.

The Impact of Trauma on the School to Prison Pipeline

Dr. Jennifer Jones, Licensed Psychologist and Associate Director of Mental Health for the Adolescent and Young Adult Populations at Riker's Island, realized through her experience the pervasiveness of early life trauma among incarcerated youth who were once themselves in schools. Approximately 70-90% of youth involved in the criminal justice system have experienced at least one trauma, with many having experienced **complex trauma**, or chronic exposure to multiple traumatic events early in life. Policies and procedures stack the odds against children from disenfranchised backgrounds in ways that increase their risk of being plucked from school systems and dropped into juvenile justice systems. For example, the widespread adoption of zero-tolerance punitive policies has led to the criminalization of even normative behavior. Once entrenched in the justice system, these children are likely to be further traumatized as they are cut off from their main social support networks and are trapped in a new environment wrought with potential for violent and violating interactions with staff and other youth. Indeed, 30-50% of youth who end up in the criminal justice system develop PTSD, the same rate experienced by soldiers in active war zones. Sadly, these same youths are likely to continue down this pathway into adult incarceration.

Undeniably, the school to prison pipeline is far from color-blind: although black youth make up only 17% of total youth, they make up

31% of arrests in America. Additionally, compared to white youth, black youth are more likely to be referred to juvenile courts, processed rather than diverted, sent to solitary confinement, and transferred to adult facilities. While criminal behavior should not be excused, systems must take a more active role in understanding its sources—it is not just bad people doing bad things but often traumatized people reacting in ways over which they have no control. Traumatized youth themselves must therefore also receive appropriate education about the potential role of trauma in driving their "choices" and behaviors as part of their rehabilitation, and the justice system must provide appropriate treatment services. Youth who fall victim to the school to prison pipeline are typically those exhibiting externalizing behaviors characteristic of the hyperarousal/reactivity criterion of PTSD. In the classroom, these children are constantly on edge and distracted, yet educators essentially expect these same children to suppress looming sources of chronic stress (e.g., food insecurity, fear of injury) to learn math and literacy. The failure of educators to recognize these behaviors as uncontrollable reactions to chronic stress and early life trauma promotes a punitive rather than caring response that ultimately exacerbates the child's anxious and/or defensive behavior. This is hugely problematic because although youth incarceration rates are decreasing, school discipline has become more frequent and severe over time, with school suspensions increasing 10% since 2000 and 3.3 million students getting suspended or expelled annually. Sadly, suspension not only leads to the loss of instructional time and lower achievement, but is also the leading indicator of future incarceration.

Dr. Jones ended by emphasizing that reversing the school to prison pipeline requires commitment to change, prevention and intervention across systems. Commitment to change can manifest in the elimination of zero tolerance policies and through the encouragement of alternatives to suspension. Prevention must occur through training for all staff to ensure their ability to understand trauma, trauma-sensitive classroom practices, and evidence-based trauma interventions, and through universal trauma screenings that can help identify at-risk children. Finally, schools must adopt evidence-based interventions (e.g., student support teams, social work services, properly tailored Individualized Education Plans) to ensure traumatized youth are not denied their right to equal education.

Peter P. v Compton Unified School District

Mark Rosenbaum, director of Public Counsel Opportunity Under Law and Adjunct Professor of Law at University of California-Irvine Law School, first presented a video overview of his 2015 suit against the Compton Unified School District, the "first suit in this country to deal with the fact that there are children going to school who suffer from trauma and are resultantly hindered from learning – they deserve equal rights to education." Touching on the scope of the problem, complex trauma or exposure to extreme stress makes students 2.6 times more likely to fail a grade, 2 times more likely to be suspended, 5 times more likely to have attention problems, and 6 times more likely to have behavior problems. Children living and attending school in places like Compton often have "unstable living situations [...] and experience pervasive discrimination and racism in their community," yet schools have disturbingly limited resources for basic education let alone trauma prevention and intervention services. In one striking example of the school community's ignorance about the toll of childhood trauma, when Compton School officials learned about a homeless student Peter P. (pseudonym) who had been living on the roof of a school building for some semblance of shelter and security, they reported him to the authorities for trespassing and suspended him from school. Unfortunately, Peter P. represents one of many students from communities like Compton who have felt the consequences of a school culture that encourages staff to react punitively to any deviations from the norm in deeply personal ways. Encouragingly, different models for trauma-sensitive schools have been successfully implemented in Washington State, San Francisco and San Diego, resulting in students' higher achievement, reduced absenteeism, and reduced behavioral problems. Importantly, each of these programs involved three essential components: school-wide trauma sensitive professional development training, restorative practices, and on-site mental health services. Trauma deeply affects students, and it is the school's moral *and* legal obligation to provide systems of support for traumatized students so that they too have a chance to succeed.

Next, Professor Rosenbaum noted the important timing of this conference given the injustices exacerbated by the new administration, which recently proposed massive education budget cuts, juxtaposed with the then upcoming 63rd anniversary of Brown v. Board of Education on May 17th, which established equal educational

opportunity as a constitutional right. He next went on to highlight three related cases exemplifying the important need for community engagement and advocacy filed on behalf of Native students from the Havasupai Tribe, students in Detroit and students in Compton. Whether resulting from culturally insensitive practices and/or lack of access to vital educational resources, the experiences of these three groups of students reflect a failure of the government to meet *all* students' needs. Just as a school without a wheelchair ramp for disabled students denies equal access to education, so too does a school without trauma-sensitive practices deny the educational rights of communities of traumatized children and their families. Fundamental to each of the above-mentioned suits is the argument that it is the federal government's legal responsibility to be aware of the issues of childhood trauma in schools and provide resources for the development of trauma-sensitive schools. Returning to the case of Peter P., Professor Rosenbaum believes that it was no accident that Peter P. ended up on the roof of the school--he wanted to be there because of his love of learning and desire for his school to serve as a safe and secure space. Unfortunately, the message implicit in his removal from school grounds was quite literally that he did not belong there. These are the misunderstandings and grossly inappropriate reactions that destroy children's potential and motivation.

PRESENTATION AND DISCUSSION

In the Name of Resiliency: Intervention v. Prevention

Bringing together the wealth of information and perspectives presented throughout the conference, Professor Troutt emphasized the importance of moving from understanding trauma toward taking action aimed at its prevention. While trauma is a part of the human experience, complex trauma "works in madly debilitating ways to corrupt opportunity oftentimes irreparably and therefore unacceptably." Creating a shared definition of trauma provides the basis for identifying a legally recognized status that can be used to legally obligate system-level responses. Recognizing childhood trauma as a civil rights issue is a critical step in creating "an infrastructure of responsibility while asserting human rights and dignities of individuals who need protecting," as was the case for people with disabilities and people who identify as LGBT.

Unfortunately, while it is undeniable that childhood trauma disparately impacts people of color and people in poverty, neither the rights of black people nor poor people are recognized as a basis for legal protection. The ubiquity of structural inequalities and institutional racism coupled with the denial of personal responsibility from any single individual or institution creates a murkiness that makes it nearly impossible to build a race- or class-based case for recognizing the societal impact of trauma. Focusing the conversation on children, who are perceived as innocent and deserving of legal protection, in the context of schools, which have pre-existing responsibilities to children during critical developmental years, was done strategically to create a convincing legal argument. Moreover, Professor Troutt concluded from the conference proceedings that expanding the definition of disability as a legally protected status to include childhood trauma represents a necessary next step for legally enforced institutional responsibility.

As a caveat, institutional responsibility does not fall solely or even predominately on the backs of schools and teachers. The legacy of childhood trauma is "the symptomatology of structural inequality, it is what happens to human beings who are subjected to a set of environmental conditions that are repeated in similar kinds of environments, similar kinds of neighborhoods, similar kinds of zip codes across the country, and therefore, it implicates much more than what a teacher can possibly do." Rather, schools represent one critical point of contact with children where those impacted by chronic trauma can be identified as early as possible; this cannot happen, however, without a school-wide adoption of trauma-sensitive practices and an infrastructure that includes the provision of school or community mental health services for at-risk children and their families. While there are similarities between the neighborhoods discussed during the conference, like Compton, Detroit and Newark, a critical take-away from today's discussions is that preventive efforts must target the structure of local institutions. Additionally, advocacy is required to garner recognition for the fact that the people most affected by childhood trauma are trapped by oppressive systems in places they cannot escape with damaging institutional norms and values. Given the myriad ways childhood trauma is embedded in systems, it is critical to focus attention on preventing and reducing the structural inequalities that are the underlying cause of this major public health issue: "institutional interaction in every community is intersectional – we rely on a range of institutions, we never ask one institution to do all the work because no one institution created the disparities."

To end, Professor Troutt opened discussion to the audience. Highlighted comments include:

- Universal precautions in schools are considered the best clinical practice for helping all children, regardless of trauma history, with minimal risk of pathologizing those deeply impacted by complex trauma.
- Schools are one of many important locales for targeting trauma given the amount of time children spend there during critical developmental periods; however, it is important to remain cognizant of the fact that schools themselves often serve as a source of trauma (e.g., bullying).
- Maternity and child health represent another point of preventive care given the well-established effects of maternal mental and physical health on child development in utero that may contribute to the intergenerational transmission of trauma.
- Interventions, while necessary, can lead to excessive referrals to mental health services that ultimately pathologize children. In the same vein, understanding trauma as something located within the individual child may inadvertently undermine teachers' perceived responsibility in cultivating a trauma-informed classroom environment (e.g., "It's not anything I'm doing wrong, it's just that Johnnie has trauma").
- Effective interventions like that in Massachusetts tend to focus on creating trauma-informed environments, but fail to consider the importance of restorative justice.
- Wraparound services must be available to not only individual children but to their whole families affected by poverty and complex trauma.
- The voices of people affected by complex trauma must inform decisions aimed at its reduction.
- Schools represent one of many possible starting places to create trauma-informed cultures, but more important than discussions of which institution represents the *best* point of entry is the creation of a shared understanding of the needs of traumatized children that can guide the efforts of different stakeholders in different systems working toward a shared agenda.

CLOSING REMARKS

Children and Trauma-Informed Care: Cautionary Tales and Cause for Hope

Dr. Bonita M. Veysey, Rutgers University-Newark Vice Chancellor for Planning and Implementation, and Professor at the School of Criminal Justice, closed the conference with five pieces of advice gleaned from those most directly affected by early life trauma: children. Dr. Veysey, a strong supporter of trauma-informed systems, urged us not to lose the voices of trauma-exposed youth in discussions that will directly impact their life trajectories.

1) It is not up to us to determine what is traumatic.

When we impose rigid definitions of trauma uniformly we fail to listen to children's own understanding of their traumatic experience. For example, while serving as a consultant in a Louisiana youth detention facility, Dr. Veysey observed an incident in which a teenage boy who had been sexually abused by his grandfather was denied the right to grieve following his grandfather's passing. The staff failed to grasp that though this boy was abused by his grandfather, he still loved him dearly and was deeply upset by the loss. Instead, they decided he needed counseling for his sexual abuse and ultimately extended his detention after labeling him as non-compliant. The well-intentioned experts robbed this boy of his sense of control and invalidated his expression of grief; that is, they re-traumatized him by failing to listen.

2) Trauma doesn't always look like distress.

Many children who have gone through a traumatic experience invest all of their energy and attention into succeeding in school and being a model student. While at face value this traumatic reaction does not appear harmful, even productive and prosocial behaviors aimed at re-establishing a sense of safety and security produce anxiety: "Just because a child is super-focused or independent doesn't mean he or she is not suffering." Accepting this fact provides a major impetus for universal trauma screenings as it is impossible to identify all traumatized children from behavioral expressions alone.

3) We are not experts in healing—the children are.

Dr. Veysey's friend, Sue Hall, created a collection of child-generated solutions to adverse circumstances. In one salient example, she became responsible for a toddler recently adopted from China who was exceptionally uncontrollable. Eventually, Sue realized that

the child's reaction reflected her anxiety over having an amount of freedom and space with which she was unfamiliar. To alleviate the child's anxiety, Sue gave her a cardboard box that she began using as a safe base for exploration until she became increasingly comfortable being in the open. We must not underestimate the subtle ways in which very young children are attuned to their own needs with proper facilitation.

4) Injury and healing are culture-bound.

In the typical Western medical narrative, people develop symptoms, receive a diagnosis, undergo treatment, and either manage their illness or are cured; however, there are other equally valid conceptualizations of illness that are inherently culturally bound and should not be dismissed. Thus, professionals must acknowledge their own cultural biases that affect how they interpret other people's narratives upon entering an interaction.

5) We ALL are healers.

We must all recognize that each interaction with a child provides an opportunity to affect that child positively or negatively, and we must choose to be healers.

CONCLUSIONS

Conference attendees consensually agreed for the urgent need to increase trauma awareness in critical early life systems like schools that can hinder or foster children's successful development. Humans are designed to adapt to and grow from traumatic experiences in the short-term, as adversity is an unavoidable part of life; however, when sources of trauma are chronic and systemically embedded, children are literally trapped in a chronic state of heightened arousal that undermines their healthy development and functioning. While schools represent one system for trauma prevention and intervention, recommendations must be applied to *all* systems (e.g., health services) to create and reinforce a trauma-informed culture. Psychological trauma affects a child holistically, from their socioemotional functioning to their academic performance to their health. Importantly, that psychological trauma disproportionately impacts people from ethnic-racial marginalized backgrounds and people living in poverty is by no means coincidental; rather, it is a reflection of structural inequalities that have been built into every system in society to deny resources and protections to the most vulnerable populations.

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The Trauma, Schools and Poverty Project at CLiME

The Rutgers Center on Law, Inequality and Metropolitan Equity (CLiME) is committed to studying the role of law and policy in encouraging or inhibiting opportunity based on place. This report is a part of our Trauma, Schools and Poverty Project (TSP), a multi-year effort to understand the relationships between structural inequality and pervasive experience of complex psychological stress and trauma.

Related Articles

"A Critical Review of the Psychological Literature" by Dr. Alexandra Margevich can be accessed here:
https://tinyurl.com/clime-trauma-lit-review

"Trapped in Tragedies: Childhood Trauma, Spatial Inequality and Law," by CLiME Director David Dante Troutt, is available for download here:
https://tinyurl.com/clime-trauma-law

Trauma, Schools and Poverty Online Portal

For related material and updates, including a full archive of the 2017 conference, visit:
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