Supporting Teacher Understanding and Intervention of the Effects of Trauma on Preschool Development and Behaviors in the Classroom

by

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University of Pittsburgh, 2023

The consequences of trauma and chronic toxic stress on young children's social and neurobiological developments are numerous and well-documented in the literature (Centers for Disease Control and Prevention [CDC], 2020; Jimenez et al., 2016; Sciaraffa et al., 2018; Statman-Weil, 2015; Zeng et al., 2019). Children exposed to trauma during early childhood (0-5 years old) can have profound challenges understanding and growing in the world around them. Educators can play a vital role in a preschooler's life, especially those children affected by trauma, through serving as a healing, loving, and encouraging individual in the school setting. My problem of practice (PoP) identified insufficient teacher skills for recognizing and addressing preschooler's mental health and trauma as a concern in the Pittsburgh Public Schools Early Childhood Education programs. Interviews with preschool teachers prior to this project indicated that trauma knowledge was not provided in university courses or job-related trainings. My change idea included the provision of monthly professional development trauma training, including reflective practice activities with the teachers and paraprofessionals. The goal for these initiatives was to increase trauma awareness and enhance teacher identification and interaction with children exhibiting trauma related behaviors. I collected and evaluated data prior to and after the trauma-based professional development trainings. The results showed a greater understanding of children's trauma related behaviors after attending the trainings. Future training will include the continuation of a trauma-informed care approach for staff introducing alternative interventions to help the

preschool child learn self-regulation, resolve problems in a typical manner, and provide behavioral strategies that will not re-traumatize the child.

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Preface

I would like to express my appreciation to Dr. Tom Akiva, and other members of the EdD faculty for their sharing of knowledge, expertise, patience, and feedback in the preparation leading to this dissertation in practice. I would like to thank my former University of Pittsburgh professors, especially Dr Karen VanderVen, Dr. Mark King, Dr. Martha Mattingly, Dr. Carl Johnson, and Dr. Nancy Curry, who provided my educational foundation and skills for my career pursuits and success. Thanks also to my defense committee including, Dr. Tracy Larson and Dr. Stefano Bagnato who employed and encouraged me to be successful within HealthyCHILD.

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1.0 Naming & Framing the Problem of Practice

The consequences of trauma and chronic toxic stress on young children's social and neurobiological developments are numerous and well-documented in the literature (CDC, 2020; Jimenez et al., 2016; Sciaraffa et al., 2018; Statman-Weil, 2015; Zeng et al., 2019). Children exposed to trauma during early childhood (0–5 years old) can have profound challenges understanding and growing in the world around them (Shonkoff & Garner, 2012). Educators can impact and play a vital role in a preschooler's life, especially those children affected by trauma, through serving as a healing, loving, and encouraging person in the school setting. There is value when the teacher who is trauma trained works with the school's mental health staff or consultants to correctly identify and address trauma related behavioral issues within the classroom. The teacher's knowledge of trauma-informed practice is ideally provided in university education or professional development training (National Association of School Psychologists [NASP], 2021). Teachers who are unfamiliar with the developmental effects of trauma and learning in the school environment, may not correctly interact with children in a supportive manner and/or identify children for the correct support services (Ruiz, 2014). Communication with teachers and families is especially critical with a child affected by a traumatic event. My theory of improvement included the teacher's needs to identify, interact, and intervene with preschool children's trauma related behaviors and recognition of children who would benefit from trauma-informed care (TIC) in the preschool classroom. This would be in collaboration with developmental healthcare consultants (DHCs) supporting teachers, students, and families.

1.1 Problem of Practice (PoP)

During the 2020 - 2021 school year, a time in which schools were operating virtually due to the COVID-19 pandemic, I identified insufficient teacher skills for recognizing and addressing preschooler's mental health and trauma as a concern in the Pittsburgh Public Schools (PPS) Early Childhood Education (ECE) programs. I recognized that there were limited formal policies or protocols to address adverse childhood experiences (ACEs) or the effects of trauma in the preschool setting and chose this as my problem of practice (PoP). Early childhood educators and administrators also acknowledged deficiencies for recognizing and intervening with children's mental health and trauma during 2020 meetings with my employer, HealthyCHILD. The connection between trauma and the effects on learning, social emotional development, and behavioral issues was not readily evident in practice. I proposed that educators may not recognize trauma's influence on behavior, especially with students affected by trauma. Pre-pandemic, the educators expressed overwhelmed feelings, saying it was not their role to deal with mental health issues in the classroom, or lacking education to deal with students having trauma. I could see myself in the role of a developmental healthcare consultant giving this support and training to educators to help them first identify then deal with children's trauma related behaviors in the classroom.

In preparation for identifying my PoP, I initially collected children's trauma related information from preschool teachers and DHCs during empathy interviews, focus groups, and questionnaires. I found that almost no participants took courses regarding trauma, identification, and intervention of children's trauma behaviors in the classroom during university education. Absence of trauma training in preparation for becoming a teacher was identified as a root cause of my PoP. Learning about the effects of ACEs, trauma, and toxic stress while in their higher

education programs can help to prepare future teachers to better recognize and understand trauma in relation to a child's cognition and behaviors (The National Council of State Education Associations [NCSEA], 2019). The lack of identification of students involved with traumas and ACEs was also related to behavioral issues in the classroom (NCSEA, 2019). Teachers have reported to me about feeling stressed, especially when attempting to focus on student learning while dealing with behavioral interference. This may be related to trauma or behavioral health issues. Teachers may also acquire secondary traumatic stress and feel unprepared to deal with a child's trauma without adequate education and training (NCSEA, 2019). Working with children affected by trauma also has emotional influence on educators commonly referred to as secondary traumatic stress (Christian-Brandt et al., 2020).

1.1.1 Guiding Questions

In support of my PoP, I reviewed evidence-based practices and resources regarding ACEs and the impact of ACEs on children's cognition, learning, behavior, and future health issues. I examined the effects on educators working with traumatized children, including experiencing secondary traumatic stress, negative job performance, lack of commitment, compassion fatigue, and higher risk of burnout. I also investigated the effects of ACEs and trauma on communication and collaboration between children, families, educators, and consultants. I looked at ACEs and trauma's roles and effects relative to race, socio-economic status, the diverse urban population, and living in underserved communities. I proposed ideas to address ACEs or the effects of trauma in the preschool setting. I identified practices that may have success with improvement, such as school resources for trauma support, professional development training and education for educators, staff, and administration.

My PoP is guided by the following questions:

1. What is the impact of ACEs, trauma and/or traumatic experience on the preschool child's development, behavior, experiences and/or learning in the school setting?
2. Are educators aware of and trained in identifying and intervening with ACES and/or trauma in preschool children?
3. What resources, policies and protocols are available for addressing trauma in the classroom and school environments?

1.2 PoP Patterns on Data

Patterns related to the PoP and supported in the literature included the relationship of trauma and ACEs on the affected child's development, behavior, and/or learning. Preschool children and their families may confront traumas, toxic stress and ACEs within their homes and communities. Secondary effects of trauma on children appear through classroom behaviors such as lack of self-regulation skills, non-compliance with the educators and routine, disruption, aggression, and extreme forms of withdraw. There is also a correlation between the number of ACEs or traumatic events and the risk for negative physical and mental health outcomes, and academic and career impact.

The absence of trauma-informed practice training in college and/or in the school and work setting was a root cause of the PoP and will be further addressed in that section. Learning about the effects of ACEs, trauma, and toxic stress in education programs can help to prepare future educators to better recognize and understand trauma in relation to a child's cognition and behaviors. Professional development training received in the university and/or employment setting

enable a teacher to be knowledgeable of ACEs and the effects of trauma. Trained educators can recognize the signs of trauma in students and assume best practices for trauma-informed schools and classrooms. Administration who also receive trauma related training may be more willing to develop school procedures related to trauma-informed education, including positive behavioral interventions and supports, restorative justice, and resiliency. There is a connection with children benefiting from early identification and positive behavioral interventions in relation to trauma. Learning was enhanced through self-regulation and resiliency with impact on future academic success (Bellis et al., 2018; Mortensen & Barnett, 2016).

The literature also links the impact of secondary traumatic stress from children on the teacher's own well-being (Lepore, 2016). Through training and information sharing, educators can become increasingly aware of exposure to secondary traumatic stress reactions to avoid compassion fatigue, burnout and achieve self-care and compassion satisfaction in support of employee wellness.

An additional pattern of ACEs and trauma's roles and effects with my PoP was in relation to race and socio-economic status. ACEs have been associated with living in under-resourced areas, in racially segregated communities, with food insecurity, poverty, and with frequent moves (CDC, 2020: National Alliance for Mental Illness [NAMI], 2022). There may be limited resources within the underserved community to support parents in dealing with the child's or their own traumas. The inclusion and cooperation of the child's parents and/or significant adults is vital to first identifying trauma or ACEs then implementing trauma-informed practice and intervention strategies. Without receiving trauma histories, the effects of severe adversity may be misdiagnosed as a learning disability or a neurodevelopmental disorder, such as ADHD. While the benefits of

introducing trauma-informed practice into schools was documented in the research, it may not be immediately evident until future long-term effects surface.

1.3 Organizational System Set Up

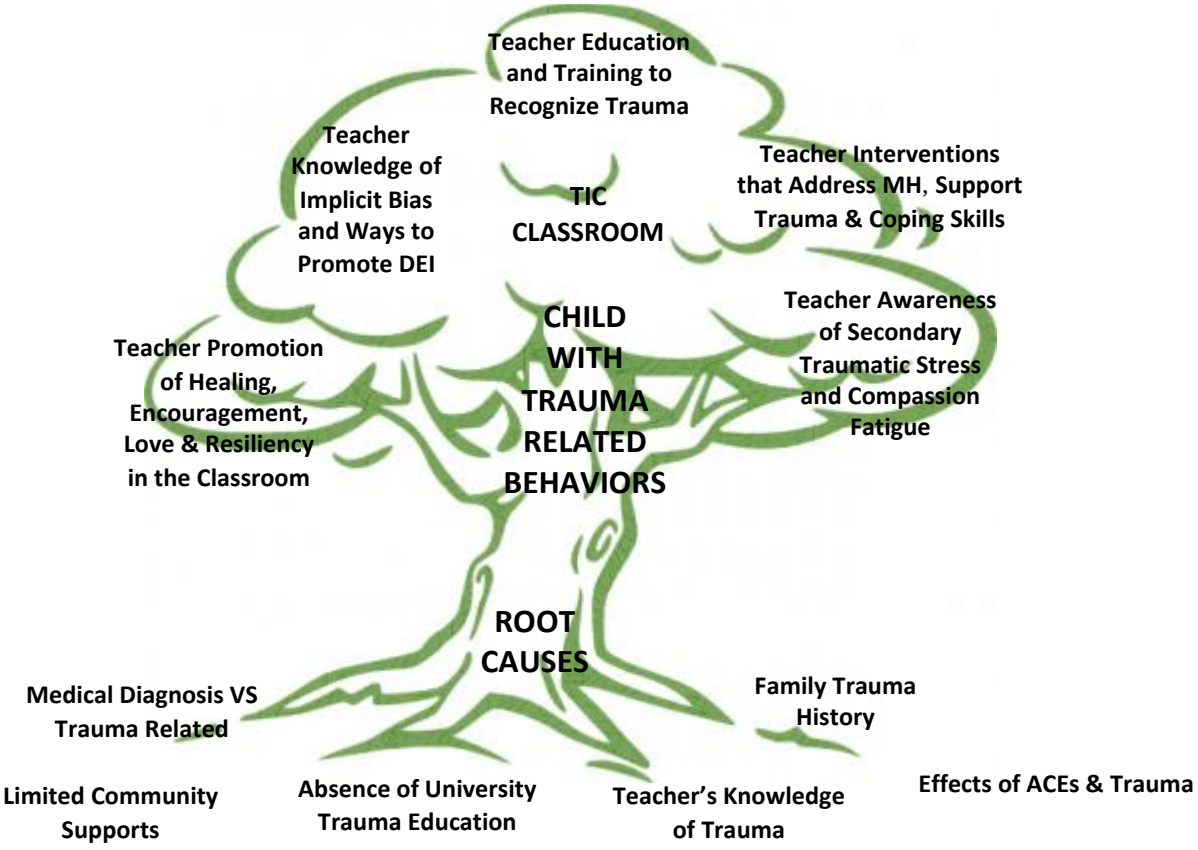

Figure 1 Trauma Tree

1.3.1 Root and Minor Causes to the PoP Supported in the Literature

Root and minor causes to the PoP were identified through the literature review and information included in the fishbone diagram, equity snapshot, process mapping, force field analysis and illustrated in the trauma tree diagram (refer to Figure 1). Each resource provided a different lens influencing a better understanding of the PoP. Discovering the root and minor causes influencing a child's development and behaviors can prove beneficial to not just the children and families, but also to the educators through a trauma-informed care program impacting resiliency and compassion satisfaction. Based on my research, I have attempted to look at each root cause and added bones to the fishbone diagram (refer to Figure 2) related to diversity, equity, and inclusion in relation to ACEs and trauma behaviors in the classroom.

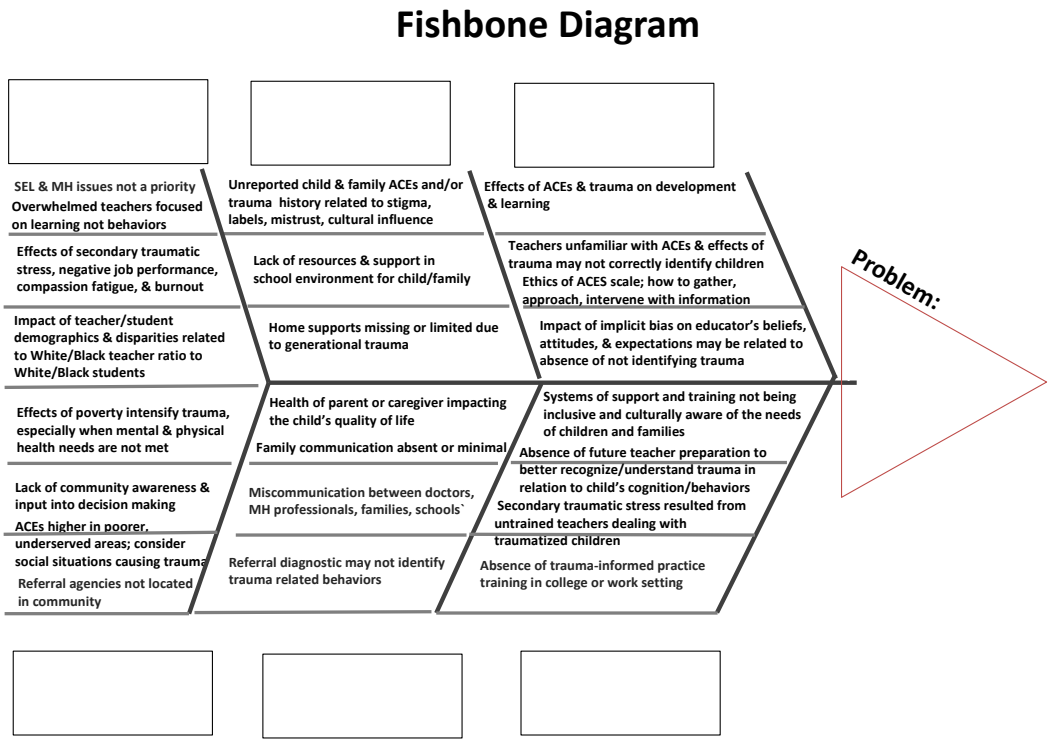

Figure 2 Fishbone Diagram

1.3.1.1 Root Cause 1: Assessment and the Effects of ACEs and Trauma on Development, Learning, and Teacher's Role

Children need a safe and secure environment complete with nurturing relationships to learn, grow, and thrive. Unfortunately, not all children have these supportive connections or surroundings and instead confront conditions of adversity and trauma putting them at higher risks for adverse childhood experiences (ACEs). The assessment of ACEs and the effects of trauma on the preschooler's development and learning is a major root cause of my PoP. There is considerable existing research linking ACEs with negative impacts not only on childhood growth and development, but also later with an increased risk of chronic disease in adulthood (CDC, 2020). The 1998 Adverse Childhood Experiences Study by Felitti et al. was landmark research connecting childhood adversities to increased health conditions in adulthood, including chronic disease, mental health concerns, and substance misuse. Felitti et al. (1998) initially identified ACEs as, "stressful or traumatic events, categorized as abuse, neglect, and household dysfunction and experienced in childhood and later related to health and disease issues in adulthood" (p. 245). The original ACE questionnaire was a 10-item, self-report inventory that asked adults whether any of the experiences listed were a part of their childhood, prior to the age of 18. Updated ACEs included exposure to domestic violence, parental divorce or incarceration, and caregiver alcohol, drug, or substance abuse disorders (CDC, 2020). The influence of ACEs on children has been associated with negative effects on development, cognition, interfering with learning, and being related to behavioral issues (CDC, 2020; NCSEA, 2019).

The impact of community-level adversities and stresses were identified as not being addressed in the original ACE study, especially for some Black parents and families (Health Federation of Philadelphia, 2013). Past ACEs studies confirmed the negative impact of ACEs on

health behaviors and health outcomes in adulthood. Many of these findings reported on primarily White, middle-class, and highly educated individuals. The Philadelphia Urban ACE study was created in 2013 for a more socioeconomical and racially diverse urban population. The original ACEs and five additional community-level stressors were included. The Philadelphia Urban ACE study proposed that living in an urban area might bring stresses not covered in the original ACE study to understand the impact of community-level adversities (Health Federation of Philadelphia, 2013). Burke et al. (2011) also found that increased ACE scores (4 or more) correlated with increased risk of learning, behavior problems and obesity within the urban population. Their study concluded the need for screening of ACEs among youth in urban areas and the development of effective primary prevention and intervention models. Alvarez (2020) used a racialization framework to examine how trauma was discussed in the literature with respect to youth in PreK-12 educational contexts. He reported, "there is a lack of systematic review of this research from a race-conscious perspective" (p. 583). Alvarez (2020) also talked about changing the social conditions like SES, poverty, food insecurity, that potentially cause trauma to occur as a more preventative approach.

The literature showed that while some children are at greater risk than others for experiencing ACEs, trauma and/or traumatic experiences, it was additionally suggested to include more child and household centered ACE situations. Childhood trauma resulting from racism, homophobia or other systemic injustices can also be unrecognized in a student's ACE score. Paul C. Gorski, founder of the Equity Literacy Institute and EdChange stated, "Treating individual traumas without naming systemic injustice means schools don't just risk leaving some traumas unrecognized; it means they risk retraumatizing students." (Gorski as cited in Gaffney, 2019).

Data from the 2016 National Survey of Children's Health (NSCH) showed that 46% of

those surveyed experienced at least one ACE with the number rising to 55% for children aged 12 to 17. (NSCH as cited in NCSEA, 2019). One in five U.S. children had two or more ACEs (CDC, 2020). Nationally, children with scores above 2-3 were considered as high-risk for later medical and mental health diagnoses and as the number of ACEs increased, so did the risk for negative health outcomes (Felitti et al., 1998; CDC, 2020).

Children having special needs (physical, emotional, and chronic health issues) and lack of caregiver/child attachment or developing a nurturing relationship were at greater risk than others for experiencing ACEs, trauma and/or traumatic experiences (Jonson-Reid & Wideman, 2017; Bollens & Fox, 2019; CDC, 2020). Families with caregivers who were abused or neglected as children, were young caregivers or single parents, and had limited educational and economic opportunities were highlighted as having potential higher risk (CDC, 2020). Influencing traumatic events included witnessing domestic violence, living with someone having mental illness or adult substance abuse, were a victim of violence, living in high poverty, had divorced parents, and had an incarcerated parent (Zeng et al., 2019). Community risks involved those with high rates of violence, crime and poverty, high unemployment rates, and easy access to drugs and alcohol (CDC, 2020). This root cause was also influenced by limited resources within underserved communities to support parents in managing their child's or their own traumas. These varying risks and influences were considered when understanding behaviors and implementing interventions in the place of practice. It was important to consider various risks and influences, especially with children living in underserved communities, as I developed my PoP to gain a better understanding and support trauma-exposed children in the place of practice. It was critical to correctly recognize children affected by trauma and create intervention plans in collaboration with the educators to

provide trauma-informed approaches and care in preschools, and in doing so, not retraumatize children.

The teachers' roles in the understanding and intervention of trauma were also related to this major root cause. When teachers are not familiar with ACEs and the effects of trauma on development and learning in the school environment, they may not identify children for support services. Studies have shown adults with higher ACEs scores during childhood correlated with not only later health problems, but also, behavioral problems, school attendance issues and risks for academic failure (Jimenez et al., 2016; Sciaraffa et al., 2018). The impact of ACEs on children can have negative effects on cognition, interfere with learning and be related to behavioral issues (CDC, 2020).

Administration not recognizing the effects of mental health and trauma related behaviors as interfering with learning is another minor cause of the problem. I have observed children's difficulties with self-regulation skills and other non-compliance behaviors during my PPS consultations. HealthyCHILD uses the ACEs scale to look at trauma related factors that may be influencing classroom behaviors. Martin et al. (2018) reported that teachers felt unprepared or ill equipped to support children with challenging behaviors (as cited in Zeng et al., 2019). Additionally, teachers may not be familiar with what ACEs are and how ACEs impact the lives of the children and the families, they support (Zeng et al. 2019). The impact of implicit bias on educator's beliefs, attitudes, and expectations may be related to the absence of not identifying trauma and was included as a minor cause (Martin et al., 2018). I wonder when educators are not prepared or trained to deal with trauma related behaviors in the classroom, is there a danger that racial inequality will be overlooked by Whites through silence, avoidance, or inactivity?

1.3.1.2 Root Cause 2: Families and Unreported Child and Family ACEs and/or Trauma History

Typically, families are the constants in a child's life and the helpers, including educators, are intermittent. A second PoP major root cause was related to families and trauma history. Families may not report child and family ACEs and/or trauma history due to parents' stigma and/or fear of reporting ACEs information, not wanting their child "labeled" throughout their education journey. Parents may also not be conscious of their own childhood traumas and discussion of any ACEs related information may be a trigger. Distrust of the school system due to negative past experiences, cultural influences, attitudes, and beliefs regarding education and trauma may be a reason for not reporting. Research indicated that parents' perceptions of school influences distrust, especially when there were feelings of absence of care and respect for Black children and parents (Hill, 2018). Parents' perspectives on their own schooling experiences related to Black parents' trust in their neighborhood schools and the public-school system in general (Hill, 2018). Negative past experiences and beliefs regarding mental health may prevent caregivers from asking for help for their child or themselves. I identified the lack of family supports and resources within the school environment as a minor cause. An additional minor cause related to not reporting ACEs or trauma may be influenced by home supports missing or limited due to generational trauma impacting caregiver capacity and beliefs, especially when faced with other challenges such as poverty, food insecurity, and trauma themselves (NCSEA, 2019).

1.3.1.3 Root Cause 3: Educators and Schools Not Addressing SEL and Mental Health Issues

School settings have been identified as an ideal place to provide mental and behavioral

health services through prevention, intervention, positive development, and regular communication between school and families (NASP, 2021). A third major root cause of the PoP involved social-emotional learning and mental health issues during class time not being a priority. Educators have discussed concerns and feeling overwhelmed with having too many children with disruptive behaviors, too little time, and not enough staff to address children's social-emotional needs during class time. This may be related to trauma or behavioral health. Consulting services not budgeted to address trauma and/or train teachers was also a minor cause. The literature identifies the benefits of providing consultation, protocols and policy solutions to address and prevent ACEs at the individual, community, and systems levels (CDC, 2020; Sciaraffa et al., 2018). The lack of teacher's identification of students involved with traumas and ACEs was related to behavioral issues in the classroom (NCSEA, 2019). Punishment, suspension, or expulsion resulted instead of understanding and support (Zeng et al., 2019; Martin et al., 2018). Zeng et al. (2019) also reported that children were more likely to be suspended or expelled if they experienced ACEs. Part of my initial intervention plan related to my PoP included a survey to assess teacher's knowledge and experience with ACEs and trauma for baseline purposes. A minor cause also surfaced during my equity snapshot summary of teacher/student demographics and disparities related to White/Black teacher ratio to White/Black students. It would be interesting to explore the potential of implicit bias and the educator's expectations, decisions, behaviors, and interactions with children and families.

Positive interventions to address this root cause include encouraging resiliency in the classroom by helping young children learn self-regulation skills, enhance self-esteem, promote social-emotional learning, and encourage problem solving. Trauma trained educators can identify and potentially impact the negative effects of ACEs through classroom-based interventions that

address mental health and support coping skills. Researchers Mortensen and Barnett (2016) reported the most protective factor for children exposed to adversity was the availability of a safe, nurturing, dependable relationship with an adult caregiver, including educators. A larger access to childhood resilience was significantly related to better health and well-being among children who had experienced ACEs (Bellis et al., 2018). Finding ways to support and encourage resilience within children who are affected by ACEs is crucial. Individuals who work with young children have an opportunity to help nurture resilience. It is critical therefore, that educators of preschoolers are knowledgeable of not only the negative outcomes of traumatic stress and ACEs, but also on resiliency and ways to reinforce resiliency with high-risk children to potentially impact outcomes.

An additional minor root cause is the emotional influence on educators working with children affected by trauma, commonly referred to as compassion fatigue and secondary traumatic stress. Compassion fatigue was defined as the "cost of caring" for others in emotional pain (Figley, 2013, p.1 as cited in Christian-Brandt et al., 2020). When educators or helpers become fully invested in a child's life, they can start to live the child's trauma or stress and be negatively affected. They can feel emotionally and physically worn out, influenced by the child's trauma and reactions and experience their own traumatic stress (Christian-Brandt et al., 2020).

The educators I work with identified the absence of resources in the workplace to not only help them to support the children, but also to manage with their own secondary traumatic stress. Educators experiencing secondary traumatic stress can feel unprepared to deal with a child's trauma, especially when they do not have adequate training to help cope and intervene. Educators working with traumatized children may not only experience secondary traumatic stress, but also negative job performance, lack of commitment, compassion fatigue, and higher risk of burnout (Shoji et al., 2015; Lepore, 2016; Blitz et al., 2016). Working in a healthy organization can be a

determinant of employee wellness. Teacher compassion satisfaction can be enhanced by having a supportive and flexible manager, receiving quality supervision with active listening and problem solving, and the provision of ongoing professional development (Christian-Brandt et al., 2020). There is a need for a supportive school administration with a commitment to addressing student trauma, behavioral issues, and reducing secondary stress among educators (NCSEA, 2019). I propose that this commitment in PPS could be through procedures addressing ACEs/trauma, providing on-going training for the educators, and collaboration with the families. I addressed maintaining a work-life balance and self-care strategies (exercise, good nutrition, relaxation, mindfulness practice, journaling, etc.) during professional development training as beneficial to decrease work and life related stress.

1.3.1.4 Root Cause 4: Universities and Absence of Trauma-Informed Practice Training for Future Teachers

The absence of trauma-informed practice training in college and/or in the school and work setting was an additional root cause and was identified in the pre-training survey. This may be problematic to educators and is relevant to my PoP. It is reasonable then, that educators receive this education and training in preparation to better identify and support children affected by trauma. A minor cause previously discussed was that teachers may also acquire secondary traumatic stress and feel unprepared to deal with a child's trauma without adequate education and training. An additional minor cause was related to systems of support and training not being inclusive and culturally aware of the needs of children and families.

1.3.1.5 Root Cause 5: Medical and Mental Health Referrals

A fifth root cause was that a referral diagnosis may not identify a trauma influenced behavior but rather focus on a learning disability (Ruiz, 2014). The mental health need may be overlooked, and the correct supportive intervention not received. Respectful family and professional partnerships are key to communication and collaboration, honoring the strengths, cultures, traditions, and expertise that families and professionals bring to this relationship. Supporting families through developing positive relationships, modeling, frequent family communication, and providing networking with other families were ways to encourage and improve collaboration (CDC, 2020; Hill, 2018; Sciaraffa et al., 2018). Family supports and communication were especially critical when a child encountered and was affected by a traumatic event. A minor root cause resulted when communication breakdowns between doctors, mental health professionals, families, and schools influenced whether a child was evaluated and connected to community mental health. The Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA) can prevent the sharing of knowledge between health care and educational settings that children move between (NCSEA, 2019). This may explain why some children do not receive mental health services for assessment and treatment, especially when there is not follow-up with parents. The family's accessibility to medical and mental health practices may also influence the child receiving assessment, connection to services communication interference with professionals and the school. Parents may also not understand the reason for evaluation and may cancel intake meetings, refuse evaluation, and services.

Children sometimes received a diagnosis, such as ADHD or disruptive behavior disorders, without professionals looking at other reasons, such as exposure to trauma, influencing

intervention and treatment (Ruiz, 2014). I have observed children's behaviors of consistent and on-going lack of self-regulation skills, non-compliance with the educators and routine, disruption, aggression, and extreme forms of withdraw during my PPS consultations. The educators often discussed "fixing" the behavioral interruption without perhaps understanding the influencing cause. A referral diagnosis may not identify a trauma influenced behavior but rather focus on a learning disability. The overlooked mental health need may result in an incorrect supportive intervention. There was concern when educators or clinicians misidentified disruptive behavior being a result of ADHD rather than being influenced by adversity and trauma in the child's life (Kuban as cited in Ruiz, 2014). The literature suggested more careful trauma assessment and screening for trauma and the creation of a trauma-informed treatment plan for the whole family (Brown as cited in Ruiz, 2014).

1.3.1.6 Root Cause 6: Limited Community Supports and Resources in Underserved Areas

The sixth major root cause included community supports with ACEs scores higher in poorer, underserved areas and referral agencies not located in the community where children and families live (Burke et al., 2011). Staff's and parents' unfamiliarity with procedures for attaining community referrals, identifying agencies, making, and keeping appointments, and agreeing for assessment and treatment were minor causes related to the problem. The PPS teachers discussed not knowing who or where to turn to regarding a child's mental health needs. FERPA and HIPAA laws prevent the sharing of knowledge between health care and educational settings that children move between (NCSEA, 2019). This may explain why some children do not receive services, especially when there is not follow-up with parents.

1.3.2 Process Mapping

One identified process from the process mapping significant to my PoP included the assessment of teacher's knowledge, understanding, and effects of adverse childhood experiences (ACEs) and trauma on preschool children's classroom behaviors, related to a root cause on the fishbone diagram (refer to Figure 2). I reflect on my positionality to think about how my own identity impacts how I work with clients of different backgrounds then my own. Clients include the community, the school, the teachers, the children, and the families. Relevant activities involve the developmental healthcare consultants (DHCs) inquiring and evaluating teachers for knowledge of trauma related behaviors of children through surveys, interviews, and personal communication. Information was compiled regarding the teacher's knowledge of trauma-informed practice assessment and intervention that they received in college education courses and/or in the work and school setting during professional development trainings. The value of the teacher's role and responsibility for correctly identifying and addressing mental health issues in the classroom was explored. In relation to figuring out the boundaries, the process started with cooperation from the teachers to participate with the assessments. The administration supported this effort by understanding the PoP's importance and supporting the teacher's role in knowing and/or learning how to identify and address student trauma associated to behavioral issues. The process would stop if the teachers did not cooperate in providing information or are resistant to change. The process would also stop if the administration would not support the teachers and allocate trauma topics through professional training to increase teacher's knowledge, understanding, and skills. The sequence of events started with the interviews/surveys, next with the provision of professional development training to enhance the teacher's knowledge and skills to impact trauma behaviors in the classroom and ended with the evaluation.

1.3.3 Force Field Analysis

The force field analysis (refer to Appendix A) of the PoP included the driving forces for change with teachers having a greater understanding of reasons for children's behaviors and learning appropriate interventions for children, through professional development training, resulting in improved behaviors. The restraining forces against change included teacher's resistance to participate with assessment (want to teach academics, not be therapists), teachers not following suggestions from DHCs and other consultants regarding interventions, and teachers blaming parents or home environment for inconsistencies between school and home when proposed interventions didn't work or when children weren't compliant. Change ideas that have some flexibility for change or can be influenced included the administration's influence on the teacher's cooperation with professional development training on trauma related topics. Administration could disrupt the equilibrium by weakening the restrainers (teachers) having the authority and power, through teacher supervision, evaluation, and budget. Administration could also support enhanced teacher/consultant relationships providing detailed preparation for teachers post formal education in the school and work setting to better recognize and understand trauma in relation to a child's cognition, development, and behaviors.

1.4 **Organizational System**

1.4.1 Overview of Professional Context and Role

The Office of Child Development (OCD) is a University of Pittsburgh - community partnership focused on research, practice, and policy effecting and improving the lives of children, youth, and families. I am a developmental healthcare consultant (DHC) with the HealthyCHILD (Collaborative Health Interventions for Learners with Differences) program housed within OCD, which is also affiliated with the School of Education. My work involves providing behavioral and emotional support to 28 preschool classrooms in the Pittsburgh Public School (PPS) Early Childhood Education (ECE) programs, with my salary and benefits funded through PPS. I interact and consult with and for children, families, and educators. The HealthyCHILD program provides trauma-informed developmental, behavioral, and mental healthcare support to children by providing educators, caregivers, parents and administrators with consultation, intervention, mentoring, education, and as needed outside referrals. The focus of the program is to support the social-emotional development and learning of young children (ages 0 - 8) in addition to teacher and parent effectiveness (Bagnato & Larson, 2018).

1.4.2 Place of Practice

Through HealthyCHILD, the place of practice is with preschool classrooms in the PPS ECE Programs. The partnership history between HealthyCHILD and PPS began in 1994, and since then has enhanced services and supports to more than 300 classrooms, 600 early childhood professionals and 45,000 children and families (Bagnato & Larson, 2018). Addressing early

childhood trauma, mental health, diversity, equity, and inclusion (DEI) is a priority for HealthyCHILD and their community partners. Having both the access to university expertise in the Office of Child Development and the opportunity to work together to challenge and adapt accepted practices has facilitated the growth of research and evidence-based practices

1.4.3 Stakeholders

For purpose of this Dissertation in Practice (DiP) I focused on one PPS, the Crescent ECE program. Crescent, located in the Homewood section of Pittsburgh, is classified as an underserved, economically disadvantaged community (Allegheny County Department of Human Services [ACDHS], 2010). Looking through a racialized organization lens, the omission of few protocols to address ACEs or effects of trauma in the preschool setting may be related to an organizational dynamic, especially since the frequency of ACEs occurs more in underserved communities (CDC, 2020). I framed this PoP in terms of organizational dynamics and not with the deficits of the people or communities in the place of practice and identified and addressed the organization towards adaptive change.

The stakeholders are the nine teachers and nine paraprofessionals (assistant teachers) at the Crescent ECE program who are most impacted by the PoP. There is inequity representation with the PPS staff. Eight teachers are female with one gender-neutral teacher represented. Eight teachers are White (89%), one teacher is Black (11%) and there is no Hispanic or Asian representation. Nine assistant teachers are female and Black (100%). Another layer to the Equity Snapshot of the school included the enrolled preschool children. Information from the PPS Crescent ECC roster as of January 2023 showed a total of 96 preschool students with 40 females (42%), and 56 males (58%). There are 95 Black (99%) and 1 White child (<1%). Within the Crescent ECE classrooms,

the majority of the teachers are White women, with the majority of assistant teachers being Black women and 99% of the students are Black. This disparity may influence a cultural and/or racial disconnect between children, families, and educators. I previously questioned the effects on young Black children's development, future learning and careers when having a majority of White teachers. Researchers from Johns Hopkins and American University outlined findings (as reported by Rosen, 2018) that Black students who are exposed to one Black teacher by third grade were 13% more likely to enroll in college. Those who had two Black teachers were 32% more likely to enroll in college. I am hoping that this and similar visible information will impact future hiring practices and teacher team pairings.

During the empathy interviews and the pre-training survey, the stakeholders and users discussed not taking courses at the university regarding trauma or identifying and intervening with a child's trauma behaviors in the classroom. Some learned about trauma through professional development (PD) trainings provided by HealthyCHILD and other agencies. The fishbone diagram explanation and the root cause analysis also explored these deficits and influence on staff's knowledge.

2.0 Theory of Improvement & Implementation Plan

2.1 Theory of Improvement and Change Ideas

My theory of improvement is if we want to improve addressing student mental health and trauma in the classroom, then we need to start with a focus on the teacher's ability to identify and interact with the preschool student's behaviors related to trauma (refer to Figure 3, Driver Diagram). This was accomplished through the DHC's assessment of the teachers' trauma knowledge, the DHC's observations of teacher interactions and relationships with students, the DHC's and teachers' review of student's trauma in relation to observed and reported classroom behaviors and the family's identification of trauma events in home or community.

My change idea for teachers that can result in improvement included the provision of monthly professional development trauma training and reflective practice activities with other teachers facilitated by me in the role of the DHC in the Crescent ECE preschool classrooms. The goal for implementation for teachers through these initiatives was to increase trauma awareness and enhance interaction skills with children exhibiting trauma related behaviors. The need for increased trauma training was previously identified during the empathy interviews, initial Qualtrics survey, and focus group responses.

Future suggestions and change ideas for the teachers included creating a trauma sensitive classroom environment with interventions and resources for the teachers, families, and students (refer to the Trauma Toolkit in Appendix D) and discussions with families to develop relationships, increase awareness of trauma and support in the home and outside referrals in the community, as needed.

2.2 Improvement Systems Measures

2.2.1 Process Measures

Ideas for the teachers that demonstrated how the change was working in relation to the process measures included monthly professional development (PD) trauma trainings on topics related to students and families affected by trauma and/or ACEs (Felitti et al., 1998). Teachers' knowledge of trauma-informed practice assessment and intervention was surveyed prior to the PDs and included if they received this education in college courses and/or in the work/school setting before the training began. PD topics were pre-determined through surveys giving input into what information was needed and would be of value to the teachers and paraprofessionals.

A mid-training professional development survey was administered after the first four PDs to access learning and look for changes in understanding the topics. Revisions to future trainings were made from information identified as needed in the survey comments/answers to improve teacher practice in the classroom as well as the prevention of preschool teacher stress related to secondary traumatic stress. I offered reflective practice activities with the teachers as an opportunity to identify students and discuss intervention and prevention for trauma-exposed children. As the DHC, SEL activities and lessons in collaboration with the teacher were offered with the teacher's perception of the importance of SEL activities observed. This will be continued and recorded in future practice. I considered the number of PDs, reflective practice activities, the number of SEL lessons and other interventions as process measures of program delivery.

2.2.2 Driver Diagram

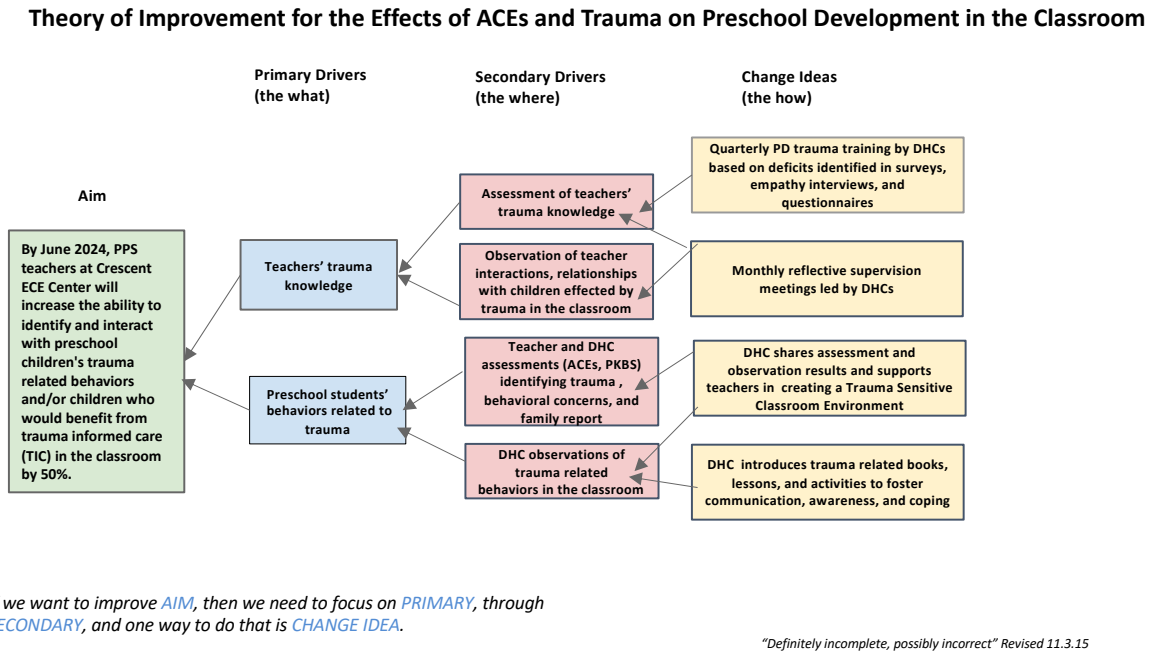

Figure 3 Driver Diagram

2.2.3 Driver Measures

In the preschool classroom I looked at improvement in the secondary driver which included the pre and post assessment of the staff's knowledge of trauma, identifying ACEs and trauma, along with my classroom observations of interactions and relationships among students with the primary driver (teachers and paraprofessionals) making progress towards reaching the aim statement and changing the system.

The primary driver with preschool children was regarding behaviors related to trauma. Improvement in the secondary driver was identified for purpose of this DiP and will be measured in future study through comparison of teachers' and DHC's assessments of children using the

ACEs scale (Felitti et al., 1998) and the Preschool and Kindergarten Behavior Scales [PKBS] (Merrell, 2003) scores. This would be most effective after trauma behaviors, concerns, and family traumas were reported, then assessments repeated six months after interventions have been initiated. DHC observations of trauma related behaviors in the classroom will be documented for intervention purposes during continued and future study of the classrooms.

2.2.4 Outcome Measures

Outcome measures for the teachers and paraprofessionals was related to their ability to identify children in need of trauma-informed practices (after training was provided through PDs) and ongoing support through reflective practice activities. These outcomes were measured through pre and post surveys and observations from the DHC. Teacher outcomes were also observed through implementation of the activities, lessons, and interventions that the DHC provided in collaboration with the teacher and paraprofessional within a trauma sensitive classroom plan.

Student measures for future study will include DHC's observed changes in teacher/student interactions before and after implementing a trauma sensitive classroom initiative, shared ACEs (Felitti et al., 1998) and PKBS (Merrell, 2003) assessment scores and results with the teachers and implementing change ideas through intervention plans.

2.2.5 Balance Measures

Balance measures were monitored looking at introduced change(s) as an improvement to the PPS ECE classrooms or if there were negative impacts on the system because of the changes put in place. I assessed the impact of change on the PPS ECE teachers, staff, students, and families

at the Crescent ECE center. Change ideas through the improvement cycle were adjusted to produce positive outcomes and effects on the total system.

3.0 Methods & Measures

3.1 Overview of PDSA Cycles

During the 2020 - 2023 school years, I identified my Problem of Practice: Inadequate supports or protocols for addressing student mental health and trauma in the PPS Early Education Programs. I saw myself in the role of DHC giving this support and education to educators to help them first identify then deal with children's trauma related behaviors in the classroom. I initiated this through Plan-Do-Study-Act (PDSA) cycles designed to study the effectiveness of professional development (PD) trainings and reflective practice meetings with teachers to promote trauma sensitive understanding and interaction in the preschool classroom. I evaluated and adjusted the results of PDSA Cycle 1 after the first four PDs. Refer to the timeline for implementing the PDSA cycles (Gantt chart, Figure 4).

SCHEDULE AND PROJECT PLAN	Start Date	Date(s) of Completion
Meet with principal and education delivery manager to discuss project	9/3/22	9/20/22
Bi-Weekly meetings with Tom Akiva, Faculty Advisor, to review project, discuss DiP committee	8/30/22	6/30/23
Contact target population (teachers/paras). Send initial survey.	10/10/22	10/24/22
Submit via email the overview paragraph to IRB.	9/20/22	10/17/22
Identify Dissertation Defense Committee	10/30/22	11/15/22
COLLECT BASELINE DATA		
Send pre-test survey out to participants	10/10/22	10/24/22
Collect, measure, and interpret baseline data	10/31/22	11/10/22
BEGIN INTERVENTION, PDSA CYCLE 1		
Design PD based on survey baseline data	10/24/22	10/31/22
Conduct first 4 PDs with teachers	10/25/22 11/22/22 12/20/22 1/24/23	 1/24/23
Collect post-test data from the sessions	2/17/23	2/21/23
Review data and make changes for 2nd PDSA cycle	2/21/23	2/26/23
BEGIN INTERVENTION, PDSA CYCLE 2		
Develop sessions 5,6,7 PDs based on survey data/staff suggestions	2/28/23	2/28/23 - 4/25/23
Conduct sessions 5,6,7 PDs with teachers	2/28/23 3/28/23 4/25/23	 4/25/23
Collect post-test data from the sessions	5/08/23	5/08/23
Review data	5/12/23	5/12/23
FINAL PREPARATIONS FOR DiP		
Summarize and conclude data from iterations	5/15/23	5/15/23
Revise and prepare DiP	5/15/23	6/02/23
Schedule Defense meeting	5/18/23	5/22/23
Submit Final DIP to committee for review	6/05/23	6/05/23
Defend DiP	6/22/23	6/22/23
Make any revisions	6/23/23	6/30/23

Figure 4 Gantt Chart

3.1.1 PDSA Cycles 1 and 2

3.1.1.1 Plan

I met with the principal and the education delivery manager at Crescent Early Childhood Education program on September 20, 2022 and proposed the trauma-related professional

development and reflective practice activities project for the teachers and paraprofessionals. I created a Likert scale survey to assess teacher's prior knowledge of trauma that they received at the university level and/or the place of practice. I collected data regarding the teachers' learning and interest through the pre-training survey (launched on October 10, 2022), a mid-training survey (administered on February 14, 2023), and a post-training survey (dispensed on April 25, 2023) after completion of all of the PD trauma trainings.

3.1.1.2 Do

I offered six, thirty-minute professional development trainings monthly with topics including an overview of trauma and ACEs, trauma identification and intervention in the classroom, compassion fatigue, and trauma topics of interest identified by the staff. I presented a seventh PD to demonstrate the Trauma Toolkit, discuss summary and wrap-up, and completion of the post-training survey. Workshops had capacity for 18 attendees, including 9 teachers and 9 paraprofessionals recruited at the school with the support of the administration. My predictions were that the staff who attended the PD trainings would have greater understanding and give better support to children exhibiting trauma related behaviors. Staff would also benefit from listening, learning, and sharing with other peers during the trainings and would be able to exchange ideas for intervening with child related trauma behaviors in the classroom.

3.1.1.3 Study

After PDSA Cycle 1, I looked at the mid-training professional development survey to assess any patterns, increase in learning, and/or suggestions for improvement after staff participated with the first four trainings. The aim of the pre-training survey was to get a baseline of the teacher's university education regarding trauma and then with the post-training survey to

assess whether the content presented impacted the staff's understanding of trauma and trauma related behaviors in the classroom. I included reflective practice activities with the staff after they attended the PDs to assess any trauma concerns, interventions, and resources to help to support them.

3.1.1.4 Act

I made modifications to the remaining three PDs based on the results of PDSA cycle 1 and the mid-survey. The PDSA cycles 1 and 2 helped to identify whether the PD workshops were effective in improving the staff's knowledge and then application of learning through interventions with children. I included information from the PDSA cycles in the data findings.

3.2 Data Collection and Findings

I collected staff data through the pre, mid, and post training surveys (refer to Appendix B) with questions regarding staff's knowledge and understanding of trauma and the learning acquired through the PD trauma trainings with the PPS staff. I analyzed the data in the Qualtrics Reports using graphs, means, descriptive statistics and frequencies.

3.2.1 Pre-test Survey

I collected the pre-test data via a Qualtrics survey, which included seven 5-point Likert scale questions, six open-ended questions, three demographic questions and one ratings question (refer to Appendix B). The questions pertained to the staff's level of education, years of paid work

experience in education, and job title. I inquired about previous trauma knowledge through higher education and professional development trainings. The participants rated topic interests regarding trauma. Nine (n=9) staff members (5 teachers and 4 paraprofessionals) completed the pre-test survey. Substantive findings were as follows:

- 33% (N=3) were not sure, 33% (N=3) said no, and 11% (N=1) didn't think so for taking any college course that included how to identify and intervene with children's trauma behaviors in the classroom. Only 1 participant answered yes for sure.
- 78% agreed (N=5 agreed; N=2 strongly agreed) and 22% (N=2) were neutral that they were affected by the traumatic stress of children in their classroom. No one disagreed or strongly disagreed.
- 56% (N=5) were neutral and 33% (N=2 agreed; N=1) strongly agreed that they knew how to identify children having trauma related behaviors in the classroom. 11%(N=1) disagreed.
- Answers to open-ended questions regarding support needs included, "We need support on how to process traumas ourselves" and "HealthyCHILD".
- The top ranked trauma related topics for professional development included, *Effects of Single Parent Families, Divorce, Separation on Children, Effects of Medical Trauma on Child/Family, Incarceration of Primary Family Member,* and *Death, Grief, and Bereavement Regarding Primary Family Member.*

These pre-test survey findings indicated that most of the staff (78%) did not take college courses related to the identification and intervention of children's trauma behaviors in the classroom. This is in accordance with a root cause of my PoP regarding the lack of trauma education and training in preparation for becoming a teacher. Many of the staff (78%) were affected by the traumatic stress of children in their classroom, with the remaining 22% responses

being neutral. Teachers working with traumatized children may be susceptible to secondary traumatic stress without prior trauma training or support. Participants were also neutral (56%, N=5) in identifying trauma related classroom behaviors with 11% (N=1) not knowing how to identify trauma. It questions whether the participants who said yes to identifying trauma know how to truly recognize trauma related behaviors without further observation and study. This related to my theory of improvement regarding the value of teachers identifying and interacting with the preschool child's trauma related behaviors in the classroom.

3.2.2 Mid-training Survey

I conducted a mid-training survey after the first four professional development trainings and reflective practices activities were presented (refer to Appendix B). The purpose of the survey was to assess the staff's learning from the PDs along with what trauma related topics they were interested in learning more about during the remaining four PDs. Seven staff members responded. All staff (17% somewhat agreed and 83% strongly agreed) felt that the trainings and reflective practice activities helped to increase their knowledge and understanding of the topics. Comments regarding the content, learning and relevancy of the PDs included, "Thank you for taking the time to work with us and to share pertinent information.", "If you could share more resources about family separation and coping mechanisms for younger students, please.", "Any resources for families for students just diagnosed with Autism, such as outside providers, therapists, financial assistance? Thank you!" and "I love your PDs. They are very helpful. Thank you for everything you do!". The comments were encouraging with the content having a positive effect on learning.

3.2.3 Post-Training Survey

I collected the post-training data via handwritten surveys and entered the information into Qualtrics. The survey included ten 5-point Likert scale questions and four open-ended questions. Learning from the six previously presented PD trainings and reflective practice activities were assessed along with suggestions for improvement (refer to Appendix B). Sixteen (n=16) staff members (8 teachers and 8 paraprofessionals) completed the post-test survey. Of those participants, 66% (N=10) attended all six PDs, 7% (N=1) attended five PDs, 13% (N=2) attended four PDs, 7% (N=1) attended two PDs and 7% (N=1) attended one PD (one did not answer this question). Substantive findings included the following:

- 82% agreed (N=7 strongly agreed; N=6 agreed) that the PD trainings helped to increase their knowledge and understanding of the topics (N=3 selected neutral; no one disagreed or strongly disagreed).
- 88% (N=6 strongly agreed; N=8 agreed) and 12% (N=2) were neutral that the PD trainings helped them identify children having trauma related behaviors in the classroom. No one disagreed or strongly disagreed.
- 44% (N=7) were neutral, 44% agreed (N=5 strongly agreed; N=2 agreed) and 13% (N=2) disagreed that after taking the PD trainings they were less affected by the traumatic stress of children in the classroom. No one strongly disagreed.
- 82% (N=11 strongly agreed; N=2 agreed), and 18% (N=3) were neutral that the PDs provided content relevant to the daily job. No one disagreed or strongly disagreed.
- 94% (N=9 strongly agreed; N=6 agreed) and 6% (N=1) were neutral in recommending the PD trainings to others. No one disagreed or strongly disagreed.

Qualitative responses from the survey concerning the most interesting topic and during the reflective practice activities were varied and generally positive. One participant reflected on considering the effects of the home environment on trauma related behaviors in the classroom. Other participants acknowledged the effects of medical trauma, grief, and death on children and families and learning how to communicate with those facing these types of traumas. One participant related that this topic directly applied to one of her students and is not a topic discussed in teacher preparation courses. This teacher talked about the death of a student by accidental gunshot in the home and having the dead child's sibling return to school. The family refused all suggestions for resources that the teachers and the DHC provided. The DHC used resources from the Grief Trauma Toolkit (refer to Appendix D) during classroom interventions to support the child at school. Other participants mentioned the effects of incarceration on children and how to work with children who have incarcerated parents as being an important topic. Two staff approached me after the PD on incarceration and talked about the effects of jail with their own family's experience. One responded that "All of them (the topics) apply in my classroom." The teachers also highlighted secondary stress and compassion fatigue as significant topics saying, "it's not really addressed." They talked about the PD making them aware of the signs of compassion fatigue and learning how to write a compassion satisfaction plan.

The post training survey was a good representation of the staff considering absenteeism, tardiness interfering with the ability to attend the early morning sessions, and other reasons for not attending the PDs. Positive results regarding the PD trainings noted the increase of knowledge and understanding of the topics, identification of trauma related behaviors in the classroom and that the content was relevant to the daily job. The findings were in support of and examined in my PoP, guiding questions, and root causes.

3.2.4 Overall Findings from the Surveys and Future Direction

Within the Crescent ECE classrooms, the majority of the teachers are White women (89%) and all of the assistant teachers are Black women (100%). The greater majority of the students attending Crescent ECC are Black children (99%). This disparity may influence a cultural and/or racial disconnect between children, families, and educators. However, when the pairing of a Black and White teaching team is collaborative, trauma sensitive, and promotes learning, it may provide positive role models for the children and impact on-going child development. Equity in hiring practices, educating White teachers about implicit bias, and development of culturally diverse teaching teams may prove beneficial to the student's current and future learning. The number of participants completing the pre-training survey (N=9) compared to the post-training survey (N=16) was almost double. This was a better representation of the staff. The increase in contributors may have been influenced by the post-test being administered in paper format at the end of the PD while the pre-test was sent virtually as a Qualtrics survey. The results showed that most attending all PDs agreed to increased knowledge of trauma topics and that the PDs helped to identify children dealing with trauma. This was in support of my PDSA cycles' predictions that the staff would have greater understanding of children's trauma related behaviors after attending the PD trainings. The responses relating to being less effected by the child's trauma (secondary stress) varied in both the pre- and post-trainings surveys. Most of the participants (78%) for the pre-test responded that they were affected by the traumatic stress of the children in their classroom with 22% remaining neutral.

The post-test results were equal in both neutral responses (44%) and agreeing and strongly agreeing (44%) that after taking the PD trainings the staff was less affected by the traumatic stress of children in the classroom. The research shows a connection between a child's trauma and the impact of secondary traumatic stress on the teacher (Lepore, 2016; Andreychik, 2019; Shoji et al.,

2015). The information provided during the PD trainings potentially impacted some of the staff's awareness to avoid compassion fatigue and learn about achieving compassion satisfaction. This would be a topic to explore further and provide increased training and resources on the topics of compassion fatigue, the impact on staff burnout, and moving towards compassion satisfaction when working with children having trauma and trauma related behaviors in the classroom.

A challenge with the project was encouraging participants to complete the pre-test and mid-training surveys to collect information beneficial to the PD trainings and topics. Thelearning environment in the school's gymnasium was not ideal, was not comfortable, and was without technology. The early morning times of the training before school started (8:17A) and time allotment of thirty minutes was not good or sufficient but was the only option given. To correct this, I would like to present the trainings during the scheduled, mandatory PPS's PD days that are offered several times a year to the entire staff. I would be able to increase the length of the trainings (2-3 hours) and have them available to more employees (potential of 200 early education staff members) impacting trauma related knowledge, skills, and abilities.

An area of improvement would be to expand the topics (e.g., childhood trauma regarding unhoused/housing insecurity, parental domestic violence, child abuse, neglect, and maltreatment, community violence, etc.). Also, including resources regarding practical interventions in the classroom with children exhibiting trauma related behaviors. I, along with other members of the HealthyCHILD staff, have developed Trauma Toolkits on various topics as a resource for educators to utilize for this purpose in their classrooms. These resources are provided virtually and in physical form to assist staff in helping the classroom's children, their families, and other educators through trauma-responsive practices. I presented the Trauma Toolkit related to grief (refer to Appendix D) during the summary review meeting. The toolkit contains resources,

activities, information, and books for staff, children, and families. The toolkit was well received by the participants and several requested additional information.

4.0 Reflections and Conclusion

I enrolled in the EdD program during a relapse of my cancer diagnosis and at the beginning of the COVID-19 epidemic. When I questioned the feasibility of starting and completing the EdD program at my "seasoned" age, Cindy Popovich, retired ADP faculty member, said to me, "You are going to turn 68 anyways, so why not get the degree!" One of the first assignments for Dr. Akiva's course was to make a Flipgrid video introduction. I was feeling so nervous to start a new education program forty-two years after receiving my masters and almost 50 years since high school graduation! My last line in the introduction dialogue while holding my senior yorkie Coco was, "You CAN teach an old dog new tricks".

I learned many new tricks through the courses and assignments of the improvement science process which I apply to my continual work with and for children, families, and staff. I kept questioning throughout this process, how does this information relate to my real passion, clinical work with children having trauma? I discovered that I was able to associate this new knowledge in the formation of my PoP and eventually created the DiP. I used every assignment from policy statements, literature review, empathy interviews, fishbone diagram, root cause analysis, theory of improvement, PDSA cycles, and other tools towards the research, support and refinement of my dissertation topic of, "The Effects of Trauma on Preschool Development in the Classroom". Now, with my motto of "the obstacle can be the opportunity" I am passionate to receive my "EdD in '23" at the young age of 68 and Coco at sweet sixteen!

In closing, I am inspired by a quote from Archbishop Desmond Tutu (n.d.). "There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they're falling in." Identifying and addressing trauma related and mental health concerns

during early childhood may be a way to go upstream and recognize causes of trauma to better intervene and promote optimal development among vulnerable children. Understanding and supportive interactions can prove beneficial to the children, families, and the educators through a TIC program impacting resiliency and compassion satisfaction for all.

Appendix A Force Field Analysis

Forces **FOR** Change		Forces **AGAINST** Change
Teachers have greater understanding of reasons for behaviors	Change idea related to my PoP	Teachers don't want to be therapists, want to teach academics
Appropriate interventions for children	Ability to identify children and intervene with trauma related behaviors in the classroom.	Teachers don't follow suggestions from consultants regarding interventions
Children's improved behaviors		Proposed interventions don't work, children are non-compliant because there isn't consistency at home/school
Enhance trusting relationships with families		Parents distrustful to share background information that can be triggering to them (own trauma)

Appendix B Pre-training, Mid-training, and Post-training Surveys

Appendix B.1 Crescent Early Childhood Education Program Pre-training Survey

I am developing some mini-professional trainings and reflective practices related to supporting teacher's and paraprofessional's understanding and intervention of ACEs and trauma related behaviors in the classroom. I wanted to first survey the staff to assess your understanding regarding trauma and ask the participants what trauma related topics you are interested in learning more about. Responses to the survey are anonymous and will be held confidential. Please complete the survey and submit it by Monday, October 24, 2022. You can email me with any questions at dae10@pitt.edu Your participation is greatly appreciated.

Thank you in advance,

Denise Esposto, MS, CCLS, 3rd Year EdD Student

Developmental Healthcare Consultant

HealthyCHILD

1. Did any of the courses you took in college include trauma or how to identify it in children? If you answered yes, please list course titles.

    - ○Yes, for sure (TEXT BOX)
    - ○Yes, I think so (TEXT BOX)
    - ○I'm not sure
    - ○I don't think so
    - ○Definitely no

2. I know how to identify children having trauma related behaviors in the classroom. If agree or strongly agree, please list the identification skills.

    oStrongly disagree
    oDisagree
    oNeutral
    oAgree (TEXT BOX)
    oStrongly agree (TEXT BOX)

3. I know how to intervene with children having trauma related behaviors in the classroom. If agree or strongly agree, please list the intervention skills.

    oStrongly disagree
    oDisagree
    oNeutral
    oAgree (TEXT BOX)
    oStrongly agree (TEXT BOX)

4. I know how to ask for help or consultation with children having trauma related behaviors in the classroom. If agree or strongly agree, please list the skills.

    oStrongly disagree
    oDisagree
    oNeutral
    oAgree (TEXT BOX)
    oStrongly agree (TEXT BOX)

5. I am affected by the traumatic stress of children in my classroom.

    oStrongly disagree
    oDisagree
    oNeutral
    oAgree
    oStrongly agree

6. I am able to keep up with trauma topics and trauma related techniques and protocols.

    oStrongly disagree
    oDisagree
    oNeutral

- ○Agree
- ○Strongly agree

7. What supports have you received from supervisors or administrators in trauma related work or learning? Please check all that apply.

   - ○No support
   - ○Consultants
   - ○Support through protocols addressing trauma
   - ○Professional Development training on trauma topics
   - ○Readings and resources on the topics related to trauma
   - ○Other (please list)

8. What is your experience with trauma sensitive classrooms or trauma informed care (TIC)?

   - ○None
   - ○Have read about it or attended a training but not practiced
   - ○Have worked in a trauma sensitive and or TIC environment
   - ○Other (please explain)

9. What assessment tools or interventions are you familiar with to address trauma in the classroom, trauma informed care and work-related exposure to stress? Please check all that apply.

   - ○Adverse Childhood Experiences scale (ACEs scale)
   - ○Professional Quality of Life: Compassion Satisfaction and Fatigue (ProQOL Scale)
   - ○Attitudes Related to Trauma-Informed Care Scale (ARCTIC Scale)
   - ○Other (please list)

10. Have you taken any courses or professional development trainings regarding trauma, the effects of trauma on children in the classroom, intervening with children affected by trauma, etc. If yes, please list or describe.

    - ○Yes (TEXT BOX)
    - ○Maybe
    - ○No

11. Have you presented any professional development trainings regarding trauma, the effects of trauma on children in the classroom, intervening with children affected by trauma, etc. If yes, please list or describe.

    ○Yes (TEXT BOX)
    ○Maybe
    ○No

12. Do you feel able to support children affected by trauma in the classroom setting?

    ○Strongly disagree
    ○Disagree
    ○Neutral
    ○Agree
    ○Strongly agree

13. Please rank the below trauma related topics 1-7, with 1 as the most interested topic and 7 being the least interested topic to learn more about. You can drag and drop them into the ranking order from the most interested topic in the top position to the least interested in the bottom position. (slider function to put in position)

    - Effects of Single Parent Families, Divorce, Separation on Children
    - Effects of Medical Trauma on Child/Family
    - Incarceration of Primary Family Member
    - Death, Grief, and Bereavement regarding Primary Family member
    - Abuse and Domestic Violence/Intimate Partner Violence
    - Food Insecurity and Homelessness
    - Community Violence

14. What is your current work position?

    - Teacher
    - Paraprofessional or Assistant Teacher
    - Mental Health professional
    - Director or administrator
    - Developmental Consultant
    - Other (TEXT BOX)

15. How would you describe yourself? Please select all that apply.

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Pacific Islander
- White
- Other (TEXT BOX)
- I choose not to answer

16. What is the highest degree or level of school you have completed?

- Highschool or GED equivalent
- Associate degree
- Bachelor's degree
- Master's degree
- Doctorate or professional degree

17. How many years of paid work experience do you have in education, teaching, mental health, administration, or other fields related to working with and for children and families?

- 0-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21-25 years
- 26-30 years
- Over 30 years

SUBMIT

We thank you for your time spent taking this survey.

Your response has been recorded.

Powered by Qualtrics

Appendix B.2 Crescent Early Childhood Education PD Mid-training Survey

Four of the HealthyCHILD mini-professional trainings and reflective practices have been presented. I wanted to survey the staff to assess your learning from the PDs along with what trauma related topics you are interested in learning more about during the remaining 4 PDS. Responses to the survey are anonymous and will be held confidential. Please complete the survey. I will collect it at the end of the week, by February 17, 2023. Your participation is greatly appreciated.

Thank you in advance,

Denise Esposto, MS, CCLS, 3rd Year EdD Student

Developmental Healthcare Consultant

HealthyCHILD

1. Please put an "X" next to the PDs you have attended on the Trauma Sensitive Classroom (8:17-8:44A on the below dates)

PD 1- The review of trauma, ACEs, and Urban ACEs (in the gym)

October 25, 2022 _____

PD 2 - Trauma related behaviors, interventions, and language for trauma support

November 22, 2022 _____

PD 3 - Teacher secondary stress, compassion fatigue, and self-care (in the gym)

December 20, 2022 _____

PD 4 - Developing a compassion satisfaction plan (via Zoom)

January 24, 2023 _____

2. The trainings have helped to increase my knowledge and understanding of the topics.
    - oStrongly disagree
    - oDisagree
    - oNeutral
    - oAgree
    - oStrongly agree

3. The Reflective Practice handouts given after each training were helpful to increase my knowledge and understanding of the topics (ACEs Think-Pair-Share, Identifying Compassion Fatigue, Developing a Compassion Satisfaction Protection Plan, Things in My Control/Out of My Control)
    - oStrongly disagree
    - oDisagree
    - oNeutral
    - oAgree
    - oStrongly agree

4. What topic was most interesting for you?

_____

5. The topics for the remaining PDs include:

    - The effects of single parent families, divorce, and separation on children
    - The effects of medical trauma on the child and family
    - The effects of incarceration of a primary family member on the child
    - The effects of death, grief, and bereavement on the child in regard to a primary family member

    Are there any other topics you would like to have presented? If yes, please list.

6. Would you prefer the remaining 4 sessions to (please check one):
   Continue to be in person in the Crescent gym _____

   Be virtual via Zoom _____

   I don't have a preference_____

7. Is there any other information you would share regarding the content of the PDs, your learning, or anything else you felt relevant to the PDs?

Thank you for your participation.

Denise

Appendix B.3 Crescent Early Childhood Education PD Post-training Survey

Six of the HealthyCHILD professional development (PD) trainings and reflective practices have been presented. I wanted to survey the staff to assess your learning from the PDs along with any suggestions for future PDs. Responses to the survey are anonymous and will be confidential. Please complete the survey. I will collect it at the end of this session. Your participation is greatly appreciated. Thank you for your support, sharing, and interest in learning.

Denise Esposto, MS, CCLS, 3rd Year EdD Student

Developmental Healthcare Consultant

HealthyCHILD

1. Please put an "X" next to the PDs you have attended on the Trauma Sensitive Classroom

PD 1- The Review of Trauma, ACEs, and Urban ACEs (in the gym)
October 25, 2022 ___

PD 2 - Trauma Related Behaviors, Interventions, and Language for Trauma Support (in the gym)
November 22, 2022 ___

PD 3 - Teacher Secondary Stress, Compassion Fatigue, and Self-care (in the gym)
December 20, 2022 ___

PD 4 - Developing a Compassion Satisfaction Plan (via Zoom)
January 24, 2023 ___

PD 5 - The Effects of Incarceration of a Primary Family Member on the Child (in the gym)
February 28, 2023 ___

PD 6 - The Effects of Medical Trauma, Death, and Grief on the Child Regarding a Primary Family Member (in the gym)
March 28, 2023 ___

2. The PD trainings have helped to increase my knowledge and understanding of the topics.

oStrongly disagree
oDisagree
oNeutral
oAgree
oStrongly agree

3. The PD trainings have helped me to identify children having trauma related behaviors in the classroom.

oStrongly disagree
oDisagree
oNeutral
oAgree
oStrongly agree

4. The PD trainings have helped me to intervene with children having trauma related behaviors in the classroom.

oStrongly disagree
oDisagree
oNeutral
oAgree
oStrongly agree

5. The PD trainings have made me feel better able to support children affected by trauma in the classroom setting.

oStrongly disagree
oDisagree
oNeutral
oAgree
oStrongly agree

6. The Reflective Practice handouts given after each PD training were helpful to increase my knowledge and understanding of the topics (*ACEs Think-Pair-Share, Identifying Compassion Fatigue, Developing a Compassion Satisfaction Protection Plan, Things in My Control/Out of My Control, Tips and Support for Children when a Family Member is Incarcerated, Grief in the Classroom*)

oStrongly disagree
oDisagree
oNeutral
oAgree
oStrongly agree

7. After taking the PD trainings, I know how to ask for help or consultation with children having trauma related behaviors in the classroom.

   oStrongly disagree
   oDisagree
   oNeutral
   oAgree
   oStrongly agree

8. After taking the PD trainings, I am less affected by the traumatic stress of children in my classroom.

   oStrongly disagree
   oDisagree
   oNeutral
   oAgree
   oStrongly agree

9. I was satisfied with the PDs overall.

   oStrongly disagree
   oDisagree
   oNeutral
   oAgree
   oStrongly agree

10. These PDs provided content that is relevant to my daily job.

    oStrongly disagree
    oDisagree
    oNeutral
    oAgree
    oStrongly agree

11. I would recommend these PD trainings to others.

- ○Strongly disagree
- ○Disagree
- ○Neutral
- ○Agree
- ○Strongly agree

12. What topic was most interesting for you and why?

_____

_____

_____

13. Please list other topics you would like to have presented in the future.

_____

_____

14. Is there any other information you would share regarding the content of the PDs, your learning, or anything else you felt relevant to the PD trainings

_____

_____

Appendix C Reflective Practice PD Training Activities

Appendix C.1 Think, Pair, Share, Reflection (PD Session 1)

- Think of a child and/or family that is currently in your classroom or you have worked with in the past who you know or believe has been affected by ACEs (Use a pseudonym and give a brief history, if known).

- How many ACEs or potential ACEs do/did they have (refer to your ACEs questionnaire)?

- What kinds of behavior(s) have/had been observed?

- Are/were these trauma-related behaviors, behavioral diagnosis, or mental health related (ADHD, etc.)?

- List some of your interventions or how you addressed and/or used interactions to support the child in the classroom.

Appendix C.2 Wearing Your Trauma Lens Reflection (PD Session 2)

Now that you have listened to the presentation on trauma related behaviors, reflect on using your trauma lens in the classroom with the children.

- In the "Trauma Lens Off" column, write some thoughts and feelings you may have had when you weren't wearing your trauma lens during observations and interactions with children. Refer to your notes from the PPT for help.
- In the "Trauma Lens On" column, reflect on reframing your thoughts and feelings from the "Trauma Lens Off" column, and write your revised response using a trauma-informed perspective. Remember that behaviors are a form of communication and focus on potential underlying reasons and causes for the behaviors.

Trauma Lens Off	Trauma Lens On

Appendix C.3 Things In and Out of My Control (PD Session 3)

Compassion Corner

TIP OF THE DAY

Trace your hand on a piece of paper.

In the area inside of the hand, write, "In my control" then list things that you can control.

In the area outside of the hand, write, "Out of my control" and list things that you cannot control.

Take a moment to reflect on your drawing. Focus on what is in your control, and recognize that you may not be able to change what is out of your control.

Take a breath and learn.

Enjoy your day, and remember, be kind to yourself!

Appendix C.4 Developing a Compassion Satisfaction Plan (PD Session 4)

What components will go into my plan? Reflect on and write your story. Think about your biggest challenges and impacts on your life

What are my Compassion Fatigue warning signs and symptoms (headaches, teeth grinding, stomach issues, fatigue, etc.)?

What things do I have control over in my life that can be changed to be less stressful (asking for help, balancing professional and personal life, etc.)?

How will I relieve stress in a way that works for me (intervention – talk about your feelings, ask for support, laugh with a coworker, etc.)?

What stress prevention/reduction strategies will I use (prevention – exercise, breathing, yoga, SMILING, etc.)

Develop a Compassion Satisfaction Plan that includes self-care strategies and ways to relieve stress. Follow your Compassion Satisfaction Plan consistently and enjoy!

Adapted from Francoise Mathieu Compassion Fatigue Train the Trainer Workbook (2008) www.compassionfatigue.ca

Appendix C.5 Tips and Support for Children when a Parent or Close Family Member is Incarcerated (PD Session 5)

What are a child's needs for support when a parent or close loved one is suddenly unavailable to them?

- To feel safe and secure.
- To have an environment free of violence.
- To have parents and/or caregivers that love and protect them.
- To have a sense of stability and routine
    - This way if things go wrong in the outside world, they still know they have a safe relationship with an adult who will comfort, help, and support them.
- They need a supportive adult
    - Someone who will recognize that their behavior problems are most likely a reflection of the recent changes in their lives.

What behaviors may a child with an incarcerated parent /close loved one display?

- increased display of anger and aggressive behavior
- not following directions (non-compliance)
- increased incidence of emotional problems such as sadness, fear, anxiety, etc.
- withdrawing from social interaction
- lower levels of social competence
- poorer academic functioning

How can adults support these children?

- Reading this information and additional resources about the effects of incarceration on families and children.
- Find out from the primary caregivers what the child knows about the incarceration and what the family is telling the child in the home environment. It may be helpful to ask the child what they think has happened to their parent or loved one. This can allow clarification and dispel any misinformation the child may have.
- Preschool children often blame themselves when something has changed in their lives (e.g., I think daddy has to stay away from me because I didn't listen or because I was bad, or I wished him to go away and he didn't return, etc.) Young children need to be told that the incarceration of their parent has no connection to anything they have done or said.
- When talking to a young child about the incarceration, avoid details and "making up a story" to explain why the parent or loved one is gone. Try to keep all

provided information simplified and honest. Sesame Street in Communities suggests how parents or the child's adults answer these 3 common questions: https://sesamestreetincommunities.org/topics/incarceration/

"Where Is Mommy/Daddy?"
(If they do not have a jail sentence) "Mommy/Daddy is in a place called jail. He's there because he may have broken a grown-up rule called a law."
(If sentenced) "Mommy/Daddy is in a place called prison for a while. Grown-ups sometimes go to prison when they break a rule called a law. He's not there because of anything you did. This is not your fault."

"When will Mommy/Daddy be home?"

If you don't know, you might say, "Mommy/Daddy won't be home for a while. We are waiting to learn more. I will let you know as soon as I find out."
If you do know, explain it in a concrete way that kids can understand. For instance, "three birthdays from now," "when you are five," or "next winter, when it's time for hats and gloves."

"Will I get to see Mommy/Daddy?"

(If yes) "You can visit Daddy in prison once in a while. I'll let you know when. Between visits you can write him letters, draw him pictures, and talk to him on the phone."
(If no) "We won't be able to visit, but you can draw pictures and write letters to each other whenever you want." (If there are legal reasons that contact is not allowed, it's important to follow that advice.)

- Children need to express emotions related to the incarceration, or those emotions can turn into challenging behaviors. Sometimes adults at home are unavailable to talk with the child and they may seek the teacher's attention. Suggestions for talking to children include remaining calm and non-judgmental as possible when talking with the child. This helps young children feel secure enough to verbalize their feelings. Children need to know that their feelings are valued which can be done by allowing them to tell you how they feel.
- Young children often have difficulty verbalizing their feelings, so alternative methods to talking include, drawing pictures about their feelings, expressing their feelings through play activities and/or music. Manipulating Play-Doh, and/or gross motor activities are also some examples of healthy outlets for feelings of hurt, anger and/or abandonment.
- Reading a book may be another way to safely encourage the child to recognize their feelings and support the growth of their coping skills. (See suggested books listed at the end.)
- Recognize that seeking counseling support is considered a strength and not a sign of weakness. Courts do not have to make counseling a mandatory process in cases of parental incarceration, but research evidence suggests that additional

support, such as counseling, helps children and families as they struggle to maintain healthy relationships. Ask your HealthyCHILD consultant about available resources such as play therapy, parent child interaction therapy (PCIT) and/or school based mental health supports.

- Using calming strategies to help the child regulate their feelings. You can help the child name and identify their emotions using visuals like a feelings faces chart, book, or poster. Activities and exercises to calm their bodies such as breathing (blowing out finger birthday candles), yoga positions (downward-facing dog, stand like a flamingo, palm presses) and the five senses grounding practice (choose one sense at a time - sight, smell, hearing, feeling, taste and focus attention on it), can be suggested when needed.
- You may also need to support parents and the child's adults recognizing that they may have mixed feelings about their partner or family member who has been incarcerated. Whatever their feelings are, it is important to recognize that the child may have different feelings about his/her parent or adult (whether negative or positive). This is particularly important for very young children (under five years old) who do not understand the decisions that have led to the incarceration of their parent or adult. They will still need to feel the incarcerated parent's or adult's love and attention. Encourage them to keep their personal feelings separate from the child and take time for themselves to share their adult feelings with other adult friends and supports in their lives.

What services are available for families dealing with incarceration?

- **Allegheny County Supports for Persons Involved in the Criminal Justice System**
  Allegheny County Department of Human Services website for persons who were or are incarcerated face challenges as they return to the community.
  https://www.alleghenycounty.us/Human-Services/Resources/Incarceration-Support.aspx

- **Families Outside Transportation Program Wesley Family Services**
  221 Penn Avenue Wilkinsburg, PA 15221
  Phone: 412.458.6456
  Fax: 412.665.8730 E-mail: familiesoutside@wfspa.org
  https://wfspa.org/wp-content/uploads/2020/02/Families-Outside-brochure-Final-2-7-20.pdf

  Offers a wide variety of support to relatives or close friends of those currently or previously incarcerated in a state or Federal prison located in PA. Services include self-help and education groups, transportation to prisons, individual and family counseling and liaison with institutions, works with recently released individuals on unemployment and training issues, offers a mentoring program for children dealing with incarceration.

- **Lydia's Place, Inc.**
  700 5th Avenue
  Pittsburgh, PA 15219
  Phone: 412-391-1013
  http://renewalinc.com/programs-services/lydias-place/

  Available Programs: Offender Family Supports, Parenting Support, Substance Abuse Services, Women Only Services, Youth and Child Services
  Lydia's Place is a non-profit agency that helps female offenders and their children in Allegheny County, PA rebuild their lives. Lydia's Place works to: help incarcerated and recently released women in Allegheny County address their addictions and become stable, productive members of society, help children and their caregivers cope with the traumatic separation from a parent, strengthen relationships between incarcerated mothers and their children, assist mothers as they make permanency decisions for their children, promote policy changes that better address the needs of incarcerated women and the children of prisoners.

- **Amachi Pittsburgh.**
  1830 Forbes Avenue, 2nd Floor
  Pittsburgh, PA 15219
  (412) 281-1288
  http://www.AmachiPgh.org/

  Amachi Pittsburgh empowers young minds to overcome the challenges of parental incarceration and reach their full potential through a mentoring partnership of community agencies. This support is provided for these children to alter the potential negative direction of their lives.

- Ask your HealthyCHILD Developmental Healthcare Consultant (DHC) for additional information and resources.

Suggested Books and Resources:

Milo Imagines the World, Matt de la Peña. Ages: (4-8 years)
Riding the subway with his older sister, young artist Milo observes the other people, imagining their lives in his notebook. So, he's surprised when the boy in the suit (who he thought might live in a castle) gets off at the same subway stop, and they both line up for the prison's visiting hours. Milo realizes he shouldn't have judged the boy based on his appearance.

Missing Daddy, Mariame Kaba & Bria Royal. Ages: (4-8 years)
A little girl who misses her father because he's away in prison shares how his absence affects different parts of her life. A father and daughter's love cannot be broken even when prison bars separate them.

Kofi's Mom, Richard Dyches. Ages: (3-5 years)
Kofi's Mom is a story about Kofi whose mother is sent to prison. It explores his feelings of loss and confusion. Through friends at school, Kofi begins to talk about his mom and look forward to her return.

Knock, Knock: My Dad's Dream For Me, Daniel Beaty. Ages: (5-8 years)
This powerful and inspiring book shows the love an absent parent can leave behind and the strength children find in themselves as they grow up and follow their dreams.

Our Moms, Q. Futrell. Ages: (5-8 years)
Meet Michael, Paul, Jennifer, and Anne! All children are different in many ways, but all have one thing in common, their moms are in prison. This book serves as a conversation starter for such a sensitive issue that impacts children in the US.

Deena Misses her Mom, Jonae Haynesworth, Jesse Holmes, Layonnie Jones, Kahliya. Ages: (4-7 years)
Lately, Deena has been getting angry. A lot. She acts out in school and keeps getting in trouble. Everyone is surprised because she used to be very calm, but that was before her mother went to jail. Her dad, her grandma, and her best friend Josey all do their best to help her out, but Deena doesn't want to talk about it. Will a day at the carnival with her Dad help her open up?

Ruffin Far Apart, Close in Heart, Becky Birtha. Ages: (4-8 years)
Kids can have all kinds of feelings and questions when a parent is incarcerated. Rafael is embarrassed. Rashid is angry. Yen wonders if it's her fault. This sensitive story illustrates a range of situations children may face with moms or dads behind bars, while reassuring them they are not alone.

The Night Dad went to Jail, Melissa Higgins. Ages: (4-8 years)
When someone you love goes to jail, you might feel lost, scared, and even mad. This colorfully Illustrated book lets children know that they are not alone in this situation. It offers age- appropriate explanations to help with difficult conversations. Told from the experience of a rabbit, this picture book is intended to make a parent's incarceration a little less frightening.

Missing Daddy, Mariame Kaba. Ages: (4-7 years)
A little girl who misses her father because he's away in prison shares how his absence affects

different parts of her life. Her greatest excitement is the days when she gets to visit her beloved father. With gorgeous illustrations throughout, this book illuminates the heartaches of dealing with missing a parent.

What Is Jail, Mommy? & Mami, Que Es Una Carcel?, Jackie Stanglin. Ages: (3-8 years)
When the truth is withheld from children, they tend to blame themselves for others mistakes and shortcomings. It is incumbent on each of us to provide age-appropriate facts to young inquiring minds. What Is Jail, Mommy? Not only explains why the parent is incarcerated but what his/ her life is like.

Sesame Street in Communities - Games, videos, handouts, and printable activities on the topic of incarceration. The book, **In My Family**, is on the website (https://sesamestreetincommunities.org/topics/incarceration/).
The incarceration of a loved one can be overwhelming for both children and caregivers. Because of the feeling of stigma, it takes special effort to start important conversations and answer kids' questions. But parents can comfort children and guide them through difficult moments just by talking. With love and support, the family can cope with the challenges of incarceration together.

Appendix C.6 . Grief in the Classroom: The Teaching Team's Guide (PD Session 6)

"*Anyone old enough to love is old enough to grieve*." — Dr. Alan Wolfelt

What is the teaching team's role?

Children can understand death and experience grief. Factors that affect a child's grieving process include (Worden, 2018):

- their developmental stage
- whether or not they witnessed the death
- previous experiences with chronic illness and/or death
- available support systems
- gender identity
- nature of the most current death

The preschooler's concept of death is limited. They think death is temporary and reversable. They may think the deceased will come back (if they pray, have good behavior, have magical thinking - the person will return).

Adults can significantly help grieving children through support and open communication. When needed, talking about death may be uncomfortable but helpful. These conversations when appropriately exchanged, may decrease a child's anxiety, reaffirm the teaching team /child relationship and help a child better understand the complexity of death (Warnick, 2015).

The teaching team is not responsible to provide grief counseling or therapy. Instead, they can offer bereavement support, which involves creating a safe environment for a child to express their emotions. The teaching team serves as a bridge between the classroom and home by reminding the child of the commitment to their wellbeing and by helping the other students to understand grief feelings, when applicable. This work can feel heavy. The teaching team is not alone in this process. **HealthyCHILD remains an active consultant for guidance.**

What does grief look like in a preschooler?

A bereaved child is processing adult-sized feelings in a child's way. They may exhibit new or intensified behaviors. Most of these behaviors are normal and will subside over time. By being aware of some potential behaviors, accommodations in the classroom space and activities to support a bereaved student can be made. Potential grief related reactions include:

- **Feelings -** anger, sadness, missing the person, irritability, moodiness, loneliness, anxiety, panic, guilt, and blame (e.g., "She got sick because I was bad.")
- **Behaviors** - seeking increased attention, toileting accidents, thumb-sucking, aggression, regression, restlessness, poor concentration, bodily distress, changes in appetite
- **Thoughts** - nightmares or scary thoughts, fixation on the circumstances of the death, denial of death, idealization of the deceased (e.g., "Dad was perfect.")

Allow children to process their emotions as needed. Consider making part of the classroom a cool down space or calming area where a child can go if they need some space and time to reflect and calm. Practice using this space with all children. Intervene when a child may be in imminent danger or risk hurting themselves or others. **Ask your HealthyCHILD Developmental Healthcare Consultant (DHC) to create a calming kit and resources to support the children.**

What to say to a bereaved child?

Any information shared should reflect a child's developmental age and caregiver preferences (Warnick, 2015). Keep the content concrete, factual, and simple, without specific spiritual and religious references.

- Talk to a family member to understand what information the child knows, the words the family uses, the family's wishes concerning the death, etc. to better support the child and family.
- If a child asks what "dead" means, simply explain, "The body no longer works. They (the deceased) cannot breathe, eat or talk on the phone. When asked, "They (the deceased) will not come back." Clear terms ground an understanding the of the finality of death (Bonoti et al., 2013).
- It is normal for children to ask questions. Some children may ask questions immediately. Others may want to talk later. Some children will not discuss death at school. Do not be afraid to tell your students that you do not know an answer.
- In the case of suicide, when asked, stress that the person who died had an illness. "Your daddy's brain wasn't healthy and that made him feel so sad and confused that he did something that caused him to die. This is a kind of sickness that you can't catch like a cold" (Sesame Street in Communities, n.d.).
- Redirection is helpful when the child is escalating to an unsafe level. If not, comfort the child and allow them to express their emotions.
- Avoid ambiguous terms like, "We lost her," "They are in a long sleep," or "He is on a trip," which may prompt behaviors like looking for the "lost" person or fearing sleep.
- Repetition is important, but children will not always want to talk about the topic.
- Follow their lead and allow the bereaved child to bring up the recent death or tragedy instead of asking for details yourself.

What should I NOT say?

The best thing to do is to **be present** for the child. **Listen** to them and **be comfortable in silence.**

DO NOT SAY or DO:

- "I know what you're going through". Instead, center the child's experience and reaffirm that their grief is unique and important.
- "You must be really sad and angry". Do not project emotions. They may be sad and angry at times, but not always. Introduce the feelings chart and have them pick the face that resonates.
- "This is hard, but it's good to remember the joys in life" or "At least they are no longer in pain". Rationalizing grief is too abstract for young children and can suppress true expression of emotions for people of all ages. Instead, ask for some favorite memories of the deceased person. Encourage show-and-tell. Draw pictures to remember.
- Don't compare the child's loss to your own. Keep the focus on the bereaved child.

How do I talk about grief in a classroom?

Following a community tragedy or death, the teaching team may need to allocate time to explain the tragedy. (Check with the administration's policies and procedures first.) Reading books and holding small conversations or doing activities are great ways to introduce the topic and provide language on an often-complicated subject. **The HealthyCHILD DHC can assist with these conversations, has additional resources for further learning, information on grief therapy, and grief resources and activities for the classroom.**

Don't forget yourself!

Supporting a bereaved child or classroom requires energy and care. This can be draining. Please take time to identify your coping methods and triggers. Allocating time to self-care and talking with others ensures that you can be present for your students, colleagues, and self.

What is a sign that I need a break? _____

What actions and spaces help me unwind? _____

Who supports me when I am stressed or down? _____

Please contact HealthyCHILD with any further questions or concerns.

Take Aways and Additional Tips for the Classroom

Be Proactive: Contact the affected child's family. Remind them that you are available to provide support resources. Take their lead on what support should look like. Normalize reaching out as something provided to all families. When applicable, ask the family of the deceased what information should be shared with the other classroom's families.

Telling a class: Depending on the circumstances, you may want to send a letter home to the entire class explaining the recent death and providing some resources. Check first with administration regarding policies and procedures and with the FSSs. When necessary and deemed important, talk to the class about what happened without going into much detail. Allow time for other students to share feelings. Ask the class how the bereaved child may be feeling now. They can draw a picture about what they think the bereaved child feels.

Allow students in the class to do something for the bereaved classmate. Ask them what helped them feel better when they were really sad. Cards or pictures can be sent to the child's home or given to the child when they return to school. School personnel should always screen these projects before delivery.

Returning to school: The other children may want to convey to their peer that "We missed you. We are glad you are back." Hearing they were missed and thought about is helpful in a time of grief. Remember that showing up can be hard for a bereaved child and every student will need different types of care and comfort. Children may express their hurt in unexpected, new ways for them, such as anger or withdrawal. Be patient and flexible, but also try to keep routines to provide some structure.

Your feelings: Appropriately expressing and modeling your feelings and emotions creates a safer space for children to express themselves and better understand one another.

Referrals and Resources for More Learning

The Highmark Caring Place (highmarkcaringplace.com) - A local organization supporting bereaved children and families.

Coalition to Support Grieving Children (grieving students.org) - Several short modules on supporting students through grief.

The Dougy Center (dougy.org) - Support, resources, and connection before and after a death.

National Center for School Crisis and Bereavement (schoolcrisiscenter.org) - Dedicated to helping schools support their students through crisis and loss.

Sesame Street in Communities (https://sesamestreetincommunities.org/topics/grief/). Activities and resources to help children grieve.

Children's Literature Focusing on Loss and Grief Emotions with Virtual Reading Links

The Invisible String by Patrice Karst. https://www.youtube.com/watch?v=2rZNTFf35Aw

The Color Monster by Anna Llenas. https://www.youtube.com/watch?v=M-6W6yk5gb4

My Yellow Balloon by Tiffany Papageorge.
https://www.youtube.com/watch?v=ZfaQn_3WSIA&t=616s (book read starts at 4 minutes)

The Goodbye Book by Todd Parr. https://www.youtube.com/watch?v=efWdOol5g6o

Glad Monster, Sad Monster by Ed Wemberley and Ann Miranda.
https://www.youtube.com/watch?v=NNTC-dSZtcA

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Appendix D Summary Review PD and Wrap-up Ceremony

Appendix D.1 Trauma Tool Kit Sample

This is a photo of a Trauma Toolkit created for the topic of The Effects of Family Medical Trauma, Death, and/or Grief on the Child. The toolkit was presented to the staff following PD 7 during the summary review and wrap-up ceremony on April 25, 2023. The plastic container has copies of resources that can be given to the staff and families. Examples of topics include, "Talking to Children about Death", Sesame Street Workshop hand-outs for staff, families and children's activities on "Grief", and "Death of a Parent, Grandparent or Sibling". Information for local agencies and brochures from the Highmark Caring Place and Cancer Bridges is also included. Several books on the topic for preschool children and accompanying activities are in the toolkit for the teachers or consultants to read with the child. All written resources are also available in virtual format and the books can be borrowed from HealthyCHILD.

Appendix D.2 Sample of Certificate of Attendance

CERTIFICATE OF ATTENDANCE

3 hours of attendance at the Trauma Sensitive Classroom Professional Developments
Crescent Early Childhood Center

PD 1- The Review of Trauma, ACEs, and Urban ACEs	10/25/22
PD 2 - Trauma Related Behaviors, Interventions, and Language for Trauma Support	11/22/22
PD 3 - Teacher Secondary Stress, Compassion Fatigue, and Self-care	12/20/22
PD 4 - Developing a Compassion Satisfaction Plan	01/24/23
PD 5 - The Effects of Incarceration of a Primary Family Member on the Child	02/28/23
PD 6 - The Effects of Medical Trauma, Death, and Grief on the Child	03/28/23

This certificate is presented to

Date

Signature

Appendix D.3 Sample of Teacher Survival Kit

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