A Professional Learning Community for Developing Trauma-Informed Practices using Participatory Action Methods

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Students with emotional and behavioral disabilities have higher rates of adverse childhood experiences. It is challenging for school districts to maintain staff working with these students due to their history of trauma and acting out behaviors. Trauma-informed practices show promising assistance to staff and students. This literature review describes trauma, students with emotional and behavioral disabilities, and the implementation of trauma-informed practices within schools. School districts must address the difficult task of attending to compassion fatigue with these teachers. Professional learning communities are a beneficial approach to making school reform and professional development, which school programs could adapt to focus on trauma-informed practices.

Keywords: Trauma-Informed Care, Special Education Services, Emotional and Behavioral Disabilities, Professional Learning Communities

Trauma and its related experiences are disruptive to students' academic and social skills, whether the triggering events happen in the community, home, or school environments. It can impact their cognitive, academic, and social/emotional/behavioral functioning (Perfect et al., 2016; Trout et al., 2006). The target of this inquiry is the staff who work with children with special care needs. Persons with disabilities are more likely to have adverse childhood experiences and to have a higher exposure than their non-disabled peers (Austin et al., 2016). Kan et al. (2020) found that for each adverse childhood experience a youth has, their likelihood of having special health care needs increases by 26% (p. 557). Research shows helping students manage the effects of trauma has a promising impact on school performance (Rolfsnes & Idsoe, 2011).

This inquiry seeks to determine whether a professional learning community (PLC), within the Washington state area, focused on trauma-informed care practices can create sustainable change for teachers serving students with emotional and behavioral disabilities, and subsequently impact their classrooms, and their schools through a participatory action research methodology. Hord (1997) defines a PLC as a group working to develop their practice that has supportive and shared leadership, collective creativity, shared values and vision, supportive conditions, and shared personal practices.

Just under half (46.3%) of youth in the United States have one or more Adverse Childhood Experiences (ACEs) (Bethell et al., 2017, p. 1). The initial study regarding ACEs was introduced by Felitti et al. (1998) in their landmark study looking at child abuse and household dysfunction related to common causes of death. The study of ACEs sparked a great focus in understanding the impact traumatic experiences have on people. Other researchers have used similar terms such as toxic stress (Franke, 2014; Shonkoff et al., 2012) and chronic stress (Evans & Kim, 2012) to also identify trauma and its impacts. The Substance Abuse and Mental Health Services Administration's (SAMHSA) Trauma and Justice Strategic Initiative (2014) defines trauma as:

> Individual trauma results from an **event**, series of events, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. (p. 7)

This definition is more inclusive than a clinical definition of trauma, which includes only persons who qualify

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for the diagnostic criteria for Posttraumatic Stress Disorder (PTSD) or another of the trauma- and stressor-related disorders. The American Psychiatric Association (2013) includes the following diagnosis in this category: reactive attachment disorder, disinhibited social engagement disorder, posttraumatic stress disorder, acute stress disorder, and adjustment disorders. SAMHSA's definition is inclusive enough to provide the context necessary to understand trauma from a broad set of needs without having a clinical understanding. For this paper, I am viewing trauma from this lens.

Trends in the rates at which youth experience different ACEs have fluctuated significantly in many areas since the year 2000. For example, parental divorce rates have decreased, and there has been a decrease in exposure to domestic violence (Finkelhor, 2020). Despite these improvements, there continue to be significant amounts of youth who have ACEs. Blodgett and Lanigan (2018) report that 44% (p. 137) of students in Washington state schools have experienced at least one adverse childhood experience. Bethell et al. (2016) explain 13% (p. 5) of these students have three or more ACEs. Compared to students with no ACEs, those with one or more ACEs are 1.65 to 4.46% (p. 5) more likely to have emotional, mental, or behavioral conditions. Children with special health care needs have disproportionately higher rates of ACEs compared to their non-disabled peers. Specific categories of ACEs are also more likely, including living with someone with mental illness, witnessing domestic violence, and witnessing or being a victim of neighborhood violence (Kan et al., 2020).

Special education services assist students with many categorical disabilities. Washington state identifies 14 different qualifying categories granting eligibility for specially designed instruction (Child with a disability or student eligible for special education, 392-172A WAC § 01035, 2007). When people consider these disabilities within schools, emotional and behavioral disability (EBD) is not often the first that comes to mind. Snyder et al. (2008) provide national statistics during the 2017–18 school year regarding special education services. About 13.7% (p. 55) of students, ages 3 to 21, had a disability that required an Individualized Education Plan (IEP). The qualifying category is most frequently for students with a specific learning disability or speech and language impairment (4.6 and 2.7% [p. 84] of the population, respectively). Students qualifying for specially designed instruction due to EBD make up 0.7% (p. 84) of the school population. School districts serve these students on a continuum based on their needs. At the level of least restrictive, this can be supporting them within their general education classroom or in a resource room. The IEP team will recommend more restrictive placements, such as self-contained classrooms or schools, when other interventions are unsuccessful. Lane et al. (2005) described that within some of these types of programs, students might have different primary disability categories. These might include specific learning disabilities, other health impairments (most notably a diagnosis of attention-deficit/hyperactivity disorder), or mild mental retardation.

Bethell et al. (2017) find that students with developmental disabilities and EBD have an increased likelihood of having at least one ACE. School non-engagement, absenteeism, and repeated grades are potentially long-term outcomes for youth with more ACEs (Bethell et al., 2014; Crouch et al., 2019). Along with impacts to school activities, youth with more ACEs often have other psychological sequelae. Some of these include mental health disturbances (e.g., panic reactions, depressed affect, anxiety, hallucinations), somatic health disturbances (e.g., sleep disturbance, severe obesity, and multiple somatic symptoms), substance abuse, and issues related to sexuality (Anda et al., 2006). The number of ACEs that children have increases the prevalence of learning/behavioral problems. Children who have experienced at least four ACEs are 51.2% more likely to have learning and behavioral problems, compared to only 3% of youth who have no ACEs (Burke et al., 2011, p. 5).

Overview of Trauma-Informed Practices

Harris and Fallot (2001) first coined the term trauma-informed services. Trauma-informed practices and care models have been adapted in many different fields and arenas in society. Jennings (2004) defines trauma-specific services as being designed to treat the sequelae of the trauma, where trauma-informed is providing sensitivity towards issues present for trauma survivors. Both perspectives are common in behavioral health systems. Trauma-informed practices have been adopted in communities and general populations (Matlin et al., 2019; Meléndez Guevara et al., 2020), social service agencies (Bloom & Sreedhar, 2008), homelessness services settings (Hopper et al., 2010), juvenile justice systems (Branson et al., 2017), and first responders and child welfare systems (Ko et al., 2008). Schools and K-12 educational systems have also looked towards trauma-informed practices to address the prevalence of ACEs and the childhood trauma students experience (Berardi et al., 2019; Cavanaugh, 2016; Chafouleas et al., 2015; Dombo & Sabatino, 2019; Dorado et al., 2016; Perry & Daniels, 2016; Pickens & Tschopp, 2017).

Washington state has an initiative called Compassion Schools (Wolpow et al., 2011; Wolpow et al., 2016),

which is available as an opt-in program. These compassion schools are declaring their intention to implement trauma-informed practices. Chafouleas et al. (2015) identify at least 17 states where trauma-informed practices have taken root within schools. These states have adopted a trauma-informed lens at varying levels, including small clusters of schools, district-wide, and state-wide implementations (Overstreet & Chafouleas, 2016).

Developing a trauma-informed classroom requires the implementation of several components. Cavanaugh (2016) provides the following fundamental principles of trauma-informed classrooms: (1) Students who have experienced trauma need school to offer a safe and consistent environment, (2) Staff should put a particular focus on having positive interactions with the students, (3) Teachers should implement a culturally responsive practice within their classroom that offers peer interaction and connection and uses a strengths-based approach. Schools that incorporate a trauma-informed lens need to connect that lens throughout their multi-tiered systems of support (MTSS) and integrate their school-wide positive behavior and supports (SWPBS) (Berardi et al., 2019; Cavanaugh, 2016; Dombo & Sabatino, 2019).

While the number of schools participating in trauma-informed initiatives increases, Maynard et al. (2019) raise concerns regarding the national push for these practices within schools. In the more than 9,000 studies they reviewed, they described "there have been no rigorous evaluations of trauma-informed approaches in schools that we could find" (p. 12). The criteria used as a rigorous evaluation included:

- The study must use a randomized or quasi-experimental study design
- It must be in a setting that serves PreK through 12-grade students
- The system must implement a trauma-informed approach that has two of the following three critical elements described by Hanson and Lang (2016) of workforce development, trauma-focused services, and organizational environment and practices
- The study must have measured outcomes related to trauma symptoms, mental health, behavior, social-emotional functioning, and academic performance

It is troubling that there were no studies that fit all of their criteria. Maynard et al. (2019) encourage school leaders and mental health professionals to be cautious about embracing and funding a trauma-informed approach within school systems before more concrete research demonstrates positive outcomes under rigorous conditions. There is evidence that trauma-specific interventions are successful (Ramirez de Arellano et al., 2014; Webb et al., 2014). Many of the components of trauma-informed care practices are included in various best practices for care within the field.

There are also promising results from trauma-informed school programs. Despite what Maynard et al. (2019) describe as rigorous evaluation, the research surrounding trauma-informed school settings has shown positive results. The HEARTS Program evaluation showed preliminary support for their program's effectiveness (Dorado et al., 2016). Meléndez Guevara et al. (2020) found cultural responsiveness and a trauma-informed approach to be successful in helping families engage in services. Chafouleas et al. (2018) demonstrate implementations such as Cognitive Behavioral Intervention for Trauma in Schools (CBITS) as effective at mitigating risk factors of trauma.

Students with Emotional and Behavioral Disabilities

While trauma-informed practices have been implemented in schools in various ways, there has been a limited focus on trauma-informed care practices directly related to children with special needs. The more ACEs a child has, the more likely they are to have deficits in learning, behavior problems, and health issues (Sciaraffa et al., 2017). This gap is even more striking in the population of youth who have emotional and behavioral disabilities. Gresham et al. (1999) describe EBD as including externalizing and internalizing behavior. Federal law uses the terminology of emotional disturbance and not EBD. It defines a student with an emotional disturbance as portraying the characteristics of the disability over a long period of time. Those characteristics also must have a marked impact on the child's educational performance (Individuals with disabilities education act, 20 U.S.C. § 1400, 2004).

Externalizing behaviors can be characterized by non-compliance, defiance, disruptive, and aggressive behaviors (Lambros et al., 1998; Walker & Severson, 1992). The more aggressive and less frequent behaviors are distinctly described by Lambros et al. (1998) as behavioral earthquakes. These outbursts can be highly significant behavioral events. Sciaraffa et al. (2017) find that educators need to help children identify, express, and cope with conflicting emotions in the classroom, especially with children who have experienced significant adversity. Internalizing behaviors such as difficulty in making and keeping friendships, depressed affect, or a

reluctance to speak regardless of their ability and skills are underrepresented in referrals for special education services (Gage, 2013).

Working with students with EBD is very challenging. Prather-Jones (2010) describes that teachers working with students with severe behavior problems require both unique personality characteristics and support. Some of these personality characteristics are (a) to be intrinsically motivated, (b) an ability to not take actions personally, (c) to have an awareness of and acceptance of their professional limitations, (d) enjoy variety and have flexibility, and (e) have a sincere interest in children with EBD. Prather-Jones (2010) also calls for the need for both administrative support and the support of their colleagues. This need for aid is especially true during their initial years of teaching. Teachers have individual and contextual risk factors that can lead to teacher burnout (Beltman et al., 2011). Schools experience difficulty retaining special educators to serve students with EBD (Bettini et al., 2019).

Compassion Fatigue and EBD Teachers

Special education teachers can experience a significant amount of compassion fatigue. When they do, they lose the motivation to teach or devalue their work with students (Andrews & Brown, 2015). Cavanaugh (2016) encourages school staff to maintain an awareness of their internal emotional state and practice emotional self-monitoring. Joinson (1992) first described compassion fatigue for persons working in a caregiving profession as a distinct form of burnout. Hoffman et al. (2007) connect the concept of compassion fatigue to understand burnout among special education teachers. Through a qualitative evaluation, they found that teachers are experiencing compassion fatigue related to loss of control, responsibility, and empathy. Teachers and helpers face significant challenges related to compassion fatigue. Valent (2013) describes the impact that helpers feel when they cannot help those they work with obtain their goals. They often feel frustration, impotence, and diminished morale (Hoffman et al., 2007).

Special education teachers have had a long-term disparity in the number of students with special needs and the number of teachers who can support those students (Boe, 2016). McLeskey et al. (2016) describe in the United States there is a long-term and chronic shortage of special education teachers. This trend is expected to get worse. Factors such as teacher case-loads and needs of enrolled students influence teacher attrition. Special education teachers who work with students who have emotional and behavioral disabilities (EBD) are among the teaching fields with the most significant shortages nationally.

Many diverse factors contribute to whether teachers are likely to leave their special education teaching positions or stay with them. Teachers with more employment opportunities are more likely to depart, though some leave for reasons not related to work. The level of education and certification status also acts as a factor, where the more prepared a teacher is, the less likely they are to quit. Factors such as salary, decision-making power, administrative support, school climate, and job design also play a part in educators continuing as special education teachers (McLeskey et al., 2016).

School administrators play an essential role in supporting working conditions for teachers of students with EBD. Improvement in working conditions helps keep more EBD teachers in their roles. Cancio et al. (2013) offer areas that administrators should focus on to help retain teachers, including (a) induction and mentoring programs, (b) outside resources and support, (c) professional development opportunities, (d) staff acknowledgment, and (e) availability of resources.

Figley (1995) compared compassion fatigue to secondary traumatic stress disorder (STSD). The promotion of STSD took place just before the transition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) DSM-III to the DSM-IV. Figley argued for a shift of only focusing on the primary trauma described as posttraumatic stress disorder (PTSD) to the inclusion of STSD as another diagnosable disorder. This was not included in the DSM-IV-TR or the more recently released fifth version (DSM-5). The most recent edition of the DSM, however, did create significant changes to diagnosing PTSD. The clustering of symptoms for PTSD must fall in the following four areas (1) re-experiencing the event, (2) heightened arousal, (3) avoidance, (4) negative thoughts and mood, or feelings (American Psychiatric Association, 2013). Ziaian-Ghafari and Berg (2019) found that the lens of compassion fatigue may be a relevant lens to understand the psychological distress in teachers working within special education.

One of the components of implementing trauma-informed practices is helping address compassion fatigue. Many of the proposed systems that involve trauma-informed care include recommendations regarding reducing secondary trauma (Harris & Fallot, 2001; Hopper et al., 2010; Jennings, 2004; Trauma and Justice Strategic Initiative, 2014). This professional development is important for school staff. A professional learning community is a process used to promote school reform (DuFour et al., 2005; DuFour et al., 2008).

The PLC Used for Professional Development

DuFour et al. (2008) provide historical context for the rise and fall of school reform. There were three

historical phases in the last half-century that school reform has gone through. These include the excellence movement, the restructuring movement, and No Child Left Behind. Gardner et al. (1983) in their landmark report, *A Nation at Risk*, pushed the excellence movement of the mid-1980s. It included reforms in public education and teacher training with changes in high school requirements, additions of technology and literacy demands, changes in scheduling and instructional delivery. In the 1990s, authors such as Murphy (1991) made arguments around restructuring schools. These calls revolved around expanding education markets and the use of market principles in school systems. In 2001, the No Child Left Behind Act (P.L. 107-110, 20 U.S.C. § 6319, 2002) required high stakes testing and holding schools accountable for student achievement levels. DuFour et al. (2008) posit that these reform models have failed to deliver due to unrealistic expectations, the complexity of the task, misplaced focus, a lack of perseverance, and a failure to attend to and appreciate the change process. They argue that professional learning communities are a more focused method for creating school reform. This movement goes alongside fields such as organizational development, leadership practices, school improvement, teacher preparation, professional development, effective schools, and change processes, which all have been additive to professional learning communities as a change creating process.

DuFour (2004) describes three ambitious ideas regarding professional learning communities. These include a focus on ensuring that students learn, developing a culture of collaboration, and concentrating on the results process. Hord (2015) goes on to explain "improvement requires exchanging what is not working for something that has the potential to do so — this means making a change — and to change requires learning what the change is and how to use it" (p. 38). The PLC is a place that can include transformative aspects and critical reflection (Servage, 2008).

The PLC is a supportive environment for professionals to engage in learning. Teachers can develop trust within a PLC and have improved collaboration (Hallam et al., 2015). Hord (1997) explains that teachers participating in PLCs have increased job satisfaction, higher morale, reduced isolation, a reduction in absenteeism, and more adaptations by teachers for their students. Van Horn (2006) shows that the PLC can increase a willingness for teachers to share what they are learning, engage in long-term inquiry, and venture into the unknown. We can leverage these positive attributes of a PLC in helping teachers learn about trauma-informed care.

Creating a PLC focusing on moving beyond academic and curriculum needs is not a new concept. Schools have used professional learning communities to increase teachers' social and emotional learning (SEL). Elias et al. (1997) describe the importance of professional development and training for school staff. The PLC is used for training teachers in SEL, but is less common than other methods (Blanton & Perez, 2011). Therefore, there has been a lack of examples of it being used to support the development and implementation of a trauma-informed classroom or school setting (Dombo & Sabatino, 2019). Elias (2003) states, "no lasting success in academic and social-emotional instruction can be expected without ongoing professional development for school personnel and support for their efforts as implementation proceeds" (p. 23). The PLC is a manner of creating school reform.

Summary

Stoll et al. (2006) describe several processes used for professional development in schools. These include formal professional development opportunities, work-based and incidental learning opportunities, self-evaluation and inquiry as a learning source, and moving from individual learning to collective learning. Teachers most often use the PLC process focused around the latter two. We have discussed that students with emotional and behavioral disabilities are at significant risk of experiencing trauma and are a population that would be highly likely to benefit from the implementation of trauma-informed practices. Students with EBD are significantly more likely to drop out of high school than their other disabled and non-disabled peers (Mitchell et al., 2019). The incarcerated juvenile population has high rates of persons with identified educational disabilities and diagnosed mental health conditions (Nelson, 2014).

These individual factors related to students and the difficulties facing special education teachers who work with these children demonstrate the need for trauma-informed care within schools. It is believed that this process can be beneficial to both the students and the staff who work with EBD students. This inquiry seeks to determine if a PLC focused on trauma-informed care practices can create sustainable change for teachers serving students with emotional and behavioral disabilities, their classrooms, and their schools through a participatory action research methodology.

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