Summer 2020

Children Living with Trauma

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A Literature Review Presented

in Partial Fulfillment of the Requirements

For the Degree of Master of Education

Table of Contents

Abstract

There are many experiences that can happen to children that may lead to trauma. This literature review uses scholarly articles and journals, as well as books, to explore the impact trauma has on children. The research shows that there are many factors that may influence a child's life and cause a child trauma. Trauma has a significant impact on the wiring of a child's brain. As a result of the wiring, or lack of wiring due to trauma, children will show deficits in physical, social emotional and cognitive skills. Many times trauma can be misunderstood and diagnosed as a disability due to the symptoms traumatized children exhibit. Children exposed to trauma will have difficulties with coping skills, impulsivity, relationships, academic skills and self-regulation. These deficits in the classroom can be altered with the correct strategies of teachers. Teachers can use calming and coping strategies to assist traumatized children in being successful in the classroom.

Children Living with Trauma

In the United States alone, over 70% of children have been exposed to at least one traumatic event within the last year (Berson & Baggerly, 2009). A traumatic event is described as the existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone (Cougle, Kilpatrick & Resnick, 2012). Being exposed to trauma has lasting effects, both internally and externally. These lasting effects can result in chronic physical and mental health problems. Physical problems resulting from trauma could be malnutrition, weight loss or gain, headaches, hyperactivity, or injuries such as broken bones. Mental health problems manifest as anxiety, depression, aggression, withdraw or irritability in response to trauma (Berson & Baggerly, 2009).

In order for teachers to help children through trauma, teachers must understand how the symptoms of trauma may present themselves differently for different children. According to a study by Centers for Disease Control and Prevention (CDC), trauma is referred to as being exposed to a high level of stress that affects the development of the brain. The CDC also states children may experience three different types of trauma: acute, chronic and complex. Acute trauma refers to one event. Chronic trauma refers to repeated exposure to traumatic events. Complex trauma refers to chronic trauma by a child's caregiver or caregivers (Plumb, Bush & Kersevich, 2016). As stated by Berson and Baggerly, a child dealing with trauma has a heightened sensitivity to everything around him/her and therefore cognitively may not be able to focus, concentrate or use a working memory within the classroom atmosphere (2009).

Teachers must know how to serve children with trauma in the classroom. In a preschool classroom, a play-based environment is a healing atmosphere for children who have experienced trauma. Too many times children facing trauma are seen as being behind and the educational

focus shifts to skill-and-drill. The pleasure of play and the ability to make choices based on interests are important healing aspects for young learners who face trauma (Sorrels, 2018). A study done by the Maryland State Education Association stated that the top four things children facing trauma need are: safety, positive relationships, a feeling of accomplishment and choices and options in daily tasks (Bartlett, Smith & Bringewatt, 2017). Keeping a predictable schedule is also important in the classroom. Children who have dealt with trauma have a fear of the unknown, and a predictable schedule can offset some of that fear. Perry and Szalavitz's work with children concluded that children living with trauma accept their situation because it is better than uncertainty (2017).

The purpose of this literature review is to develop an understanding about childhood trauma. Important topics that emerged include: reasons children deal with trauma, the brain's reaction to trauma, why children dealing with trauma can be misdiagnosed, what trauma looks like in a classroom, and how educators can help kids facing trauma in the classroom.

Review of the Literature

Why Children Deal with Trauma

Berson and Baggerly linked the prevalence of adverse childhood experiences, referred to as ACEs with the existence of trauma. ACEs occur before the age of 18 and may include traumatic events like neglect, abuse or parental mental health (2009). A study conducted about ACEs was done by the Kaiser Permanente and the Center for Disease Control and Prevention. The goal of the study was to investigate how stressful experiences, or ACEs, are connected to adult health outcomes. The study focused on many different ACEs that children may experience. The most common ACEs reported were: abuse (physical, sexual and emotional), neglect (physical and emotional), domestic violence and divorce. The findings of the study showed that

the majority of the children show deficits in one or more developmental area (Nicholson, Perez, & Kurtz, 2019).

As found in the study by Berson and Baggerly, seven out of ten children are faced with trauma (2019). There are many different circumstances that may lead to trauma. Sorrels discussed the situations she encountered when volunteering at a hospital and helping with children facing trauma, beginning in infancy. Sorrels described the population of infants in the hospital as those left on a doorstep, left in parks, left in trash cans or infants with incarcerated parents (2018). The effects of the trauma may lead to an early death, because as the infant grew there was not a strong attachment with caring adults (Nicholson, Perez, & Kurtz, 2019). Some children experience traumatic events years after infancy, as noted in a study done on types of adversity which lead to trauma. Some common ACEs noted are immigration, bullying, losing a parent or being involved with the foster care system. Experiencing trauma as an infant may affect the individual for a lifetime. Another study reported by Blitz, Anderson and Saastamionen on ACEs focused on low-income urban youth. The study discovered a heightened level of exposure to ACEs for children who lived in poverty (2016). Natural disasters are another common cause of childhood trauma. Project Fleur-de-lis created a program in New Orleans to assist families after the trauma of Hurricane Katrina. Researchers found the children that went through Hurricane Katrina were experiencing depression, disruptive behavior, anxiety and somatic complaints. All these symptoms were discovered to be the aftermath of trauma (Lee, Danna & Walker, 2017). Whether children experience ACEs in infancy or later in childhood, the effects can be long-term and life altering.

The Brain's Reaction to Trauma

The brain can be a signpost for trauma experienced during childhood. According to a study done by the National Survey of Children's Health, 35 million children in the United States are living with trauma. Children who lived with trauma have unseen scars on the brain and brain development (2011-2012). Perry and Szalavitz's work with children facing trauma acknowledged that brain development occurs in a specific sequence. Some regions of the brain progress earlier than others, and successful maturation of later regions relies on the development of earlier regions. The first areas of the brain to develop are the lower and central areas. These areas are responsible for blood pressure, heart rate and reaction to emotional responses. The lower part of the brain sends direct connections to the other parts of the brain. If there is a disconnect within the lower or central part of the brain, all other areas will be affected (2017).

Perry and Szalavitz believed that human experiences influenced how the brain matured. Perry found through his work with children that early experiences left lasting imprints on the brain. Dr. Seymour Levine researched baby rats and the brain's response to stress, which supported Perry's findings (2005). The study showed that even a small amount of stress, lasting only a few minutes, had an impact on the developing brain. The change in the brain matter was evident for years to come. This confirmed Perry's belief that stress in a developing brain could leave lasting imprints. After all, the brain is a very complex machine. The brain regulates so many different emotions, behaviors and thoughts (2018). According to a study done by the Minnesota Longitudinal Study of Parents and Children, the brain was going through rapid growth and reorganization during the first two years of life. When environmental factors halt the growth, the structure on that region of the brain may become permanent. Even if environmental conditions improve, the brain may not improve (2012).

Beginning in the womb and stretching into early adulthood, human brain activity is very complex. The brain is composed of nearly 86 million neurons, or brain cells. Within each neuron there are support cells, known as glia (Perry & Szalavitz, 2018). Perry and Szalavitz suggest that the varied architecture of the brain is a result of how four networks connect into specialized systems. The four major parts include: the brainstem, the diencephalon, the limbic system and the cortex. The brain is organized from the inside out, with the central and lower systems of the brainstem and the diencephalon being the least complex systems. The brainstem is responsible for regulatory functions such as heart rate, blood pressure, body temperature and breathing. These systems develop first and then more complex development takes place in the limbic system. This development then leads into the most complex system, the cortex. The diencephalon and the limbic system are responsible for emotions that affect behavior. The cortex is responsible for decision making, planning, speech and language. Although there are four separate systems, they all work together (Perry & Szalavitz, 2018).

A child who has experienced trauma may show abnormalities in all systems of the brain. This is due to the fact that the functional chain may be broken if connections are not made between neurons. A break in the neuron to neuron connections, the synapses, can cause underdevelopment in many areas. For example, sleep problems can affect the brainstem, those problems can then lead to problems with fine motor control (diencephalon and cortex), which can lead to social and relational delays (limbic and cortex), which can result in speech and language deficits (cortex). This break in the chain of neurons can happen at a young age when a child has a heightened level of stress, or trauma (Perry & Szalavitz, 2018). According to research on brain function done in the *Journal of Religion and Health*, the right hemisphere played a greater role in the storing of sensory information. Within the right hemisphere images are formed

of mental context and experiences that affect those images. The left hemisphere plays a greater role in information processing and language usage, driven by the Broca. The Broca is suppressed by trauma and will therefore not properly connect with the right hemisphere. The break between the left and right hemispheres connecting for a trauma sensitive child causes periods of speechless terror. Speechless terror is an episode in which children that sense trauma remain speechless (Gostečnik, Lukek & Cvetek, 2014).

From her work with children facing trauma from infant into the preschool years, Sorrels pointed out that the brain is constantly receiving and processing data. All this data, such as sounds, sensations or sights, is processed in the brainstem to produce an appropriate response. When stress hormones are released, the body perceives danger. This response can produce increased heart rate, respiration and blood pressure as the body decides whether to fight, flight, or freeze. As soon as the threat or stress is eliminated, the body goes back to functioning normally. For a child experiencing trauma, the fight, flight or freeze decision may be engaged at all times. This chronic stress and trauma may damage certain parts of the brain, and that damage can last a lifetime. The areas in the brain that do not get activated will not change. The areas of the brain that get repeatedly activated will change (2018). Trauma can lead to many responses by the brain, some lasting years beyond the trauma. The variety and pervasiveness of the overt symptoms can be difficult to decipher.

Why Children Dealing with Trauma Can Be Misdiagnosed

Through her work helping children dealing with trauma, Sorrels found that adults assume that all children are resilient (2018). Perry and Szalavitz's research, however, shows that the vast majority of children with developmental delays or behaviors have been exposed to neglect, chaos and/or violence. Children that were exposed to these traumatic events often showed signs of

impulsivity and developmental delays. Up until the last two decades, parents, teachers and psychiatrists felt that medication could cure children showing signs of impulsivity and/or delays (2018).

Perry and Szalavitz pointed out that many times a child who has experienced trauma, may be diagnosed with Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD). Youth experiencing trauma may use 100% of focus to analyze faces of teacher and peers for threats. Other typically adjusted students are able to focus on the lesson. However, giving a diagnosis of ADD or ADHD is only focusing on the symptoms the child is exhibiting (2018). A study done by Council for Exceptional Children in 2009 points out that early signs of trauma can be mistaken for disorders. If trauma is mistaken for a disorder the child will not get the proper support to overcome the traumatic experience (Statman-Weil, 2015). According to a study done by Nadeem, Cappella, Holland and Coccaro another reason a student could be misdiagnosed is due to the fact that teachers base student performance on data. The study found teachers were less likely to guide instruction based on student behavior, but rather based on academic interventions and performance data (2016).

Perry and Szalavitz described how only treating the symptoms of trauma can lead to a misdiagnosis rather than finding the source of the behavior. The misdiagnosis may lead to interventions for a child dealing with trauma. As a baby, Leon was born into a family with a father, mother, and a brother. The mother had a low IQ and did not have appropriate parenting skills. She would leave Leon in his crib at home for many hours a day, while her and the brother left for errands and exploration. As a result, Leon learned at a young age that crying elicited no human response. He had to fend for himself and self-soothe rather than relying on others. Leon did not hear language and did not interact with others. As Leon grew older and began school, he

was immediately labeled a problem student. Teachers could not control Leon's behavior; he was disruptive and aggressive. It was determined that it was unsafe for Leon to be around a large group of children. Leon was labeled with ADHD and put in a self-contained classroom. Since Leon had never witnessed how to act in a social atmosphere, he often copied what he saw. Being in a self-contained classroom was only more detrimental for Leon's development, because he was unable to witness what typically adjusted peers were doing. Had Leon been surrounded by normal peers, he may have formed healthy relationships and learned models of proper social behavior. ADHD medication did not fix Leon's mal-adapted behavior. He struggled for many years, until he ended up in prison as a teenager (2018).

Leon is just one example of professionals trying to "fix" a child, without knowing the root of the problem. Perry worked with many children that had traumatic childhoods and struggled in school after being given a diagnosis (Perry and Szalavitz, 2018). Sorrels noted that many children who have experienced trauma are diagnosed with either ADD, ADHD, oppositional defiant disorder, bipolar disorder, obsessive compulsive disorder, or depression. Sorrels pointed out that when children are labeled with a disorder, the disorder is merely the symptom of the underlying trauma. If only the symptoms are treated, then the neurochemical changes in the brain are ignored. This is similar to putting a bandage on an amputation; the wound continues to bleed (2018).

What Trauma Looks Like in a Classroom

Children are not wired to be resilient and bounce back on their own from early trauma (Perry & Szalavitz, 2018). The classroom environment must be prepared to identify potential symptoms of underlying trauma. According to a post-traumatic stress study done by Lonigan, Phillips and Richey, children will face a variety of feelings due to trauma, such as: depression,

irritability, fear, aggression, withdrawal and anxiety (2003). A study done for Head Start Trauma Start found traumatized children may be trying to figure out the boundaries of world around them. As these children confront barriers or rigid rules, they may display aggression, hitting and tantrums (Holmes, Levy, Smith, Pinne & Neese, 2015).

According to a study done by the National Child Traumatic Stress Network in 2006, there are three different categories of symptoms that children who experience trauma may exhibit in the classroom. The first is physical, which can be headaches, stomachaches, weight change, a higher than normal state of alertness and sleep deprivation. In the classroom, a student exhibiting physical symptoms may constantly complain about not feeling well, constantly looking around the room, rest his/her head on desk throughout day or experience a change in how the child's clothes fit. The second category is behavioral symptoms, which may include: social-isolation, attention seeking, aggression, regression and risk-taking. A child that is disruptive, talks about inappropriate ideas, sucks his/her thumb, and does not talk to others may be displaying symptoms of trauma. The third category is emotional symptoms, such as: easily angered, easily cries, does not demonstrate trust, shows fear and low self-confidence. In the classroom, this child may exhibit mood swings, may become overwhelmed easily, or may resist working with others. The last category is cognitive symptoms which may include: inability to focus, low skill development, and traumatic flashbacks. A student experiencing cognitive symptoms may fidget in the classroom, have poor memory, or exhibit a low skill set (Bell, Limberg & Robinson, 2013).

Many children who have experienced trauma have a difficult time with attachment. Based on her work with children exposed to trauma, Sorrels discusses three types of attachment that may be seen in the classroom by children who have experienced trauma. The first is insecure

avoidant. This type of attachment is seen by a child who does not like to be comforted or helped, seems withdrawn, a loner, angry, blames others and lacks empathy. The second type of attachment is insecure ambivalent. A child who is demanding, clingy, compulsive, fidgety and demonstrates low attention span may struggle with insecure ambivalent attachment. The third attachment type is disorganized. This type of attachment is shown by a child who is unpredictable, has meltdowns, shows strange behaviors and is in a constant state of alarm. Trauma can also play a key role in a child's social skills. In a classroom this child will have problems with self-regulation, empathy, turn taking, sharing, joining in play, and conflict resolution (2018).

How Educators Can Help Children Facing Trauma in the Classroom

Sitler found that traumatized children in the classroom are often seen as lazy, careless, unmotivated and disengaged (2008). Maslow, however, said children first need physiological needs met, followed by a sense of security and thirdly a sense of belonging, or emotional security (1987). According to a study done by the Department of Pediatrics and the University of Oklahoma Health Sciences Center, there are many things that can be done in the classroom to help meet these needs for children, especially by reinforcing safety and security. For some students who have experienced trauma, reinforcement of safety and security may need to be done periodically throughout each day. Times of transition or over stimulation may require additional safety and security reinforcement. Some classroom strategies that can help during times of transitions are holding hands, singing quiet songs, working together on an activity of the child's choice or using calming activities such as deep breathing. It is also important for a teacher to respond to the child's thoughts in a calm manner. Teachers should also be willing to listen to and accept a child's feelings. Feelings can be expressed through conversation, through play, or

through role playing. Daily choice of free play may give the child the control they are seeking. School expectations and safety rules should also be revisited frequently (Gurwitch, Silovsky, Schultz, Kees & Burlingame 2001).

According to research done by Bruce Perry and the Child Trauma Academy, keeping a routine is important for children that have experienced trauma. A routine allows the child to always know what is coming next. Sticking with a consistent routine will help traumatized children practice self-regulation. To help repair regulatory abilities, children can use their bodies during sensory activities. This can be drumming or dancing during music, jumping while counting, or using a fidget toy while listening to a story. Strengthening relationships is also an important concept in the classroom, especially for children who are dealing with trauma. Consistent positive daily interactions with both teachers and peers builds strong interpersonal relationships (Bruznell, Waters & Stokes, 2015). According to a study done by Gay in urban communities, developing close relationships with and among students build strengths within families and communities. Communities can be brought together using culture, heritage, and oppression as foundations of teaching and learning (2014).

Research by Statman-Weil showed that trauma can alter how children are able to play in imaginative and creative ways. Imaginative and creative play are important skills for a child's social emotional, physical and cognitive skills that lead to success in school. Play allows children to learn about the world around them and how others experience the world. The ability to see how others act during play gives a glimpse into how children learn develop competence and control in situations that may be scary and have a need for conflict resolution (2015). Traumatized children can be confused about information in certain events. They may blame themselves or have irrational thoughts about situations. As traumatized children attempt to work

through these situations it is important for the teacher to listen to the concerns and provide support and consistency. These students may also ask a lot of questions repeatedly. This may be frustrating for teachers, but it is important for traumatized children to hear consistent answers to their questions multiple times (Gurwitch, et. al., 2001).

Social emotional learning is an integral part of learning for children exposed to trauma. A study on the importance of social and emotional learning by the Collaborative for Academic, Social, and Emotional Learning (CASEL) described social emotional learning as the process through which children acquire and apply the skills needed to understand emotions, manage emotions, show and feel empathy, create and maintain positive relationships, and make responsible decisions (Barr, 2018). One strategy Sorrels discussed for social emotional skill development is to be aware of what emotions look like. Learning outcomes can be achieved by discussing what people look like when they feel a certain emotion. Children can also use a mirror when experiencing an emotion so that they can see how their face and body is reacting. Teaching empathy can be done by asking children questions about how they feel, or where does it hurt, or what caused the hurt. Increased awareness of feelings leads to empathy, because similar feelings can be observed in others (2018).

Other aspects of social emotional learning include taking turns and sharing. This can be done by praising a child when he or she successfully takes a turn, by setting a timer for the child's turn to expire, and by planning activities where children have to share materials. A teacher can also teach social emotional skills by sitting down with children to narrate the details of a conflict through conversation. Although it is important to teach children to make amends after a conflict, it is not important to make a child say "I'm sorry". Often times the child is only

sorry that he/she got caught. Rather, teach children strategies to make things better, including: make a card, give a hug, play a game together or share a toy (Sorrels, 2018).

Maryland State Education Association stated children need to feel loved and a sense of belonging in a classroom. Becker and Luther have studied the social emotional factors affecting achievement outcomes among disadvantaged students. This research encourages building positive relationships both between teacher and student, and student to student as a way of creating classroom belonging. Additional recommendations include promoting a personal sense of self and learning to manage emotions (Day et. al., 2017). Brinamen and Page pointed out that the teacher-student relationship can be difficult at times, and that teachers need to use reflective practices to build relationships with children exposed to trauma. It is important to not take their actions personally, but instead stop and identify feelings. Next, think about the situation and make a hypothesis as to why the children may be acting the way they are (2012). Sorrels encouraged buddy activities so that children can feel they belong amongst their peers. She also recommended modeling positive relationships and giving the children plenty of opportunities to choose whether or not they work alone (2018).

Planning is an integral part for teaching traumatized children. Self-regulation can be taught throughout the day by planning movement breaks throughout the day. Self-regulation can also be taught through numerous sensory activities, such as play-dough and hands on activities, as well as short burst of exercise. These type of scheduled activities provide consistency as well as the opportunity for students to regulate their heart rate (Brunzell, et. al., 2015). Blitz and Anderson pointed out that prolonged exposure to stress takes a toll on a traumatized child's heart rate. This prolonged exposure can cause high levels of stress hormones that can be detrimental to

health. Traumatized students will benefit from moving and actions to keep their heart rate consistent throughout the school day (2016).

A study done in a Danish City after a factory explosion reported positive effects from all children living with trauma due to an effective response. The school implemented coping resources following six dimensions for children affected by the explosion. The six dimensions included: belief, affect, social interaction, imagination, cognition, and physiology. The study found that the majority of students had a positive outcome by using strategies within each dimension. For belief the students would find meaning in the traumatic event. To teach affect, the students used worry dolls and safe place exercises. Social interaction involved exercises in giving and receiving social support. Imagination lessons included guiding imagination and drawing. Cognitive learning focused on cope cards, reconstruction of trauma and narratives. Lastly, the physical dimension taught relaxation techniques and butterfly hugs (Ronholt, Karsberg & Elklit, 2013).

Conclusion

The purpose of this literature review is to understand childhood trauma and how that trauma effects those children in school. This research was needed for educators to better understand children dealing with trauma. Understanding is needed regarding what the symptoms of trauma look like in the classroom, but also the causes and strategies to use when working with trauma-affected children. This literature review also provides statistics and evidence about the large number of children affected by trauma.

35 million children in the United States are living with trauma and the number seems to grow from year to year (RB-Banks & Meyer, 2017). The concept of childhood trauma is especially prevalent today as our world is going through a pandemic. Children have been out of

school for months and adjusting to a new normal. A study done by a trauma nurse, Karen Macauley, pointed out that summer break is a stressful time for some communities. Long, hot days, and bored children can trigger violence within the home and with caregivers. These hot, cranky children can be the victims of violence (2015). Soon however, schools will open back up, and children will again need to adjust to a new normal. Some of these children may have experienced a variety of traumatic events while out of school. Some traumas could include lack of nutrition, fear caused by troubling news on television, seeing a loved one become ill, or being home all day in a home atmosphere with abuse or neglect (NYU Langone Health, 2020).

Research on childhood trauma will continue as professionals try to identify how to help these children. Research has shown that there is not one single factor that creates trauma for children. Rather, there is a wide range of different events that can cause children to face trauma. Research also shows that the effects of trauma causes changes within the wiring of the brain. Traumatic events will overstimulate some areas of the brain. When the lower area of the brain is focusing on survival skills, it is missing opportunities to connect with the other reasoning portions of the brain. Research has also shown that children are misdiagnosed when professionals focus strictly on the behaviors. Treating the behaviors of how children deal with trauma is different, and not effective, in helping children work through traumatic events.

Research has proven that traumatized children may show specific behaviors in the classroom. Some of these behaviors may include negative behaviors, lack of focus, or becoming withdrawn. Research has also shown that teachers can play a significant role in helping traumatized children be successful in the classroom. Traumatized children will show positive results when given opportunities to express themselves in a safe atmosphere through conversation, play and role-play. Another important aspect in the classroom is building positive

relationships between teachers and peers, as well as peers to peers. These recent studies have shown that trauma can be understood, and educators can help traumatized children be successful.

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