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Pennsylvania School Social Workers' Trauma-Informed Practices: Status and Future Needs

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ABSTRACT OF THE DISSERTATION

PENNSYLVANIA SCHOOL SOCIAL WORKERS' TRAUMA-INFORMED PRACTICES: STATUS AND FUTURE NEEDS

By

Jessica L. Schoonmaker, LCSW

Kutztown University|Millersville University, 2024

Directed by Dr. John G. Vafeas, DSW, LSW

The idea of trauma-informed practices is a broad concept that can be utilized to create a safe environment in which individuals, families, communities and organizations that have been exposed to trauma can be and feel supported. Trauma-informed practices are important due to the pervasive nature of trauma exposure (Kilpatrick et al., 2013). Traumatic experiences can impact individuals' physical and mental health over the course of their lifespans (Avery, et al., 2021; Centers for Disease Control, 2021; Gonzalez et al., 2016; McWey, 2020; Mersky et al., 2019; Porche et al., 2016; SAMHSA, 2014a; Trauma Informed Care Implementation Resource Center, 2021; Zyromski et al., 2022). Absent appropriate interventions, affected individuals may demonstrate various trauma reactions, suffer from mental health symptoms, and exhibit difficulties in the school setting as a result of their experiences (Brandell & Ringel, 2019; Clearly et al., 2017; Dodd et al., 2023; Dorsey et al., 2017; Ellis & Tate, 2022; Gilboa-Schectman et al., 2010; Gonzalez et al., 2016; Krystal, 1978; McLaughlin et al., 2013; Perfect et al., 2017; SAMHSA, 2022; Trauma-Informed Care Implementation Resource Center, 2021; U.S. Department of Homeland Security, 2021; van der Kolk, 2000). Schools are in a unique position to provide support to students who have experienced traumatic events due to the number of hours

spent in school each day. This study surveyed 239 Pennsylvania school social workers and obtained qualitative data from 10 school social workers via focus groups to obtain information regarding their use of trauma-informed practices and interest in professional development regarding trauma-informed practices. Despite variables in the work setting influencing their use and interest in professional development related to trauma-informed practices, participants reported that they are using this form of engagement and wanting to learn more via quality professional development sessions that are tailored to their learning needs.

Keywords: trauma-informed practices, school social work, social-emotional learning, multi-tiered systems of support, restorative practices

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Chapter 1: Introduction

The goal of this research is to assess relationships between factors in the workplace and social workers' use of trauma-informed practices in the school setting and to identify needs for continuing education and professional development. In a previous small qualitative study conducted by this researcher regarding determinants of help-seeking behaviors among adolescents experiencing suicidality and mental health symptoms in the school setting, two main themes that emerged were the effect that school staff's knowledge about trauma had on whether or not students felt safe asking for help and whether or not staff were and felt equipped to work with students with a high level of trauma-related needs (Schoonmaker, 2022). The more knowledgeable staff were and felt, the more successful they were in engaging with students regarding their mental health symptoms and vice versa (Schoonmaker, 2022). These findings were supported by previous research indicating that students experiencing mental health symptoms and suicidality were more likely to seek support from school staff and adults who they felt were supportive and fostered a positive attitude about mental health (Haavik et al, 2019; Pearson & Hyde, 2020; Wang et al, 2020). Additionally, although the interviewed staff expressed interest in training about trauma, they reported that they did not feel as though they were being provided with professional development that met their needs as much as it checked a box to meet state requirements placed upon the district (Schoonmaker, 2022). Berger et al. (2023) and Chudzik et al. (2022) both found that participants in their studies felt that more training regarding trauma was both necessary and desirable. It is also important to note that Carroll et al. (2021) found in their study that participating school staff not only desired more professional development, but specifically wanted meaningful and flexible professional development that was useful without adding to their stress level.

Problem Statement

Issued in 2018, Pennsylvania's Act 44 calls for each school entity in the Commonwealth to provide at least three hours of trauma-informed training to all school staff every five years (Pennsylvania General Assembly, 2018). In addition to being a state mandate, addressing trauma can also be considered an issue of basic human rights and social justice because when an individual who is already more likely to be a member of a vulnerable population faces a traumatic event and its aftermath, their basic right to safety and security is stolen and it is society's, and often the school's responsibility to provide a an environment in which students can engage in the healing process (Ehrbacher & Singer, 2018; Mersky et al., 2019; Singer & Slovak, 2011; Springer et al., 2020; Voith et al., 2020). Social workers have an ethical responsibility to address social problems, like trauma exposure of youth, while addressing social injustices (Voith et al., 2020) and improving social work practice through education, including the improvement of trauma-informed practices in the school setting (National Association of Social Workers, 2021) while school staff in general have a professional responsibility to meet the needs of their students, including their mental health needs (Crepeau-Hobson, 2013; Larson Etscheidt et al., 2022; "Principals Can Help," 2022; U.S. Department of Education, 2021).

Research shows that trauma and traumatic experiences are pervasive throughout the nation's population and world-wide, with research showing varied responses to surveys about trauma exposure, likely due to differing definitions of the concept of "trauma" (Mersky et al., 2019). Generally speaking, trauma or traumatic experiences are events or experiences that have a negative lasting effect on an individual's functioning (Substance Abuse and Mental Health Services Administration, 2014a), but this will be explored further in Chapter 2. Research indicates between fifty percent (Johnson, 2019) and over eighty-nine percent (Kilpatrick et al., 2013) of surveyed individuals reported trauma exposure. Specific to children, defined as those

under eighteen years of age, 588,229 were reported as victims of child abuse or neglect in the United States in 2021, with the majority of the victims being under four years of age (Children's Bureau, 2021). In Pennsylvania, there were reported to be 4,683 victims of child abuse or neglect at a rate of 1.8 per 1000 children in 2021, most likely physical or sexual abuse, with 4,439 being first-time victims at a rate of 1.7 per 1000 children (Children's Bureau, 2021). Nationally, the reported number of victims of child abuse or neglect was 8.1 per 1000 in 2021 with 5.7 per 1000 being first-time victims (Children's Bureau, 2021). In Pennsylvania, adolescents were more likely to be victims of child abuse or neglect than younger children, which differed from the national trend of young children being more likely to be victimized (Children's Bureau, 2021).

Traumatic experiences can impact individuals' physical and mental health over the course of their lifespans (Avery, et al., 2021; Centers for Disease Control, 2021; Gonzalez et al., 2016; McWey, 2020; Mersky et al., 2019; Porche et al., 2016; SAMHSA, 2014a; Trauma Informed Care Implementation Resource Center, 2021; Zyromski et al., 2022). Absent appropriate interventions, affected individuals may demonstrate various trauma reactions or suffer from mental health symptoms as a result of their experiences (Brandell & Ringel, 2019; Clearly et al., 2017; Dodd et al., 2023; Dorsey et al., 2017; Ellis & Tate, 2022; Gilboa-Schectman et al., 2010; Gonzalez et al., 2016; Krystal, 1978; McLaughlin et al., 2013; Perfect et al., 2017; SAMHSA, 2022; Trauma-Informed Care Implementation Resource Center, 2021; U.S. Department of Homeland Security, 2021; van der Kolk, 2000). Some trauma reactions may include a diagnosis of Post-Traumatic Stress Disorder (Cleary et al., 2017; Dodd et al., 2023; Dorsey et al., 2017; Sami & Hallaq, 2018; Wong et al, 2016), aggressive behaviors (Brandell & Ringel, 2019; Perfect et al., 2017; Rizeq & McCann, 2022; van der Kolk, 2000), reenacting the traumatic experience (Brandell & Ringel, 2019; Perfect et al., 2017; van der Kolk, 2000), anxiety symptoms (Brandell

& Ringel, 2019; Dorsey et al., 2017; Krystal, 1978; Perfect et al., 2017), substance abuse (Brandell & Ringel, 2019; Cleary et al., 2017; Gilboa-Schectman, 2010; Perfect et al., 2017; Rizeq & McCann, 2022; van der Kolk, 2000), dissociation (Krystal, 1978; van der Kolk, 2000), difficulties with self-regulation (Brandell & Ringel, 2019; Krystal, 1978; Perfect, 2016), academic difficulties (Gonzalez et al., 2016; Perfect et al., 2017), a sense of giving up known as psychogenic death (Krystal, 1978), self-harming behaviors (Brandell & Ringel, 2019; Krystal, 1978; Modrowski et al., 2019; Rizeq & McCann, 2022; Sami & Hallaq, 2018; Wong et al., 2016), and suicidality (Dodd et al., 2023; Ellis & Tate, 2022; Krystal, 1978; Perfect et al., 2017; Rizeq & McCann, 2022). In the school setting, students who have experienced trauma may find it difficult to verbalize their needs and their actions, resulting from fight-flight-freeze-fawn responses, exhibiting behaviors that may be misunderstood as acting out (Berardi & Morton, 2019) and then treated as discipline issues, and must be managed by school staff, potentially leading to secondary traumatic stress symptoms and staff turnover (Bell et al., 2003; Hallinan et al., 2019; Ingersoll, 2001; White, 2006).

As a result of the COVID-19 pandemic, schools were closed, leading to the social isolation of students, reducing students' access to mental health services, and increasing trauma exposure (Lewis et al., 2023; Subramaniam & Wuest, 2022; U.S. Department of Education, 2021). It is believed that this increased exposure to trauma was, at least in part, caused by increased home and family stressors, including financial difficulties due to COVID-related job loss (He et al., 2021; Phelps & Sperry, 2020; Pincus et al., 2020; U.S. Department of Homeland Security, 2021), grief and loss (Holmes et al., 2021), and chronic stress (He et al., 2021; Lewis et al., 2023), compounding the effects of the trauma that they may have already been experiencing (Walker et al., 2021). Due to the COVID-19 pandemic causing increased exposure to trauma and

a reduction in access to preventative and treatment services, the U.S. Department of Homeland Security issued a Public Awareness Bulletin (2021) expressing concern about the potential for an increased threat of targeted violence in schools. This has shown to be true in the immediate aftermath of the pandemic with a surge in gun violence in schools and on school property (Walker et al., 2021; Woodrow Cox & Rich, 2021) and violence in schools, including against staff (American Society of Safety Professionals, 2022). This is of concern to school administrators, mental health professionals, social workers, and other school staff because exposure to violence and gun violence is considered a type of trauma exposure, potentially exacerbating existing trauma reactions, or causing new reactions (Bailey, 2020; Borg et al., 2021; Murtonen et al., 2012; Walker et al., 2021). Additionally, exposure to school shootings has negative impacts on witnesses' academic performance (Milam et al., 2010), school attendance, and subsequent mortality (Levine & McKnight, 2020).

It is also important to note that working in these environments and with these youth impacts the staff, at times leading to emotional exhaustion (Olivier et al., 2021), secondary traumatic stress, and feelings of burnout (Fleckman et al., 2022), potentially decreasing their ability to be effective and empathetic when working with students and families and leading to an increase in staff turnover (Ingersoll, 2001).

It is argued that secondary trauma, a term often used interchangeably with vicarious trauma (Figley, 2002; Sutton et al., 2022) despite some arguments against doing so (Baird & Kracen, 2006; Kerig, 2019), a concept that will be discussed at length in Chapter 2, is an unavoidable hazard for those who work in settings with high concentrations of individuals exposed to trauma, including schools (Bell et al., 2003; Hallinan et al., 2019; White, 2006), especially since hearing about children's trauma can be particularly difficult for providers of care

(Figley, 1995; McCall et al., 2022). Engaging with traumatized individuals in an empathetic manner and creating relationships that are encouraged to help heal from trauma, can lead to a "cost to caring" (Figley, 1995, p.1) and can be detrimental to those providing care if steps are not taken to keep the caregivers safe and healthy (Cerney, 1995; White, 2006). Despite a traditional focus on individual self-care, a recent shift is focused on organizational culture changes that support staff and normalizes experiences of secondary traumatic stress symptoms when working with traumatized populations (Bell et al., 2003) and the importance of doing so in the school setting (Hydon et al., 2015). One such method of doing so, while also providing effective care to students, is through trauma-informed practices (Cafaro et al., 2023; Champine et al., 2022; Giacomucci, 2023; Handran, 2015; Minne & Gorelik, 2021) in addition to administrative support and oversight (Howell et al., 2019).

Statement of Purpose

This research aims to explore the status of trauma-informed practices in Pennsylvania public school systems by examining school social workers' preparation for utilizing trauma-informed practices and what manner trauma-informed practices are being utilized in the school setting to help determine current needs and guide future direction in implementation planning. This research aims to improve both direct social work practice and social work education in alignment with the NASW Code of Ethics, NASW Standards for School Social Work Services, and Council on Social Work Education's 2022 Educational Policy and Accreditation Standards.

Trauma-informed organizations, including schools, strive to promote the well-being of clients as well as staff (Kruse & Edge, 2023; Menschner & Maul, 2016; Mersky et al., 2019; SAMHSA 2014a). This form of practice is considered effective as supported staff are more effective and productive and less likely to experience burnout (Camacho et al., 2020), secondary

traumatic stress (Shaw, 2022), and to leave their position (Dombo & Whiting Blome, 2016; Hallinan et al., 2019; Handran, 2015; Kruse & Edge, 2023), and it helps students exposed to trauma overcome its negative effects in a safe manner (Fondren et al., 2019; Mersky et al., 2019; SAMHSA 2014a).

Rationale and Significance

Youth who have experienced a traumatic event are more likely to struggle in the academic setting (SAMHSA, 2014a) as a result of impaired academic abilities (Gonzalez et al., 2016), difficulties concentrating, and behavioral dysregulation (Brandell & Ringel, 2019; Dorsey et al., 2017; Gonzalez et al., 2016; Krystal, 1978; Perfect, 2016; Presnell, 2018). It is believed that youth experienced a great deal of trauma because of the COVID-19 pandemic and are, in turn, exhibiting more reactions in school (Subramaniam & Wuest, 2022). Additionally, these trauma responses and related behaviors can have negative effects on the staff working with these students (Axup & Gersch, 2008; Hydon et al., 2015; Olivier et at., 2021) and hearing their stories of trauma (Borntrager, 2012; Hydon et al., 2015; Mayor, 2021), leading to secondary trauma reactions (Handran, 2015; NCTSN, 2017), burnout (Fleckman et al., 2022; Handran, 2015; Kruse & Edge, 2023; Wink et al., 2020), and ultimately leaving the field (American Society of Safety Professionals, 2022; Kruse & Edge, 2023). This waterfall effect can increase the burden on remaining staff due to increased workloads (Carroll et al., 2022), lower morale, and negative impacts on the work environment (Bloom, 2014), and can decrease the quality of care to students (Handran, 2015; Wink et al., 2020).

Schools are in a unique position to provide necessary interventions to youth that can offset the negative impacts of trauma due to the amount of time students spend in school (Borntrager et al., 2012; Ehrbacher & Singer, 2018; Springer et al, 2020), allowing them to forge

stable, meaningful relationships with staff (Berardi & Morton, 2019; Subramaniam & Wuest, 2022), including staff trained in the mental health field (Joseph et al., 2020), such as school counselors (Zyromski et al., 2022) and school social workers (Sedillo-Hamann, 2022). However, these very same factors that allow school staff members to help students overcome the negative effects that trauma may have on their lives often negatively affect school staff members and the school community as a whole due to the effects of secondary traumatic stress (Borntrager et al., 2012), or the effects on the caregiver as a result of empathizing with individuals who have experienced traumatic events (Figley, 1993), which will be described in more detail in Chapter 2.

It is imperative that more research be conducted regarding trauma, trauma prevention, and trauma-informed practices, particularly in schools, in an effort to meet the ethical mandates set forth by the National Association of Social Workers (2021). The Code of Ethics states that social workers are to help those in need while addressing social problems (2021). Trauma exposure is arguably a major societal problem (Cohen & Mannarino, 2015) and a public health concern due to the number of individuals affected and its burden on society (Kraemer Tebes et al., 2019; SAMHSA, 2014a; Woodbridge et al., 2016).

The NASW Code of Ethics (2021) and the NASW Standards for School Social Work Services (2012) also state that social workers, and more specifically, school social workers, are to challenge social injustices by pursuing social change, particularly regarding those who are oppressed and vulnerable. This concept is closely aligned with the NASW Standards for School Social Work Services' (2012) concept of advocacy. Schools serve children and youth, an inherently vulnerable population, particularly if exposed to trauma. Additionally, although anyone can be exposed to trauma (SAMHSA, 2014a), it is more likely that individuals from some oppressed and vulnerable populations are at higher risk of exposure to traumatic

experiences as well as more significant trauma reactions than those not from these marginalized populations (Cleary et al., 2017; Ellis & Tate, 2022; Johnson, 2019; Mersky et al., 2019; Yun et al., 2022). Such high-risk populations include racial and ethnic minorities (Everytown, 2023; Joseph et al., 2020; Woodbridge et al., 2016; Yun et al., 2022), non-Western populations (Hughes, 2006), immigrant populations (Cleary et al., 2018; Woodbridge et al., 2016), LGBTQ youth (Ellis & Tate, 2022; Yun et al., 2022), youth living in poverty (Everytown, 2023; Johnson, 2019; McLaughlin et al., 2013; Porche et al., 2016), youth living in urban areas (Borg et al., 2021; Everytown, 2023), and homeless youth (Wong et al., 2016). Many of these affected youth are also more likely to only receive mental health services or supports in the school setting rather than in a traditional clinical setting (Arora & Persaud, 2019; Farmer et al., 2003; Ijadi-Maghsoodi, et al., 2018; Pearson & Hyde, 2020; Singer & Slovak, 2011; Springer et al., 2018; U.S. Department of Homeland Security, 2021; Woodbridge et al., 2016), and even more so as a result of the COVID-19 pandemic (Gee et al., 2020; Keels, 2020; Pincus et al., 2020; U.S. Department of Homeland Security, 2021).

The NASW Code of Ethics (2021) and the NASW Standards for School Social Work Services (2012) also both require social workers and school social workers to constantly strive to improve their practice via professional development and continuing education. Furthering research surrounding trauma-informed practices in the school setting and striving to improve training and education for staff in this area, meets the mandates set forth by the National Association of Social Workers and Competencies 2, 4, 6 and 7 of the Council on Social Work Education's 2022 Educational Policy and Accreditation Standards. Competency 2 is related to social, racial, economic, and environmental justice, Competency 4 is related to research-informed practice and practice-informed research, Competency 6 is related to engagement for

direct services with individuals, groups, communities, families, and organizations, and Competency 7 is related to assessment of individuals, groups, communities, families, and organizations (Council on Social Work Education, 2022). It should be noted that a study conducted by Boel-Studt et al. (2022) found that the majority of BSW and MSW programs surveyed in the United States and Canada provide trauma education by integrating it into existing courses, but also through workshops and some stand-alone courses. Those programs that reported not offering trauma-education cited staffing and prioritization of other content as barriers to doing so (Boel-Studt et al., 2022).

This study aims to explore at what level trauma-informed practices are being implemented in Pennsylvania schools by district school social workers and to determine next steps for improving support to students and staff. This study hopes to determine how prepared Pennsylvania's school social workers are to implement trauma-informed practices in their current work and what is affecting the use of trauma-informed care in the school setting.

Research Questions

In an effort to meet the goals of this study, the research questions being posed include:

R $_{1.1}$: What is the perceived level of preparedness of school social workers' use of trauma informed practice?

More specifically, this question is focused on the training and education that school social workers received prior to their employment as school social workers as well as training and professional development since beginning their careers. This researcher is interested in the type, amount, and setting in which the education was received, if it was received at all.

R $_{1.2}$: Are there any relationships between identified factors in the work setting and the use of trauma-informed practices by school social workers?

This question is intended to obtain information regarding whether trauma-informed practices are being utilized by school social workers and whether factors in the workplace have a relationship with its use.

> $R_{1.3}$: Is there a relationship between education about trauma-informed practices and the use of trauma-informed practices by school social workers?

This question, along with the prior question, is intended to explore factors that are believed to have a relationship with the use of trauma-informed practices in the school setting. This question is designed to examine the relationship between education about trauma-informed practices and the use of trauma-informed practices by school social workers.

> $R_{1.4}$: Is there are relationship between identified factors and participants' reported interest in more training related to trauma-informed practices?

Once a baseline understanding of training and education and current practices has been established, this research question is designed to determine the next steps for future practice and research. This question is designed to gain and better understanding of what Pennsylvania's school social workers want regarding professional development and what may be supporting or hindering their access to this education.

It is hypothesized that participants reporting a higher level of preparedness will report a higher use of trauma-informed practices in their daily practice. It is further hypothesized that factors that have significant relationships with trauma-informed practice use by school social workers will include caseload size, job tasks, and participants' reported level of knowledge and training about trauma-informed practices. Finally, it is hypothesized that most participants will

express interest and need for more education about trauma-informed practices but will also report job-related factors as a barrier to obtaining this education.

Definitions of Key Terminology

Pennsylvania Public School

In Pennsylvania, there are 500 public school districts ranging in size from about 200 to over 140,000 students (Pennsylvania Department of Education, 2023a). These districts are categorized into six regions across Pennsylvania based on their physical location: South Central, Central/North Central, Southwest, Southeast, Northeast, and Northwest (PDE, 2023a). Public schools in Pennsylvania are governed by school boards comprised of officials elected to specific terms who, via their state board, work closely with the state Department of Education to ensure districts abide by all state and federal laws, policies, and regulations (Pennsylvania Department of Education, 2023b). These districts are funded by a combination of, primarily, state tax and local property tax revenue, and a small amount of federal support (Park, 2011).

School Social Worker

The term “school social worker” is being defined based on the criteria set forth by the Pennsylvania Department of Education (PDE) as this study is taking place in the public school system in Pennsylvania. Currently, PDE requires that, for individuals to be employed as a school social worker in Pennsylvania public schools, they must have a master's degree in social work and either a valid social work license or clinical social work license through the Pennsylvania Department of State, Bureau of Occupational Affairs (Pennsylvania Department of Education, 2023c). Also, starting in August 2026, school social workers must obtain a PK-12 School Social Worker Educational Specialist Certificate (PDE, 2023c). Currently employed school social workers within the state who complete the application process prior to the deadline will be able

to obtain the certification through a grandfathering process, but newcomers will need to complete an accredited school social worker certification program (PDE, 2023).

The School Social Work Association of America outlines the roles of school social workers which are further detailed by the Pennsylvania Department of Education. The School Social Work Association of America tasks school social workers with (Frey et al., 2013):

- Providing evidence-based education, behavior, and mental health services to students including implementing, monitoring, and evaluating these services;
- Promoting a school climate and culture that is conducive to student learning and teaching excellence by promoting effective policies, assisting with training staff, and strengthening school-family-community engagement; and
- Maximizing access to both in-school and community-based resources to maintain a continuum of services, increase access to services, and to engage in collaboration and cooperation.

The Pennsylvania Department of Education (2011) states that school social workers may be tasked with:

- Conducting formal and informal assessments of student functioning, developmental history, family and community structure, interpersonal relationships, adaptive behavior, and cultural factors that may influence learning;
- Using student, family, school, and community assessments to develop appropriate interventions to improve student learning;
- Developing intervention plans consistent with curriculum, student needs, strengths, social and cognitive functioning, and cultural experiences;

- Assisting in the planning of therapeutic, remedial, and behavioral modification activities provided by the educational agency;
- Providing direct interventions to students, including individual and group therapy, counseling, and educational and informational programs;
- Providing case work to children and their families, including parent education and self-advocacy;
- Providing parent counseling and training to help them acquire the necessary skills to support the implementation of their child's specialized educational program;
- Assisting students and their families in gaining access to formal and informal community resources;
- Consulting with stakeholders to facilitate understanding of factors in a student's home, education agency and community that affect their educational experience;
- Consulting and collaborating with educational agency personnel, parents and community resources in areas that impact student learning (e.g., mental health, behavior management, school safety, diversity, crisis management, child abuse and neglect);
- Assisting other staff in collaborating with community agencies and organizations;
- Working with individuals, groups, and organizations to develop programs and systems that promote student welfare and achievement;
- Promoting collaboration among community health, mental health, and welfare service providers and facilitate greater access to these services for students;

- Participating in interagency panels to assist with the effective integration of services to students; and
- Coordinating and/or implementing bullying prevention efforts for districts.

Trauma

Per SAMHSA, trauma can be defined as resulting:

> from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, and emotional, or spiritual wellbeing. (SAMHSA, 2014a, p. 7)

This will be discussed in greater detail in Chapter 2, including alternate definitions to be considered.

Secondary Traumatic Stress

Secondary traumatic stress, a term coined by C. R. Figley (1993), is the resulting behaviors and emotions from being aware of trauma experienced by another and wanting to help alleviate this individual's suffering. The symptoms are almost identical to post-traumatic stress disorder (Figley, 1995).

Trauma-Informed Practices

Trauma-informed practices, or trauma-informed care, are services provided to a client or client population that take into consideration the broad impact of trauma and potential for recovery, recognizes the signs and symptoms of trauma, and responds to these by integrating knowledge about trauma into policies, procedures, and practices while actively striving not to retraumatize and to prevent secondary traumatic experiences in staff (Handran, 2015; Menschner & Maul, 2016; Mersky et al., 2019; SAMHSA, 2014a). In practice, this may look like

generalized screening for trauma experiences before diagnosis (Griffin et al., 2011), respecting clients' boundaries around disclosures while validating their feelings, collaborating with other professionals to more effectively meet clients' needs, meeting clients where they are at, striving to create a physically and emotionally safe environment, and working with clients and their existing networks to help strengthen and build relationships and natural support networks (Meléndez Guevara et al., 2021; Taylor et al., 2019).

Overview of Research Design

This study is a mixed methods study including an online survey and virtual focus groups. Participants were selected from a database of school social workers maintained by the Center for the Study of School Social Work at Kutztown University, forming the sampling frame. This database is based off Pennsylvania Department of Education's annual report of school personnel, specifically, school social workers. The smaller sample of participants for the qualitative focus groups was chosen via convenience sampling from the larger survey sample. Participants were asked to provide their contact information if interested in participating in the focus groups to obtain a richer, more well-rounded understanding of the questions posed. Participants were chosen from volunteers to create a sample that included representatives from rural, suburban, and urban districts, as well as small, medium, and large districts. Efforts were also made to include as many regions from across the state as possible but were limited by the self-selection sampling method.

Role of the Researcher

This researcher was directly involved in all steps of this study. She designed the study, selected participants, reached out to potential participants, led the focus groups, and then analyzed both the quantitative and qualitative data. It is also important to note that this researcher

is a school social worker in a Pennsylvania public school but did not contribute to the data or focus groups as a participant.

Due to this researcher's role as a school social worker in the state being studied, there was a possibility that some participants could be the researchers' colleagues, so confidentiality and the option to not participate were made explicit throughout the study.

Researcher Assumptions

It is this researcher's belief that response rates would be lower than desired due to the very reason this topic is being studied- concerns about burnout, high student need, and the need for more staff support. It was also assumed that respondents would have a high level of general knowledge about trauma and trauma-informed care but not be utilizing evidenced-based interventions due to the demands placed upon them.

Organization of the Dissertation

In Chapter 2, a comprehensive review of existing literature related to trauma and trauma-informed practices integrated with pertinent theoretical perspectives is provided. In Chapter 3, the research design is outlined, variables are reviewed and explained along with the research population, data collection methods, data analysis methods, and a discussion related to trustworthiness, and limitations. Chapter 4 outlines and discusses the findings from this study in detail, including unexpected findings. Chapter 5 details how the data was analyzed, interpreted, and synthesized. Limitations are again reviewed. In Chapter 6, the information previously presented is tied together to form a conclusion and to pose recommendations for future practice and research. Following these chapters, the reader can find all applicable references, tables, charts, and coding materials for review in the appendices.

Chapter 2- Literature Review

An extensive literature review was conducted to determine the history of trauma studies and the most current evidence-based practices in the field. This literature review helped guide this study based on social work theory, gaps in the literature, and existing research.

Literature Selection Strategies

The literature for this review was selected via an online search utilizing a number of databases including EBSCO*Host*, PsycArticles, PsycInfo, EBSCO eBooks, Social Sciences Citation Index, ERIC, Social Work Abstracts Plus, Education Source, ProQuest Dissertations & Theses Global, ProQuest eBooks, JSTOR, Science Direct, SpringerLink, and SAGE Journals Online, as well as directly searching the internet for specific articles via their titles and digital object identifiers (DOIs). To find appropriate articles and books through online searches, words and phrases were searched utilizing the "keyword" search option. Such searches included: trauma, trauma-informed practices, trauma in schools, trauma treatment, trauma theory, school social work, social-emotional learning, restorative practices, multi-tiered systems of support, secondary trauma, burnout, vicarious trauma, barriers to trauma-informed care, and deeper searches spurred by concepts discussed in the literature located. As the literature was reviewed, articles and books were then located in the reference sections of the reviewed literature and direct searches for these titles were conducted.

Previously, this researcher conducted research surrounding suicide prevention in adolescents and suicide assessment in the school setting. Much of this information was found to be applicable to this topic. When searching for appropriate literature for these topics, similar search methods were utilized- online searches were conducted via online databases including EBSCO*Host*, PsycArticles, PsycInfo, EBSCO eBooks, Social Sciences Citation Index, ERIC, Social Work Abstracts Plus, Education Source, ProQuest Dissertations & Theses Global,

ProQuest eBooks, JSTOR, Science Direct, SpringerLink, and SAGE Journals Online using keywords including: suicide, suicide prevention, suicide assessment, adolescents, suicide prevention in schools, and suicide assessment in schools. As in this current literature review, the literature found through the above-mentioned databases led to a larger web of literature through a review of applicable literature cited throughout the works.

Theoretical Framework

SAMHSA (2014a) argues that trauma can be experienced both by the individual and the community. As such, it is necessary to approach trauma prevention and intervention from a perspective that takes both the individual and their larger environment into consideration. The ecological perspective and general systems theory both do this (Gitterman et al., 2021; Payne, 2020). The ecological perspective suggests that individuals must adapt to their environment but also that individuals alter their environment and that a balance must be struck between the two to find a healthy equilibrium for all because each level is affected by the other (Bronfenbrenner & Cole, 1979; Gitterman et al., 2021; Payne, 2020). Similarly, the general systems theory, derived from studies in science, states that everything is connected, and that change can be affected anywhere along the continuum to create a new norm that is better for the individual and other involved parties to reach equilibrium for the system (Payne, 2020; von Bertalanffy, 1950). In both the ecological perspective and general systems theory, the system or environment can vary- a small social group, a school, a family, a community, or another affected system that the targeted individual is involved in and that targeting some level of this system and improving it can improve the quality of life for the targeted individual (Bronfenbrenner & Cole, 1979; Payne, 2020; von Bertalanffy, 1950). These theories argue that it is possible for individuals and various-sized groups to be impacted, positively or negatively, by their environments. However, it is also

possible to exact change (i.e., treatment) anywhere within the system and affect the system as a whole, including the targeted individual or population.

Despite his use of different language, Figley (1978) observed this phenomenon of the influence of environment on individuals in his studies of stress disorders among Vietnam veterans. He found that external and broad-scale environmental factors can impact individuals over time (Bonnes et al., 2003/2016; Figley, 1978; Russel & Ward, 1982). This is further complicated by the way that individuals and their environments must interact with one another and engage in constant exchanges over time (Bonnes et al., 2003/2016; Gitterman et al., 2021). Figley (1978) argues that this combination of time and war-related factors impacted soldiers' mental health in a negative way leading to trauma reactions, then known as neurosis (Figley, 1978).

Also relevant to trauma-informed practices due to the importance of relationships, is the concept of attachment. Attachment theory argues that individuals require a relationship with someone during development to feel safe and secure and to, later, learn to develop relationships with others (Brandell & Ringel, 2019; Forkey et al., 2021; Keller, 2018; Payne, 2020). These attachments begin during the first year of life and are strongest with the individual's primary attachment figure- the person who provides them with the highest level of care and attention (Bowlby, 1969; Bowlby, 1980; Bowlby, 1988; Keller, 2018). After forming this primary attachment, the individual can form secondary attachments and begin learning to explore the world and take risks, typically beginning in late toddlerhood (Bowlby, 1969; Bowlby, 1980; Bowlby, 1988; Brandell & Ringel, 2019; Keller, 2018; Payne, 2020). However, absent this key initial relationship, individuals struggle to develop later relationships, platonic and romantic, and may be unable to heal from traumas faced later in life (Forkey, 2021). It is important to keep in

mind, however, that attachment theory was developed within the Western culture and does not take into consideration cultures that raise children via non-Western methods, including in large family or community settings in which multiple adults assume caretaking roles (Keller, 2018). For this study's purposes, however, the concept is still relevant in that the argument is that relationships in general are pertinent for the well-being of students.

It is currently argued that the most effective prevention against trauma and the way to heal from trauma, is one safe, stable, and nurturing relationship with an adult and social connectedness (Brandell & Ringel, 2019; Forkey et al., 2021; McWey, 2020; Perry & Szalavitz, 2017; Simcock et al., 2021). When individuals are faced with interpersonal traumas, or have these core connections broken, they struggle with feelings of distrust, betrayal, shame, and have difficulties connecting with others (Hughesdon et al., 2021). Similarly, staff facing secondary traumatic stress symptoms also benefit from social support and relationships with their colleagues (Borntrager et al., 2012; Camacho et al., 2020; Handran, 2015). Notably, in their mixed-methods study regarding compassion satisfaction, secondary traumatic stress, and burnout among teachers working in marginalized communities, Fleckman et al. (2022) found that among their two samples (n = 130, n = 145), “Educators are further encouraged by the meaningful relationships they develop with students and their families through their work...” (p. 942).

Working from these perspectives, to adequately prevent trauma and address the effects of trauma and secondary traumatic stress in the school setting on individuals, steps must be taken to address the school community as a whole. By improving staff’s ability to identify and address trauma and secondary traumatic reactions and limit re-traumatization within the school setting via staff development and education, it is believed that the school community will become a

safer, more cohesive place for students to heal and form meaningful relationships with one another and staff.

Also, important to consider is the Contemporary Trauma Theory, which provides a core foundation for understanding how trauma can impact one's biopsychosocial functioning (Goodman, 2017). This theory argues that trauma can lead to issues in the following areas (Goodman, 2017):

- Dissociation. As a defense mechanism, the individual's psyche may dissociate, or divide, during the traumatic experience (Janet, 1907; Yalch & Burkman, 2019).
- Attachment. As a result of the traumatic experience and its effects, the individual may struggle to form and/or maintain healthy attachments with others (Yalch & Burkman, 2019).
- Reenactment. The individual may, in some manner, reenact the trauma that they experienced, through relationships, behaviors, etc. allowing them some semblance of control (Centers for Disease Control, n.d.).
- Later adulthood. Due to trauma exposure when younger, individuals may later experience poorer health outcomes, mental health issues, interpersonal issues, and diminished capacity (Ehlert, 2013).
- Emotional capacities. Due to changes in the brain caused by exposure to trauma, discussed in a later section, individuals exposed to trauma may struggle with emotional regulation, identification of emotions, hyperarousal, numbing, and other emotional responses (Centers for Disease Control, n.d.; Ehlert, 2013; Pan & Yang, 2021).

Review of Literature

The following sections focus on the existing literature surrounding trauma-informed care in schools beginning with the early studies on trauma, the current treatments available, and the state of trauma-informed practices in the schools. Following a review of what exists in the literature, an overview of what is suggested moving forward and the current gaps and needs for future exploration and growth is presented.

History and Evolution of "Trauma" as a Concept

The concept of trauma was born in the late nineteenth century when neurologist Jean Martin Charcot worked with women displaying "hysterical" symptoms at the Hôpital du Salpêtrière in Paris (Brandell & Ringel, 2019; van der Kolk, 2000). Prior to his studies, these women, showing symptoms including paralysis, amnesia, convulsions, and memory loss, were often treated via hysterectomy as it was believed that hysteria was an illness of the uterus (Brandell & Ringel, 2019). Charcot, though, found that these patients had suffered through events including rape, violence, and other remarkable events, and that the experiences were the causes of the symptoms (Brandell & Ringel, 2019; van der Kolk, 2000). As research into these symptoms continued, the connection between the symptoms and the uterus were disproven and trauma reactions were no longer viewed as a disease or something afflicting only women.

This research was continued by Pierre Janet who studied the connection between traumatic experiences and personality development and behaviors (Brandell & Ringel, 2019). He argued that, despite Charcot's continued connection between "hysteria" and the physical body, the studied symptoms were psychological in nature and that symptoms could be caused by the mere idea of an accident or an incident without one occurring (Janet, 1907). He was the first to introduce the concept of Post-Traumatic Stress Disorder (van der Kolk, 2000). He argued that traumatic experiences made it difficult for individuals who have experienced trauma to

assimilate new experiences into their personal consciousnesses. This could lead to the dissociation of elements of the trauma, leading to a decline in functioning, unless reintegrated into the individual's consciousness (Janet,1907; van der Kolk, 2000) through long-term treatment (Brandell & Ringel, 2019).

During the same period, Sigmund Freud and Josef Breuer began studying and writing on the topic after visiting Hôpital du Salpêtrière (van der Kolk, 2000). In their writings, Freud and Breuer argued what was known at the time as hysterias, which could last for years, were caused by some form of psychological trauma, and that the symptoms were diverse (Brandell & Ringel, 2019; Freud & Breuer, 1952; Krystal, 1978; van der Kolk, 2000). Freud and Breuer defined trauma as, "Any experience which gives rise to the distressing affects of fright, anxiety, shame or psychical pain…" (Freud & Breuer, 1952, p. 9). Freud later moved from the ideas of dissociation and trauma reactions to his more well-known ideas surrounding repressed memories of unacceptable sexual and aggressive wishes (Brandell & Ringel, 2019; Freud & Breuer, 1952; Krystal, 1978; van der Kolk, 2000). However, it is not a far stretch to connect these ideas surrounding repressed memories to those surrounding childhood traumas.

Studies in trauma continued with soldiers and veterans from World War I, World War II, and the Vietnam War. Abram Kardiner, M.D. noticed and studied the shared symptoms of many soldiers including hypochondriasis, aggression, paralysis, epileptic symptoms, and re-enactments of events (Brandell & Ringel, 2019; Kardiner, 1941; van der Kolk, 2000). Kardiner adds to the understanding of trauma and how it affects individuals by explaining that traumatic events impact individuals' understandings of their world and their beliefs about their capacities to deal with the world (Kardiner, 1941). He suggests that the goal of treatment is to revise these beliefs about the individuals' worldviews and self-perceptions to include what has changed in their lives

before they become permanent in their maladaptive form (Kardiner, 1941). Following the Vietnam War, it was discovered that, despite shorter tours of direct combat, veterans were returning with elevated levels of post-traumatic symptoms and difficulties acclimating to family and civilian life (Figley, 1978). It was later determined that, due to the unpredictable, guerrilla nature of this war, soldiers were forced to disconnect, similar to individuals in a concentration camp, causing damage to their inner selves (Figley, 1978). Krystal (1978) described experiences of survivors of Nazi concentration camps, including psychic surrender and psychogenic death in which they have shut off so completely that their bodies give up.

This concept of a physical reaction, although extreme in the case of psychogenic death, aligns with van der Kolk's argument in "The Body Keeps Score" (2014) that some traumatic memories can either be too much for an individual or can later cause lasting physical reactions to stimuli. He argues that these reactions can be connected to repressed memories that were too painful for the psyche to process at the time of the event. However, there is much controversy surrounding the idea of repressed memories as they can be unreliable and modified by others without an individual realizing it (Loftus, 2003; Urban et al., 2019). Research is ongoing in this area, but there is some evidence that brain activity differs slightly when true memories are reactivated versus false memories (Stark et al., 2010).

Definition of "Trauma."

The concept of trauma continues to evolve, and with this evolution, many definitions continue to be utilized. The issue of defining "trauma" has been problematic for many years and concern about this was raised by Anna Freud in 1967 due to her belief that the many definitions would cause the concept to lose value (Krystal, 1978). The American Psychiatric Association (2013) defines trauma as an event that is threatening or perceived as threatening to an

individual's safety. The Trauma-Informed Care Implementation Resource Center defines trauma as a resulting problem due to being exposed to an incident or events that are either life threatening or emotionally disturbing that have lasting negative effects on a person's functioning and mental, social, emotional, physical, and/or spiritual well-being (2021). However, for this paper's purposes, SAMHSA's concept of trauma is used. This definition was chosen as it stresses the importance of the individual's perception of the experience, allowing for the creation of one's own reality. This social constructivist viewpoint embodies the social work value of self-determination (NASW, 2021; Payne, 2020; Witkin, 2012). SAMHSA defines trauma as resulting:

> from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, and emotional, or spiritual wellbeing. (SAMHSA, 2014a, p. 7)

What is key to keep in mind from this definition is that what is important is that the trauma results from what is experienced as harmful or life-threatening to the individual, not what may actually be harmful or life-threatening.

Types of Trauma. There are various forms of trauma that an individual can experience. These types of traumatic experiences include (SAMHSA, 2014b):

- Natural traumatic experiences or human-caused traumatic experiences
- Individual, group, community, or mass traumatic experiences
- Interpersonal traumas
- Developmental traumas
- Political terror and/or war
- Re-traumatization caused by systems.

Natural Traumatic Experiences. Natural traumatic experiences are experiences that are typically unavoidable and are often referred to as "acts of God," (SAMHSA, 2014b). Such traumatic experiences may include hurricanes, floods, epidemics, famine, (SAMHSA, 2014b), and natural disasters (SAMHSA, 2022). Traumatic experiences caused by humans are a result of human failure and could be an accident or intentional (SAMHSA, 2014b). Such events may include structural collapse, car accidents, abuse or neglect, acts of violence, poisoning, gas explosions, or robberies (Mersky et al., 2019; SAMHSA, 2014b; SAMHSA, 2022; Trauma-Informed Care Implementation Resource Center, 2021).

Individual Traumas. Individual traumas are events or experiences that primarily affect one person (SAMHSA, 2014b). These types of acts may include a car accident, sexual assault, or experiencing a long-term medical condition (Mersky et al., 2019; SAMHSA, 2014b; SAMHSA, 2022). Group trauma, like community and mass trauma, refers to events or experiences that impact a group of individuals that have something in common such as a group of co-workers, first responders, or a shared culture (SAMHSA, 2014b). Examples of these types of events may include hate crimes, acts of violence, being exposed to toxic agents when responding to a crisis, the loss of a colleague, or a large-scale event such as war or an act of terrorism (Mersky et al., 2019; SAMHSA, 2014b; SAMHSA, 2022; Trauma-Informed Care Implementation Resource Center, 2021).

Interpersonal Traumas. Interpersonal traumas are traumatic events that occur, often over an extended period of time, between individuals (SAMHSA, 2014b). Such experiences include domestic violence or intimate partner violence, physical and sexual abuse, sexual assault, and elder abuse (Mersky et al., 2019; SAMHSA, 2014b; SAMHSA, 2022; Trauma-Informed Care Implementation Resource Center, 2021).

Developmental Traumas. Developmental traumas are events or experiences that take place during an individual's various developmental stages, or childhood in general, and have an impact on their later development (SAMHSA, 2014b). These include adverse childhood experiences (ACEs), negative experiences during childhood that impact their later development and well-being into adulthood (CDC, 2021; Duffy & Comly, 2019; Forkey, et al., 2021; Merrick et al., 2017; SAMHSA, 2014b; Trauma-Informed Care Implementation Resource Center, 2021). Developmental traumas and ACEs may include physical abuse or neglect, emotional abuse or neglect, the loss of a parent, exposure to parental substance abuse or mental illness, or living in poverty (CDC, 2021; Duffy & Comly, 2019; Mersky et al., 2019; SAMHSA, 2014b; SAMHSA, 2022; Trauma-Informed Care Implementation Resource Center, 2021). It has been found that, not only does exposure to individual ACEs have a negative effect on individuals, but also, these negative effects increase as exposure increases (Felitti et al., 1998; Gilbert et al., 2015). Research has shown that exposure to at least one ACE, with ACEs including exposure to mother being treated in a violent manner, parental divorce or separation, parental incarceration, living with a household member with substance abuse problems, living with a household member with mental illness, experiencing physical abuse, experiencing emotional abuse, experiencing sexual abuse, experiencing physical neglect, or experiencing emotional neglect during the first eighteen years of life, can negatively impact long-term health, mental health, and productivity outcomes for study participants (Felitti et al., 1998; Gilbert et al., 2015).

Political Terror and War. Political terror and war are traumas that will likely have long-term effects on any survivors (SAMHSA, 2014). Impacted individuals may include those exposed to war conditions (Barron et al., 2013; Figley, 1978; Kardiner, 1941; Krystal, 1978) or

acts of terrorism (Mersky et al., 2019; SAMHSA, 2014b) and refugees (Brar-Josan & Yohani, 2019; Mersky et al., 2019; SAMHSA, 2014b).

Re-traumatization Caused by Systems. Re-traumatization caused by systems is when something happens within the treatment setting that leads the client to feel as though they are experiencing a new trauma (SAMHSA, 2014b). This is the reason for trauma-informed practices, to try to prevent this from happening and to promote positive outcomes (SAMHSA, 2014b). Re-traumatization can occur due to a lack of knowledge, insensitivity, the use of isolation or restraints, not recognizing or screening for signs or a history of trauma, not providing adequate safety or a sense of safety, not providing privacy, and not providing clients with a sense of empowerment or a voice (SAMHSA, 2014b).

Impact of Trauma on the Brain. When youth are exposed to traumatic experiences, the physical structure of the brain changes leading to changes in behavior and functioning, and the ability to process and integrate experiences (Brandell & Ringel, 2019). These changes are caused when the release of stress hormones, including cortisol and adrenaline (Trauma-Informed Care Implementation Resource Center, 2021), that allow the individual to respond to a perceived threat in an effort to remain safe through the fight, flight, freeze, or fawn responses occur too frequently and cause a toxic stress response (Forkey et al., 2021; Pitman, 1989; Trauma-Informed Care Implementation Resource Center, 2021). The area of the brain most affected by this toxic stress response include the limbic system, which is the part of the brain that helps the part of the brain responsible for unconscious functions and responses communicate with the part of the brain responsible for higher-order functioning including rational thought (Forkey et al., 2021). Similarly, staff working with individuals affected by trauma undergo changes to their limbic system from hearing these trauma stories and reacting to them (Tyler, 2012). Included in

this affected area of the brain are the amygdala, the brain's alarm system, and the hippocampus, the part of the brain that allows the brain to learn new things and to store memories (Forkey et al., 2021). Damage to the hippocampus is what causes the trauma-exposed individual to struggle to integrate new memories into their world concept due to the painful, traumatic memories that are not fully integrated (Forkey et al., 2021; O'Keefe & Nadel, 1978).

Trauma Reactions in Youth. There is no predefined or scripted way that an individual will react to trauma. Trauma reactions are a result of the brain responding to a perceived threat and the resulting changes to the brain chemistry and structures. Once exposed to trauma, youth may exhibit any number of reactions, behaviors, or symptoms, if any at all, depending on their age at exposure, the experience, their history, and their beliefs (Perfect et al., 2017). Compounding traumas can also impact how youth respond (Abraham et al., 2021; Sami & Hallaq, 2018; Wong et al., 2016). Youth exposed to trauma may have difficulties with self-regulation- both behaviors and emotions (SAMHSA, 2014a). Trauma reactions are broad and may include mental health symptoms such as depression (Wong et al., 2016), anxiety (Abraham et al., 2021; SAMHSA, 2014b; SAMHSA, 2022; Sami & Hallaq, 2018), and post-traumatic stress disorder (Cleary et al., 2017; Dodd et al., 2023; Hughesdon et al., 2021); self-harming behaviors (Modrowski et al., 2019; SAMHSA, 2022; Sami & Hallaq, 2018; Wong et al., 2016) and suicidality (Dodd et al., 2023; Ellis & Tate, 2022; Rizeq & McCann, 2023); feelings of guilt, shame (SAMHSA, 2014b; SAMHSA, 2022), and distrust (Hughesdon et al., 2021; Modrowski et al., 2019; SAMHSA, 2014a); behaviors including aggression (Dodd et al., 2023), gambling, sexual promiscuity (Rizeq & McCann, 2023; SAMHSA, 2022), impulsivity, and substance use (Rizeq & McCann, 2023; SAMHSA, 2014b; SAMHSA, 2022); and difficulties connecting socially (Hughesdon et al., 2021; Subramaniam & Wuest, 2022), concentrating (Dodd et al.,

2023; SAMHSA, 2014a; SAMHSA, 2014b), and succeeding in the academic setting (NCTSN, 2017; Porche et al., 2016; SAMHSA, 2022). It is important to take note that these behaviors often are observed in the classroom setting, often presenting as social difficulties and problematic behaviors that continue despite interventions (Creswell Báez et al., 2019), and must be addressed by school staff daily (Ingersoll, 2001).

Definition of "Secondary Traumatic Stress"

Secondary traumatic stress is the resulting behaviors and emotions from being aware of trauma experienced by another and wanting to help alleviate this individual's suffering (Figley, 1993). The symptoms are nearly identical to post-traumatic stress disorder (Figley, 1995). It is often considered an unavoidable hazard of working with populations and individuals who have experienced trauma, particularly in high concentrations (Bell et al., 2003; Hallinan et al., 2019; White, 2006). Symptoms of secondary traumatic stress are similar to symptoms of trauma exposure and can present in many ways (Figley, 1995; Hydon et al., 2015; White, 2006). Physically, individuals may present with fatigue (Hydon et al., 2015), sleep disruption, somatic symptoms, low energy, difficulties breathing (Hydon et al., 2015; White, 2006), changes in appetite, or an impaired immune system (White, 2006). Emotionally, individuals may present with denial, guilt about not doing enough, feeling overwhelmed, feelings of fear, feelings of hopelessness, (Hydon et al., 2015), feeling numb or detached, anxiety, hypersensitivity, sadness or depression, powerlessness (Hydon et al., 2015; White, 2006), irritability, rage, anger, and a decreased sense of safety (White, 2006). Behaviorally, individuals may present with changes in routine, acting in a withdrawn manner, utilizing negative/unhealthy coping mechanisms, self-injurious behaviors, suicidality (Hydon et al., 2015), and having nightmares (Hydon et al., 2015; White, 2006). Cognitively, individuals may present with a diminished ability to concentrate,

difficulties with decision-making, decreased self-esteem, self-doubt, blaming others, experiencing trauma imagery (Hydon et al., 2015), and hypervigilance (Hydon et al., 2015; White, 2006). Interpersonally, individuals may present with physically withdrawing from others, becoming emotionally unavailable, a decreased interest in intimacy or touch, being impatient, mistrusting others, a projection of blame (Hydon et al., 2015), isolation (Hydon et al., 2015; White, 2006), and increased interpersonal conflict (White, 2006). Spiritually, individuals may present with questioning the meaning of life, a lack of self-satisfaction, anger toward a Higher Power, questioning religious/spiritual beliefs (Hydon et al., 2015), and the loss of a sense of purpose (Hydon et al., 2015; White, 2006). Professionally, individuals may present with putting forth poor work effort, low performance in tasks or responsibilities, low morale that affects relationships with other staff (Hydon et al., 2015), apathy, and low motivation (White, 2006).

The impacts of secondary traumatic stress can be reduced through education about trauma, secondary trauma, and trauma-informed care (Bell et al., 2003; Handran, 2015; White, 2006). Additionally, support from colleagues (Skaalvik & Skaalvik, 2011), the organization (Bell et al., 2003; Handran, 2015; Skaalvik & Skaalvik, 2011; White, 2006), and supervision (Bell et al., 2003; White, 2006) along with self-care practices (Bell et al., 2003) are helpful in reducing symptoms.

Clinical Treatment Modalities

Trauma and its effects are pervasive and detrimental to those affected and on society as a whole (Dorsey et al., 2017; McWey, 2020; SAMHSA, 2022). Although some youth will heal with time and natural supports, many will not and will require mental health treatment (SAMHSA, 2022). There are a number of evidence-based and emerging treatment options available for those experiencing traumatic stress symptoms (Dorsey et al., 2017; McWey, 2020;

SAMHSA, 2022) with the effectiveness varying based on the individual, when it is provided, and the traumatic experience (National Child Traumatic Stress Network, 2003). These treatment modalities will be explored further in the following subsections.

Trauma-Focused Cognitive Behavioral Therapy & Cognitive Behavioral Therapy (TF-CBT & CBT). In trauma-focused cognitive behavioral therapy and cognitive behavioral therapy aimed at reducing traumatic stress symptoms, trained mental health professionals utilize several approaches to work with clients. These approaches include teaching stress management and relaxation skills to minimize sensation related to the trauma, utilizing exposure techniques or talking about the traumatic experience and related feelings, creating a narrative related to the experience to help the individual begin to process and master their feelings, correcting distorted views and untrue beliefs about and as a result of the experience, and many involve the youth's caretakers and contain a component that educate them about caring for the traumatized youth (Children's Bureau, 2018; Cohen & Mannarino, 2015; Dorsey et al., 2017; Lenz & Hollenbaugh, 2015; Lewey et al., 2018; McWey, 2020; National Child Traumatic Stress Network, 2003; Peters et al., 2022; SAMHSA, 2014b; Stewart et al., 2021; Walker et al., 2021). TF-CBT and CBT can be provided at the individual level, to the individual and a non-offending caretaker, or at the group level, as well as in conjunction with other treatment modalities (Dorsey et al., 2020; McWey, 2020). TF-CBT and CBT are considered well-established, evidence-based treatment modalities for trauma reactions for adolescents and school-aged children (Dorsey et al., 2017; Hoogsteder et al., 2022; McGuire et al., 2020), probably efficacious for preschool-aged children (McGuire et al., 2020), and slightly more effective than eye-movement desensitization and reprocessing by some (Lewey et al., 2018) but not others (Hoogsteder et al., 2022). It is important to note that other studies argue that, although TF-CBT appears to be promising with

the adolescent population, more studies should be conducted (Peters et al., 2021). Similarly, a cognitive behavioral therapy group program targeting adolescent students who scored high on the Children's Revised Impact of Events Scale living in areas that resulted in ongoing exposure to violence was determined to be successful but requiring more further studies (Barron et al., 2013).

Eye Movement Desensitization and Reprocessing Therapy (EMDR). Eye movement desensitization and reprocessing therapy is a structured, phased form of treatment in which the goal is to assist the patient in reprocessing a traumatic event. EMDR is completed by trained practitioners that are required to be licensed mental health professionals with a minimum of two years of clinical experience who have undergone specialized training, although it is recommended that they also pursue clinical hours and professional consultation to obtain an EMDR certification (Rapid Transformational Therapy, 2023). Treatment goals are achieved by helping the patient relive the event in a non-threatening manner so that the event can be stored and assimilated in a more functional and healthy manner in the memory (Civilotti et al., 2021) through relaxation techniques and moving their eyes rapidly while focused on the traumatic memory (Lewey et al., 2018; SAMHSA, 2014b). This treatment can be modified so that it is effective with children and adolescents and is considered an effective treatment modality (Lewey et al., 2018), although larger studies are recommended to determine if the results can be replicated (Civilotti et al., 2021). This aligns with other studies which have found EMDR to be probably efficacious (Dorsey et al., 2017). It is important to note that Hoogsteder et al. (2022) found that EMDR was equally as effective in reducing trauma symptoms and externalizing behaviors as was TF-CBT.

Prolonged Exposure Therapy. Another treatment modality found to be effective at reducing distress and increasing functioning in adolescents experiencing post-traumatic stress disorder symptoms is prolonged exposure therapy (Gilboa-Schectman et al., 2010; SAMHSA, 2014b). Prolonged exposure therapy is a form of cognitive-behavioral therapy which involves psychoeducation, in vivo exposure, imaginal exposure, revisiting the memory of the trauma, and homework assignments (Gilboa-Schechtman et al., 2010; van Minnen et al., 2012). Despite evidence that prolonged exposure therapy is effective at treating PTSD and post-traumatic stress symptoms, a downfall of this therapy is length of treatment as this can be a barrier to individuals due to time, costs, and other constraints (Booysen & Kagee, 2021). As such, steps have been taken to modify the course of treatment to shorten the programming into a more condensed version- brief prolonged exposure therapy- increasing access to the service (Booysen & Kagee, 2021). It was found in their study in South Africa that participants, even with complicating factors, had a reduction in PTSD symptoms after participating in this brief prolonged exposure therapy (Booysen & Kagee). Another reason that prolonged exposure therapy is not used rather than traditional TF-CBT is the concern that it could exacerbate PTSD or comorbid symptoms rather than help (van Minnen et al., 2012; SAMHSA, 2014b). Research shows that this form of treatment can typically be used safely, although it is recommended that it not be utilized with patients whose depressive symptoms are more severe than their PTSD symptoms or with those who have current suicidal ideations or behaviors until these other symptoms and behaviors are stabilized via alternate treatment methods (van Minnen et al., 2012).

Critical Incident Stress Debriefing (CISD). Immediately after a crisis event, some mental health professionals provide critical-incident stress debriefing, or critical incident stress management (Hughes, 2006; Plaggemars, 2000; SAMHSA, 2014b). The tenet behind this form

of brief treatment is the belief that allowing survivors to express their thoughts and feelings about their experiences as soon as possible after the event, typically in a group setting, will provide some relief and resolution about what occurred to prevent longer-term symptoms (Brandell & Ringel, 2019; Plaggemars, 2000; SAMHSA, 2014b). This brief treatment was created within the framework of a western majority culture and, although it is flexible, does not take into complicating factors including historical and ongoing trauma or racial and cultural dynamics that are different, and without a high level of cultural competence and consideration, may not be effective in all communities (Hughes, 2006). Studies have shown that there is no evidence that this this form of treatment is effective and that, in fact, individuals who chose not to engage in this discussion fared better in the long-term than those who chose to participate in the debriefing (Brandell & Ringel, 2019).

Mindfulness. Mindfulness is the practice of being present in the moment and paying attention to that moment with an open mind and without judgement (Kabat-Zinn, 1994; SAMHSA, 2014b). Although mind-body skills, group and individual, were determined to still be at the possibly efficacious and experimental levels respectively in one meta-analysis (Dorsey et al., 2017), teaching mindfulness skills to trauma-exposed youth, particularly in the school setting, is still recommended to help strengthen their mental health (Walker et al., 2021). A systematic review determined that mindfulness practices are considered safe but further research should be conducted to confirm these findings (Wong et al., 2018). A study conducted by Malboeuf-Hurtubise et al. (2021) found that mindfulness practices reduced mental health symptoms in elementary school students and could be implemented via a virtual platform effectively. It is also important to note that mindfulness is contraindicated with some populations and was found to be more harmful to those with pre-existing mental health conditions than

traditional social-emotional learning training programming (Kuyken et al., 2022; Miller et al., 2023).

Trauma-Informed Practices

Trauma-informed practices, or trauma-informed care, are services provided to a client or client population that takes into consideration the broad impact of trauma and potential for recovery, recognizes the signs and symptoms of trauma, and responds to these by integrating knowledge about trauma into policies, procedures and practices while actively striving not to retraumatize (Mersky et al., 2019; SAMHSA, 2014a). Trauma-informed practice spans the entire time that an individual works with an agency-from walking in the door through discharge- and should be part of every encounter with every staff member (SAMHSA, 2014b). Engaging in this practice is a mindset shift from seeing behaviors as a problem to seeing behaviors as adaptations to traumatic experiences and symptoms of something larger (SAMHSA, 2014a).

SAMHSA (2014a) suggests four "R's" to help remember the main points in trauma-informed practices. These include realization, recognition, response, and resistance (SAMHSA, 2014a). They argue that in trauma-informed practices individuals and agencies must have a basic realization about trauma and how trauma affects individuals, groups, families, communities, and organizations. This includes the potential resulting behaviors, mental health symptoms, and health conditions, and how trauma can impact the treatment process (SAMHSA, 2014a). SAMHSA (2014a) also stresses the importance of providers recognizing the signs of trauma and how these signs may present differently in individuals, cultures, and populations. Screenings may assist with identifying trauma (Griffin et al., 2011; SAMHSA, 2014a; SAMHSA, 2014b). Individuals and organizations should then respond in a trauma-informed manner at all levels and take into consideration their practices and policies to determine if they are trauma-informed or

could potentially be unintentionally retraumatizing (SAMHSA, 2014a). Training should be provided as needed to ensure that all staff are knowledgeable and able to provide trauma-informed care (SAMHSA, 2014a). When engaging in practice, attempts must be made to resist re-traumatization of the client and the staff (SAMHSA, 2014a; SAMHSA, 2014b). This is done by being aware of language, safety, cultural practices, and body proximity, being trustworthy and transparent, giving clients a voice and opportunities for peer support, and other such factors and considerations (SAMHSA, 2014a; SAMHSA, 2014b).

Factors Affecting the Use of Trauma-Informed Practices in the Field. Despite previously mentioned arguments that embedding trauma-informed practices within organizations and daily practices benefits clients and practitioners, there is evidence that doing so does not always happen quickly or smoothly. In work with individuals experiencing homelessness or who were at risk of experiencing homelessness, barriers to implementing trauma-informed practices included availability and access to supports and services, time, and resources in an online survey of 91 staff and administrators (Crawford, 2022), and training not being a panacea for all areas in a pre- and post-test study of trauma-informed practices involving 88 participants (Burge et al., 2021). A qualitative study of four participants interviewed until the point of saturation regarding child welfare involvement with trafficked mothers found that staff burnout was a major barrier to the use of trauma-informed practices as staff were too disengaged to take the time to listen to clients and to connect (Stoklosa et al., 2022). It was also found in the field of social work research that differences between researchers and participants could be a barrier to the use of trauma-informed practices due to difficulties establishing and maintaining trust and a sense of safety while still empowering participants and showing genuine empathy in Voith et al.'s (2020) case study involving 54 low-income, predominantly African American males in the criminal

justice system. It is easy to assume that this could translate into a barrier in direct practice as well. In an Australian mixed-methods study with 24 front line clinicians regarding the use of trauma-informed practices in a multidisciplinary health setting, it was found that barriers to the use of trauma-informed practices included limited training about trauma-informed practices and vicarious trauma in addition to accessing ongoing professional development, high levels of stress related to workload pressures, the challenge of working with clients with complex trauma with specified timeframes, funding, recruitment, and staff well-being/self-care (Lovell et al., 2022).

However, Burge et al. (2021) did find that training showed growth in some areas of trauma-informed care, and it is a useful tool, if not the only tool to encourage improvement in practice. Also, Crawford (2022) found that the smallest agency in their study with a low amount of funding showed the highest amount of trauma-informed practice use, indicating that high accountability and the use of staff training of colleagues is a positive factor for trauma-informed practice utilization. Also, agencies with funding specifically allotted for trauma-informed care training and high oversight and accountability were found to also score high in trauma-informed care use (Crawford, 2022). Lovell et al. (2022) found that staff reported that trauma-informed care resulted in good client outcomes and was aligned with the teachings and professional beliefs of staff.

Trauma-Informed Practices in the School Setting. Schools are uniquely positioned to incorporate trauma-informed practices due to a nationwide push to implement strategies to improve school safety, such as trauma-informed practices (Duffy & Comly, 2019). This push includes Pennsylvania's 2018 Act 44 which requires schools to provide at least three hours of trauma-informed education to staff every five years (Pennsylvania General Assembly, 2018). Schools provide an opportunity for early screening and intervention, which are both shown to be

beneficial in improving symptoms and long-term outcomes (Gonzalez et al., 2015; Rishel et al., 2019; Woodbridge et al., 2016). Schools also already have programming in place that can easily be modified to incorporate trauma-informed practices without adding anything additional to the day or onto staff's already heavy workload. Such programming includes the multi-tiered systems of support, restorative practices, and social-emotional learning practices which will be described in detail in the following subsections. Despite the importance of incorporating trauma-informed practices in the school setting, some barriers to doing so have been identified. These barriers include issues surrounding staff and administrative support (Martin et al., 2021; Parker et al., 2021), prioritization of other responsibilities, stigma related to mental health, language, and cultural barriers (Langley et al., 2013), and staff training needs (Anderson et al., 2015; Martin et al., 2021).

Multi-Tiered Systems of Support (MTSS). A multi-tiered system of support is a universal schoolwide system of supports that is divided into three tiers based on levels of needs spanning low, moderate, and high, with the low level of supports being provided at a school-wide level (Chafouleas et al., 2016; Kelly et al., 2010). Many school systems already have an MTSS program in place for academic and behavioral needs, and as such, it is not a big leap to incorporate the trauma-informed concepts into this programming. However, to do so effectively, it is imperative that schools build their capacity to meet students' needs appropriately and not to simply refer them through the special education process; not all trauma reactions warrant special education services (Gherardi et al., 2021).

Tiered trauma-informed practices in schools include tier 1 universal, preventative practices such as creating a safe environment for students, SEL programming, professional development about trauma for staff (Gee et al., 2020), universal screenings (Pincus et al., 2020),

disciplinary policies, and parent/caregiver engagement (Duffy & Comly, 2019), and increasing protective factors (Zyromski et al., 2022). Tier 2 interventions, provided to students who are known to have experienced trauma and are exhibiting some symptoms (Gee et al., 2020), may include group or individual CBT programming at a lower intensity, and tier 3 interventions, provided to students who are considered to be the highest need (Gee et al., 2020), may include group or individual CBT programming at a higher intensity or referrals to community mental health professionals and supports (Duffy & Comly, 2019; Gee et al., 2020; Pincus et al., 2020). It is important to note that two systematic reviews of trauma-informed care interventions in the school setting found that interventions are predominantly offered at the tier 2 level (Ding et al., 2023; Stratford et al., 2020), with a third review finding that most services being offered at the group or individual level, indicating tier 2 or tier 3 (Herrenkohl et al., 2019).

Restorative Practices. Like trauma-informed practices, restorative practices are more of a mindset shift than actual practice. Restorative practices in the school setting are defined in Australia as:

> …creating and nurturing meaningful and just relationships… Restorative Practice helps us recognise our inherent connections to one another and our communities. Good quality relationships between students, teachers, school leadership and other staff humanise the classroom and help create an effective learning environment. Restorative Practice is a way of being, thinking, interacting, teaching and learning – with relationships at the centre of all we do, every day. (Restorative Schools Australia, n.d.).

Restorative practices are multi-tiered and focused on building, maintaining, and rebuilding relationships within a school community (Joseph et al., 2020; Restorative Schools Australia, n.d.) through the use of group discussions held in a circle format or one-to-one (Joseph et al., 2020).

These meetings are utilized to discuss and resolve problems, discuss questions, obtain feedback from a group, establish relationships through conversations and games, and can even be utilized to discuss academic topics (Costello et al., 2019a). Restorative practices address behavioral and disciplinary issues in a manner that does not exclude students or shame them, but helps them learn, repair relationships, and be reintegrated into their school community in a welcoming manner while learning important social skills, gaining a voice and learning self-efficacy, and developing healthy attachments (Costello et al., 2019b; International Institute for Restorative Practices, 2014; Sedillo-Hamann, 2022). Restorative practices are an alternative to exclusionary zero-tolerance policies, found to fuel the school-to-prison pipeline (DiClemente, 2021; Sedillo-Hamann, 2020), that is more equitable (Protonentis et al., 2021; Sedillo-Hamann, 2020), encourages social justice (Gherardi et al., 2021), and is aligned with social work ethics (NASW, 2021).

Social-Emotional Learning (SEL). The Collaborative for Academic, Social, and Emotional Learning defines this concept, often utilized in schools as:

> the process through which all young people and adults acquire and apply the knowledge, skills, and attitudes to develop healthy identities, manage emotions and achieve personal and collective goals, feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions (CASEL, 2020, p. 1).

Because traumatic events affect the way children regulate their emotions (Presnell, 2018) and connect socially (Hughesdon et al., 2021; SAMHSA, 2014a; SAMHSA, 2014b; Subramaniam & Wuest, 2022), teaching them skills to offset these impacts is important to their success in both the academic setting and larger society (Flanagan & Rodriguez, 2021; Gherardi et al., 2021). Social-emotional learning in the school setting is a tier 1 intervention that can, and often is, provided to

all students that can be modified to incorporate trauma-informed concepts (Mendelson et al., 2020; Pawlo et al., 2019). To do so, it is necessary to consider the emotional stability of the adults in the school setting as these are the individuals who are expected to form safe and stable relationships with their students while teaching and demonstrating healthy emotional regulation (Pawlo et al., 2019). It is necessary for staff to be and feel supported so they can maintain their own emotional health and remain engaged in supporting students (Walker, 2023). Staff also must be trained and knowledgeable about what they are expected to teach to students, particularly when working with a trauma-exposed population. In a study conducted by Flanagan and Rodriguez (2021), many school staff being asked to provide SEL programming to trauma-exposed students reported needing more education about providing support to their students. These same study participants reported a lack of time and a need for more training as barriers to implementing trauma-informed SEL in their classrooms (Flanagan & Rodriguez, 2021).

Trauma-informed SEL programming is also strengths-based, allowing students to become more resilient (Pawlo et al., 2019). Finally, trauma-focused SEL programming, like all SEL programming, teaches students to identify and talk about their emotions and practice age-appropriate social and emotional skills with assistance from staff (Flanagan & Rodriguez, 2021; Mendelson et al., 2019; Pawlo et al., 2019; Walker et al., 2021). In addition to lessons, programming may include mindfulness (Mendelson et al., 2020; Walker et al., 2021), calm spaces (Walker, 2023), and grounding activities (Presnell, 2018).

Cognitive Behavioral Intervention for Trauma in Schools (CBITS). The most clinical form of trauma-informed practice offered in the school setting is the Cognitive Behavioral Intervention for Trauma in Schools program, a modified version of TF-CBT that is provided by trained school mental health professionals, such as a school social worker, to students exhibiting

trauma reactions (Dutil, 2019; Jaycox et al, 2012). This program includes a combination of group, individual, and parent sessions as well as educational sessions for the students' teachers (Jaycox et al., 2012). This form of treatment has been found to be effective and beneficial to both students and the overall learning environment (Allison & Ferreira, 2017; Dutil, 2019; Hoover et al., 2018). It is important to consider, however, that there are noted barriers to providing clinical interventions in the school setting that include funding, a lack of space, concerns about confidentiality (Dutil, 2019), time and caseload size (Teasley et al., 2012), a lack of administrative support, and a heavier focus on academics than on student mental health (Nadeem et al., 2018).

Screening. In addition to providing services to students, school staff are able and recommended to screen students for trauma exposure (Gonzalez et al., 2015; Rishel et al., 2019; SAMHSA, 2014a; SAMHSA, 2014b; Woodbridge et al., 2016). Universal screening of students is considered a tier 1 intervention that can help determine a need for a higher level of intervention (Pincus et al., 2020). Of concern, though, is that although many tools exist to assess children's trauma experiences and resulting symptoms, few standardized tools exist to allow for early adolescent self-reporting on these topics (Woodbridge et al., 2016).

Trauma-Informed Mindset Based Programming. In addition to specific trauma-informed programming in the school setting, school staff also can implement broad programming into their practices. These broader programs are often multi-tiered, incorporate a variety of trained staff, and are based on the earlier mentioned forms of trauma-informed practices in schools (Presnell, 2018; Somers & Wheeler, 2022), some used in settings with limited access to formal mental health staff (Arnold et al., 2020). The focus of this broader, trauma-informed mindset in the school setting is on responding to students in an empathetic

manner, even when they are displaying difficult and problematic behaviors (Thomas et al., 2019). The mindset shifts from “what is wrong with you?” to “what is happening with you?” to lead to what is being seen right now (Thomas et al., 2019).

One such program is the RAP (Relax, Be Aware, and do a Personal Rating) Club which is led by a trained staff member and community member and integrates mindfulness, cognitive behavioral therapy skills, and psychoeducation about the effects of trauma and stress (Arnold et al., 2020; Mendelson et al., 2020; Shepardson et al., 2016). This program was seen as a proactive way to help students learn skills to manage their own stress (Arnold et al., 2020) but there were found to be some issues with retention in the programming (Mendelson et al., 2021).

Another program in the literature was a social-emotional learning program that partnered a school district with a local community-based organization to help build social capital and added staff education and supervision (Creswell Báez et al., 2019). Despite mixed findings, once the effects of trauma were considered, positive changes were seen in those with lower reported trauma exposure. Levels of trauma exposure were divided into low, moderate, and high categories that were determined via Adverse Childhood Experience scores per self-report survey results (Creswell Báez et al., 2019). The researchers suggested that a longer period of time or higher levels of support may be necessary to see positive results in those with greater levels of trauma exposure (Creswell Báez et al., 2019). Similarly, the S.I.T.E. Framework (Lohmiller et al., 2022) and TIES (Trauma-Informed Elementary Schools) program (Rishel et al., 2019) train school staff through outside agencies then provide services to students through tiered programming, which may include referrals for mental health services in the community.

Gaps in the Literature

Missing from the literature is information regarding evidence-based methods of educating staff on how to engage in effective trauma-informed practices and when this training is necessary. Recommendations are made about the necessity of trauma-informed practices in schools (Chafouleas et al., 2016; Gonzalez et al., 2015; Pawlo et al., 2019; Pincus et al., 2020; Rishel et al., 2019) and for the training of staff (Duffy & Comly, 2019; Gee et al., 2020; Johnson, 2019; NASW, 2012; NASW, 2021; PA General Assembly, 2018; Schoonmaker, 2022; Zakzewski et al., 2017), but little to no mention is made regarding how to do so to best meet staff's needs. There are also questions as to whether this training is effective in increasing knowledge and ability to work with students who have experienced trauma effectively (Sonsteng-Person & Loomis, 2021).

How to maintain the momentum of programming and staff buy-in once programming is started is also missing from the literature. New programs are exciting and fresh, but once they have been in place for a period of time, it is easy for staff and students to fall into routine and for these programs to no longer be implemented with fidelity. It is necessary to obtain more information regarding staff attitudes about and beliefs about the feasibility of implementing and maintaining strong trauma-informed programming within the school systems (Overstreet & Chafouleas, 2016) and the long-term sustainability of these programs (Gonzalez et al., 2016). If programming is not implemented thoroughly, correctly, and consistently, it will not be effective.

There is also little written about working with subpopulations and cultural responsiveness (Stratford et al., 2020). This includes meeting the specific needs of a community rather than using a generalized script or program intended for a generic audience that is not sensitive to unique situations or traumas (Stratford et al., 2020; Wong et al., 2016).

Summary

The fields of trauma and trauma-informed practices have continued to grow and branch into specialized fields of study since the time of Charcot, Janet, Freud, and Breuer. Although this field has come a long way from believing that hysteria was a condition of the uterus, there is an infinite amount of knowledge still unknown about the implications of trauma on humans and how to prevent and treat these effects. The school system, though vast, is only one of many areas yet to be fully understood in terms of its role in helping youth affected by trauma. The aim of this study is to add to the field by determining the current state of trauma-informed practice used by school social workers in Pennsylvania public schools and what factors may be affecting this use.

Chapter 3- Methodology and Research Approach

The aim of this study was to explore the status of trauma-informed practices in Pennsylvania public school systems by examining school social workers' preparation for utilizing trauma-informed practices and delivery of trauma-informed practices in the school setting. These topics were explored through an online survey distributed via e-mail containing twenty-five questions and two virtual focus groups based, primarily, on the results of the survey tool, to help determine current needs and guide future direction in implementation planning. This study examined the following four research questions:

> R $_{1.1}$: What is the perceived level of preparedness of school social workers' use of trauma-informed practice?

Utilizing mixed methods explained in greater detail in Chapter 5, this researcher hoped to determine what factors are related to school social workers' preparedness to utilize trauma-informed practice, specifically whether they have been taught about trauma-informed practices. Of interest was how and at what level this learning took place. Quantitative data was analyzed utilizing univariate and bivariate statistics. Qualitative data was analyzed utilizing

thematic analysis. In doing so, data from focus groups was transcribed, coded and recoded utilizing a combination of open and focused coding (based on themes that emerged from survey results) until themes emerged and could be analyzed (Belgrave & Seide, 2019) then compared and analyzed alongside survey data to further understand this topic (Burke Johnson & Walsh, 2019).

H $_{1.1}$: Levels of preparedness will vary with newer social workers having a higher perceived level of preparedness to utilize trauma-informed practices than those who have been in the field longer.

H $_{0.1}$: There is no relationship between school social workers' time in the field and perceived level of preparedness to utilize trauma-informed practices.

R $_{1.2}$: Are there any relationships between identified factors in the work setting and the use of trauma-informed practices by school social workers?

Utilizing cross-tabulation analysis, specifically utilizing Pearson's chi-square and a significance level of 0.05, this research question examined the various factors that may be encouraging or inhibiting the use of trauma-informed practices by school social workers in the public-school setting. Consideration was given to the idea that trauma-informed practices may not be used at all, but what is important is the "why" the practice is or is not being used, although what form and the frequency was also being examined.

H $_{1.2}$: Identified factors in the work setting will have a relationship with the use of trauma-informed practices by school social workers.

H $_{0.2}$: Identified factors in the work setting will not have a relationship with the use of trauma-informed practices by school social workers.

R $_{1.3}$: Is there a relationship between education about trauma-informed practices and the use of trauma-informed practices by school social workers?

Using the same methods as in R $_{1.2}$, this research question continued to explore the factors that may be encouraging or inhibiting the use of trauma-informed practices by school social workers in the public school setting.

H $_{1.3}$: There is a relationship between school social workers' education related to trauma-informed practices and their use of trauma-informed practices.

H $_{0.3}$: There is no relationship between school social workers' education related to trauma-informed practices and their use of trauma-informed practices.

R $_{1.4}$: Is there are relationship between identified factors and participants' expressed interest in more training related to trauma-informed practices?

After information was obtained about previous education and training and current use of trauma-informed practices, it was important to understand how school social workers view this practice's future. Following the same methodology as described in the earlier research questions, this question aimed to gain a better understanding of study participants' expressed interest in engaging in professional development and what factors may influencing their ability to do so, so that one could more easily make recommendations for future planning and research in this field.

H $_{1.4}$: There is a relationship between identified factors and participants' interest in engaging in further professional development regarding trauma-informed practices

$H_{0.4}$: There is no relationship between identified factors and participants' interest in engaging in further professional development regarding trauma-informed practices.

This chapter outlines and operationally defines the main concepts, independent and dependent variables, and attributes of the study, participant selection, data collection methods, methods of analysis, and methods for controlling threats to the validity of this mixed methods study.

Variables

In this section, the variables examined are discussed. Due to the nature of this study, there are many factors that must be considered as variables. The dependent variables include trauma-informed practices and continuing education. The independent variables include demographic information, professional experience, level of preparation and education, district setting, and factors affecting the use of trauma-informed practices. Based on the level of measurement of the variables of the study, appropriate data presentation and analysis techniques were employed. These techniques primarily included frequency distributions, measures of central tendency and dispersion, crosstabulations, and non-parametric tests. This is described in greater detail in Chapter 4.

Dependent Variables

The dependent variables considered were based on the research questions being posed. These variables included the use of trauma-informed practices by school social workers and continuing education.

- Use of Trauma-Informed Practices: This variable measured what methods of evidence-based trauma-informed practices are being utilized by participants across the state and factors that may be affecting this use.

    - Methods of Trauma-Informed Practices: Included methods, in addition to the open-ended "other" option, included trauma-focused cognitive behavioral therapy (Dutil, 2019; Jaycox et al., 2012), Restorative Practices (Joseph et al., 2020; Restorative Schools Australia, n.d.), trauma-focused social-emotional learning programming (CASEL, 2020; Fondren et al., 2019; Mendelson et al., 2020; Pawlo, 2019), trauma-focused multi-tiered systems of support (Chafouleas et al., 2016; Kelly et al., 2020), and a general trauma-focused mindset/the use of trauma-focused language (Presnell, 2018; Somers & Wheeler, 2022; & Thomas et al., 2019).

- Continuing Education: This variable measured what participants' interests and needs regarding trauma-informed continuing education and training are. It is important to understand what current needs are to continue improving the state of trauma-informed practices and because higher levels of training and knowledge about trauma-informed practices have been linked to more positive attitudes about utilizing trauma-informed practices (Orapallo et al., 2021). This was measured because arguments are being made about the necessity of this training (Hydon et al., 2015; Lawson et al., 2019; Menschner & Maul, 2016) and higher levels of training and knowledge about trauma-informed practices have been linked to more positive attitudes about utilizing trauma-informed practices (Orapallo et al., 2021) and improved services to students (Brunzell et al., 2021). Higher levels of training and understanding also decrease the impacts of secondary traumatic stress on staff (Bell et al., 2003; Brunzell et al., 2021; Handran, 2015; Parker & Henfield, 2012). Considered were participants' training interests and needs, including the methods of training that participants desire.

Independent Variables

The independent variables considered in this study included demographic information, professional experience, and level of preparation and education. Independent variables considered included:

- Demographic Information:
    - Gender Identity: This category inquired about participants' gender identities. In an effort to be inclusive, this question was posed in an open-ended manner and responses were combined as appropriate during the cleanup and coding portion of data analysis.
    - Age: This category inquired about participants' ages again utilizing an open-ended question. Responses were combined as appropriate during the cleanup and coding portion of data analysis.
    - Racial and Ethnic Identity: This category inquired about participants' racial and ethnic identities utilizing an open-ended question. Responses were combined as appropriate during the cleanup and coding portion of data analysis.
- District Setting: This category was designed to obtain information about participants' school districts including the region in which they are located, determined by the Pennsylvania Department of Education (2023a), and their school locale classification, also determined by the Pennsylvania Department of Education, including urban, suburban, and rural (2023c). It is argued that students living in low-income rural areas experience higher levels of exposure to trauma and struggle to access supportive services than those living in other areas (Shaw, 2022). However, it is also argued that staff working in urban districts face high levels of stress that impact their mental health and

ability to perform their job (Camacho et al., 2020) as a result of student exposure to poverty, community violence, and discrimination (Borg et al., 2021; Shernoff et al., 2011). Additionally, it is argued that students living in low-income communities, such as those often seen in urban and rural areas, were impacted more significantly by the COVID-19 pandemic, compounding existing trauma reactions (Brunzell et al., 2021). Students living in poverty are at higher risk of experiencing trauma and exhibiting signs and symptoms in the school setting (Johnson, 2019; Milam et al., 2010), leading school staff to be on the front lines of supporting these students and risking secondary traumatic stress symptoms (Balbuena, 2021; National Education Association, 2016; Shaw, 2022).

- Level of Preparation: This category examined how school social workers have been exposed to education regarding trauma-informed practices and how well it prepared them to actually utilize their skills in this area. It is necessary for staff to feel confident in their ability to provide trauma-informed care to their students adequately and safely (Menschner & Maul, 2016). Professional self-efficacy has also been found to be a protective factor against burnout and secondary traumatic stress (Fleckman et al., 2022; Nygaard et al., 2017).
- Professional Experience: This category was designed to consider factors involving school social workers' experience as professionals and, more specifically, school social worker professionals. These factors include level of education, type of social work licensure and length of time this license was held, length of time practicing in school social work, whether participants hold the PK-12 School Social Worker Educational Specialist Certificate, information about participants caseloads, and what tasks participants spend most of their time fulfilling. It is important to note here that there is some evidence

indicating that that job role overload can lead to stress and burnout in school staff (Cooper et al., 2022), and as earlier noted, high stress levels and burnout can affect the likelihood that staff will utilized trauma-informed practices (Lovell et al., 2022; Stoklosa et al., 2022). Additionally, prioritization of other responsibilities over trauma-informed practices in the school setting has been found to affect the use of trauma-informed practices (Langley et al., 2013).

    - Years of school social work experience: This category considered how many years the participant has been working within a school social work position. This is important to consider as there is some evidence that staff new to the field have not yet had the experience to develop the resilience necessary to effectively cope with clients' traumas, but it can be learned (Cox & Steiner, 2013) and they need time to develop necessary skills (Parker & Henfield, 2012), while more tenured staff reported higher levels of positivity and self-efficacy in another study (Camacho et al., 2020).
    - Case Load Size: This category considered approximately how many students each participant is responsible for providing services to within the school/district setting. There is some evidence that case load size can impact staff stress level and reduce staff's ability to effectively provide adequate services to students (Caringi et al., 2015) and that job role overload can lead to high levels of stress and burnout (Cooper et al., 2022) and directly affect whether staff will choose to implement trauma-informed practices (Lovell et al., 2022).

- Factors Affecting Trauma-Informed Practice Use: This category was designed to measure various factors that may affect school social workers' use of trauma-informed practices.

Factors considered included administrative support, preparation, knowledge and self-efficacy, and attitudes about trauma-informed practices. Prior research has shown that administrative support (Martin et al., 2021; Parker et al., 2021), staff beliefs about trauma-informed practices (Lovell et al., 2022), and quality of training (Anderson et al., 2015; Crawford, 2022; Lovell et al., 2022; Martin et al., 2021) have been found to affect social workers' use of trauma-informed practices in various fields of practice.

Rationale for Research Design

A research design was utilized for this study in order to both cast a wide net to obtain a large amount of data to analyze quantitatively (Hutchinson & Chyung, 2023) while also holding focus groups to provide clarity and to add a level of richness and depth to the results through qualitative analysis (Aresi et al., 2017; Epp et al., 2022). Mixed methods research allowed the researcher to obtain and analyze both quantitative and qualitative data, in this case from the same pool of participants, (Creswell, 2009), aligning with Greene et al.'s (1989) seminal concept of "complementarity." They suggest that, at times, utilizing mixed methods allows researchers to use the different styles of research to clarify and enhance the data obtained from another (Greene et al., 1989). In doing so, a set of checks and balances is set up to see if the data from the quantitative and qualitative portions of the study corroborate or negate one another (Rubin & Babbie, 2017), similar to Greene et al.'s (1989) idea of "triangulation," in which information from one portion of a study is used to either corroborate information from the other or to show discrepancies that may exist. The utilization of a mixed methods study allows for methodological triangulation (Flick, 2019). A solely qualitative study was not appropriate at this time as this is an early exploratory study and a wide rather than deep view was desired (Blazejewski, 2021; Creswell & Poth, 2018)

An online survey was utilized to reach as many participants as possible without adding additional stress or burden to their day. Despite the historically low response rates on online surveys (Creswell, 2009; Rubin & Babbie, 2017), it was believed that the ease of this format for participants would encourage participation despite the heavy workload placed upon school social workers and would provide more consistent and reliable results than telephone interviews (Thyer, 2010). It is important to point out that it was not believed that utilizing an online format would not add any undue hardship or add any additional barriers due to the population being included in the study, a risk noted by Creswell and Poth (2018). Due to their employment status and the utilization of work e-mail addresses to reach potential participants, it was likely that these individuals would have access to the necessary technology and the ability to read the documents provided.

Additionally, two focus groups were held via an online platform (Zoom) to encourage participation from a wider pool of participants across the state in a time and cost-effective manner (Creswell & Poth, 2018). Focus groups were chosen rather than individual interviews to encourage interactions between participants to obtain a richer understanding of their experiences (Krueger & Casey, 2014; Morgan, 1997; Peek & Fothergill, 2009) while also enhancing the idea of safety and community among a group of somewhat homogeneous peers based on their shared work experience as school social workers (Epp et al., 2022; Madriz, 1998; Peek & Fothergill, 2009). These interactions allowed participants to express differing opinions and to explore and elaborate on similar experiences they may have had (Rossman & Rallis, 2003). This online platform allowed individuals to participate from a location of their choice without needing to travel and limits the disruption to their day (Epp et al., 2022). Consideration was given, though,

to limits that could be created by the online environment including disruptions in internet connectivity and difficulty observing body language (Epp et al., 2022).

The combination of a Likert scale-based survey, allowing a broader range of responses from participants than yes or no questions (Rubin & Babbie, 2017), and open-ended focus group questions allowed this researcher to obtain a broad understanding about the factors contributing to social workers' knowledge about and use of trauma-informed practices then obtain more details about the actual use of trauma-informed practices in the field, similarly to the way this method was utilized in a study by Chokshi and Goldman (2021) in their measurement of knowledge and use of trauma-informed practices.

Survey Tool

A survey tool titled, *Practices and Preparation of Public School Social Workers in Pennsylvania,* was created for this study by this researcher. This 25-question tool was designed to measure factors possibly affecting the use of trauma-informed practices by school social workers in Pennsylvania and factors possibly affecting the accessibility of and interest in continuing education, specifically related to trauma-informed practices. Questions were created from the information garnered through an extensive literature review related to trauma-informed practices and trauma-informed practices in the school setting.

A pilot study of the survey tool was conducted with a small sample of eight participants recruited via e-mail (see Appendix A for pilot recruitment email). The pilot survey was completed to determine instrument validity, construct validity, face validity of the questions posed, readability of the tool, and timing. The pilot survey is available in Appendix B. The pilot sample included both school social workers and social workers engaged in academic research.

Due to time constraints, this researcher was unable to conduct cognitive interviews in which participants are interviewed about how they may answer questions in the survey to determine how questions are processed and understood by potential participants (Lee et al., 2021). However, when the pilot survey was conducted, open-ended questions were included to include some of the aspects that would have been captured by cognitive interviewing and to help determine a basic level of construct validity (Lee et al., 2021). The limited size of this study makes it necessary for further testing to truly determine construct, or content, validity at this stage to be confident that concepts are being fully examined (Field, 2018; Rubin & Babbie, 2017). However, face validity can be assumed at this point based on the feedback provided indicating that the questions do in fact ask what this researcher was hoping to study (Rubin & Babbie, 2017; Thyer, 2010). The pilot study included all recruitment and study material intended to be utilized in the final study to determine if the burden on participants was reasonable, how long the survey tool was expected to take, and if there were any issues that could be resolved early in the process (Lee et al., 2021; Rothgeb, 2008; Ruel et al., 2016; Schreiber, 2008).

It was determined through pilot testing that the survey tool could be completed within the anticipated 15-minute time frame with ease, with the average time to complete taking approximately 9 minutes. Suggestions were made to streamline the appearance and flow of the tool and these suggestions were incorporated. Typos were pointed out and corrected. Finally, it was requested that more detail be provided in sections regarding tasks and scales and these suggestions were incorporated where appropriate and technologically feasible.

Research Setting

This research was conducted in the Commonwealth of Pennsylvania's public school system comprising 500 public school districts ranging in size from about 200 to over 140,000

students (PDE, 2023a). These districts are categorized into six regions across Pennsylvania based on their physical location: South Central, Central/North Central, Southwest, Southeast, Northeast, and Northwest (PDE, 2023a). Additionally, these districts are categorized as urban, suburban, and rural, based on population size (PDE, 2023c). Although the locale codes utilized by the Pennsylvania Department of Education (2023c), based on the NCES Locale Classifications and Criteria actually include twelve classifications ranging from a large city to a remote rural area (Geverdt, 2019), for the purposes of this study and to ensure ease of use of the tool by participants, the classification was simplified to "urban," "suburban," and "rural."

Research Population and Sample

The target population for this study included public school social workers in the Commonwealth of Pennsylvania currently working with pre-kindergarten through 12th grade students. The term "school social worker" is defined in Chapter 1 and is based on requirements set forth by the Pennsylvania Department of Education. Those not meeting these requirements were excluded from study participation as they are not considered public school social workers per state requirements, even if they are carrying out similar tasks within a school setting. These individuals were not intentionally recruited. No vulnerable populations were included in this study.

Selection Process

The sampling frame was comprised of all school social workers employed in Pennsylvania public schools, estimated at 753 school social workers based on records available to this researcher. However, due to concerns about a low response rate related to work demands in the public school system, nonprobability convenience and snowball sampling was utilized for this sample (Rubin & Babbie 2017; Thyer, 2010). Survey participants were recruited via email

and asked to forward the survey to other Pennsylvania public school social workers they know. Due to the request to forward the survey, the Pennsylvania Association of School Social Work Personnel shared the body of the email and survey link on their members only Facebook page, possibly recruiting more participants.

A pre-formatted recruitment e-mail (Appendix C) explaining the purpose of the survey, potential risk, and potential benefits was sent to all public-school social workers in Pennsylvania whose email addresses are available via the database compiled and maintained by the Center for the Study of School Social Work at Kutztown University. By design, if the desired sample size (n= 150) was not obtained within 10 days of the initial recruitment e-mail being sent, a second preformatted follow-up e-mail (Appendix D) was prepared to be sent to the lists requesting those who have not participated to consider doing so. This second "nudge" e-mail was sent in addition to an e-mail thanking participants for their assistance and reminding others of the opportunity to participate before the survey link was closed (Appendix E). At the time the survey was closed, the desired sample size was exceeded (n = 239).

The sample for the focus groups was selected solely via convenience sampling. A question on the online survey asked participants to provide their contact information if they were interested in participating in the focus group and invitations to participate were sent via the Center for the Study of School Social Work at Kutztown University. It was this researcher's initial hope to hold two focus groups (n= 6 per group). This sample size was chosen based on the recommendation that an ideal focus group size is one that fosters open communication between all participants and is not so large that voices in the group can be easily overshadowed by others, with an ideal size varying based on what the researcher hopes to accomplish and the time allotted (Peek & Fothergill, 2009). Survey responses resulted in 54 interested participants. A subsequent

e-mail was sent to schedule focus groups at times most convenient for participants (Appendix F). After scheduling, a confirmation email including information regarding consent, risks, and confidentiality was sent to all participants (Appendix G). Two focus groups were held (n = 6, n = 4) via the Zoom online meeting platform utilizing a focus group script to guide the conversations (Appendix I).

Characteristics of the Sample

The sample for this study was designed to consist solely of individuals actively employed as public school social workers in Pennsylvania. Per requirements set forth by the Pennsylvania Department of Education, these individuals must hold a master's degree of Social Work and be either a Licensed Social Worker or a Licensed Clinical Social Worker in Pennsylvania. Potential participants may hold a PK-12 School Social Worker Educational Specialist Certificate, but this was not grounds for exclusion from the study. Participants' educational levels and licensure status will be discussed in Chapter 4. However, participants were also asked about certification and the results, indicating that the majority of participants have received their PK-12 School Social Worker Educational Specialist Certificate, are presented below.

Table 1

Survey Participants' PK-12 School Social Worker Educational Specialist Certificate Status

	N	%
Yes	188	78.7
No	51	21.3

Table 2

Focus Group Participants' PK-12 School Social Worker Educational Specialist Certificate Status

	N	%
Yes	7	70.0
No	1	10.0
Did Not Respond	2	20.0

Participants were recruited for this study via their work e-mail addresses, available through a database maintained by the Center for the Study of School Social Work at Kutztown University. The sample was designed as a convenience snowball sample as prospective participants were encouraged to forward the survey to their school social worker colleagues who may not have been captured in the existing database. The entire population, approximately 700 school social workers, were recruited based on information from previous similar online survey research conducted with Pennsylvania school staff (Imhof, 2023; Marshall, 2021) that resulted in low response rates, n = 158 (Marshall, 2021) and n = 88 (Imhof, 2023). In choosing a sample size, important in determining whether results are truly statistically significant (Burmeister & Aitkin, 2012), reviewing sample selection methods of similar studies and published tables can be helpful (Israel, 1992).

Participants were selected for the focus groups via convenience sampling. Participants from the online survey were asked as part of the survey to provide their contact information if they were interested in participating in a focus group. From this pool, a sample of convenience chosen to participate in Zoom focus groups.

The resulting sample (n = 239) was similar demographically to Pennsylvania's public school social workers population based on data from the 2022-23 school year (Pennsylvania Department of Education, 2024a). It is necessary to note that the demographic information was

not collected in the same manner in this study as it was by the Pennsylvania Department of Education, but the information is closely aligned.

Table 3

Pennsylvania Public School Social Workers' & Survey Participants' Racial Make-Up

	PA School Social Workers		Survey Participants	
	N	%	N	%
Black or African American	46	7.2	6	2.5
White	565	88.8	184	77.0
Asian	6	.9	1	.4
Multi-Racial	3	.5	6	2.5
Hispanic	16	2.5	1*	.4

*Ethnicity was measured separately from Race in this study but not by PDE.
Note: 42 survey participants (17.6%) opted out of the question pertaining to race.

Figure 1

Race of Survey Participants

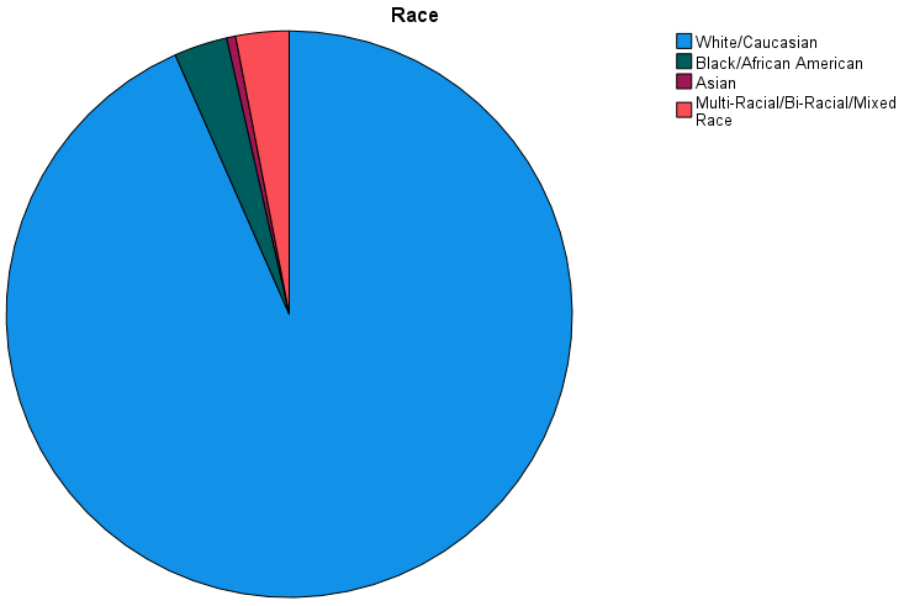


Table 4

Focus Group Participants' Racial/Ethnic Make-Up

	N	%
White	8	80.0
Hispanic	1	10.0
Did Not Respond	1	10.0

*Note: No Focus Group participants identified as African American

Table 5

Gender of Pennsylvania's Public School Social Workers & Survey Participants

	PA School Social Workers		Survey Participants	
	N	%	N	%
Male	63	9.9	21	8.8
Female	573	90.1	190	79.5
Other/Did Not Answer			28	11.7

Figure 2

Gender of Survey Participants

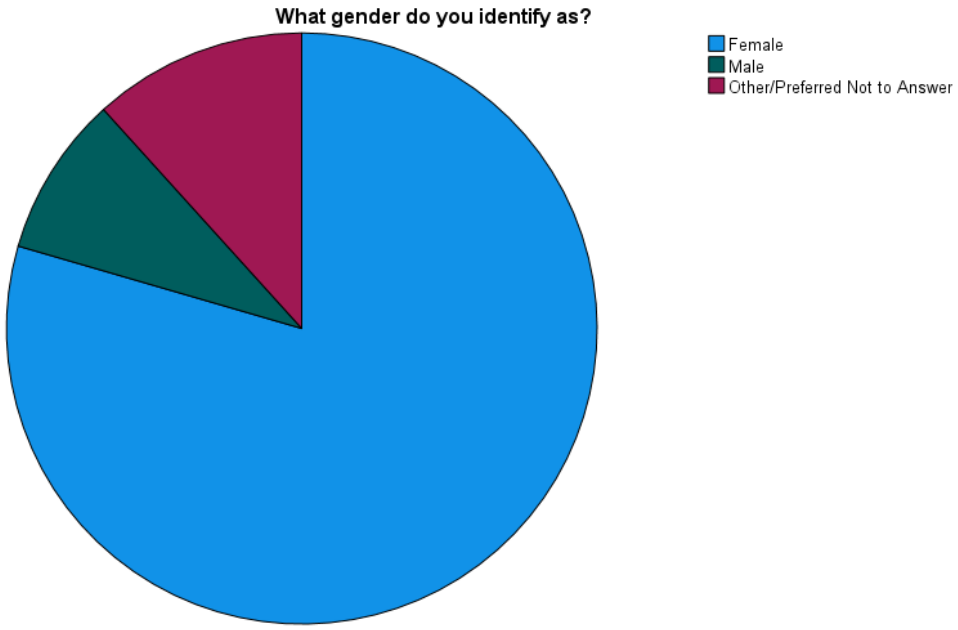


Table 6

Gender of Focus Group Participants

	N	%

Male	2	20
Female	7	70
Did Not Answer	1	10

In addition to the demographic makeup of the sample, it is important to consider characteristics of where participants are working. Questions were asked of both survey and focus group participants about the region (Table 8, Figure 3) and type of district (or intermediate unit) for which they are employed (Tables 9 and 10, Figure 4) and can be compared with the statewide data in Table 7 (Pennsylvania Department of Education, 2024a; Pennsylvania Department of Education, 2024b).

Table 7

Pennsylvania School Social Workers- Regional Data

	N	%
Central/North Central	35	5.5
Northeast	50	7.9
Northwest	18	2.8
South Central	218	34.3
Southeast	96	15.1
Southwest	70	11.0
Unknown*	157	24.7

*Data regarding the regions for Intermediate Units was not explicitly available.

Table 8

Survey Participants- Regional Data

	N	%
Central/North Central	25	10.5
Northeast	28	11.7
Northwest	7	2.9
South Central	40	16.7
Southeast	55	23.0
Southwest	49	20.5

Do Not Know/Prefer Not to Answer	9	3.8
Did Not Respond	26	10.9

Figure 3

Survey Participants' Regional Data

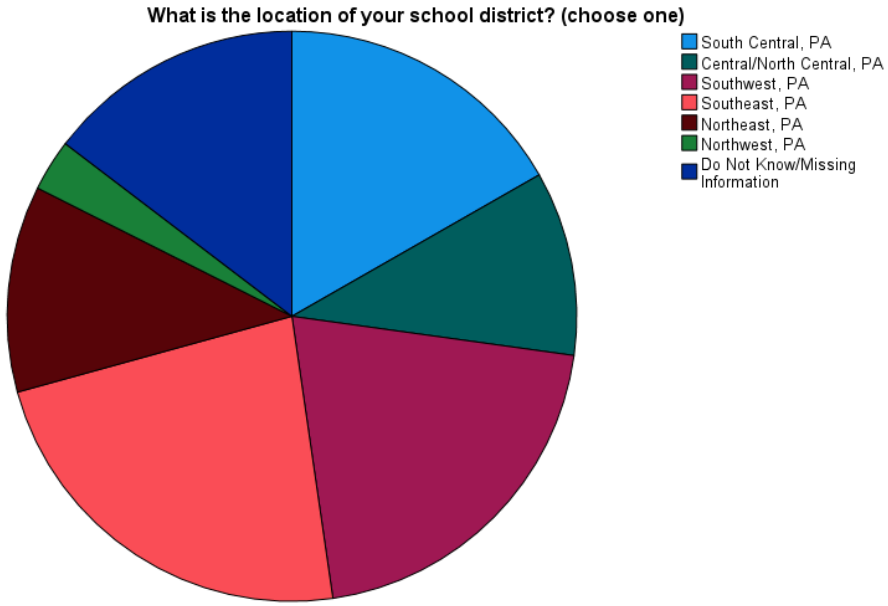


Table 9

Survey Participants- District Type

	N	%
Rural	27	11.3
Suburban	51	21.3
Urban	105	43.9
Do Not Know/Prefer Not to Answer	49	20.5
Did Not Respond	7	2.9

Figure 4

Survey Participants' District Type

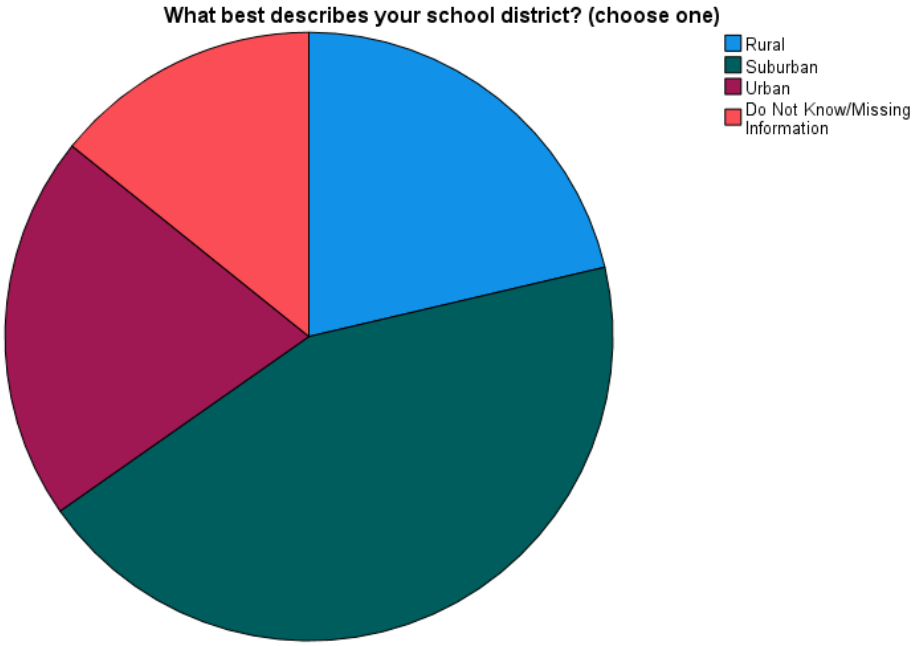


Table 10

Focus Group Participants- District Type

	N	%
Rural	1	10.0
Suburban	4	40.0
Urban	1	10.0
All*	3	30.0
Did Not Respond	1	10.0

*Intermediate Unit participants reported that, due to the nature of their positions, they cover multiple districts that vary in location and type.

Review of the demographic and district/intermediate unit characteristic information for Pennsylvania, survey participants, and focus group participants indicate that, although not identical, the study samples are representative of the population being studied.

Ethical Considerations

No vulnerable populations were chosen to be involved in this study. The overall risk to participants was minimal to none. However, it is possible that participants with a trauma or secondary trauma history may have been at higher risk of psychological distress when answering

some of the survey or focus group questions simply due to the nature of the research topic. The potential risk for psychological distress was explained in the letter presented with the survey and before the focus groups' start (see Appendix G). Participants were given the opportunity to opt out of the study and not to answer any questions of their choosing. Additionally, participants were provided with state and national mental health hotline contact information and reminders to contact their Human Resources regarding Employee Assistance Programs or mental health providers through their health insurance (Pennsylvania Department of Education, 2020) as needed for support.

Data Collection Methods

Data was collected primarily via an online survey instrument (see Appendix H). This method was selected due to its ease of use for participants during the school year. It was this researcher's belief that an online survey would elicit a higher response rate for staff who were in the midst of their school year without adding an additional perceived burden.

Additionally, supplemental information was garnered via focus groups. These focus groups were held with volunteer participants via the online platform, Zoom. The script utilized in these focus groups is available in Appendix I.

Issues of Trustworthiness

Steps were taken throughout the design and implementation of this study to increase validity and reliability while reducing errors and bias. However, it is impossible to account for all limitations and, unfortunately, the nature of self-report surveys and new tools creates issues in these errors.

Validity and Reliability

Steps were taken to ensure a high level of validity and reliability in this study. However, it is important to point out that the tools utilized in this study were created for this study and require further testing to establish validity and reliability with certainty. Pilot testing of the survey tool, as discussed above, was conducted to establish face validity and ensure participants understood what was being asked. Inter-coder reliability testing was completed. External validity cannot be determined as the study size was small and limited to school social workers within Pennsylvania. Reliability cannot be determined with certainty as this study was a one-time cross-sectional study not repeated with similar or dissimilar populations.

Limitations and Delimitations

Limitations of this study include the small sample size limited to just Pennsylvania's public school social workers and cross-sectional design. As such, results cannot be transferred to any other population or time period. It is possible that a different population or a similar population at a different time may present different results.

Additionally, the self-report nature of this study is considered a limitation. There is a chance of respondent bias due to participants attempting to answer the questions in a way that is more socially desirable or acceptable and self-selection bias in which participants who are interested in the topic choose to participate and those who are not interested did not want participate in this sort of study (Rubin & Babbie, 2017). It is also important to consider the impact that concern about protecting one's employer or employment status may have on self-reporting.

Another limitation to consider is that the study does not explore the effects of cultural beliefs on the use of trauma-informed practices, something that came out during the focus

groups. This is an area that is important to keep in mind and will be discussed later in Chapter 6 regarding suggestions for further research.

Positionality Statement

I am currently employed as a school social worker in a Pennsylvania public school and was previously employed as a child welfare worker for over 10 years. I have spent almost two decades working in fields that left me exposed to the trauma of others, particularly children. As such, this is a topic that I am passionate about. In my current role, I am a district trainer regarding trauma and Restorative Practices. Also, as part of my DSW program, I created and presented several workshops regarding trauma, trauma-informed practices, and secondary traumatic stress.

Additionally, I am the parent of two school-aged children, one of whom has struggled a great deal in the school setting due to encountering adults who are not confident in their ability to work with trauma-exposed students. I firmly believe this is work that can be done by all with continuing education and support for our youth's benefit.

Summary

A cross-sectional, mixed methods study was utilized to examine factors with relationships to school social workers' use of trauma-informed practices in Pennsylvania public schools. Through e-mail recruitment, Pennsylvania's approximately 700 school social workers were contacted and asked to participate in both an online survey and Zoom focus groups. By doing so, information was gathered that could be analyzed to help determine potential correlations and make recommendations about future research and practice.

Chapter 4- Findings

This chapter will discuss the findings of the survey and focus group portions of this study, including where they overlapped and diverged. A combination of methods was utilized to analyze the survey and focus group data separately and then to bring the information together to create a rich depiction of the current status and needs of Pennsylvania's school social workers.

Methods utilized include thematic analysis to analyze and understand the concepts that emerged during the two virtual focus groups and both univariate and bivariate analysis of the quantitative data from the survey. These analytic methods led to mixed support of this researcher's hypotheses, described in detail in the following sections.

Data Analysis

This researcher analyzed the survey data using the IBM SPSS Statistics software package, Version 28.0.1.0. Due to the primarily nominal level of the data being analyzed, correlations were tested using Pearson's chi-square test to assess for association (Field, 2018). Other forms of analysis include descriptive statistics including mean, mode, median, and standard deviation.

Prior to starting the focus groups, this researcher created an a priori codebook (available in Appendix J) based on information obtained from an initial review of survey data. The focus group data was analyzed by first transcribing the data from video and audio recordings into NVivo 12 Plus. Once transcribed, this researcher reviewed the transcriptions in written form. The transcripts are available for review in Appendix K. The codebook was updated to reflect key points and themes that emerged during the focus groups. This researcher then completed an initial coding of each transcription. After taking time to reflect, review the codebook, and rest, this researcher reviewed and, where appropriate, updated the coding in both transcripts. After this step, a second coder reviewed 100% of the transcripts due to their short lengths and the

feasibility of doing so (O'Conner & Joffe, 2020) for inter-coder reliability. A conversation was held between this researcher and the second coder to discuss coding discrepancies and determined that, although there were some variances, they were minor and were based primarily on differences on the understanding on the concept of "climate."

Intercoder Reliability Assessment

Although there are no clear guidelines regarding the necessary number of coders to achieve inter-coder reliability, arguably at least two coders, particularly on a smaller study such as this, are adequate to achieve reliability (Church et al., 2019; O'Conner & Joffe, 2020). Due to the small size of this study, it was feasible for the full transcripts of both focus groups to be coded by both coders (100% of the total documents), even though the literature suggests that it is acceptable to utilize 10 to 25% of documents during the intercoder reliability review process (Campbell, Quincy, Osserman, & Pederson, 2013; O'Conner & Joffe, 2020).

A coding comparison was conducted utilizing NVivo 12 Plus. The coding comparison resulted in an 85.37% agreement over two transcripts. This both falls within the range of 74-94% agreement suggested to be acceptable (Wilson-Lopez, Minichiello & Green, 2019) and above the 80% minimum acceptable range for acceptability (Campbel et al., 2013) in the literature. Additionally, Cohen's kappa was calculated, and the overall score was found to be .84, indicating an almost perfect agreement (Burla, et al., 2008). Cohen's kappa and percent agreement were measured for the parent codes as recommended in the literature to gain a better understanding of the coders' agreement on the different codes and the transcripts (Campbell et al., 2013; Hruschka et al., 2004). Per Burla et al. (2008), Kappa measures of .81-1 are considered almost perfect and Kappa measures of .61-.08 are considered satisfactory/solid agreement. The results are noted in the table below.

Table 11

Parent Code Intercoder Reliability Testing Results

	% Agreement	Cohen's Kappa
Use of TIP	81.25	.812
Standardization	75.00	.750
Professional Development	77.50	.775
Factors	84.09	.841
Past Training	100.00	1.00
Approaches	87.50	.875

As determined by both overall and parent code percent agreement ratings and Cohen's kappa ratings, the intercoder reliability in this study was determined to be, at a minimum, satisfactory.

Thematic Analysis

After the focus groups were transcribed and coded, the codes were reviewed for overlaps and relationships. These relationships were noted in handwritten memos kept by this researcher. Following the process of thematic analysis including recognizing and noting patterns until themes emerged (Braun & Clarke, 2006; Padgett, 2017; Rossman & Rallis, 2003), the final themes that emerged included: The Role of Connection in Trauma-Informed Practices, School Staff's Understanding of Trauma and Trauma-Informed Practices, Systemic Factors, and Training Needs.

The Role of Connection in Trauma-Informed Practices. This theme emerged, primarily, during discussion about times that participants successfully engaged with students, families, or colleagues in a trauma-informed manner, but also while discussing beliefs about what trauma-informed practices are. Participants spoke of the importance of connecting with students to be able to engage with them in a productive manner,

> I can say that for the school district that I work for it, it's the relationships that students have and it's been the biggest biggest piece of, like, getting the students' buy-in is having a person that knows that they're checking in on me, they're actually looking to see me do better, and they're not just expecting me to do something on my own, but having someone checking in with them, checking out with them. It's just that, that biggest piece of building that relationship, 'cuz if we don't have it, it's it's been, it's been difficult to try to get anything from a student. So, they're buying in at least, to want to have something to work on or having a person to talk to about what's going on with them or just to even be that person to go to whenever they need something.

Also, participants noted that engaging in forging connections is not just reserved for families and students, but it is necessary with colleagues as, as discussed in a later section, school social workers are held responsible for educating colleagues about trauma-informed practices. One participant questioned her ability to apply the skills she uses with students to colleagues,

> You know, like, how can I be understanding of like, if I'm understanding of resistant students I need to be understanding of resistant teachers and how do I, what do I, what do I need to know to connect with them?

This concept about connection and relationships as a form of trauma-informed practices was noted to not be something unique to trauma-informed practices, but to simply be good social work practice. One participant summarized this idea by stating, “Like in social work, like, it's, in my eyes trauma-infor- the trauma-informed lens IS the social work lens.”

School Staff’s Understanding of Trauma and Trauma-Informed Practices. Another theme that emerged from the focus group conversations was the barrier to fully implementing

trauma-informed practices in the school setting due to issues surrounding how the concepts of trauma and trauma-informed practices are understood by school staff. Concerns raised included how “trauma” is defined and the idea that there is no common language around trauma-informed practices as well as there being different levels of understanding and, therefore, implementation of trauma-informed practices within schools and districts.

Participants spoke of discrepancies in language about trauma and trauma-informed practices a great deal. For example, one participant noted,

> When I was listening, was just about people knowing about trauma. I think there's, there's different definitions of what trauma is [Absolutely.] and I think everyone has a different understanding of trauma.

While another pointed out that

> And so, you have different perspectives on what "trauma" is. Different districts have different perspectives on, different definitions indeed, on what trauma is, or what trauma-informed, and also when I'm speaking with kids.

When schools, districts, and staff members are not speaking the same language and using the same definitions about trauma and trauma-informed practices, it leads to a difference in services provided to students that are called the same thing. One participant questioned what trauma-informed practices should look like, even when defined well, “You know, what this is, we're all this chat about trauma-informed, what does it really mean in practice?” While another expressed frustration that one of her schools claims to be trauma-informed despite her disagreement with this claim,

> I think, for me, there's a discrepancy between what people think are trauma-informed practices and what they actually are. So, there's a building that I work in that administratively they've said that, okay, when the students enter your classroom, you have them give you a thumbs up if they're having a good day or a thumbs down if they're having a bad day because we're trauma-informed. And I'm like, mm, yeah, that's great, but that is not, you can't call yourself trauma-informed simply by a thumbs up or a thumbs down. There's so much more to, and we know there's a continuum, right, of of having that support in terms of trauma, so for me, I feel like there's a, there's a discrepancy there between what you think you're doing and that you're having an impact.

Additionally, when efforts are made to provide education around this topic to school staff, these efforts are sometimes met with resistance because it is something that non-mental health staff do not see as a priority or understand its importance, "...or they may see it as just the next thing coming into the school system that will come and go quickly."

> And I don't know what is going on in, you know, the teachers' colleges as far as how they're being taught about it. Is it even being prioritized? Is it an elective?
>
> That's just been interesting to see how now it's like, I don't want to say a buzzword, but it is. It's used a lot more than I realized, but I'm glad but I also don't want to see a word that people are sick of. You know, another thing that we have to do. So, you gotta be careful.

Systemic Factors. A theme that emerged that that seemed particularly frustrating to focus group participants centered around systemic factors, factors that cannot be controlled by school social workers including time, how social workers are utilized by their employers, and staff

turnover. These factors affect if and how trauma-informed practices can be implemented and how well.

At the outset, participants expressed concern about finding time to engage in trauma-informed practices with fidelity as it takes a great deal of time to forge connections and hold meaningful conversations with students to discover underlying causes of behaviors.

> So just, I think, sometimes time is the reason that trauma-informed practice isn't always everyone's go-to because you need to to meet with that student or talk to with that student or pull that student aside instead of just saying "hey, cut that out," right, because his behavior was different than the last time this substitute was in for him. So, time, I think, time is a big barrier.

Instead, it is easier for school staff to perform the work at the surface level once the school year is in full swing, “I think once teachers are in the grind it becomes harder to find those moments to get to know students at a deeper level.” Additionally, it is difficult for school staff to be trained to engage in this work at a more meaningful level so it is not solely the responsibility of the schools’ mental health professionals,

> It's tough because of the ability, there's so many trainings that schools have to have staff, so is that another one that you can try to fit in in the middle of all the requirements.

In part, finding the time for these necessary trainings is due to issues of staff turnover and needing to maintain training for all new staff.

> ...however, new staff, new, you know, needing to keep up with that training is sometimes hard to keep, you know, offering it again and having it again. Finding time to be able to do that.

Although schools are required to train all staff about trauma and trauma-informed practices, the burden does fall on the schools' mental health staff, primarily the school social workers. This presents an issue, though, when the school social workers' role is not clear. For some, where they will be from day-to-day even varies.

> I'm actually in a South Central Region High School right now, up in a South Central Region County, but tomorrow I'll be in a different South Central Region District. Who knows where I'll be on Wednesday, but I'll check tomorrow.

For these social workers, the expectations about what a school social worker is and what a school social worker does varies from site to site, "... we could be serving in many different roles FOR districts, so it's gonna look a little different. And some could be direct service some may not." During the two focus groups, different roles were discussed by the participants, many detracting from the social workers' ability to take time to engage directly with students in a meaningful, trauma-informed manner, but also allowing them to teach others about trauma.

> Another role is I am a trainer for our training and consultation department on trauma and Lakeside trainer, so just trying to get that out to the district.

> Or I have different roles in different districts as what I'm sometimes I'm assigned a specific class, which could be IU kids, it could be special education kids. Here at my current high school placement, for example, I have a more, I guess, generic caseload and I work with the people from the guidance department. I'm the "mental health" person I guess, but I work with SAP [Student Assistance Program] teams.

> I don't do really anything, like, IEP-wise [Individualized Education Plan], mental health-wise.

> Yeah, and for me, in my district, I tend to work with the families and the caregivers more so than direct with the students. But I think a lot for me would be kind of educating the parents and letting them know, you know, these certain behaviors in the school are because of, you know, XY and Z. So even kind of looking at how I can do that better for the parents and the caregivers of the kiddos.

School social workers can advocate for themselves about their position and role, but ultimately, their administrators decide what school employees are expected to do as part of their role and function in the district or intermediate unit. When social workers fill a variety of roles, it changes how they are able to engage in trauma-informed practices in the school setting.

Training Needs. A theme arrived at via deductive analysis (Rossman & Rallis, 2003) based on more direct questions related to the quantitative survey and an existing research question was about training needs. This researcher directly asked focus group participants about their past experiences with training and professional development about trauma and trauma-informed practices and then asked what participants would like to see in the future. Participants overwhelmingly agreed that they wanted professional development of higher quality and that was practical and useful, specifically, “So, I think everybody is looking for that secret of what, what they can do with students.”

Simply having training about trauma and trauma-informed practices is not adequate. The quality of the training and meeting the trainees' learning needs is important.

> Can I just add, too, about the type of training? That I don't think necessarily that the trainings are very clear as far as what trauma is and how. I think some places will just do

an hour or two hours, voila and now suddenly we're all trauma trained. But what does that really mean?

In particular, making this learning something that that can both foster a higher level of understanding and engagement, "I would like more in-depth discussion and pulling together some of the things I've heard and, the way I see it, maybe, we need to be looking at, for example, case discussions- what are the issues?" and then provide the learners with something they can take back that is useful in their everyday practice. One participant stated, "I feel like a lot of times at trainings they talk about what is trauma-informed practices but they don't get down to what you can put in your toolbox to take away," while another suggested that at trainings they should offer something tangible and useful, "But like, here's a huge toolbox and you take out of here what it is you like and toss the stuff you don't, that's okay."

Research Question #1

The first research question posed the question, "what is the perceived level of preparedness of school social workers' use of trauma-informed practices?" Prior to assessing perceived preparedness, it is important to consider formal preparedness.

Table 12

Survey & Focus Group Participants' Highest Level of Social Work Education

	Survey Participants		Focus Group Participants	
	N	%	N	%
BSW or Other	3	1.3	0	0.0
MSW	228	95.4	7	70.0
DSW/Ph.D.	8	3.3	2	20.0
Did Not Respond	0	0.0	1	10.0

Results indicated that a large majority, 98.7%, of survey participants (n = 239) have a master's degree in social work or higher, indicating a high level of formal preparation within the sample. Focus group participants (n = 10) reported a similar level of education, with 90% (n = 9) reporting a master's degree in social work or higher.

It is important to consider that this sample's reported level of education is similar to the most recent data available regarding public school social workers' level of education in Pennsylvania (Pennsylvania Department of Education, 2024) from the 2022-23 school year.

Table 13

2022-23 Pennsylvania Public School Social Workers' Highest Level of Education

	N	%
High School Diploma	5	.79
Bachelor's Degree	39	6.1
Master's Degree	575	90.4
Doctoral Degree	16	2.5

Although it is unknown if these individuals have master's and doctoral degrees in social work or other fields, 92.9% (n = 636) of the public school social workers were reported to be highly educated. It is important to point out that .79% (n = 5) of practicing school social workers in the state at the time only held bachelor's degrees, not in alignment with state requirements for this position.

Table 14

Survey & Focus Group Participants' Licensure Status

	Survey Participants		Focus Group Participants	
	N	%	N	%
LSW	179	74.9	9	90.0

LCSW	50	20.9	0	0.0
Other or None	10	4.2	0	0.0
Did Not Respond	0	0.0	1	10.0

Survey participants (n = 239) were largely licensed as social workers in the state of Pennsylvania, with 95.8% (n = 229) holding a social work license or clinical social work license. It should be noted that one participant is licensed in another state with others reporting pending licensure exams or home and school visitor certification. Focus group participants also reported a majority, 90% (n = 9) being licensed as social workers in Pennsylvania. One participant did not respond as all questions were optional. The licensure status of Pennsylvania's public school social workers was not available for comparison and is a limitation of this study.

Additionally, study participants were asked how many years they have held their social work license or clinical social work license (see Appendix L for Table 15: Survey Participants' Time Licensed). The range was 40, with the minimum number of years being 0 (less than one year) and the maximum of years being 40. The mean number of years was 12.44 and the median was 11 years with a standard deviation of 8.9. The most frequently reported number of years (mode) was 4.

Several questions were asked of survey participants to gauge their perceived level of preparedness to utilize trauma-informed practices and how they received this preparation. These questions were posed using a Likert-scale asking participants to answer using a rating (0- Not at all to 5- Very Much, including a Do Not Know option).

Table 16

Survey Participants' Perceived Level of Preparedness to Use Trauma-Informed Practices

	N	%
Less than Very Much	137	57.3
Very Much	83	34.7
Missing Information	19	7.9

When asked directly about their perceived level of preparedness to use trauma-informed practices, participants largely reported feeling prepared to do so with responses falling primarily in the "Somewhat" to "Very Much" categories (totaling 88.7%). As such, for analysis purposes, the raw data was recoded into the categories seen in the table above, "Less than Very Much" and "Very Much."

Table 17

Survey Participants' Understanding of Trauma-Informed Practices

	N	%
Less than Very Much	70	29.3
Very Much	150	62.8
Missing Information	19	7.9

A majority (62.8%, n = 150) of participants reported understanding the concept of trauma-informed practices "Very Much." It should be noted that no one chose "Not At All," "Very Little," or "2" (less than "Somewhat" but more than "Very Little") despite the wider range of responses to the earlier question about preparedness. Due to this small range of responses, the raw data was recoded into the categories of "Less than Very Much" and "Very Much" for the purposes of data analysis.

The following questions inquired about the preparation participants (n = 239) received and how well they felt it prepared them to engage in trauma-informed practices.

Table 18

Perceived Preparation by BSW Programs to Use Trauma-Informed Practices

	N	%
Less than Somewhat	43	18.0
Somewhat	39	16.3
More than Somewhat	29	12.1
Not Applicable/Missing Information	128	53.6

It is interesting to note that the largest response category to this question was the "Not Applicable/Missing Information" category. It is not known if participants chose not to answer because they could not recall their experiences, completed their undergraduate degree in a field other than social work, were uncomfortable answering, or if there was another phenomenon at work. For those that found this question to be applicable, the majority (42.2%, n = 43) found that their undergraduate social work program prepared them "Less than Somewhat" to utilize trauma-informed practices after graduation with only 28.4% (n = 29) participants reporting that they felt that their program prepared them "More than Somewhat" to utilize trauma-informed practices.

Table 19

Perceived Preparation by MSW Programs to Use Trauma-Informed Practices

	N	%
Less than Somewhat	39	16.3
Somewhat	72	30.1
Between Somewhat & Very Much	52	21.8
Very Much	47	19.7
Not Applicable/Missing Information	29	12.1

Despite the low response rate to the earlier question regarding the preparation provided by BSW programs, 87.9% (n = 210) of participants chose to provide information regarding their MSW programs' ability to prepare them to utilize trauma-informed practices upon graduation. Responses were skewed toward the middle with 30.1% (n = 72) of participants reporting they felt that their MSW programs prepared them "Somewhat" and 21.8% (n = 52) prepared them "Between Somewhat & Very Much." Similarly, focus group participants reported learning about trauma-informed practices in their MSW programs, "Graduate school. Probably was the best time to learn it. Mostly because it, it's a specific field." It is important to note, though that 16.3% of participants (n = 39) reported that they felt that their MSW programs prepared them "Less than Somewhat" to utilize trauma-informed practices. One focus group participant did report that he did not learn about trauma-informed practices in graduate school because of the time he attended school, although they did learn about the general concepts,

> But, because it's like, yeah, I know that, and I, I trained, I didn't learn learn about trauma-informed practice when I was at grad school. I got my social work badge in 1989 then before many people were even been born who are practicing now... And we knew about, and we knew about, you know, again in the 80s, we knew about sexual abuse- that had been going on for millennia and decades. Anyway, although it wasn't necessarily called that.

Table 20

Perceived Preparation by DSW/Ph.D. Programs to Use Trauma-Informed Practices

	N	%
Less than Somewhat	5	1.3
Somewhat	10	4.2
More than Somewhat	6	2.5

Not Applicable/Missing Information	218	91.2

Similar to the question regarding the preparation provided by the undergraduate social work programs, the question about the preparation to utilize trauma-informed practices provided by DSW/PhD. programs had a low response rate. It is this researcher's belief that the low response rate was likely due to the low number of participants who reported having this level of social work education (n = 8). However, 21 survey participants gave a rating of their doctoral education experience, indicating that some have doctoral degrees not in social work. It is necessary to keep these factors in mind when considering the data resulting from this question as it is not known who provided the information and what programs the data is about. The majority of participants who responded receiving this level of education (47.2%, n = 10) reported that they felt that their doctoral education only prepared them "Somewhat" to utilize trauma-informed practices followed by 28.6% (n = 6) of participants who felt that their programs prepared them "More than Somewhat."

Further questions were asked regarding preparation to utilize trauma-informed practices obtained through less formal avenues. This data can be found in Tables 21-27 in Appendix L.

At the outset of this study, this researcher proposed the following hypotheses regarding participants' perceived levels of preparedness to utilize trauma-informed practices:

> $H_{1.1.}$: Levels of preparedness will vary with newer social workers having a higher perceived level of preparedness to utilize trauma-informed practices than those who have been in the field longer.

$H_{0.1}$: There is no relationship between school social workers' time in the field and perceived level of preparedness to utilize trauma-informed practices.

In order to determine if the hypothesis or null hypothesis were supported, this researcher recoded the survey categories that determined length of experience, including how long they have been licensed social workers and how long they have been practicing as school social workers, in an effort to create categories that could be run through the SPSS crosstabs analysis method. See Table 28 and Table 29 for the recoded data.

Table 28

Survey Participants' Time Licensed – Recoded

	N	%
Less Than 5 Years	57	23.8
5 - Less Than 11 Years	58	24.3
11- Less Than 20 Years	58	24.3
20+ Years	63	26.4

Table 29

Survey Participants' Time Practicing in School Social Work

	N	%
Less Than 4 Years	58	24.3
4 - Less Than 9 Years	61	25.5
9 - Less Than 19 Years	57	23.8
19+ Years	63	26.4

After this information was recoded, it was analyzed using the crosstabs feature in SPSS with the data regarding how prepared participants reported feeling to effectively use trauma-informed practices.

Table 30

Cross-Tabulation: Participants' Years Licensed/Preparedness to Effectively Use Trauma-Informed Practices Raw Scores

	Less Than Very Much	Very Much	Total
	N	N	N
< 5 Years	26	25	52
5 to < 11 Years	40	12	52
11 to < 20 Years	35	19	54
20+ Years	34	25	59
Total	136	81	217

Table 31

Cross-Tabulation: Participants' Years Licensed/Preparedness to Effectively Use Trauma-Informed Practices Percentages

		Less Than Very Much	Very Much	Total
		%	%	%
< 5 Years	% Within < 5 Years	52.0	48.0	100.0
	% Within Preparedness	19.1	29.6	23.0
5 to < 11 Years	% Within 5 to < 11 Years	76.9	23.1	100.0
	% Within Preparedness	29.4	14.8	24.0
11 to < 20 Years	% Within 11 to < 20 Years	64.8	35.2	100.0
	% Within Preparedness	25.7	23.5	24.9
20+ Years	% Within 20+ Years	57.4	42.6	100.0
	% Within Preparedness	25.7	32.1	28.1
Total	Within Time Licensed	62.7	37.3	100.0
	% Within Preparedness	100.0	100.0	100.0
	% of Total	62.7	37.3	100.0

Table 30 and Table 31 indicate that majority (n = 136, 62.7%) of participants reported feeling “Less Than Very Much” prepared to effectively use trauma-informed practices. The smallest gap was reported in the less than 5 years licensed group, with 52% (n = 26) reporting feeling “Less Than Very Much” prepared versus 48% (n = 25) feeling “Very Much” prepared and the largest gap existing in the 5 to < 11 years licensed group, where 76.9% (n = 40) of participants reported feeling “Less Than Very Much” prepared to effectively use trauma-informed practices as compared to 23.1% (n = 12) who reported feeling “Very Much” prepared. This same group of participants made up 29.4% of participants reported feeling “Not Very Much” prepared to effectively use trauma-informed practices. Using the crosstabs calculation, it was found that there is not a significant relationship between survey participants’ years licensed as a social worker and their perceived preparedness to effectively use trauma-informed practices $x^2(3) = 7.786$, $p = .051$, refuting this researcher’s hypothesis and supporting the null hypothesis.

Table 32

Participants’ Years Practicing School Social Work/Preparedness to Effectively Use Trauma-Informed Practices Cross-Tabulation

	Preparedness to Effectively Use Trauma-Informed Practices					
	Less Than Very Much		Very Much		Total	
	N	%	N	%	N	%
< 4 Years	33	24.3	21	25.9	54	24.9
4- < 9 Years	35	25.7	16	19.8	51	23.5
9- < 19 Years	32	23.5	21	25.9	53	24.4
19+ Years	36	26.5	23	28.4	59	27.2
Total	136	100.0	81	100.0	217	100.0

Table 32 shows that participants are essentially equally likely to report feeling “Less Than Very Much” prepared to effectively use trauma-informed practice despite differences in

years practicing in school social work. When looking within each category, this appears to be accurate. Among those in the field less than 4 years, 61.1% (n = 33) reported feeling "Less Than Very Much" prepared to effectively use trauma-informed practices. Of those in the field 4 to less than 9 years, 68.6% (n = 35) of participants reported feeling "Less Than Very Much" prepared to effectively use trauma-informed practices. 60.3% (n = 32) of participants in the field 9 to less than 19 years reported the same. Finally, 61.0% (n = 36) of participants in the field for 19 or more years reported feeling "Less Than Very Much" prepared to effectively utilize trauma-informed practices. Using the crosstabs calculation, it was found that there is no significant relationship between survey participants' years in practice as a social worker and their perceived preparedness to effectively use trauma-informed practices $x^2(3) = 1.018$, $p = .797$, refuting this researcher's hypothesis and supporting the null hypothesis. It is also important to note that there are no notable differences in raw numbers or percentages in response trends.

Research Question #2

The second research question posed the question, "Are there any relationships between identified factors in the work setting and the use of trauma-informed practices by school social workers?" The crosstabs analysis feature in SPSS was used to assess associations between social workers' district locations, job roles (re-coded), another other job-related factors, and the use of trauma-informed practices. All data of significance and related frequencies are noted in this section. The remaining crosstabs analyses can be found in Appendix M for review.

Table 33

Survey Participants' Use of Specific Forms of Trauma-Informed Practices

	Practice Utilized		Practice Not Utilized	
	N	%	N	%
TF-CBT	80	33.5	159	66.5

Restorative Practices	120	50.2	119	49.8
TF-SEL	121	50.6	118	49.4
TF-MTSS	76	31.8	163	68.2
TF-Mindset	133	55.6	106	44.4
Screenings	34	14.2	205	85.8
Other	15	6.3	224	93.7
None/None Reported	29	12.1	210	87.9

The majority of participants reported having a trauma-informed mindset (55.6%, n = 133) and using trauma-informed social-emotional learning (50.6%, n = 121) and Restorative Practices (50.2%, n = 120). A surprisingly low number of participants reported using screenings as part of their practice (14.2%, n = 34).

Table 34

Survey Participants' Overall Use of Trauma-Informed Practices

	N	%
0 or 1 Type Used/Reported	70	29.3
2 Types Used/Reported	64	26.8
3 Types Used/Reported	53	22.2
4+ Types Used/Reported	52	21.8

Participants reported using between 0 and 6 types of trauma-informed practices. A small majority of participants reported using between 0 and 2 types of trauma-informed practices (56.1%, n = 134).

When assessing for association between district setting and type, it was determined via cross-tabulation analysis that there were no significant relationships between district setting in the state and how many forms of trauma-informed practices participants reported using (see

Appendix M). Similarly, there were no significant relationships found between district type and how many forms of trauma-informed practices participants reported using (see Appendix M).

Table 35

Survey Participants' District Setting by Region

	N	%
South Central	27	19.0
Central/North Central	34	12.3
Southwest	48	24.6
Southeast	52	26.7
Northeast	27	13.8
Northwest	7	3.6

As evidenced by Table 35, the Southeast region was slightly overrepresented, and the Northwest region was largely underrepresented. It is suspected that this was due to the use of social workers employed by intermediate units rather than directly via school districts in some areas of the state. This researcher found that many intermediate units had strong firewalls and attempts to engage these social workers in the study were unable to go through. Additionally, it is possible that more remote areas of the state have fewer social workers than more urbanized areas of the state (i.e., Southeast and Southwest regions).

Figure 5

Survey Participants' District Setting by Region

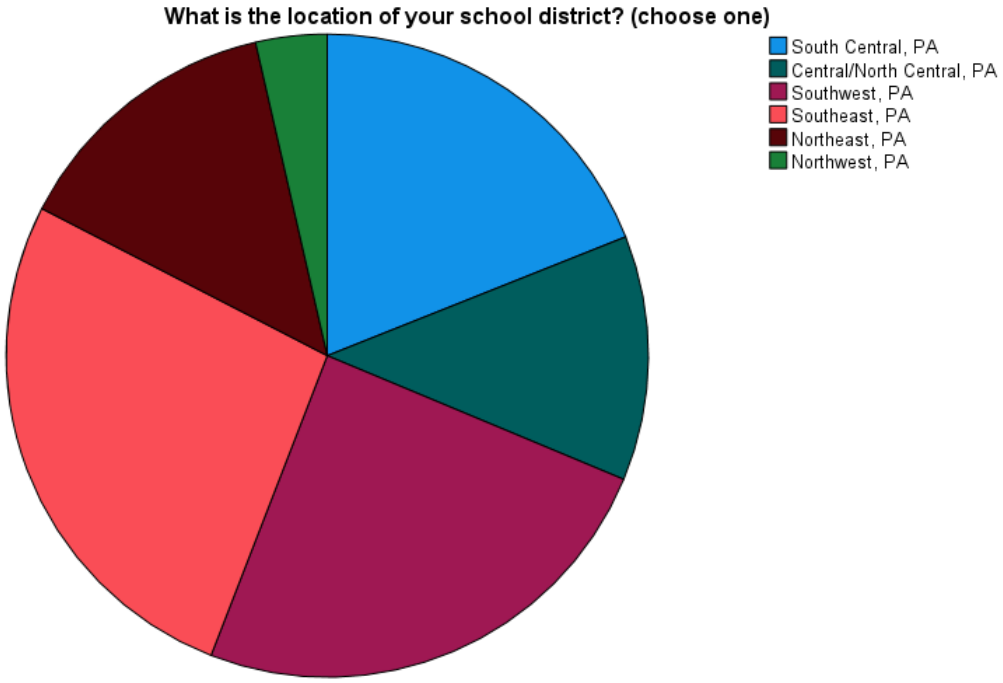


Figure 5 provides a visual representation of the information in Table 36, further emphasizing the low representation of the Northwest Region, particularly when juxtaposed with the southern regions.

Table 36

Cross-Tabulation: District Setting by Region & Use of Trauma-Informed Practices

	0 or 1 Types Reported/ Used		2 Types Reported/ Used		3 Types Reported/ Used		4+ Types Reported/ Used		Total	
	N	%	N	%	N	%	N	%	N	%
South Central	9	18.4	14	35.9	7	15.2	7	15.2	37	19.0
Central/ N. Central	5	10.2	4	7.4	5	10.9	10	21.7	24	12.3
Southwest	19	38.4	13	24.1	8	17.4	8	17.4	48	24.6
Southeast	11	22.4	15	27.8	14	30.4	12	16.1	52	26.7
Northeast	4	8.2	5	9.3	10	21.7	8	17.4	27	13.8
Northwest	1	2.0	3	5.6	2	4.3	1	2.2	7	3.6
Total	49	100.0	54	100.0	46	100.0	46	100.0	195	100.0

Table 36 shows that, despite some spikes in numbers, there are no significant differences between regions in the use of trauma-informed practices. Of note is that 41.7% (n = 10) of participants from the Central/North Central region reported using 4 or more types of trauma-informed practices, 39.6% (n = 19) of participants from the Southwest region reported using 0 or 1 type of trauma-informed practices, and 42.9% (n = 3) of participants from the Northwest region reported using 2 forms of trauma-informed practices. Using the crosstabs calculation, it was found that there is no significant relationship between district setting and the number of forms of trauma-informed practices reportedly used by participants, $x^2(15) = 18.942$, $p = .216$.

Table 37

Survey Participants' District Setting by Type

	N	%
Rural	49	25.1
Suburban	99	50.8
Urban	47	24.1

The largest represented district setting in this sample was "Suburban" (n = 99, 50.8%). There was a nearly even representation of "Rural" and "Urban" districts at 25.1% (n = 49) and 24.1% (n = 47) respectively.

Table 38

Cross-Tabulation: District Type & Use of Trauma-Informed Practices

	0 or 1 Types Reported/ Used		2 Types Reported/ Used		3 Types Reported/ Used		4+ Types Reported/ Used		Total	
	N	%	N	%	N	%	N	%	N	%
Rural	14	28.6	12	22.2	12	26.1	11	23.9	49	25.1

Suburban	25	51.0	28	51.9	19	41.3	27	58.7	99	50.8
Urban	10	20.4	14	25.9	15	32.6	8	17.4	47	24.1
Total	49	100.0	54	100.0	46	100.0	46	100.0	195	100.0

Table 38, simply due to the number of participants (n = 99), makes it appear as though participants representing suburban districts were more likely to report using 0 to 4+ types of trauma-informed practices than those participants representing rural (n = 49) and urban districts (n = 47). When looking within categories, participants from rural districts were almost equally likely to report using 0 or 1 types (28.6%, n = 14), 2 types (24.5%, n = 12), 3 types (24.5%, n = 12), and 4+ types (22.4%, n = 11) of trauma-informed practices. Those representing suburban districts were less likely to report using 3 types of trauma practices (19.2%, n = 19) than they were the other options. Finally, those representing urban districts were less likely to report using 4+ types of trauma-informed practices (17.0%, n = 8) than they were to report using 3 or fewer types. Using the crosstabs calculation, it was found that there is not a significant relationship between district type and the number of forms of trauma-informed practices reportedly used by participants, $x^2(6) = 4.437$, $p = .618$.

In order to analyze the association between job tasks and the use of trauma-informed practices, this researcher first recoded reported job tasks from individual tasks to the number of tasks reportedly performed on a routine basis.

Table 39

Survey Participants' Daily Activities/Time Spent at Work

	Routine Activity		Not a Routine Activity	
	N	%	N	%
Completing Assessments	57	23.8	182	76.2

Creating Plans	122	51.0	117	49.0
Individual Student Work	201	84.1	38	15.9
Group Student Work	120	50.2	119	49.8
Family Work	176	73.6	63	26.4
Administrative Duties	163	68.2	76	31.8
Stakeholder Collaboration	113	47.3	126	52.7
Connections to Community Resources	186	77.8	53	22.2
Class Coverages	31	13.0	208	87.0
Non-SW Duties	39	16.3	200	83.7

It is important to note that a majority of participants reported spending much of their time focusing on tier 2 work, services designed for those deemed at moderate risk often provided in the group setting, and tier 3 work, services for those deemed at high risk or who have not responded to lower levels of intervention which are typically provided to individuals. However, is also of importance that 68.2% (n = 163) of participants spend a great deal of their day focused on administrative duties, described in the survey as "documentation, etc."

Table 40

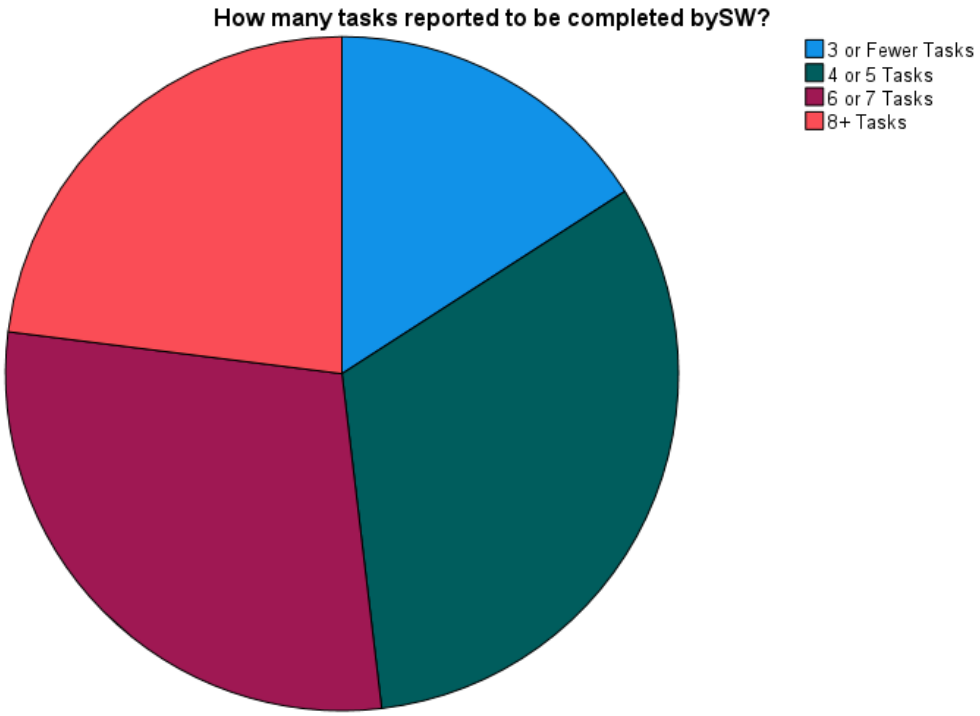
Participants' Number of Reported Job Tasks- Recoded

	N	%
3 or Fewer Tasks	38	15.9
4 or 5 Tasks	77	32.2
6 or 7 Tasks	69	28.9
8+ Tasks	55	23.0

As evidenced by Table 40, most participants (32.2%, n = 77) reported engaging in 4 or 5 job tasks in their position as a school social worker. This is visually represented below in Figure 6.

Figure 6

Participants' Number of Reported Job Tasks- Recoded



Detailed information regarding how many job tasks participants reported engaging in is available for review in Table 41 in Appendix M. Key points from this data set, though, is that the maximum number of reported job tasks was 11 and the minimum number of reported job tasks was 1. The mean was 5.68, the mode was 5, and the standard deviation was 2.165.

Table 42

Cross-Tabulation: Participants' Number of Reported Job Tasks & Use of Trauma-Informed Practices

	0 or 1 Type Used/Reported		2 Types Used/Reported		3 Types Used/Reported		4+ Types Used/Reported		Total	
	N	%	N	%	N	%	N	%	N	%

3 or Fewer Tasks	19	27.1	12	18.8	2	3.8	5	9.6	38	15.9
4 or 5 Tasks	23	32.9	24	37.5	18	34.0	12	23.1	77	32.2
6 or 7 Tasks	16	22.9	19	29.7	18	34.0	16	30.8	69	28.9
8+ Tasks	12	17.1	9	14.1	15	28.3	19	36.5	55	23.0
Total	70	100.0	64	100.0	53	100.0	52	100.0	239	100.0

Table 42 indicates an association between the number of tasks participants reported completing as part of their work and the number of trauma-informed practices they reported engaging in as part of their work. The chart shows that the more tasks participants reported completing, the more forms of trauma-informed practices they also reported engaging in. Those participants who reported completing three or fewer different job tasks reported they were most likely to engage in 0 or 1 type of trauma-informed practices (48.7%, n = 19). This category of participants was, overall, second most likely to report using 0 or 1 form of trauma-informed practices (27.1%, n = 19), likely due to numbers (total n = 38). Those participants who reported engaging in 4 or 5 job tasks reported being most likely to engage in 2 types of trauma-informed practices (31.2%, n = 24), closely followed by 0 or 1 type (29.9%, n = 23). Overall, this group was most likely to engage in both 0 or 1 type of trauma-informed practice (32.9%, n =23) and 2 types of trauma-informed practices (37.5%, n = 24). Those participants who reported engaging in 6 or 7 job tasks reported being most likely to engage in 2 types of trauma-informed practices (27.5%, n = 19), closely followed by 3 types (26.1%, n = 18). This group was tied for the most likely to engage in 3 types of trauma-informed practices with those participants who reported engaging in 4 or 5 job tasks (34.0%, n = 18). Finally, those participants who reported engaging in 8 or more job tasks reported being more likely to engage in 4 or more types of trauma-informed practices (34.5%, n = 19). These participants were, overall, most likely to report using

4 or more types of trauma-informed practices (36.5%, n = 19). Using the crosstabs calculation, it was found that there is significant relationship between the number of job tasks participants reported engaging in and the number of forms of trauma-informed practices reportedly used by participants, $x^2(9) = 25.534$, $p = .005$. This is discussed in greater detail above.

Another factor considered was caseload size. The smallest caseload reported was 8 students and the largest was 7000 students. The mean was 457 students (rounded to a whole number as students are being discussed) and the most frequently reported caseload size (mode) was 60 students. The original data is available for review in Table 43 in Appendix M. The recoded data is below.

Table 44

Survey Participants' Caseload Size- Recoded

	N	%
< 45 Students	51	25.0
45 to < 115 Students	52	25.5
115 to < 600 Students	44	21.6
600+ Students	57	27.9

Of note is the number of participants reporting a caseload of over 600 students. This may be, at least in part, due to participants being responsible for more than one building withing their district or intermediate unit.

Table 45

Study Participants' Reported Caseload by Building

	N	%
1 Building	109	48.4
2 or 3 Buildings	55	24.4

4+ Buildings	61	27.1

As evidenced by Table 45, 51.5% (n = 116) of participants reported being responsible for more than one building.

Using the crosstabs calculation, it was found that there was no significant association between caseload size and the number of forms of trauma-informed practices reportedly used by participants, $x^2(9) = 12.149$, $p = .205$. results are available in Table 46 Appendix M.

Additional factors considered included whether teaching and administrative staff in participants' buildings/districts used trauma-informed practices, if participants' administrators were supportive of their use of trauma-informed practices, and if participants felt physically and emotionally safe in their work settings. These variables are explored below.

Table 47

Participants' Reports of Teacher Use of Trauma-Informed Practices

	N	%
Yes	94	49.5
No	46	24.2
Do Not Know	90	26.3

What is interesting to note is how many participants were unable to answer whether the teachers they work with daily were using trauma-informed practices. However, it was also refreshing to note that 49.5% (n = 94) of responding participants did report that they were aware that their teaching colleagues were actively engaging in trauma-informed practices.

Using the crosstabs calculation, it was found that there was no significant association between teachers' use of trauma-informed practice and the number of forms of trauma-informed

practices reportedly used by participants, $x^2(6) = 10.893$, $p = .092$. The cross-tabulation results are available in Table 48 in Appendix M.

Table 49

Participants' Reports of Administrator Use of Trauma-Informed Practices

	N	%
Yes	104	54.7
No	46	24.2
Do Not Know	40	21.1

Similarly to the data regarding teachers, the majority of responding participants (54.7%, n = 104) reported that their administrators were engaging in trauma-informed practices.

Using the crosstabs calculation, it was found that there was no significant relationship between administrators' use of trauma-informed practices and the number of forms of trauma-informed practices reportedly used by participants, $x^2(6) = 9.454$, $p = .150$. The cross-tabulation results are available in Tables 50 in Appendix M.

Table 51

Administrators' Support of Participants' Use of Trauma-Informed Practices

	N	%
Somewhat or Less	67	35.3
More Than Somewhat	55	28.9
Very Much	68	35.8

Participants reported feeling almost equally supported by administrators "Somewhat or Less" (35.3%, n = 67) and "Very Much" (35.8%, n = 68).

Using the crosstabs calculation, it was found that there was no significant association between administrators' support of participants' use of trauma-informed practices and the number of forms of trauma-informed practices reportedly used by participants, $x^2(6) = 4.295$, $p = .637$. The cross-tabulation results are available in Table 52 in Appendix M.

Table 53

Participants' Reports of How Physically Safe They Feel in the Work Setting

	N	%
Somewhat or Less	34	17.9
Between Somewhat & Very Much	62	32.6
Very Much	94	49.5

Overall, participants reported feeling more than "Somewhat" physically safe in their work settings (73.1%, n = 156), with most reporting feeling "Very Much" so (49.5%, n = 94).

To determine if there was a relationship between participants' sense of physical safety in the work setting and participants' reported use of trauma-informed practices, a cross-tabulation analysis was run between these variables. The findings were not significant, $x^2(6) = 4.313$, $p = .634$, indicating that there is no relationship between participants' sense of physical safety and how much participants reported using trauma-informed practices. The cross-tabulation results are available in Table 54 in Appendix M.

Table 55

Participants' Reports of How Emotionally Safe They Feel in the Work Setting

	N	%
Somewhat or Less	56	29.5

Between Somewhat and Very Much	67	35.3
Very Much	67	35.3

Although, as with participants' reported sense of physical safety in the work setting participants reported feeling mostly more than "Somewhat" emotionally safe (70.6%, n = 134), these numbers are notably lower than when considering physical safety.

To determine if there was a relationship between participants'' sense of emotional safety in the work setting and participants' reported use of trauma-informed practices, a cross-tabulation analysis was run between these variables. The findings were not significant, $x^2(6) = 6.116$, $p = .410$, indicating that there is no relationship between participants' sense of emotional safety in the work setting and how much participants reported using trauma-informed practices. The cross-tabulation results are available in Table 56 in Appendix M.

$H_{1.2}$: Identified factors in the work setting will have a relationship with the use of trauma-informed practices by school social workers.

$H_{0.2}$: Identified factors in the work setting will not have a relationship with the use of trauma-informed practices by school social workers.

At this time, the only identified factor found to be significant regarding a relationship with the number of trauma-informed practices reported to be used by participants was the number of work tasks performed by participants. The data indicated that the more work-related tasks participants reported performing, the more forms of trauma-informed practices they also reported engaging in. This factor supports this researcher's hypothesis that there is a relationship between factors in the work setting and the use of trauma-informed practices by school social workers. However, other factors considered including district setting, district type, caseload,

teachers' use of trauma-informed practices, administrators' use of trauma-informed practices, administrators' support of the use of trauma-informed practices, and participants' sense of physical and emotional safety in the work setting were not found to have significant relationships with participants' reported use of trauma-informed practices. Overall, support for this researcher's hypotheses are mixed and will be discussed further in Chapter 5.

Research Question #3

The third research question posed the question, "is there a relationship between education about trauma-informed practices and the use of trauma-informed practices by school social workers?" To determine this, cross-tabulation analyses were run between the number of trauma-informed practices reported by participants and participants' ratings of their educational and professional development experiences related to trauma-informed practices as well as their reported beliefs about the importance of professional development about trauma-informed practices. As with the earlier two research questions, only significant results will be described below. Information related to nonsignificant findings can be located in Appendix N.

Table 57

BSW Programs: How Prepared Participants Reported Feeling Prepared to Use Trauma-Informed Practices

	N	%
Less Than Somewhat	43	38.7
Somewhat	39	35.1
More than Somewhat	29	26.1

Table 57 shows that the majority of participants who completed a BSW program felt that their programming prepared them "Less Than Somewhat" or "Somewhat" to utilize trauma-informed practices. This sentiment was echoed by one focus group participant who reported, "Undergrad I

feel like was very generic information and just going into what major you're going into unless you were into social work or directly working in some type of counseling but it was very generic information when it was undergrad…" indicating that most undergraduate programs were more generalized unless the students knew, specifically, what fields they were interested in studying.

Cross-tabulation analysis was run to determine if there was an association between how well participants reported feeling their BSW programs prepared them to utilize trauma-informed practices and how many forms of trauma-informed practices they reported using. The findings were not significant, $x^2(6) = 3.862$, $p = .695$. Detailed information is available for review in Table 58 in Appendix N.

Table 59

MSW Programs: How Prepared Participants Reported Feeling Prepared to Use Trauma-Informed Practices

	N	%
Less Than Somewhat	39	18.6
Somewhat	72	34.3
Between Somewhat & Very Much	52	24.8
Very Much	47	22.4

Of those participants who reported completing a MSW program, slightly more reported feeling that their program prepared them "Somewhat" and "Less Than Somewhat" (52.9%, n = 111) than feeling that their program prepared them more than "Somewhat" (47.2%, n = 99). This information is similar to what was discussed during the focus groups as some participants reported learning about trauma-informed practices in graduate school, "…once I got to master's it was a lot more into to that topic." While others did not, "…because it's like, yeah, I know that,

and I, I trained, I didn't learn learn about trauma-informed practice when I was at grad school" and "For me, although it wasn't called trauma-informed back when I was in grad school… Like in social work, like, it's, in my eyes trauma-infor- the trauma-informed lens IS the social work lens."

Cross-tabulation analysis was run to determine if there was an association between how well participants reported feeling their MSW programs prepared them to utilize trauma-informed practices and how many forms of trauma-informed practices they reported using. The findings were not significant, $x^2(9) = 8.452$, $p = .489$. Detailed information is available for review in Table 60 in Appendix N.

Table 61

DSW/Ph.D. Programs: How Prepared Participants Reported Feeling Prepared to Use Trauma-Informed Practices

	N	%
Less Than Somewhat	5	23.8
Somewhat	10	47.6
More Than Somewhat	6	28.6

Table 61 shows that the largest percentage of participants who reported participating in a DSW or Ph.D. program felt that their program prepared them "Somewhat" (47.6%, n = 10) to effectively use trauma-informed practices. No focus group participants reported completing a DSW or Ph.D. program.

Cross-tabulation analysis was run to determine if there was an association between how well participants reported feeling their DSW/Ph.D. programs prepared them to utilize trauma-informed practices and how many forms of trauma-informed practices they reported using. The

findings were not significant, $x^2(6) = 1.867$, $p = .935$. Detailed information is available for review in Table 62 in Appendix N.

Table 63

Certification Courses: How Prepared Participants Reported Feeling Prepared to Use Trauma-Informed Practices

	N	%
Somewhat or Less	85	48.6
More Than Somewhat	90	51.4

Responding participants reported almost equally feeling "Somewhat or Less" (48.6%, n = 85) and "More Than Somewhat" (51.4%, n = 90) prepared to effectively use trauma-informed practices by the certification courses they participated in.

Cross-tabulation analysis was run to determine if there was a relationship between how well participants reported feeling certification courses they participated in prepared them to effectively utilize trauma-informed practices and how many forms of trauma-informed practices they reported using.

Table 64

Cross-Tabulation: Level of Preparation Provided by Certification Courses & Practice & Participants' Use of Trauma-Informed Practices

	0 or 1 Types Used/Reported		2 Types Used/Reported		3 Types Used/Reported		4+ Types Used/Reported		Total	
	N	%	N	%	N	%	N	%	N	%
Somewhat or Less	18	45.0	31	62.0	16	34.0	22	52.6	85	48.6
More Than Somewhat	22	55.0	19	38.0	31	66.0	18	47.4	90	51.4

Total	40	100.0	50	100.0	47	100.0	38	100.0	175	100.0

Table 64 indicates that, not only are the participants who reported the certification courses they participated in prepared they "Somewhat or Less" more likely (62.0%, n = 31) to use two types of trauma-informed practices in the school setting than those participants who reported feeling "More than Somewhat" prepared by their certification courses (38%, n = 19), but they are also more likely to report using two types of trauma-informed practices (36.5%, n = 31) than 0 or 1 type (21.2%, n = 18), 3 types (18.8%, n = 16), or 4+ types (25.9%, n = 22). Participants who reported feeling "More Than Somewhat" prepared to effectively use trauma-informed practices were most likely to report using 3 types of trauma-informed practices (66.0%, n = 31) compared those who reported feeling "Somewhat or Less" prepared (34.0%, n = 16). Within the group, these participants are still most likely to report using 3 types of trauma-informed practices (34.4%, n = 31) compared to 0 or 1 type (24.6%, n = 22), 2 types (21.1%, n = 19), and 4+ types (20.0%, n = 18). Cross-tabulation analysis was run to determine if there was an association between how well participants reported feeling certification courses they participated in prepared them to effectively utilize trauma-informed practices and how many forms of trauma-informed practices they reported using. Findings were significant, $x^2(3) = 8.036$, $p = .045$.

Table 65

New Staff Induction/Formal Mentoring Programming: How Prepared Participants Reported Feeling Prepared to Use Trauma-Informed Practices

	N	%
Not At All	50	27.2
Less Than Somewhat	73	39.7
Somewhat or More	61	33.2

Table 65 indicates that responding participants reported that, overall, participation in new staff induction and/or formal mentoring programming did not do a great deal to prepare them to effectively use trauma-informed practices. Participants reported that, if at all, they felt less than prepared to do so by these forms of workplace programs (66.9%, n = 123).

Cross-tabulation analysis was run to determine if there was an association between how well participants reported feeling that new staff induction and/or formal mentoring programming prepared them to utilize trauma-informed practices and how many forms of trauma-informed practices they reported using. The findings were not significant, $x^2(6) = 9.874$, $p = .130$. Detailed information is available for review in Table 66 in Appendix N.

Table 67

Professional Experience/On-the-Job Experience: How Prepared Participants Reported Feeling Prepared to Use Trauma-Informed Practices

	N	%
Somewhat or Less	46	21.2
Between Somewhat & Very Much	61	28.1
Very Much	110	50.7

Responding participants reported that, overwhelmingly, they felt that their professional experience prepared them “Somewhat” or more, leaning toward “Very Much” to effectively utilize trauma-informed practices (78.8%, n = 171). Focus group participants also spoke of their professional experiences, specifically with students receiving emotional support services, enhancing their understanding of trauma and trauma-informed practices.

> And really gravitating toward emotional support students for some reason, like, I really enjoy being able to get in there and really work with the and figure out what makes them tick and just starting to know some of their histories and being like "wow, like, this is such, such a high population of these ES kiddos who have experienced those big traumatic events." So just being willing to and being interested in being able to help them.
>
> … I was the emotional support social worker and it's so interesting how, like, that was such a culture shock coming from, like, a reg, you know, a big public district to, like, a small school with, like, all ES kids and you see, like, there's how much trauma they've had and trying to not only just understand it all but then, you know, figure out how you can be trauma-informed with all of those different kids who have had a ton of different types of trauma and how to, like, you know, differentiate and all those things.

Cross-tabulation analysis was run to determine if there was a relationship between how well participants reported their professional experience prepared them to utilize trauma-informed practices and how many forms of trauma-informed practices they reported using. The findings were not significant, $x^2(6) = 7.132$, $p = .309$. Detailed information is available for review in Table 68 in Appendix N.

Table 69

Professional Development: How Prepared Participants Reported Feeling Prepared to Use Trauma-Informed Practices

	N	%
Somewhat or Less	74	34.6

Between Somewhat & Very Much	64	30.4
Very Much	75	35.0

Responding participants reported almost equally feeling that their experiences with professional development prepared them to effectively utilize trauma-informed practices “Somewhat or Less” (34.6%, n = 74) and “Very Much” (35.0%, n = 75). Focus group participants reported their first exposure to training about trauma and trauma-informed practices was through professional development, “Training through the district and our IU.” One participant spoke of a professional development experience that deeply impacted her mindset.

> I feel like it was the first in-service that I attended back in 2018 when we talked about ACEs and I first watched the Nadine Burke-Harris video which I have since watched a hundred times and could probably recite. I think that was, not that I had never heard about trauma, but that was the first time I think I connected, wow this is something that a lot of our students experience. And I remember the Director of Student Services at the time saying "okay, we're not gonna run out and give all the kids the ACE survey now, we're going to assume that all of our kids have experienced some type of Adverse Childhood Experience." So, just kind of that kind of shifted my mindset.

However, concerns were raised about the quality of trainings provided to educators and school staff in general as a result of time constraints,

> … I don't think necessarily that the trainings are very clear as far as what trauma is and how. I think some places will just do an hour or two hour voila and now suddenly we're all trauma trained. But what does that really mean?

Cross-tabulation analysis was run to determine if there was a relationship between how well participants reported their professional development experiences prepared them to utilize trauma-informed practices and how many forms of trauma-informed practices they reported using. The findings were not significant, $x^2(6) = 4.554$, $p = .602$. Detailed information is available for review in Table 70 in Appendix N.

Table 71

Professional Conferences: How Prepared Participants Reported Feeling Prepared to Use Trauma-Informed Practices

	N	%
Somewhat or Less	63	30.9
Between Somewhat & Very Much	80	39.2
Very Much	61	29.9

A small majority of responding participants reported feeling that their experiences with professional experiences prepared them "Between Somewhat & Very Much" to effectively use trauma-informed practices (39.2%, n = 80). One focus group participant spoke of attending professional conferences and being able to tie what she learned at these sessions with lived experiences to better understand the concepts of trauma and trauma-informed practices.

> I know I'm an adoptive parent, so during the last whatever, 15 years, our lives with my oldest son just some of the trainings I had to go to along with some of the conferences I've been to as a social worker, heard different pieces of, you know, this word 'trauma' and, like, how it's connected to, you know, like, it kind of opened up my eyes to, like, some of the things we were going through and hearing, oh okay, that's what could be going on in his little life and how he's 26.

Table 72

Cross-Tabulation: Level of Preparation Provided by Professional Conference Experiences & Participants' Use of Trauma-Informed Practices

	0 or 1 Types Used/ Reported		2 Types Used/Reported		3 Types Used/Reported		4+ Types Used/Reported		Total	
	N	%	N	%	N	%	N	%	N	%
Somewhat or Less	20	42.6	19	31.7	9	18.8	15	30.6	63	30.9
Between Somewhat & Very Much	18	38.3	29	48.3	17	35.4	16	32.7	80	39.2
Very Much	9	19.1	12	20.0	22	45.8	18	36.7	61	29.9
Total	47	100.0	60	100.0	48	100.0	49	100.0	204	100.0

Table 72 shows that as responding participants reported a higher level of perceived preparation, the most frequently reported number of trauma-informed practices utilized increased. Those participants who reported feeling "Somewhat or Less" prepared to use trauma-informed practices by their professional conference experiences were the most likely to report using 0 or 1 type of trauma-informed practice (42.6%, n = 20). Additionally, 0 or 1 type of trauma-informed practice was the most frequently reported number of practices reported by those who reported feeling "Somewhat or Less" (33.3%, n = 30) followed very closely by two types of trauma-informed practices (30.2%, n = 19). Those participants who reported feeling "Between Somewhat & Very Much" prepared to use trauma-informed practices by their professional conference experiences were the most likely to report using two types of trauma-informed practices (48.3%, n = 29). Two types of trauma-informed practices were the most commonly reported number of practices reportedly used by those who reported feeling "Between Somewhat & Very Much" prepared (36.2%, n = 29). Finally, those participants who reported feeling "Very Much" prepared to effectively use trauma-informed practices by their professional conference

experiences were the most likely participants to report using three types of trauma-informed practices (45.8%, n = 22) as well as 4+ types of trauma-informed practices (36.7%, n = 18). Within this group of participants, the most commonly reported number of trauma-informed practices utilized was three (36.1 %, n = 22). Cross-tabulation analysis was run to determine if there was an association between how well participants reported their professional conference experiences prepared them to utilize trauma-informed practices and how many forms of trauma-informed practices they reported using. The findings were significant, $x^2(6) = 14.995$, $p = .020$. As discussed above, the more participants reported they felt their professional conference experiences prepared them to use trauma-informed practices, the more forms of trauma-informed practices they reported using as part of their roles as school social workers.

Table 73

Independent Study: How Prepared Participants Reported Feeling Prepared to Use Trauma-Informed Practices

	N	%
Somewhat or Less	61	31.8
Between Somewhat & Very Much	63	32.8
Very Much	68	35.4

A slight majority of responding participants reported feeling "Very Much" prepared to use trauma-informed practices by their independent study experiences (35.4%, n = 68). One focus group participant spoke of her positive learning experience via independent study.

> But to answer your question, one of the ways I learned was just through reading a book, *What Happened to You* by Dr. Perry and Oprah Winfrey. It was fabulous and through that, my complete understanding of trauma has, has changed, has altered it and has developed

and I, it just gave me a whole new perspective about the brain and how the brain's functioning and what's happening. And, yeah, so that's, that's how I learned, and I just thought it was absolutely phenomenal and I've read some more of his stuff.

Table 74

Cross-Tabulation: Level of Preparation Provided by Independent Study Experiences & Participants' Use of Trauma-Informed Practices

	0 or 1 Types Used/ Reported		2 Types Used/Reported		3 Types Used/Reported		4+ Types Used/Reported		Total	
	N	%	N	%	N	%	N	%	N	%
Somewhat or Less	18	43.9	21	39.6	13	26.0	9	18.8	61	31.8
Between Somewhat & Very Much	15	36.6	19	35.8	15	30.0	14	29.2	63	32.8
Very Much	8	19.5	13	24.5	22	44.0	25	52.1	68	35.4
Total	41	100.0	53	100.0	50	100.0	48	100.0	204	100.0

Table 74 shows that as responding participants reported a higher level of perceived preparation, the most frequently reported number of trauma-informed practices utilized increased. Those participants who reported feeling "Somewhat or Less" prepared to use trauma-informed practices by their professional conference experiences were the most likely to report using 0 or 1 type of trauma-informed practice (43.9%, n = 18). This category of participants was also most likely to report using two types of trauma-informed practices (39.6%, n = 21). Within category, the most frequently reported number of trauma-informed practices was two (34.4%, n = 21). Those participants who reported feeling "Very Much" prepared to effectively use trauma-informed practices by their independent study were the most likely participants to report using three types of trauma-informed practices (44.0%, n = 22) as well as 4+ types of trauma-informed practices (52.1%, n = 25). Within this group of participants, the most commonly reported number

of trauma-informed practices utilized was 4+ (36.8 %, n = 25). Cross-tabulation analysis was run to determine if there was a relationship between how well participants reported their professional conference experiences prepared them to utilize trauma-informed practices and how many forms of trauma-informed practices they reported using. The findings were significant, $x^2(6) = 14.995$, $p = .020$. As discussed above, the more participants reported they felt their professional conference experiences prepared them to use trauma-informed practices, the more forms of trauma-informed practices they reported using as part of their roles as school social workers.

Table 75

Professional Supervision: How Prepared Participants Reported Feeling Prepared to Use Trauma-Informed Practices

	N	%
Less Than Somewhat	72	38.7
Somewhat or More	114	61.3

As indicated above in Table 75, most responding participants reported that they felt professional supervision prepared them “Somewhat or More” to effectively engage in trauma-informed practices (61.3%, n = 114).

Cross-tabulation analysis was run to determine if there was an association between how well participants reported their professional supervision experiences prepared them to utilize trauma-informed practices and how many forms of trauma-informed practices they reported using. The findings were not significant, $x^2(3) = 5.274$, $p = .153$. Detailed information is available for review in Table 76 in Appendix N.

Table 77

Participants' Beliefs: Importance of Professional Development About Trauma & Trauma-Informed Practices

	N	%
Less Than Very Much	40	18.5
Very Much	176	81.5

Table 77 shows that an overwhelming majority of responding participants believe that there is a need for ongoing professional development regarding trauma and trauma-informed practices. As discussed, when reviewing themes that emerged during focus groups, training and professional development was an identified area of need both for school social workers and other school staff.

Cross-tabulation analysis was run to determine if there was an association between participants' beliefs about the need for ongoing professional development about trauma and trauma-informed practices and how many forms of trauma-informed practices they reported using. The findings were not significant, $x^2(3) = 3.811$, $p = .283$. Detailed information is available for review in Table 78 in Appendix N.

This researcher's original research question was, "is there a relationship between education about trauma-informed practices and the use of trauma-informed practices by school social workers?" The hypothesis and null hypothesis are noted below:

$H_{1.3}$: There is a relationship between school social workers' education related to trauma-informed practices and their use of trauma-informed practices.

$H_{0.3}$: There is no relationship between school social workers' education related to trauma-informed practices and their use of trauma-informed practices.

As with research question #2, the results are mixed. Formal education and other educational experiences typically put into place through formal avenues were found to have no significant relationship with participants' reported use of trauma-informed practices. However, professional development experiences more often sought by individuals independently, including professional conferences and independent study, were found to have significant relationships with participants' use of trauma-informed practices. These findings will be discussed further in Chapter 5. At this time, this researcher's hypothesis is supported in some educational realms and the null hypothesis is supported in others.

Research Question #4

The fourth research questioned asked, "is there a relationship between identified factors and participants' interest in participating in more training related to trauma-informed practices?" In order to determine if any such relationships exist, crosstabulation analyses were run between the variable regarding whether or not participants expressed interest in further professional development about trauma-informed practices and variables related to participants' beliefs about the importance of such training (see Table 77 for frequencies), the ease of access to professional development opportunities, their administrators' support of them attending professional development, and barriers they may be facing in accessing professional development opportunities. As with the previous research questions, only significant results will be described below. Information related to nonsignificant findings can be located in Appendix O.

Table 79

Participants' Interest in Further Professional Development Regarding Trauma-Informed Practices

	N	%
Interested	141	59.0
Not Interested	98	48.0

Table 79 indicates that, although a majority of participants (59.0%, n = 141) expressed interest in further professional development regarding trauma-informed practices, it is not a large majority. This does align with ideas that surfaced in both focus groups; although participants expressed interest in further professional development, they also made a point to note that, absent more advanced training, staff are losing interest, “Sometimes you say, ‘oh, we're going to do trauma training’ and everyone's like ‘oh, here we go again.’” Discussion centered around the idea that many current school social workers and school staff members have already received the basics regarding trauma-informed care.

> And so I know, here at the IU we tried to do a trauma 2.0 and increase, you know, for those who already had already been trained because you get a lot of glossy eyed individuals at trainings where they're like "I know this stuff" so you have to step it up and try to make it something relevant to what we're experiencing now.

Table 80

Cross-Tabulation: Importance of Professional Development About TIP and Participants’ Interest in Further Professional Development About TIP

	Interested		Not Interested		Total	
	N	%	N	%	N	%
Less Than Very Much	18	12.8	22	29.3	40	18.5
Very Much	123	87.2	53	70.7	176	81.5
Total	141	100.0	78	100.0	216	100.0

Although the table shows that those participants who reported feeling it was "Very Much" important for school social workers to receive ongoing professional development about trauma-informed practices were more likely than those who responded with "Less Than Very Much" to express interest and no interest in further professional development regarding trauma-informed practices, this was due to the much larger total number of respondents in this category (n = 176 compared to n = 40). Of note, though is that of those participants who responded with "Less Than Very Much," 55.0% (n = 22) responded that they were not interested in receiving further professional development about trauma-informed practices. In contrast, of those participants who responded with "Very Much," 69.9% (n = 123) expressed interest in receiving further professional development about trauma-informed practices. Using the crosstabs calculation, it was found that there is significant association between participants' beliefs about whether social workers should receive ongoing professional development regarding trauma-informed care and participants' expressed interest in further professional development regarding trauma-informed care, $x^2(1) = 8.906$, $p = .003$. Fisher's Exact Test was considered due to the small sample size, and was also significant at $p = .005$, but as each cell had an expected count of 5 or greater, this test is not necessary (Field, 2018). As discussed above, those participants who reported believing ongoing professional development for school social workers about trauma-informed care was important were more likely to express interest in this type of professional development for themselves.

Table 81

How Easily Participants Are Able to Access Professional Development About Trauma-Informed Practices

	N	%
Somewhat or Less	90	44.7

Between Somewhat & Very Much	52	24.8
Very Much	64	30.6

The largest group of responding participants reported that they are able to "Somewhat or Less" easily access professional development opportunities about trauma-informed practices (44.7%, n = 90). This is of concern and important to note as in Table 77 it was determined that the majority of responding participants expressed interest in obtaining further professional development regarding trauma-informed practices.

Table 82

Cross-Tabulation: Ease of Access and Participants' Interest in Further Professional Development About TIP

	Interested		Not Interested		Total	
	N	%	N	%	N	%
Somewhat or Less	69	51.1	21	29.6	90	43.7
Between Somewhat & Very Much	32	23.7	20	28.2	52	25.2
Very Much	34	25.2	30	42.3	64	31.1
Total	135	100.0	71	100.0	206	100.0

Table 82 indicates that those participants who reported lower levels of ease of access to trauma-informed practice professional development opportunities also expressed more interest in attending such sessions (51.1%, n = 69) while those who reported high levels of ease of access reported not being interested in attending the trauma-informed professional development (42.3%, n = 64). When looking at the ease of access categories, the reported interest in attending further professional development about trauma-informed practices decreases as ease of access increases.

66.7% (n = 69) of participants who reported “Somewhat or Less” ease of access to professional development expressed interest in these ongoing training opportunities, 61.5% (n = 32) of participants who reported “Between Somewhat and Very Much” ease of access reported interest in further trauma-informed practice professional development, and 51.1% (n = 34) of participants who reported “Very Much” ease of access reported interest in participating in ongoing professional development related to trauma-informed practices. Using the crosstabs calculation, it was found that there is significant association between participants’ beliefs about how easily participants reported being able to access professional development and participants’ expressed interest in further professional development regarding trauma-informed care, $x^2(2) = 9.669$, $p = .008$. As discussed above, as access to professional development about trauma-informed practices was reported to become more difficult, reported interest was reportedly higher.

Table 83

Participants’ Perceived Support by Administrators to Engage in Trauma-Informed Practices Professional Development

	N	%
Somewhat or Less	92	44.7
Between Somewhat &Very Much	51	24.8
Very Much	63	30.6

Table 83 shows that, again, although the majority of participants expressed an interest in participating in professional development about trauma-informed practices, almost half (44.7%, n = 92) of participants reported feeling only “Somewhat or Less” supported by their administrators to do so. Only 30.6% (n = 63) reported feeling “Very Much” supported by their administrators to attend professional development opportunities regarding trauma-informed practices.

To determine whether there was relationship between perceived support of administration and participants' interest in attending trauma-informed practices professional development, a cross-tabulation analysis was run between these variables. The findings were not significant, $x^2(2) = 3.216$, $p = .200$, indicating that there is no relationship between administrator support and participants' reported interest in attending professional development. The cross-tabulation results are available in Table 84 in Appendix O.

Table 85

Potential Barriers to Trauma-Informed Practices Professional Development Participation Reported by Participants

	Experienced		Not Experienced	
	N	%	N	%
Cost/Financial Constraints	153	64.0	86	36.0
Work Demands	149	62.3	90	37.7
Time	138	57.7	101	42.3
Availability of Professional Development Opportunities	95	39.7	144	60.3
Home/Family Responsibilities	60	25.1	179	74.9
None	32	13.4	207	86.6
Other	8	3.3	231	96.7
Not Interested	2	.8	237	99.2
TIP Not Useful	2	.8	237	99.2

Table 85 details the barriers participants were asked whether they faced when trying to access professional development about trauma-informed practices. Of note is that only 32 responding participants (13.4%) denied experiencing any barriers. The three most common barriers included the cost of professional development or other related financial constraints (64.0%, n = 153),

demands in the workplace (62.3%, n = 149), and finding the time to engage in the professional development sessions (57.7%, n = 138). It is key to remember that time and school social workers' many roles did emerge as part of a major theme related to systemic factors.

A new variable was created to consider the number of barriers reported by participants. The original, uncoded frequency chart for this variable is available for review in Table 86 and Figure 7 in Appendix O. This raw data was recoded for analysis purposes. However, of importance is that both the median and mode were three reported barriers.

Table 87

Number of Barriers to Engaging in Professional Development Participants Reported Encountering- Recoded

	N	%
0-1	49	20.5
2	49	20.5
3	79	33.1
4	47	19.7
5+	15	6.3

This recoded data shows that most participants reported facing three or fewer barriers to participating in professional development.

Figure 8

Number of Barriers to Engaging in Professional Development Participants Reported Encountering- Recoded

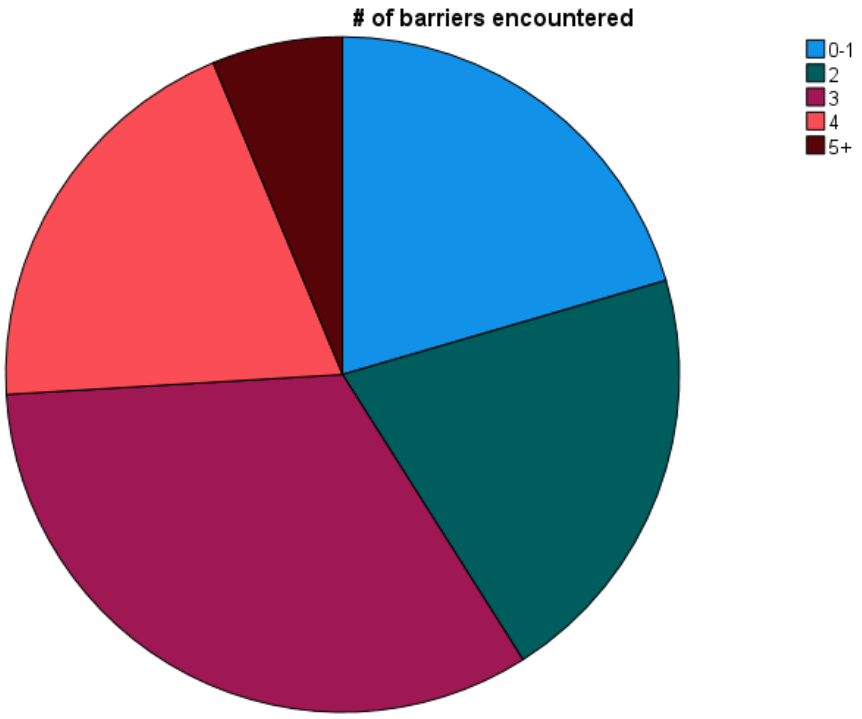


Figure 8 provides a visual representation of the recoded data.

Table 88

Cross-Tabulation: Number of Barriers Reportedly Faced & Participants' Interest in Further Professional Development about TIP

	Interested		Not Interested		Total	
	N	%	N	%	N	%
0-1	13	9.2	36	36.7	49	20.5
2	30	21.3	19	19.4	49	20.5
3	48	34.0	31	31.6	79	33.1
4	36	25.5	11	11.2	47	19.7
5+	14	9.9	1	1.0	15	6.3
Total	141	100.0	98	100.0	239	100.0

Table 88 shows that those participants who reported three barriers to participating in professional development related to trauma-informed care expressed the highest level of interest in this training (34.0%, n = 48) and those that reported experienced the fewest barriers (0-1) expressed

the lowest level of interest in professional development related to trauma-informed care (36.7%, n = 36). When looking at interest in participating in professional development related to trauma-informed care, the data is slightly different. The participants reporting 0-1 barriers still reported a high level of disinterest in participating in the training, (73.5%, n = 36). Of those reporting barriers, the interest level increases overall as the number of barriers increase. 61.2% (n = 30) of participants reporting two barriers reported interested in continued professional development about trauma-informed care, 60.8% (n = 48) of participants reporting three barriers reported interested in continued trauma-informed practices professional development, 76.6% (n = 36) of participants who reported four barriers reported interest in the same ongoing professional development, and 93.3% (n = 14) of participants who reported five or more barriers reported interested in further professional development regarding trauma-informed practices. Cross-tabulation analysis was run to determine if there was an association between how many barriers to accessing trauma-informed practices professional development and expressed interest in such training. Findings were significant, $x^2(3) = 34.881$, $p < .001$. As discussed above, as participants' barriers increased, their interest in continued training increased.

This researcher's original question was, "is there are relationship between identified factors and participants' desire for training related to trauma-informed practices?" The following hypotheses were suggested:

> $H_{1.4}$: There is a relationship between identified factors and participants' interest in engaging in further professional development regarding trauma-informed practices
>
> $H_{0.4}$: There is no relationship between identified factors and participants' interest in engaging in further professional development regarding trauma-informed practices.

Through the use of cross-tabulation analysis, participants' interest in ongoing professional development regarding trauma-informed practices was analyzed with variables including beliefs about the importance of ongoing professional development about trauma-informed practices for school social workers, availability of professional development, administrators' encouragement to participate in professional development, and the number of barriers faced by participants to participate in professional development. All factors, except for encouragement by administrators were significant, supporting this researcher's hypothesis that identified factors have a relationship with participants' interest in participating in further professional development regarding trauma-informed practices. This will be discussed further in Chapter 5.

Chapter 5- Analysis and Synthesis

This chapter will analyze the findings of this study in comparison to existing literature related to the use of trauma-informed practices in schools on a larger scale. Concepts discussed will include connection, the effects of understanding on the use of trauma-informed practice, systemic factors, and the discrepancies between training needs and existing training opportunities for school social workers.

Connection

A theme that emerged during the focus groups was the concept of connection, the cornerstone of trauma-informed practices (Scott, 2020). Participants spoke of the importance of listening, building relationships, and encouraging relationships between students and other safe adults with whom they are connected, "…hey, maybe today I'm not your person, that's okay, I'm not offended by that, who is your person, let's find your person." They also spoke of using connections as a way to empower students and families,

> They wanna be shown respect and they deserve to be shown respect and so, just allowing the time to kinda talk about their stories and what works for them and what doesn't work for them and while, yes, there are going to be academic demands, I think just being willing to, to listen to them and allowing them to be part of the decision-making process as much as then can be is, is something that certainly would be helpful and, you know, families as well.

Connection was not directly inquired about in the survey. However, it did emerge through the styles of trauma-informed practices and common daily tasks reported as most frequently utilized by participants. These include the trauma-informed mindset, which requires responding to students in an empathetic manner (Thomas et al., 2019) creating an environment where students feel safe and supported (Herrenkohl et al., 2019), trauma-informed social emotional learning where students are taught social emotional skills in a supportive, strengths-based environment to build resiliency (Creswell Báez et al., 2019; Flanagan & Rodriguez, 2021), and trauma-informed restorative justice which promotes an accepting community in which students and staff are able to accept ownership for their decisions without shame or punitive, re-traumatizing consequences (Sedillo-Hamann, 2022). Additionally, the most commonly reported school social work task was working with students on an individual level, followed by connecting families and students to community resources, then engaging with families. Each of these tasks is a form of connecting and community building, which has been shown to not only be beneficial to students' academic performance (Fraser & Price, 2011; Subramaniam & Wuest, 2022) but also to help mitigate the effects of trauma-exposure (Brandell & Ringel, 2019; Forkey et al., 2021; McWey, 2020; Perry & Szalavitz, 2017; Simcock et al., 2021; Stokes & Brunzell, 2019; Wilson-Ching & Berger, 2024).

It is important to note here that a significant relationship was found between the number of tasks participants reported routinely completing as part of their job role and how many forms of trauma-informed practices they reported utilizing as part of their practice. This was the only significant job-related factor found to have a relationship with the number of forms of trauma-informed practices participants reported using. The relationship was the opposite of what this researcher expected to find. This researcher suspected that the more job tasks participants reported engaging in, the fewer forms of trauma-informed practices they would report utilizing based on existing literature (Lovell et al., 2022). However, the opposite was actually found through this study. It is important to consider the wide range of roles that school social workers are expected to, and do, fill across the micro-, mezzo-, and macro-levels that vary between districts and intermediate units (Ding, et al., 2023; Teasley & Richard, 2017) also discussed in the focus groups (see Chapter 4). It is possible that, in an effort to fulfill these roles and job expectations, participants are, essentially, doing it all. It is also possible that participants are simply doing what they do best—fostering relationships to make positive changes (Mack, 2022).

Understanding of Trauma-Informed Practices

A theme that emerged during the focus groups was the idea that the way trauma-informed practices is understood by school mental health staff, teachers, and school administrators greatly affects the way it is utilized within classrooms, schools, school districts, and intermediate units. Not only does the understanding of the concept matter, but the language used also matters. What is “trauma” and what is “trauma-informed practices” and is there a shared definition among staff? Interestingly, the factors related to education about trauma-informed practices that were found to have a significant relationship to the use of trauma-informed practices by participants were those forms of education and professional development that tend to be more specialized

and, often, sought out by those who are already interested and, at least, somewhat knowledgeable about specific topics. These included professional certification courses, professional conferences, and independent study. Those forms of training and professional development that are more general to social workers and school staff, such as social work degree programs and work-related programming, were not found to have a significant relationship with the use of trauma-informed practices. The very thing that should help offset the concerns raised in the focus groups, formal and employer-based professional development, was found by the survey to have no relationship with participants' use of trauma-informed practices. Concerns regarding professional development will be discussed later in this chapter, but a question about what is being taught in college to prospective teachers was raised during one focus group, "And I don't know what is going on in, you know, the teachers' colleges as far as how they're being taught about it. Is it even being prioritized? Is it an elective?" Results reviewed in Chapter 4 indicate that, although responses are mixed, school social workers are receiving some education about trauma-informed practices in their BSW, MSW, and DSW/Ph.D. programs. It is not clear if this is the case for educators and school administrators. Of importance is that years of experience (years as a school social worker/years as a licensed social worker) did not have a significant relationship to the use of trauma-informed practices. This does align with perspectives from the focus groups in which participants spoke of learning about trauma-informed practices at different times of their careers but being equally engaged in using it with fidelity. This difference in education, compiled with differing definitions of the word "trauma" (Mersky et al., 2019), creates an environment in which it is difficult to effectively implement school-wide trauma-informed practice programming. A focus group participant noted,

> I think, for me, there's a discrepancy between what people think are trauma-informed practices and what they actually are… I feel like there's a, there's a discrepancy there between what you think you're doing and that you're having an impact. Are we actually implementing trauma-informed interventions across the board and keeping those things in mind when we're working with with students?

Systemic Factors

Interestingly, in a previous qualitative study completed by this researcher with school staff regarding adolescent mental health and help-seeking behaviors (Schoonmaker, 2022), a theme that emerged was the role of systemic factors. This was a factor that emerged in this study as well. Focus group participants expressed concerns and frustrations about the impact that time, varying job roles, and funding have on their ability to effectively use trauma-informed practices as well as their colleagues' ability to use trauma-informed practices in the work setting. Participants, as discussed in Chapter 4, spoke of not knowing where they will be from day to day and having many job roles ranging from working with students with special education needs to working with displaced students to working only with parents and caregivers to providing staff education to addressing student attendance concerns. Survey results mirrored this with a range of job tasks being completed by participants. As previously explored in the section above, job tasks had the opposite expected relationship with the use of trauma-informed practices when survey results were analyzed. It is unknown if participants are taking on so much because they are this engaged in relationship-building and supporting their clients, if they feel they must do all of these tasks because other staff will not or cannot, or if it is being mandated by their administrators.

Additionally, focus group participants voiced concerns about how time limits can affect how well trauma-informed practices can be implemented by school staff.

> So just, I think, sometimes time is the reason that trauma-informed practice isn't always everyone's go-to because you need to to meet with that student or talk to with that student or pull that student aside instead of just saying "hey, cut that out," right, because his behavior was different than the last time this substitute was in for him. So, time, I think, time is a big barrier.

This concern was mirrored in a program evaluation study completed in two schools involving over 500 schools by Creswell Báez et al. (2019). This study found that students wanted staff to know they were trying to change but it is not something that is instantaneous- it takes time, particularly when they continue to face daily challenges. To see true change, staff must be prepared and able to engage in these practices daily, not just short term, which requires top-down support to ensure long-term implementation and sustainability (Dorsey et al., 2017). This was also discussed in one of the focus groups as one district is starting this work of long-term implementation,

> …trying to make it where we're not, this is not just a new concept, we're not just, we're not, not one more thing, you know, you go, you go to an in-service and there's one more thing and you do it for a month or two and then you learn about the new thing you're doing now.

Time was not explored as a factor related to the implementation of trauma-informed practices as part of the quantitative portion of the study.

Funding was also discussed as a barrier during the focus groups when discussing what participants wish they could access to assist them in implementation of trauma-informed practices in their work. One participant stated,

> We need more money for mental health fields to support a lot of the actual, you know, resources that we have 'cuz it's very limited. You can do mental health but if you're not, if you don't have insurance or you don't have money, it it just, it doesn't happen. So funding, definitely for sure, funding.

This statement was immediately met with head nods and murmurs of agreement. Another participant spoke up with information regarding a grant that was recently released in Pennsylvania that participants expressed a great deal of interest in. It is no surprise that concerns about cost and funds were discussed as this was mirrored in the literature when discussing barriers to implementing trauma-informed programming in schools (Arnold et al., 2020; Herrenkohl, 2019; Lovell et al., 2022)

Funding, time, and work demands will be discussed further in the next section regarding professional development as these factors were not directly addressed in relation to the use of trauma-informed practices in the survey.

Training Needs and Existing Barriers

Focus group participants unanimously expressed their interest in further professional development regarding trauma-informed practices while 59% (n = 141) of survey participants expressed interest in further professional development in trauma-informed practices, mirroring the findings of Berger et al. (2023) and Chudzik et al. (2022). However, concerns were raised about the quality and accessibility of trainings.

Focus group participants expressed frustration about the quality of professional development opportunities available both to school social workers and to teaching staff. Concerns raised were that training courses are general overviews that are not standardized across the state and do not go beyond the surface-level. This concern is closely aligned with one of the top barriers reported by survey participants- availability of professional development. Once social workers have exhausted existing training opportunities, what is left?

> And I guess I'm just concerned for the educators, like, the teachers, because it's up to the district to pick what training they get and if they only allot two hours, it's just not enough… So, I wish there was just a standard of this is what every educator gets as the basis of the training.

> I would like more in-depth discussion and pulling together some of the things I've heard and, the way I see it, maybe, we need to be looking at, for example, case discussions- what are the issues?... What are the elements of trauma that we need to be sensitive to? How can I help? How, how can I be of service? ... It's about, I always see our job as helping square pegs and round holes. What can I do for the peg? What can I do for the hole? To make it a more appropriate fit. So, I think I would like us to be more practice-based. You know, what this is, we're all this chat about trauma-informed, what does it really mean in practice? … And so I know that we can adapt and adjust, but I think that we need to be empowering ourselves because I think that if, if you're a Master's level social worker, you've got, you've got crazy mad skills already and it's about learning how to use them and apply them to the situation.

Survey participants also reported facing barriers to engaging in professional development. The top reported barriers included cost/financial constraints, work demands, time,

and availability of professional development opportunities. As noted in the section above, funding can be an issue in implementation of school-wide programming, which likely makes it worse for individual requests for training. Unfortunately, with the current post-COVID political climate, it is anticipated that school funding concerns will only worsen (Vassallo, 2023). Also discussed at length above are the number of work demands participants are faced with. If participants are engaging in so many activities during the workday, it goes without saying that time would be of concern. This is particularly an issue if a school social worker requesting time away to engage in a professional development session is the only school social worker in a building or district.

Survey data analysis showed significant relationships between barriers to professional development and interest in participating in professional development regarding trauma-informed practices. However, instead of this researcher's belief that an increase in barriers to attendance would be associated with a lower level of interest, the opposite was suggested in the data. Upon review of the data, it is suspected that when participants have a higher level of interest in professional development, they are more likely to encounter barriers to attendance, whereas participants who are not interested in attending will not encounter these barriers because they will not be seeking the opportunities in the first place.

Issues of Trustworthiness

As previously discussed in Chapter 3, steps were taken throughout the design and implementation of this study to increase validity and reliability while reducing errors and bias. However, it was impossible to account for all limitations and, unfortunately, the nature of self-report surveys and new tools creates issues in these errors.

Validity and Reliability

Steps were taken to ensure a high level of validity and reliability in this study. However, it is important to point out that the tools utilized in this study were created for this study and require further testing to establish validity and reliability with certainty. Pilot testing of the survey tool, as previously reviewed, was conducted to establish face validity and ensure participants understood what was being asked. Inter-coder reliability testing was completed, and details were reported in Chapter 5. External validity cannot be determined as the study size was small and limited to school social workers within Pennsylvania. Reliability cannot be determined with certainty as this study was a one-time cross-sectional study not repeated with similar or dissimilar populations.

Limitations

Limitations of this study include the small sample size limited to just Pennsylvania's public school social workers and cross-sectional design. As such, results cannot be transferred to any other population or time period. It is possible that a different population or a similar population at a different time may present different results.

Additionally, the self-report nature of this study is considered a limitation. There is a chance of respondent bias due to participants attempting to answer the questions in a way that is more socially desirable or acceptable and self-selection bias in which participants who are interested in the topic choose to participate and those who are not interested do not participate in this sort of study (Rubin & Babbie, 2017). To try to minimize this effect, the title of the survey was about school social work practices in general, not specifically trauma-informed practices. It is also important to consider the impact that concern about protecting one's employer or employment status may have on self-reporting.

Another limitation to consider is that the study does not explore the effects of cultural beliefs on the use of trauma-informed practices, something that came out during the focus groups. This is an area that is important to keep in mind and will be discussed later in Chapter 6 regarding suggestions for further research.

Summary

Chapter 5 synthesized the results of the qualitative and quantitative portions of this research study in context with the existing literature. This researcher's hypotheses were partially supported as was discussed above. Suggestions for school social work, trauma-informed practices in schools, and future research will be discussed in Chapter 6.

Chapter 6- Conclusions and Recommendations

As discussed in Chapters 4 and 5, various factors are related to both school social workers' use of trauma-informed practices and their interest and ability to access continued education regarding trauma-informed practices. These factors are often out of the social workers' control as they are related to their workplace. As such, making changes to increase access to professional development and to improve access to services for students becomes an issue of advocacy, a major tenet in both school social work and social work in general.

Recommendations for Social Work Curricula

Both survey and focus group data were mixed, albeit underwhelming, regarding how well their formal social work programs prepared them to utilize trauma-informed practices. The Council on Social Work Education explicitly argues that social work education programs are expected to train students in these programs around nine competencies. However, none of these competencies make mention of trauma or trauma-informed education, despite speaking of equity, advocacy, intersectionality, and the use of evidence-based practices (CSWE, 2022). This is true

in the National Association of Social Workers Code of Ethics (2022) and the NASW Standards for School Social Workers (2012) as well. Absent explicit wording regarding “trauma” and “trauma-informed practices” in these guiding documents, it will continue to be difficult for schools to obtain funding for programming and education around these topics, for school social workers to justify time away from work to attend professional development sessions, and, ultimately, for social workers to engage in this work with fidelity.

It is recommended that the CSWE and social work education programs explicitly add wording about “trauma” into their program descriptions and mandates so that programs are required to teach about different forms of evidence-based and evidence-informed trauma-informed practices in their courses. It is also recommended that consideration be given to adding similar wording to the NASW Standards for School Social Work Services. Informed and educated social workers are prepared and effective social workers. When working in the school setting, it is likely that school social workers will be faced with students disclosing trauma exposure or displaying behaviors that are trauma reactions. Absent a basic understanding about what they are dealing with and how to effectively handle it, these school social workers will be doing their clients an injustice and, potentially, retraumatizing these individuals.

Recommendations for Teacher Education Curricula

The 2022 CAEP Standards, including the Advanced-Level Standards, make no mention of “trauma” or “trauma-informed” practices when laying out expectations of teacher education programs (Council for the Accreditation of Educator Preparation, 2022). Focus group participants expressed concerns about the lack of education provided to teachers about trauma and trauma-informed practices leading to discrepancies in service provision in their buildings, districts, and intermediate units. Additionally, because this is not taught early on, it becomes

difficult to engage teaching staff in trainings about trauma and trauma-informed practices later on, as expressed by a focus group participant,

> …how to create buy-in for staff who maybe don't feel like it's something that they need to do or don't see the benefit of it…But how to create buy-in on a teacher level, on an administrative level, on a district level.

It is this researcher's recommendation that language regarding "trauma" be added to the CAEP standards. This addition sets forth an expectation that prospective teachers will be educated about the concept of trauma and what it may look like in their classrooms. If teachers enter the workforce with a general understanding of trauma and the effects of trauma, this makes the implementation of tier 1 interventions easier and, hopefully, ongoing professional development more engaging for staff.

Recommendations for Professional Development

Recommendations for professional development opportunities regarding trauma and trauma-informed practices are applicable to both school social workers and non-mental health school staff as both roles work directly with students daily. The only caveat is considering that school social workers are expected to provide training to other school staff members about these topics (PDE, 2023c). Recommendations include making professional development sessions more practical, more discussion-based and hands-on, and offering higher level and higher quality opportunities.

Focus group and survey participants (via the "Other" comments option) expressed frustrations that, when they are able to access professional development opportunities about trauma and trauma-informed practices, these trainings are of poor quality, or their existing knowledge is above the training sessions' offerings. Consideration must be given when choosing

presenters and training sessions for the audience, the audience's needs and current knowledge level, and the trainers' expertise and level of understanding about the topic. Cost and time are often factors but these cannot outweigh the needs of the staff receiving the training.

Specific Professional Development Suggestions

It is specifically suggested that training sessions be more advanced, practical, and interactive. These professional development sessions should happen at different levels—district, building, intermediate unit, and county. It is suggested that these sessions include staff from various departments—a truly multi-disciplinary approach.

These sessions should be tiered throughout the school year, beginning with introductory sessions and deepening understanding as the year progresses. In later years, introductory sessions should be offered to new staff separately during induction and other opportunities to allow more tenured staff to continue to build their knowledge-base without starting over. These induction sessions also provide a great opportunity for more tenured staff to train new staff and to build their leadership skills and to mentor new staff regarding the building, district, or intermediate unit's trauma-informed climate.

It is suggested that these sessions should be interactive to keep participants engaged and to promote learning in a manner that is applicable to attendees. This interaction can include case discussions in which groups of participants are given the opportunity to brainstorm ways to address hypothetical situations they could be faced with in the school setting. These case studies could then be presented to the group allowing the larger group to leave with a list of skills, a toolbox of sorts, that they can use immediately upon returning to work. This also allows participants to recognize the work they are already doing; to recognize that each training session does not require them to learn something new, perhaps they just need to view their current

practice through a new, more purposeful, and mindful lens. In addition to case studies and group discussion, participants should have the opportunity to practice the skills being taught and reviewed, such as breathing or mindfulness, they are being asked to use with students themselves when possible. This allows them to not only see how they do work, but also to act as a reminder that regulation skills are helpful to staff as much as they are to students.

When possible, training sessions should be offered by in-house staff. By having training sessions and professional development sessions offered by in-house school social workers and other staff, it helps build staff capacity and community. If this is not possible, other community partners should be included to help build connections within the school, district, or intermediate unit community. Finally, when applicable, these sessions should include school, district, or intermediate unit data regarding how trauma-informed interventions are or are not affecting the student population and school community.

Recommendations for Future Research

This study, as previously discussed, was a cross-sectional study of a small sample of Pennsylvania's public school social workers. The design of this study makes the application of the findings to larger portions of the population. Additionally, the sample was self-selected as participation was voluntary. These limitations, in addition to findings from this study, led to this researcher's suggestions for future research, which are discussed in the following sections.

Trauma-Informed Practices Research: Teachers and School Administrators

A great deal of the conversations in both focus groups centered around participants' non-mental health colleagues' use of and understanding about trauma and trauma-informed care. Additionally, survey participants reported not knowing if their non-mental health colleagues were using trauma-informed practices in the school setting. It is recommended that further

research focuses more on non-mental health staff's understanding of trauma and use of trauma-informed practices, including the factors affecting this use (similar to this study). Results could be compared to this study or a similar study of school mental health staff.

Trauma-Informed Practices Research: Larger Population and Longitudinal

A limitation to this study was the limited sample and cross-sectional design. It is recommended that future research in this area include a larger sample that is more representative of the nation as a whole to include different perspectives, state expectations, and social work roles. It is also important to consider longitudinal data to explore trends over time as legislation and educational policies change, are implemented, and are interpreted in states and districts. Also, of importance to consider is how the COVID-19 pandemic continues to affect students, staff, and districts over time.

Trauma-Informed Practices Research: Cultural Implications

A short-coming of this study was that, while important, cultural implications were beyond its scope. The idea that culture plays a role in how trauma is understood and the ways that trauma-informed practices are utilized in the school setting was brought up in both focus groups but was not the main focus of discussion. In the future, further research with a dedicated focus group to the interplay between culture, cultural beliefs, trauma, and trauma-informed practices in the school setting should be conducted. It will be important to consider factors including stigma, help-seeking behaviors, and staff sensitivity to differences in student and family experiences.

Conclusion

The purpose of this study was to determine if there were any relationships between identified factors and both the use of trauma-informed practices by school social workers and the interest in participating in future professional development about trauma-informed practices by

school social workers in Pennsylvania. It was determined that some of the identified factors did have a relationship with the use of trauma-informed practices and some of the identified factors did have a relationship with participants' interest in participating in future professional development. Important takeaways are that school social workers in Pennsylvania are using trauma-informed practices as part of their work and are not only interested in further professional development, but in quality professional development.

This dissertation has delved into the existing literature and explored new data via a mixed methods study to add to existing research on the topics related to trauma-informed practices in the school setting. The importance of this work cannot be overstated and must be continued to ensure the safety, health, and well-being of our students, schools, and communities (Avery, et al., 2021; Centers for Disease Control, 2021; Gonzalez et al., 2016; McWey, 2020; Mersky et al., 2019; Porche et al., 2016; SAMHSA, 2014a; Trauma Informed Care Implementation Resource Center, 2021; Zyromski et al., 2022). Beyond continuing research, as social workers, it is our duty to advocate for our educational and training needs so that we can better meet the needs of our students, families, and communities (NASW, 2012; NASW, 2021). It is this researcher's belief that, through continuing research in this area and advocating for what we need to better serve our clientele, we can begin to take steps to increase our students', families', districts', and communities' resilience so they become better equipped to face future challenges and traumatic experiences (Gherardi et al., 2021).

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Appendix A- Pilot Recruitment E-Mail

Good afternoon! My name is Jessica Schoonmaker, and I am a current DSW student at Kutztown University. For critiquing and piloting my research survey, Dr. Vafeas, my research advisor, suggested that you would be an ideal person to assist me in my research, the Practices and Preparation of Public School Social Workers in Pennsylvania. I would greatly appreciate it if you could take approximately 20 minutes out of your day to review and complete my original survey and answer the additional component of the survey monkey designed specifically for this pilot group. Below is the recruitment letter being sent to potential participants and the link to the survey. Thank you in advance for your time and consideration.

Dear Participant,

My name is Jessica Schoonmaker, LCSW, I am a fellow school social worker and a doctoral candidate at Kutztown University completing my dissertation and I am asking for your help by completing a survey related to the practices and preparation of public school social workers. I am inviting you to participate in this study by completing the attached online survey tool. The attached Survey Monkey survey is expected to take approximately 15 minutes of your time. Please feel free to share this link with any Pennsylvania public school social workers you know who may be willing to participate.

If you choose to participate, you will be asked questions about your past training, current practices, and interest in future professional development. Participation in this research study is voluntary and you may discontinue participation or opt out of any questions at any time without any penalty or consequence. There is no compensation for participating in this study. There is no known risk to participating in this study, but should you experience any discomfort as a result of this survey, there are resources attached to the end of this letter.

This survey does not include any identifying information unless you choose to be contacted about participating in a focus group. All data will be reported collectively and remain confidential and anonymous.

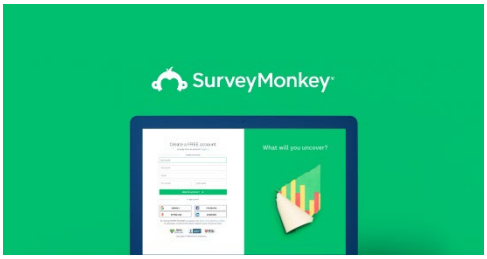
By participating in the online survey (link below), I hereby give my consent. I have read the information described above and have received a copy of this information. I was given the opportunity to ask questions I had regarding the research study and have received answers to my satisfaction. I am 18 years of age or older and voluntarily consent to participate in this study. If you have any questions at any time regarding this study or survey, please contact this researcher directly at jscho812@live.kutztown.edu. If you have any questions or concerns about the rights of research participants, please contact the IRB Committee at Kutztown University at 484-646-4167.

Thank you for your participation!

Resources

- Suicide & Crisis Lifeline: Dial 988
- Crisis Text Hotline: Text PA to 741741
- Pennsylvania Support & Referral Helpline: Call 855-284-2494 (TTY: 724-631-5600)
- 9-1-1/Visit your nearest emergency room
- Contact your district's Employee Assistance Program
- Contact a mental health provider of your choice via your health insurance

Survey Link:
https://www.surveymonkey.com/r/QNFQH9T



Practices and Preparation of Public School Social Workers in Pennsylvania

Take this survey powered by surveymonkey.com. Create your own surveys for free.

www.surveymonkey.com

Appendix B- Pilot Survey

Practices and Preparation of Public School Social Workers in Pennsylvania- PILOT

This survey is anticipated to take approximately 10-15 minutes of your time. Please review the questions and choose the answer that is most appropriate. You may refuse to answer any question or discontinue at any time. Your time and consideration are greatly appreciated. By participating in this online survey, I hereby give my consent.

Practices and Preparation of Public School Social Workers in Pennsylvania- PILOT

Professional Experience

This section is designed to obtain information regarding participants' professional experience and education.

1. What is your highest level of social work education? (choose one)

- ◯ BSW
- ◯ MSW
- ◯ DSW/Ph.D
- ◯ Other (please specify)

2. What social work license do you currently hold in Pennsylvania? (choose one)

- ◯ LBSW
- ◯ LSW
- ◯ LCSW
- ◯ Currently pending transfer from another state
- ◯ Other (please specify)

3. How long have you been a licensed social worker or clinical social worker? (in years)

4. How long have you been practicing as a school social worker? (in years)

5. Do you currently hold a PK-12 School Social Worker Educational Specialist certification in Pennsylvania?

- ◯ Yes
- ◯ No

6. What grade level/grade levels are on your case load? (choose all that apply)

- ☐ Elementary School
- ☐ Middle School/Junior High School
- ☐ High School
- ☐ All levels
- ☐ No specific grade level(s)

7. How many school buildings are you responsible for?

8. Approximately how many students are you responsible for?

9. I spend most of my time at work: (check all that apply)

- ☐ Completing assessments
- ☐ Creating plans to support student needs
- ☐ Engaging with students individually
- ☐ Engaging with students in a group format
- ☐ Engaging with families
- ☐ Performing administrative duties
- ☐ Collaborating with stakeholders
- ☐ Connecting students/families to community resources
- ☐ Supporting staff/colleagues
- ☐ Other building duties
- ☐ Other (please specify)

Practices and Preparation of Public School Social Workers in Pennsylvania- PILO

Use of Trauma-Informed Practices

This section is designed to obtain information about the use of trauma-informed practices by participants and the factors that may be affecting the use of trauma-informed practices. It is expected that some participants will have no experience with trauma-informed practices and others will have a great deal; responses are available for all levels of experience. For the purpose of this study, trauma-informed practices are defined as services provided to a client or client population that:

- take into consideration the broad impact of trauma and the potential for recovery

- recognize the signs and symptoms of trauma

- strive to create an environment that is not re-traumatizing

- strive to take steps to prevent secondary traumatic stress in staff

10. Which of the following trauma-informed practices do you use? (check all that apply)

- ☐ TF-CBT (trauma-focused cognitive behavioral therapy)
- ☐ Restorative Practices
- ☐ Trauma-focused SEL (social-emotional learning) programming
- ☐ Trauma-focused MTSS (multi-tiered system of support)
- ☐ Other (please specify)
- ☐ None
- ☐ Trauma-focused mindset/language
- ☐ Trauma screenings

11. My school administration is supportive of the use of trauma-informed practices. (please rate)

Not at All	Very Little		Somewhat		Very Much	Do Not Know
○	○	○	○	○	○	○

12. I understand what trauma-informed practices are. (please rate)

Not at All	Very Little		Somewhat		Very Much	Do Not Know
○	○	○	○	○	○	○

13. I find it easy to use trauma-informed practices. (please rate)

Not at All	Very Little		Somewhat		Very Much	Do Not Know
○	○	○	○	○	○	○

14. I feel prepared to effectively use trauma-informed practices. (please rate)

Not at All	Very Little		Somewhat		Very Much	Do Not Know
○	○	○	○	○	○	○

15. I know how to create an environment where students feel physically and emotionally safe. (please rate)

Not at All	Very Little		Somewhat		Very Much	Do Not Know
○	○	○	○	○	○	○

16. I feel physically safe in my work environment. (please rate)

Not at All	Very Little		Somewhat		Very Much	Do Not Know
○	○	○	○	○	○	○

17. feel emotionally safe in my work environment. (please rate)

Not at All	Very Little		Somewhat		Very Much	Do Not Know
○	○	○	○	○	○	○

18. I find it easy to remain aware of underlying trauma when working with students exhibiting challenging behaviors. (please rate)

Not at All	Very Little		Somewhat		Very Much	Do Not Know
○	○	○	○	○	○	○

19. I believe that trauma-informed practices are effective in improving my students' behaviors. (please rate)

Not at All	Very Little		Somewhat		Very Much	Do Not Know
○	○	○	○	○	○	○

20. I believe that trauma-informed practices are effective in improving my students' attendance. (please rate)

Not at All	Very Little		Somewhat		Very Much	Do Not Know
○	○	○	○	○	○	○

21. I believe that trauma-informed practices are effective in improving my relationships with my students. (please rate)

Not at All	Very Little		Somewhat		Very Much	Do Not Know
○	○	○	○	○	○	○

Practices and Preparation of Public School Social Workers in Pennsylvania- PILO

Preparation for the Use of Trauma-Informed Practices

This section is designed to obtain more information regarding the preparation and education participants received regarding trauma-informed practices.

22. How much did the following educational opportunities prepare you for using trauma-informed practices?

	Please Rate
Formal social work education (BSW/MSW/DSW/Ph.D)	
Certification course(s)	
New staff induction programming/formal mentor programming	
Professional experience/on-the-job experience	
Professional development opportunities	
Professional conferences	
Independent study (i.e., reading, research, etc.)	
Professional supervision	

Practices and Preparation of Public School Social Workers in Pennsylvania- PILO

Continuing Education (Part 1)

This section is designed to obtain more information regarding participants' attitudes about future professional development.

23. I believe it is important for school social workers in Pennsylvania to receive ongoing education updates regarding trauma-informed practices. (please rate)

Not at All	Very Little		Somewhat		Very Much	Do Not Know
○	○	○	○	○	○	○

24. I can easily access professional development/continuing education regarding trauma-informed practices. (please rate)

Not at All	Very Little		Somewhat		Very Much	Do Not Know
○	○	○	○	○	○	○

25. My administration encourages accessing professional development regarding trauma-informed practices. (please rate)

Not at All	Very Little		Somewhat		Very Much	Do Not Know
○	○	○	○	○	○	○

26. I am interested in participating in future professional development regarding trauma-informed practices. (please rate)

Not at All	Very Little		Somewhat		Very Much	Do Not Know
○	○	○	○	○	○	○

Practices and Preparation of Public School Social Workers in Pennsylvania- PILO

Continuing Education (Part 2)

Thinking about your professional development interests, please answer questions #27 - #29.

27. I would like to participate in professional development that focuses on:(choose all that apply):

- ☐ Crisis intervention
- ☐ Grief and loss
- ☐ Trauma-informed practices
- ☐ Restorative practices
- ☐ Attendance interventions
- ☐ Social-emotional learning programming
- ☐ Other (please specify)
- ☐ None
- ☐ Multi-tiered systems of support
- ☐ Secondary trauma/vicarious trauma
- ☐ Self-care
- ☐ Motivational interviewing

28. I prefer the following style(s) of professional development (choose all that apply):

- ☐ Employer-based professional development
- ☐ Professional certification programs
- ☐ Professional conferences
- ☐ Other (please specify)
- ☐ None
- ☐ Independent study

29. I have encountered the following barriers limiting my engagement in professional development opportunities regarding trauma-informed practices (choose all that apply):

- [ ] Availability of professional development opportunities
- [ ] Cost/financial constraints
- [ ] Time
- [ ] Work demands
- [ ] Other (please specify)
- [ ] Home/family responsibilities
- [ ] I do not see this method as useful
- [ ] No interest in further training at this time
- [ ] None

Practices and Preparation of Public School Social Workers in Pennsylvania- PILO

Demographics

This section is designed to obtain general demographic information regarding participants and their school districts.

30. What is your age?

31. What gender do you identify as?

32. What race and ethnicity do you identify as?

Race

Ethnicity

33. What best describes your school district? (choose one)

- ◯ Rural
- ◯ Suburban
- ◯ Urban
- ◯ I do not know/prefer not to answer

34. What is the location of your school district? (choose one)

- ◯ South Central, PA
- ◯ Central/North Central, PA
- ◯ Southwest, PA
- ◯ Southeast, PA
- ◯ Northeast, PA
- ◯ Northwest, PA
- ◯ I do not know/prefer not to answer

35. OPTIONAL: I am interested in participating in a virtual (Zoom) focus group to discuss this topic further. My e-mail address is:

36. Is there anything else you would like to add?

Practices and Preparation of Public School Social Workers in Pennsylvania- PILO

Pilot Survey Questions

Thank you for taking the time to review and complete my survey regarding the practices and preparation of school social workers in Pennsylvania. To help further refine this tool and confirm face validity for the purposes of this study, I ask that you take a few more moments to answer the following questions about this tool and your experience completing it.

37. I was able to complete this survey within the suggested 15 minutes. (please rate)

Not at All	Very Little		Somewhat		Very Much	Unable to Answer
◯	◯	◯	◯	◯	◯	◯

38. The survey was clear and easy to understand. (please rate)

Not at All	Very Little		Somewhat		Very Much	Unable to Answer
◯	◯	◯	◯	◯	◯	◯

39. I understood what the questions were asking me. (please rate)

Not at All	Very Little		Somewhat		Very Much	Unable to Answer
◯	◯	◯	◯	◯	◯	◯

40. I recommend making changes to this survey.

- ◯ Yes
- ◯ No

41. Please provide more information regarding your answer to #40.

42. Please provide any additional feedback that you feel may be helpful to the researcher regarding this survey tool.

Appendix C- Survey Recruitment E-Mail

Dear Participant,

My name is Jessica Schoonmaker, LCSW, I am a school social worker and a doctoral candidate at Kutztown University completing my dissertation. I am asking for your help by completing a survey related to the practices and preparation of public-school social workers and by sharing this link with any Pennsylvania public school social workers you know who may also be willing to participate. I am inviting you to participate in this study by completing the attached online survey tool. The attached Survey Monkey survey is expected to take approximately 10-15 minutes of your time.

If you choose to participate, you will be asked questions about your past training, current practices, and interest in future professional development. Participation in this confidential research study is voluntary and you may discontinue participation or opt out of any questions at any time without any penalty or consequence. No identifying information is collected unless you choose to be contacted about participating in a focus group in the future. There is no compensation for participating in this study. There is no known risk to participating in this study, but should you experience any discomfort as a result of this survey, there are resources attached to the end of this letter.

By participating in the online survey (see link below), I confirm that I am 18 years of age or older and voluntarily consent to participate in this study. I have read the information described above and have received a copy of this information. I was given the opportunity to ask questions I had regarding the research study and have received answers to my satisfaction.

If you have any questions at any time regarding this study or survey, please contact this researcher directly at jscho812@live.kutztown.edu. If you have any questions or concerns about the rights of research participants, please contact the IRB Committee at Kutztown University at 484-646-4167.

Please click on this survey link to complete the survey:
https://www.surveymonkey.com/r/26XXXPM

Thank you for your participation!

Resources

- Suicide & Crisis Lifeline: Dial 988
- Crisis Text Hotline: Text PA to 741741
- Pennsylvania Support & Referral Helpline: Call 855-284-2494 (TTY: 724-631-5600)
- 9-1-1/Visit your nearest emergency room
- Contact your district's Employee Assistance Program
- Contact a mental health provider of your choice via your health insurance.

Appendix D- Nudge E-Mail

Dear Participant,

Greetings, again! In an attempt to reach more participants, I am contacting you with a reminder regarding an email sent on December 7, 2023, requesting participation in a survey related to the practices and preparation of public-school social workers. If you have already completed this survey, I thank you for your time. If you have not done so, I am again inviting you to participate in this study by completing the attached online survey tool. The attached Survey Monkey survey is expected to take approximately 10-15 minutes of your time.

If you choose to participate, you will be asked questions about your past training, current practices, and interest in future professional development. Participation in this confidential research study is voluntary and you may discontinue participation or opt out of any questions at any time without any penalty or consequence. No identifying information is collected unless you choose to be contacted about participating in a focus group in the future. There is no compensation for participating in this study. There is no known risk to participating in this study, but should you experience any discomfort as a result of this survey, there are resources attached to the end of this letter.

By participating in the online survey (see link below), I confirm that I am 18 years of age or older and voluntarily consent to participate in this study. I have read the information described above and have received a copy of this information. I was given the opportunity to ask questions I had regarding the research study and have received answers to my satisfaction.

If you have any questions at any time regarding this study or survey, please contact this researcher directly at jscho812@live.kutztown.edu. If you have any questions or concerns about the rights of research participants, please contact the IRB Committee at Kutztown University at 484-646-4167.

Please click on this survey link to complete the survey:
https://www.surveymonkey.com/r/26XXXPM

Thank you for your participation!

Resources

- Suicide & Crisis Lifeline: Dial 988
- Crisis Text Hotline: Text PA to 741741
- Pennsylvania Support & Referral Helpline: Call 855-284-2494 (TTY: 724-631-5600)
- 9-1-1/Visit your nearest emergency room
- Contact your district's Employee Assistance Program
- Contact a mental health provider of your choice via your health insurance

Appendix E- Reminder E-Mail

Dear Participant,

Before the holidays, I asked you to participate in a survey regarding trauma informed practices by school social workers in PA. I thank you for taking time out of your busy schedule to complete my survey related to the practices and preparation of public-school social workers. As social workers, we know how important community is, and without you, the completion of my project would not be possible!
If you have not yet completed my survey but you would still like the opportunity to do so, please review the original e-mail attached to this document regarding risks, benefits, and consent and then click the link below.

Once again, I thank you for your time and participation!

Please click on this survey link to complete the survey:
https://www.surveymonkey.com/r/26XXXPM

Thanks again,
Jessica Schoonmaker, School Social Worker
Kutztown University DSW Candidate

Appendix F- Focus Group Scheduling E-Mail

Dear Participant,

Thank you for your interest in participating in a focus group to discuss your experiences and opinions related to the practices and preparation of school social workers in Pennsylvania! Participation is voluntary. In an effort to accommodate everyone's busy schedules while still including as many voices as possible, several sessions are being offered. Please respond to this email with the sessions that work with your schedule by Friday, January 19, 2024. I look forward to meeting with you!

___ Sunday, January 21, 2024 @10:15am

___ Sunday, January 21, 2024 @ 1:00pm

___ Monday, January 22, 2024 @ 5:00pm

___ Sunday, January 28, 2024 @ 11:00am

___ Monday, January 29, 2024 @ 4:00pm

___ Friday, February 2, 2024 @ 12:00pm

___ Monday, February 5, 2024 @ 9:00am

___ Monday, February 5, 2025 @ 1:00pm

Thank you for your time and participation!

Appendix G- Focus Group Consent and Confirmation E-Mails

Dear Participant,

Thank you for your expressed interest in participating in a focus group related to the practices and preparation of school social workers in Pennsylvania! I look forward to hearing your thoughts about this topic and those of the other participants who volunteered to meet. Please note, I made every effort to accommodate everyone's availability but not every time slot could be filled.

If you choose to participate in the scheduled online focus group, you will be asked questions about your past training, current practices, and interest in future professional development, similar to those in the online survey, while engaging in dialogue with other Pennsylvania school social workers through the online Zoom platform. The online session will be audio and video recorded for the purposes of this study.

Participants' confidentiality will be protected as much as possible through the use of self-chosen aliases which they will be asked to refer to one another by and enter in their Zoom ID box. Additionally, participants have the option to turn their cameras off at any time. All data collected will be reported with identifying information removed and by alias or in a compiled format.

Participation in this research study is voluntary, and you may discontinue participation or opt out of any questions at any time without penalty or consequence. There is no compensation for participating in this study. There is no known risk to participating in this study, but should you experience any discomfort as a result of this survey, there are resources attached to the end of this letter. Following the online focus group, ten minutes will be allotted for participants to remain in the virtual meeting space to meet with the researcher privately if needed.

By participating in the online Zoom focus group at 4:00pm on Monday, January 29, 2024 (link below), I hereby give my consent. I have read the information described above and have received a copy of this information. I was given the opportunity to ask questions I had regarding the research study and have received answers to my satisfaction. I am 18 years of age or older and voluntarily consent to participate in this study.

If you have any questions at any time regarding this study or survey, please contact this researcher directly at jscho812@live.kutztown.edu. If you have any questions or concerns about the rights of research participants, please contact the IRB Committee at Kutztown University at 484-646-4167.

Thank you for your participation!

Jessica Schoonmaker is inviting you to a scheduled Zoom meeting.

Topic: Jessica Schoonmaker's Zoom Meeting
Time: Jan 29, 2024 04:30 PM Eastern Time (US and Canada)

Join Zoom Meeting

https://kutztown.zoom.us/j/91484380260?pwd=bDVldnRZbDNnWlZlYTdKdTF6YXl6UT09

Meeting ID: 914 8438 0260
Passcode: 262382

One tap mobile
+13017158592,,91484380260#,,,,*262382# US (Washington DC)
+13052241968,,91484380260#,,,,*262382# US

Dial by your location
• +1 301 715 8592 US (Washington DC)
• +1 305 224 1968 US
• +1 309 205 3325 US
• +1 312 626 6799 US (Chicago)
• +1 646 876 9923 US (New York)
• +1 646 931 3860 US
• +1 346 248 7799 US (Houston)
• +1 360 209 5623 US
• +1 386 347 5053 US
• +1 507 473 4847 US
• +1 564 217 2000 US
• +1 669 444 9171 US
• +1 669 900 6833 US (San Jose)
• +1 689 278 1000 US
• +1 719 359 4580 US
• +1 253 205 0468 US
• +1 253 215 8782 US (Tacoma)

Meeting ID: 914 8438 0260
Passcode: 262382

Find your local number: https://kutztown.zoom.us/u/abbqYkICGb

Resources

Suicide & Crisis Lifeline: Dial 988
Crisis Text Hotline: Text PA to 741741

Pennsylvania Support & Referral Helpline: Call 855-284-2494 (TTY: 724-631-5600)
9-1-1/Visit your nearest emergency room
Contact your district's Employee Assistance Program
Contact a mental health provider of your choice via your health insurance

Dear Participant,

Thank you for your expressed interest in participating in a focus group related to the practices and preparation of school social workers in Pennsylvania! I look forward to hearing your thoughts about this topic and those of the other participants who volunteered to meet. Please note, I made every effort to accommodate everyone's availability but not every time slot could be filled.

If you choose to participate in the scheduled online focus group, you will be asked questions about your past training, current practices, and interest in future professional development, similar to those in the online survey, while engaging in dialogue with other Pennsylvania school social workers through the online Zoom platform. The online session will be audio and video recorded for the purposes of this study.

Participants' confidentiality will be protected as much as possible through the use of self-chosen aliases which they will be asked to refer to one another by and enter in their Zoom ID box. Additionally, participants have the option to turn their cameras off at any time. All data collected will be reported with identifying information removed and by alias or in a compiled format.

Participation in this research study is voluntary, and you may discontinue participation or opt out of any questions at any time without penalty or consequence. There is no compensation for participating in this study. There is no known risk to participating in this study, but should you experience any discomfort as a result of this survey, there are resources attached to the end of this letter. Following the online focus group, ten minutes will be allotted for participants to remain in the virtual meeting space to meet with the researcher privately if needed.

By participating in the online Zoom focus group at 9:00am on Monday, February 5, 2024 (link below), I hereby give my consent. I have read the information described above and have received a copy of this information. I was given the opportunity to ask questions I had regarding the research study and have received answers to my satisfaction. I am 18 years of age or older and voluntarily consent to participate in this study.

If you have any questions at any time regarding this study or survey, please contact this researcher directly at jscho812@live.kutztown.edu. If you have any questions or concerns about the rights of research participants, please contact the IRB Committee at Kutztown University at 484-646-4167.

Thank you for your participation!

Jessica Schoonmaker is inviting you to a scheduled Zoom meeting.

Topic: Jessica Schoonmaker's Zoom Meeting
Time: Feb 5, 2024 09:00 AM Eastern Time (US and Canada)

Join Zoom Meeting
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Resources

Suicide & Crisis Lifeline: Dial 988
Crisis Text Hotline: Text PA to 741741
Pennsylvania Support & Referral Helpline: Call 855-284-2494 (TTY: 724-631-5600)
9-1-1/Visit your nearest emergency room
Contact your district's Employee Assistance Program
Contact a mental health provider of your choice via your health insurance

Appendix H- Survey

Practices and Preparation of Public School Social Workers in Pennsylvania

This survey is anticipated to take approximately 10-15 minutes of your time. Please review the questions and choose the answer that is most appropriate. You may refuse to answer any question or discontinue at any time. Your time and consideration are greatly appreciated. By participating in this online survey, I hereby give my consent.

Practices and Preparation of Public School Social Workers in Pennsylvania

Professional Experience

This section is designed to obtain information regarding participants' professional experience and education.

1. What is your highest level of social work education? (choose one)

- ◯ BSW
- ◯ MSW
- ◯ DSW/Ph.D
- ◯ Other (please specify)

2. What social work license do you currently hold in Pennsylvania? (choose one)

- ◯ LBSW
- ◯ LSW
- ◯ LCSW
- ◯ Currently pending transfer from another state
- ◯ Other (please specify)

3. How long have you been a licensed social worker or clinical social worker? (in years)

4. How long have you been practicing as a school social worker? (in years)

5. Do you currently hold a PK-12 School Social Worker Educational Specialist certification in Pennsylvania?

- ◯ Yes
- ◯ No

6. What grade level/grade levels are on your case load? (choose all that apply)

- ☐ Elementary School
- ☐ Middle School/Junior High School
- ☐ High School
- ☐ All levels
- ☐ No specific grade level(s)

How many school buildings are you responsible for?

Approximately how many students are you responsible for (are on your case load)?

9. I spend most of my time at work: (check all that apply)

- ☐ Completing assessments
- ☐ Creating plans to support student needs
- ☐ Engaging with students individually
- ☐ Engaging with students in a group format
- ☐ Engaging with families
- ☐ Performing administrative duties (documentation, etc.)
- ☐ Other (please specify)
- ☐ Collaborating with stakeholders
- ☐ Connecting students/families to community resources
- ☐ Supporting staff/colleagues
- ☐ Class coverages
- ☐ Non-social work duties (i.e., lunch duty, hall duty, etc.)

Practices and Preparation of Public School Social Workers in Pennsylvania

Use of Trauma-Informed Practices

This section is designed to obtain information about the use of trauma-informed practices by participants and the factors that may be affecting the use of trauma-informed practices. It is expected that some participants will have no experience with trauma-informed practices and others will have a great deal; responses are available for all levels of experience. For the purpose of this study, trauma-informed practices are defined as services provided to a client or client population that:

- take into consideration the broad impact of trauma and the potential for recovery

- recognize the signs and symptoms of trauma

- strive to create an environment that is not re-traumatizing

- strive to take steps to prevent secondary traumatic stress in staff

10. Which of the following trauma-informed practices do you use? (check all that apply)

- [ ] TF-CBT (trauma-focused cognitive behavioral therapy)
- [ ] Restorative Practices
- [ ] Trauma-focused SEL (social-emotional learning) programming
- [ ] Trauma-focused MTSS (multi-tiered system of support)
- [ ] Other (please specify)
- [ ] Trauma-focused mindset/language
- [ ] Trauma screenings
- [ ] None

11. Teachers in my school use trauma informed practices.

- ◯ Yes
- ◯ No
- ◯ I do not know

12. Administrators in my building use trauma-informed practices.

- ◯ Yes
- ◯ No
- ◯ I do not know

13. Please answer the following questions regarding factors affecting your ability to use trauma-informed practices utilizing the rating scale provided (Not at all to Very Much).

	Please Rate
My school administration is supportive of the use of trauma-informed practices.	
I understand what trauma-informed practices are.	
I find it easy to use trauma-informed practices.	
I feel prepared to effectively use trauma-informed practices.	
I know how to create an environment where students feel physically and emotionally safe.	
I feel physically safe in my work environment.	
I feel emotionally safe in my work environment.	
I find it easy to remain aware of underlying trauma when working with students exhibiting challenging behaviors.	
I believe that trauma-informed practices are effective in improving my students' behaviors.	

I believe that trauma-informed practices are effective in improving my students' attendance.	
I believe that trauma-informed practices are effective in improving my relationships with my students.	

Practices and Preparation of Public School Social Workers in Pennsylvania

Preparation for the Use of Trauma-Informed Practices

This section is designed to obtain more information regarding the preparation and education participants received regarding trauma-informed practices.

14. Please use the provided scale to rate how much the following educational opportunities prepared you for using trauma-informed practices. (Not at all to Very Much)

	Please Rate
Formal social work education (BSW)- skip if not applicable	
Formal social work education (MSW)- skip if not applicable	
Formal social work education (DSW/Ph.D)- skip if not applicable	
Certification course(s)	
New staff induction programming/formal mentor programming	
Professional experience/on-the-job experience	
Professional development opportunities	
Professional conferences	
Independent study (i.e., reading, research, etc.)	
Professional supervision	

Practices and Preparation of Public School Social Workers in Pennsylvania

Continuing Education (Part 1)

This section is designed to obtain more information regarding participants' attitudes about future professional development.

15. Please use the provided scale to rate your beliefs regarding your beliefs about future professional development. (Not at All to Very Much)

	Please Rate
I believe it is important for school social workers in Pennsylvania to receive ongoing education updates regarding trauma-informed practices.	
I can easily access professional development/continuing education regarding trauma-informed practices.	
My administration encourages accessing professional development regarding trauma-informed practices.	

Practices and Preparation of Public School Social Workers in Pennsylvania

Continuing Education (Part 2)

Thinking about your professional development interests, please answer questions #16 - #18.

16. I would like to participate in professional development that focuses on: (choose all that apply):

- ☐ Crisis intervention
- ☐ Grief and loss
- ☐ Trauma-informed practices
- ☐ Restorative practices
- ☐ Attendance interventions
- ☐ Social-emotional learning programming
- ☐ Other (please specify)
- ☐ None
- ☐ Multi-tiered systems of support
- ☐ Secondary trauma/vicarious trauma
- ☐ Self-care
- ☐ Motivational interviewing

17. I prefer the following style(s) of professional development (choose all that apply):

- [ ] Employer-based professional development
- [ ] Independent study
- [ ] Professional certification programs
- [ ] Professional conferences
- [ ] Other (please specify)

  _____

- [ ] None

18. I have encountered the following barriers limiting my engagement in professional development opportunities regarding trauma-informed practices (choose all that apply):

- [ ] Availability of professional development opportunities
- [ ] Home/family responsibilities
- [ ] I do not see this method as useful
- [ ] Cost/financial constraints
- [ ] No interest in further training at this time
- [ ] Time
- [ ] Work demands
- [ ] Other (please specify)

  _____

- [ ] None

Practices and Preparation of Public School Social Workers in Pennsylvania

Demographics

This section is designed to obtain general demographic information regarding participants and their school districts.

19. What is your age?

20. What gender do you identify as?

21. What race and ethnicity do you identify as?

Race

Ethnicity

22. What best describes your school district? (choose one)

- ◯ Rural
- ◯ Suburban
- ◯ Urban
- ◯ I do not know/prefer not to answer

23. What is the location of your school district? (choose one)

- ◯ South Central, PA
- ◯ Central/North Central, PA
- ◯ Southwest, PA
- ◯ Southeast, PA
- ◯ Northeast, PA
- ◯ Northwest, PA
- ◯ I do not know/prefer not to answer

24. OPTIONAL: I am interested in participating in a virtual (Zoom) focus group to discuss this topic further. My e-mail address is:

25. Is there anything else you would like to add regarding factors affecting your use of trauma-informed practices or engaging in professional development?

Appendix I- Focus Group Script

Thank you for taking time out of your day and volunteering to be a part of today's focus group. My name is Jessica Schoonmaker, and I am both a DSW candidate with Kutztown University and a school social worker in Pennsylvania. Also with us today is Dr. Barbe Fogarty of Kutztown University who will be assisting as my note-taker so that I do not miss anything important!

I ask that the that the information discussed today remain confidential. Please do not share this information with others; it is important that we feel safe so that we can share freely. As stated in my email, please ensure that you have all changed your Zoom identifier to your chosen alias as this is the name you will be identified by in today's focus group and, later, when I report my findings. You have the option to turn off your camera at any time, to opt out of any question, and to leave the online focus group without penalty at any time.

As stated in my earlier email, today's session is to be recorded. Please raise your hand or use the Zoom raised hand feature to show your agreement with this. (WAIT- if there are individuals who disagree, discussion will be held re: scheduling another time without the recording feature allowing them to opt out at this time but to still participate later). Thank you, I will begin recording the session now.

include some sort of warm up/friendly chatter to make people more comfortable

As previously mentioned in my emails, today's questions will be heavily focused on trauma-informed practices. There are no right or wrong answers- my goal for this discussion is explore what is happening in this field in Pennsylvania's schools, including your thoughts, feelings, and experiences. In order to have a shared definition and shared language, for the purposes of this study, trauma-informed practices are defined as services provided to a client or client population that:

- takes into consideration the broad impact of trauma and the potential for recovery
- recognizes the signs and symptoms of trauma
- strives to create an environment that is not re-traumatizing
- strives to take steps to prevent secondary traumatic stress in staff

Before we begin, are there any questions?

1. Can you describe any factors that may be affecting your use of trauma-informed practices with students and families? Prompt: Can you explain this more?
    a. Can you describe your district's current status of use of trauma-informed practices? *Prompt: Can you explain this a little further? What's the current climate? What is the current level of acceptance of TIP in the district?*
2. Let's take some time to talk about our comfort-level with trauma-informed practices.
    a. How did you come upon this concept or method of practice?
    b. What do you think about continuing education in this area?
    c. Would you have changed anything about your experience?
3. How do others in your school setting engage in trauma-informed practices?
    a. How does this affect your practice? *Prompt: Can you give me an example?*

4. Thinking about the approaches you are using in your practice with students and families, how do trauma-informed practice fit? *Prompt: What approaches are you finding to be most effective?*
5. If you were to attend a professional development session about trauma-informed practices, what areas would be most preferable, useful, or interesting to you? *Prompt: Specific practices, advocacy, refreshers, overviews, etc.*
6. Is there anything else you would like to add/that we missed?

Thank you again for your time and insight. I will remain available through this link for the next 10 minutes for anyone who would like to meet with me individually. I can also be reached via my email address. Please do not hesitate to reach out to me. Have a great (DAY/EVENING/ETC.)!

Appendix J- Code Book

Name	Description
Approaches	approaches of engagement, etc. being used with students, families, and colleagues (may include TIP, specific forms of practice, or general concepts)
Boundaries	mentions of setting/maintaining boundaries as part of practice
Connection	mentions of connection/connecting as part of practice
Family work	mentions of engaging with families (vs. students/colleagues) in practice
Listening	mentions of "listening" as a part of practice
Relationships	mentions of creating/maintaining/the importance of relationships as part of practice
Specific Types	mentions of specific types of practices being utilized (i.e., evidence-based, clinical, etc.)
Staff Education	mentions of engaging the education of colleagues as an expected role/part of daily practice
Factors	Factors affecting the use of trauma-informed practices (positively or negatively)
Climate	mentions of district climate/attitudes regarding TIP and how this may be affecting the use of TIP
Definition	Varying definitions/working definitions of trauma; understanding of "trauma" and "trauma-informed practices"
Funding	Funding as a factor (positive or negative) re: the use of this practice
Staff Beliefs	Beliefs of non-MH staff re: TIP (positive or negative)
Staff Training	Training of non-mental health staff re: TIP as a factor (positive or negative)
Staff Turnover	Staff turnover as a factor (positive or negative)

Stigma	effects of stigma on the use of TIP
Support	how supported staff feel (positive of negative) by other staff re: using TIP
Time	influence of time on use of TIP (positive or negative)
Varying Roles	Varying roles of SW & conflicting demands of these roles
Past Training	how and when became aware of/learned TIP
Professional Development	PD related to trauma-informed practices and its effects of use (positive or negative)
Advocacy	mentions of advocacy as a training need/interest
Buy-In	mentions of staff buy-in as a training need/interest
Funding	mentions related to money or funding - how it affects training/PD
Interests	Desired trainings, changes, etc.
Toolbox	Specific mentions related to interest in a toolbox to access (MH and non-MH staff)
Magic Wand	how to change PD if there were no limitations
Quality	thoughts about the quality of PD available
Staff Turnover	impact of staff turnover on trainings/PD
Time	positive of negative impacts of time on PD/training
Standardization	discussion related to standardizing state expectations related to trauma/TIP in the school setting
Use of TIP	Whether or not TIP is being used and to what extent
By MH Staff	TIP use by SWs/SCs/etc.
Non MH Staff	TIP use by teachers/admin/etc.

What is Already Being Done	Using TIP but calling it something else (practices are TIP by definition but it is "just SW")

Appendix K- Focus Group Transcripts

Focus Group #1 Script

Jess: So, again, I know we're all at the end of a Monday and we just came off of a full moon week. So, if anybody needs to take a deep breath feel free to do that now because I know my students here have certainly been through the full moon and my biological children have been experiencing it as well.

So, as previously mentioned in my e-mail, today's questions are going to be heavily focused on trauma-informed practices. There are no right or wrong answers, and my goal for the discussion is to explore what is happening in the field in Pennsylvania schools. That includes your thoughts, feelings, and your experiences. In order to have a shared definition and a shared language for the purposes of this study, trauma-informed practices are going to be defined as services provided to a client or client population. So in our situation, primarily students, student families, and school staff. That take into consideration the impact of trauma and the potential for recovery. It recognizes the signs and symptoms of trauma, strives to create an environment that is not retraumatizing, and it strives to take steps to prevent secondary traumatic stress in staff- so us and our colleagues. So before we begin with that, are there any questions? (Pause) I know I sent the e-mail asking you to fill in some of the demographic information, but is there anything for the good of the group that is important for us all to know about your school or your school district?

Ann: The only thing I would add, and it would apply to Paul as well, he and I are in the same intermediate unit. So when you said district, we could be serving in many different roles FOR districts, so it's gonna look a little different. And some could be direct service some may not. So, yeah.

Paul: I'm actually in a South Central Region High School right now, up in a South Central Region County, but tomorrow I'll be in a different South Central Region District. Who knows where I'll be on Wednesday, but I'll check tomorrow.

Jess: I imagine that's hard to schedule around.

Allie: Yeah, and I'm also at an IU, different county though. So, same kind of situation.

Jess: And I will try to be cognizant of that going forward. I apologize, with being in a school in a district, it's easy to get caught in that language. So, thank you. Okay. Alright, so, my first question for the group to discuss is can you describe any factors that could be affecting your use of trauma-informed practices with your students and families? What's going on?

Mya: Umm for me specifically, my school district, it's been a lot of homelessness going on and having that being one of the biggest barriers. You know, trying to get students' attention on certain things but then at the same time, it's like, it's not as important right now as to what's actually happening to them outside of the schools. So, a lot of the times it's been, you know, one of the biggest barriers is having a place to live.

Jess: And Paul, you were going to add something?

Paul: Yeah, I was going to say, as an IU employee, an IU worker, we're in different school districts. And so you have different perspectives on what "trauma" is. Or I have different roles in different districts as what I'm sometimes I'm assigned a specific class, which could be IU kids, it could be special education kids. Here at my current high school placement, for example, I have a more, I guess, generic caseload and I work with the people from the guidance department. I'm the "mental health" person I guess, but I work with SAP teams. And so it really depends. Different districts have different perspectives on, different definitions indeed, on what trauma is, or what trauma-informed, and also when I'm speaking with kids. I'm obviously the same person, I know from different buildings, there may be different reasons why they came to me. There may be, trauma may be the top or trauma may be informing a lot of their behavior and perspectives on the world. I'll just leave it at that.

Bonnie: For me, I think because the school staff are all at very different levels of understanding what trauma-informed is (Paul: Mmhmm). It's sometimes difficult to interact with teachers who have no idea what being trauma-informed is and their background- they've been in education for 35 years and theirs is discipline first worry about what's wrong with the kid later. So, helping them to understand what trauma is and how it may have affected that child is a difficult road. So, that's probably my biggest struggle, is helping those who have no training in trauma-informed. 'Cuz we're just starting out on that journey in our district.

Paul: Sure.

Sue: Yeah, I would agree with that. I would agree that staff has definitely probably one of a challenge. For our district, homelessness is huge and also kind of violence in the community is also big. We've also had a lot of recent fires and that does kind of happen during wintertime. A lot of space heaters, that sort of thing. But, just kind of recently I'm thinking of a little 1st grader, but since his fire he, his mom was in the hospital, and just his anxiety throughout the day and being so concerned about who's picking him up. You know, where's my mom, that sort of thing.

It's just affected him so much and the staff is just really struggling how to manage him and how to deal with him.

Allie: And school refusal behaviors is another huge area (Sue: Mmm.)

Ann: For my roles have different ones, so different focuses, but like, I'm the preschool social worker. So for that, I'm seeing a lot of like, the need, oh well, we're trying to, we've done some trainings now- Trauma 101 through Lakeside we've offered to all of our staff, back for the preschool program back in the summer. But, that was good, however, new staff, new, you know, needing to keep up with that training is sometimes hard to keep, you know, offering it again and having it again. Finding time to be able to do that. But, to see, again, understanding there's a lot of expulsion and children that are in daycares, so outside of our programs that are being expelled. And the questioning is whether or not there is a trauma piece to that- like what's going on in their life and trying to help daycares/childcare centers around us to understand that. So, getting that word out is something, you know, I try to do. So that's the one role. Another role is I am a trainer for our training and consultation department on trauma and Lakeside trainer, so just trying to get that out to the district. It's tough because of the ability, there's so many trainings that schools have to have staff, so is that another one that you can try to fit in in the middle of all the requirements. So trying to figure that out. There is something else but I forget what it was so that's my different roles.

Sue: I definitely would agree with the staff turnover. Even, like, newer teaching staff. I would agree with that. That it's very hard to keep up with the trainings.

Jess: So, just kind of off of that, a question that popped into my head, is there are all these trainings and there is a high level of staff turnover, how interested or engaged in this type of learning do you find your colleagues to be? You know, in adding this piece?

Mya: I feel like a lot of the teachers who work predominantly with special education or mental health services, I feel like that group is probably the biggest invested, more invested into this topic, more because they're working with a lot of students who fall under that category. And teachers who are ELL, so English as a second language is also one of the teachers, the groups that we feel as have a lot more interest in it because of the population they work with. And as far as the other teachers, I feel like if it's not on the professional development day, it's not the first thing on their radar. (Sue: Mmhmm)

Sue: I would agree with that. In my school district, we have once a month kiddos have a half a day one Wednesday so that kinda has built in teachers being forced to, you know, not just one every quarter, it's pretty frequently. So, I think that's been helpful for our staff anyway.

Paul: I think uh, sorry. (Jess: Nope, go for it- overlapping). I think the issue is also with newer staff and turnover of staff and having been trained as a teacher myself as well many moons ago. That there's so much when you're a teacher, a new teacher, you're just learning how to "control" and, I use that world advisorly, control or deliver curriculum to 20 maybe 30 or maybe even a dozen kids. It's hard, it's really hard to be a teacher and then you get the "mental health" people, you gotta use that word advisorly, and your administrators say 'well we gotta be worried about bullying, we gotta be worried about trauma, we gotta be worried about all of the other stuff that causes our kids to act out.' And that's kinda hard, it's kind hard just getting used to the idea of getting up every morning and getting into work before the kids, getting the curriculum, getting the lesson together and all the wonderful stuff that they learn to teachers' college. Getting that together is hard enough on the first two years. And so then you've got some more stuff. And that isn't necessarily, I mean, we know that, we get that because we've been around for many years, but it's actually feeling, and I'll be interested in your comments, but you've really gotta sell the idea of trauma to educators. It's not something they've necessarily been brought up to think about.

Ann: I'm gonna add then to that, I've found by, I don't know, it's not really surveys, but, kind of whatever you wanna call it, but, not very much has still been trained in the school, like, college portion of it. So that you, and those who have maybe attended school, I don't know, 20 years ago, they haven't either been given it or like, I'm guessing like, unless your having someone make you do it, you may not have the opportunity to do the training. (Paul: Mmhmm) You may not be knowing about it. So, I hope that made sense. I don't know, it's being recorded, so.

Allie: Can I just add, too, about the type of training? That I don't think necessarily that the trainings are very clear as far as what trauma is and how. I think some places will just do an hour or two hour voila and now suddenly we're all trauma trained. But what does that really mean?

Sue: That's what I was gonna touch on too, is that I don't think, like I think when some staff hear "trauma" they think of either severe physical abuse, sexual abuse, that sort of thing but it's SO much more. (Paul: Mm hmm) Trauma is such a big umbrella, so I think they're so focused on certain things with that word rather than actually what it is. (Paul: Yeah)

Ann: Yeah, I just did a youth mental health first aid training the other day and one of the parts is you ask everybody about ACEs and (Paul: Mmm) I was surprised to see hands still going up that

didn't know what that is, but yet by now I don't know why I'm surprised. But it's still not known yet. (Paul: Yeah)

Jess: How did all of you learn about this concept of trauma-informed practices? Do you remember?

Mya: Graduate school. Probably was the best time to learn it. Mostly because it, it's a specific field. Undergrad I feel like was very generic information and just going into what major you're going into unless you were into social work or directly working in some type of counseling but it was very generic information when it was undergrad but once I got to Master's it was a lot more into to that topic.

Paul: I think it's a question of definition as well and thank you for your definition earlier, Jess, which I'll be honest with you, I listened to the first sentence and rawr (made talking motion with hand) after that. And my apologies, I'll own my beating in response. But, because it's like, yeah, I know that, and I, I trained, I didn't learn learn about trauma-informed practice when I was at grad school. I got my social work badge in 1989 then before many people were even been born who are practicing now. And that isn't to say I don't know anything about it, I mean. Ann was talking about, sorry to quote you on top, Ann was talking about Adverse Childhood Experiences and I was learning about that in the '90s. Maybe I, maybe I knew about that before, I don't remember. But certainly, you know, so I was aware of that and we were aware of, you know, people. I'm sure Jane Adams knew something about if horrible things happened to you, you know, back in the 1890s, I'm sure she knew about the notion of trauma-informed practice but again it wasn't necessarily, you know, no disrespect, you know, not in a Ph.Ds. and a a big ton of research had been done on it at the time, but we knew about it. And we knew about, and we knew about, you know, again in the 80s, we knew about sexual abuse- that had been going on for millennia and decades. Anyway, although it wasn't necessarily called that. And you get flavors of the month or flavors of the year and yet again it was ACEs back in the 90s.Now, when I was first introduced to it, and obviously people still talk about it now. There's a Search Institute. We're using ACEs like in back in the 90s and then we went through bullying and such, the Olweus programs and we were all trained in that. And now, and now the flavor is trauma. And not to say it's not important but, you know, there's, certainly learning, if you're learning about bullying you learn about the trauma. We do a lot of work with special ed kids who are new migrants into the country, and you know if you are in a, in a refugee camp and if you were born and raised in a refugee camp in Southern Sudan, then came to Central PA, there's trauma there. I mean, we know about that and we experienced it but, you know, whether that's really, you know, well, I'm sure there is an ACE for that. You know, it's things change but we kind of know. And I'll be honest with you, I kind of bristled a bit when you talked about old teachers, I think, older people know about it, but it's just different. You know, the words are different, I think. You know, before, before school shootings in America we were worried about, you know, what people were doing. It didn't all suddenly start with Columbine. (Allie: Paul) I'm, I'm done. Sorry.

Allie: That's okay. I was just thinking about what you were saying and I didn't want to lose it. When I was listening, was just about people knowing about trauma. I think there's, there's different definitions of what trauma is (Paul: Absolutely.) and I think everyone has a different understanding of trauma. But to answer your question, one of the ways I learned was just through reading a book, "What Happened to You," by Dr. Perry and Oprah Winfrey. It was fabulous and through that, my complete understanding of trauma has, has changed, has altered it and has developed and I, it just gave me a whole new perspective about the brain and how the brain's functioning and what's happening. And, yeah, so that's, that's how I learned and I just thought it was absolutely phenomenal and I've read some more of his stuff. (Paul: Sure.)

Ann: For me, I, like to pinpoint the exact time, I can't. I know I'm an adoptive parent, so during the last whatever, 15 years, our lives with my oldest son just some of the trainings I had to go to along with some of the conferences I've been to as a social worker, heard different pieces of, you know, this word 'trauma' and, like, how it's connected to, you know, like, it kind of opened up my eyes to, like, some of the things we were going through and hearing, oh okay, that's what could be going on in his little life and how he's 26. But, like, putting those pieces together and really seeing that as a need for other people to understand, you know, what kids are going through and what they've been through to understand why they are, you know, possibly where they're at right now. So, that part was, like, a huge piece. And wanting to bring it to, like, here at our intermediate unit, letting, you know. I can remember, and Paul was here before me, but, when this wasn't even a term that we really even noted or looked at with our kids and so wanting to get that out.

And, like, getting people trained in our, in our own system here on this new, you know, newish to us term, but yeah, so. That's just been interesting to see how now it's like, I don't want to say a buzzword, but it is. It's used a lot more than I realized, but I'm glad but I also don't want to see a word that people are sick of. You know, another thing that we have to do. So, you gotta be careful.

Bonnie: For me, although it wasn't called trauma-informed back when I was in grad school (Paul: Sure.). Like in social work, like, it's, in my eyes trauma-infor- the trauma-informed lens IS the social work lens. Like, you're looking at all the components of the person. What has affected their life? Is it medical? Is it physical? Is it, you know, sexual abuse? You know, were they homeless at some point? So you're looking at all of those components and that's what we learned in grad school; really being compassionate for where the person's at today. So, when this trauma-informed movement came along, I did, I did then go for formal training, but it was just, you know, kind of reminding me of my social work training.

Jess: So, you've talked about the professional development that you've seen in your areas, whether it's a district or a school or an IU, and you've talked about your training and your experience learning about trauma and trauma-informed practices. What are your thoughts on the current continuing education in this area and any thoughts about changing the experiences that you've had or, you know, were they adequate with this training and the current professional development?

Ann: I personally feel that in some ways, it's adequate for those who have never heard of it at all but then what I think we get a lot is is we need more training for us at our level. And so I know, here at the IU we tried to do a trauma 2.0 and increase, you know, for those who already had already been trained because you get a lot of glossy eyed individuals at trainings where they're like "I know this stuff" so you have to step it up and try to make it something relevant to what we're experiencing now. So I think a little bit of both.

Sue: Yeah, I would agree with that and I think, I mean, I think being, you know, having our license and then also I was a caseworker for years, so I still kinda keep in contact with some people at the county level so certain trainings that they go to sometimes I kinda jump on it or I'm like "oh that sounds good" so we have our networking groups, so that's helpful, too to to, you know, have those trainings. But, I definitely think the difference between what educators get and us is kind of hard to find that fine line.

Bonnie: And I guess I'm just concerned for the educators, like, the teachers, because it's up to the district to pick what training they get and if they only allot two hours, it's just not enough. And if the teachers get to pick what session they get and if it's a different topic, they may be completely missing a really key piece of what being trauma-informed is. So, I wish there was just a standard of this is what every educator gets as the basis of the training. Like, I understand there's the trauma-informed plan through the state and every district has to submit it and get it approved and all that, but they can have a lot of variance in there and that just concerns me. And I don't know what is going on in, you know, the teachers' colleges as far as how they're being taught about it. Is it even being prioritized? Is it an elective? You know, so that just concerns me.

Jess: Thank you. So, earlier on there was a lot of talk about the different needs and the different levels of needs of students that you're working with. So, the question that I have about that is what are the different types of approaches that you're working- that you're using to work with these students that you're finding that are effective? Whether they are, like, the traditional trauma-informed approaches or not. My interest is what can we share among our, you know, reasonably small group; in the state, there's maybe about 700 school social workers. You know, to try to create maybe a database of what works with our kids that maybe somebody else isn't using. So that's kind of my little thought there. So, what does work in different scenarios?

Mya: I can say that for the school district that I work for it, it's the relationships that students have and it's been the biggest biggest piece of, like, getting the students' buy-in is having a person that knows that they're checking in on me, they're actually looking to see me do better, and they're not just expecting me to do something on my own, but having someone checking in with them, checking out with them. It's just that, that biggest piece of building that relationship, 'cuz if we don't have it, it's its been, it's been difficult to try to get anything from a student. So, they're buying in at least, to want to have something to work on or having a person to talk to about what's going on with them or just to even be that person to go to whenever they need something.

Sue: Yeah, and for me, in my district, I tend to work with the families and the caregivers more so than direct with the students. I don't do really anything, like, IEP-wise, mental health-wise. But I think a lot for me would be kind of educating the parents and letting them know, you know, these certain behaviors in the school are because of, you know, XY and Z. So even kind of looking at how I can do that better for the parents and the caregivers of the kiddos.

Allie: I agree. I second it. Connection. Connection and relationship is so critical. You know, we have to build connections to school to people and that kind of keeps, that keeps our kids coming back, and that, you know, that's our, that's the gateway to working with families. And then when we get to that point we do some CBT. I work with a lot of kids with school refusal behaviors so we do some exposure therapy and some family work.

Jess: Anybody else have anything to add? (Informational statement re: Zoom time limits and how to re-access to link when the current meeting ends & an update on time) So were talking about professional development and how they could change and how they could be better. So, if you were to attend a PD session about trauma-informed practices, what would you like to see in them or what would you like the topic to be? If you had a magic wand and say "I want to go to this training about this," what would it be?

Paul: I would like more in-depth discussion and pulling together some of the things I've heard and, the way I see it, maybe, we need to be looking at, for example, case discussions- what are the issues? You know for example, the kid who's in a resettlement camp in, you know, South Sudan last summer. What are the elements of trauma that we need to be sensitive to? How can I help? How, how can I be of service? How can I help that kid and their family adjust, and indeed, the school? It's about, I always see our job as helping square pegs and round holes. What can I do for the peg? What can I do for the hole? To make it a more appropriate fit. So, I think I would like us to be more practice-based. You know, what this is, we're all this chat about trauma-informed, what does it really mean in practice? Because I, I think it, and I'll be honest with you, I think in some ways it's like, yeah, we know that, and or, this is what I do know this is how I can

use what I do know in the, you know, in this particular circumstance. It's kind of empowering us as, empowering each other. You're talking about CBT, I had, I had no idea what CBT was. That was, when I first came because I trained before, before that. I know it's important and I know that approach is important and I know that some of the work I do is or was brief therapy which is what it was called when I was young. And so I know that we can adapt and adjust, but I think that we need to be empowering ourselves because I think that if, if you're a Master's level social worker, you've got, you've got crazy mad skills already and it's about learning how to use them and apply them to the situation. You can quote me on that if you want.

Jess: I like that, crazy mad skills. Does anybody else have any thoughts about your magic wand professional development session?

Ann: I'm going to add to what Paul just said. It's interesting because I think one of the pieces, the cultural piece, the, like, Paul mentioned, in children were were a year ago in a refugee camp or a refu- you know, some sort of situation, a war-torn area and now they're here, and that understanding and, not understanding, that, like, that empathy part too. They may not even had education the way we have it. You know, and this may be the first experience in in a classroom setting at a desk, you know, like, whatever that may be. I am surprised at some of the things I do hear at times where I'm like, that people cannot understand that that's not just gonna be a simple transition, and that they should just be understanding. But that doesn't even have to be the children who experienced that, that could be a child who, who just went through a fire last week like Sue was saying (Paul: Yeah). It's like, how can they, their brains are not, they're not here right now, like, so (Paul: Yeah) yeah. So, I don't know what you want to call that, but, I don't know if empathy is the right word, but, I don't know. (Jess: another mention re: Zoom limits and how to re-access the link to rejoin the meeting)

Jess: Okay, so we were talking about our magic wand professional development sessions. Oh, and funding is unlimited, it is truly a magic wand.

Allie: I would love to listen to Dr. Perry and go to his, he has an educational trauma-type thing. And I would just love to bring that into schools and have everybody understand exactly what he's talking about. Especially with the brain, and the way it just, the way we work, the way we function and it gives, it means that we're not, like, broken and we're not, you know, crazy, Ooh, look at that crazy person- no! That person, that person, you know, had this happen and now they're responding in, oh, we all would, like, our, it's just fascinating stuff, I would love to have more training on that.

Jess: So more on the actual chemical, biological pieces?

Allie: Yeah, he actually has a school-based training. He actually does have something. I forget the name of it or else I'd tell you. I can't recall names of things like that but, yeah, there is some sort of trauma-based training for educators and it's an entire program. I know of one school district in Pennsylvania that is actually doing it and they have a few social workers who are, like, becoming train the trainers and it's a very intensive program, though. And probably super expensive. I would love that, though. I would love to learn more about that.

Jess: Let me just review. On your own, just so you are aware, you guys covered all of my questions, so thank you. So, is there anything else that you think that we might have missed that you were like oh my gosh, I wish I would have added this? Any final closing thoughts?

Mya: We need more money for mental health fields to support a lot of the actual, you know, resources that we have 'cuz it's very limited. You can do mental health but if you're not, if you don't have insurance or you don't have money, it it just, it doesn't happen. So funding, definitely for sure, funding.

Ann: Are you all aware that there's $100 million that's being released to all of our districts across Pennsylvania. It actually, you can, the school districts should be being told about it soon and receiving webinars on this and it's supposed to be toward mental health and it's through a grant with Pennsylvania Prime and PCCD- Pennsylvania Crime and Delinq- wait- Delinquency (Paul: PCCD). Thank you, Paul! Yeah, so that should be known to districts. It's gonna be how they use it is gonna be interesting, so, and of course it's across Pennsylvania, so 100 million divided by how many, you know, districts and schools, but.

Allie: Now, what they should do is they should ask all their school social workers and we will allocate the funds (Ann: Uh-huh) appropriately (Ann: Yup). We'd make very good use of the money (Ann: Yup, I don't think that's being done, Allie). Now, I seriously doubt it. However, however.

Paul: But Jess was asking what would do if we (Allie: Yeah, there you go), so. (Ann: Apply for the grant).

Jess: Anything else before I stop recording?

Mya: Can you put the name of that grant on the chat so that I can look that up?

Ann: Yeah, can you give me, I will look it up really quick in my e-mail 'cuz I have it.

Mya: Thank you.

Ann: You're welcome.

Jess: Alright, and I am going to stop recording.

Focus Group #2 Script

Jess: So thank you guys, I know you're all busy and everybody's, like, on the phone or finishing up meetings. I know my morning was really hectic as well. I have a student who, I'm totally stealing this from her, but she always says that life is lifeing or life isn't lifeing. I don't know if anyone else is feeling that this morning, but life is not lifeing today, so, I definitely appreciate that little phrase from her. So I mentioned in my earlier e-mails and, you know, from using my survey, because that's how you guys all got linked up with me, today's questions are going to be heavily focused on trauma-informed practices. I am aware that there's a lot more to being a school social worker but I had to narrow the scope for the purposes of my research. There are no right or wrong answers and my goal for this discussion is to explore what's happening, like, what is actually happening in the field in Pennsylvania schools. So, it includes your thoughts, your feelings, and your experiences. In order to have a shared definition and shared language, which is something that really did come up in last week's focus group is having that shared definition. So, for the purposes of this study, trauma-informed practices are defined as services provided to a client or client population that takes into consideration the broad impact of trauma and the potential for recovery, that recognizes the signs and symptoms or trauma, that strives to create and environment that is not retraumatizing, and it strives to take steps to prevent secondary traumatic stress in staff. So, before we begin, are there any questions? (all heads shaking "no") Okay. So before we start, I know that I sent the e-mail out, asking for some stuff about you and about your district, but is there anything that you feel, for the good of the group, is important for everyone to know about you, about your pa- about your history as a school social worker, or about your district, that might, you know, explain a little about your answers?

Shana: I'd say for me, I'm newer to the school social work part of it. I took the position here at this South Central Region School District probably like, I'm in my 3rd year no. I worked in a clinical setting before that. I did everything from a TSS up through outpatient therapy, family

therapist, so kind of trauma-based therapy. And we had a program that was situated in the, actually we, we're in the South Central Region School District. I started that and ran that for about 10 years so that's kind of how it led to the opening of this position. So I come from, I feel like a, like a, it wasn't just straight into school social working.

Jill: Jessica, I work in a rural school district. However, we have 110 students that come to our elementary building from a Section 8 housing community, so we have a rural school district but have some urban issues from that community from that 110 students. They make up about one-fifth of our building population.

Jess: Thank you.

Joy: I work in a school district that I cover five out of the six buildings and there is a transitional trauma-informed emotional support classroom staffed by outside providers in several of our buildings that is specific for students who have experienced trauma. So, when I answer the questions, I plan on answering them separate from that program. So, I really am not involved. I mean, I collaborate with the transitional classroom staff, but I'm going to answer the questions for the rest of the buildings, so separately from any transitional classroom programming that goes on because that is a separate contract that the district has and not necessarily something that I have influence over.

Jess: Okay, thank you.

Tim: I am coming from a district that I believe is the fastest growing district in all of Pennsylvania. I think last I knew it was my Southwest Region district. I'm in the suburbs of a large urban area. We have a large South Asian population and we also have, we're viewed as a very affluent district, but we do have a lot of students who are also a little more rural. I put down suburban, but some of our students probably would more identify as, as rural. So we have a really interesting mix of students. We probably have more low socioeconomic students than most people would realize.

Jess: Thanks guys. That does help a lot, especially as we move forward with the other questions. Okay, so, keeping this information in mind, that really does feed right into this first question. Can you describe or provide, you know, some details regarding any factors that could be affecting your use of trauma-informed practices with your students and families? So, you know, what's leading to that, when you're working with them? Influencing it?

Tim: I think going back to what I said about our population, having a large South Asian population, there is a lot of stigma involving mental health with that population. So, even though we have a large South Asian population, which is primarily Indian, I do not often get the chance to work with those students because there's, like I said, there's stigma about mental health. Either not believing in it or just not wanting to think it's necessary for those families.

Shana: I think sometimes, for me, it can be walking that line between, like, what's my own personal practice might be one thing but when I'm interacting I have a lot of things where I'm working with administration and (group nods), like, the teacher population is large and the buy-in. I think we all go for, like, what the buy-in is and how much, you know, you can be seen as, like, "the softie" or the ones that, like, we're almost, like, too understanding about things and that's, it can kind of influence. It almost takes some of your power away, I think, in some essence where you kind of have to walk that line between making sure you're presenting as someone who's going to hold a boundary while being, like, trauma-informed.

Jess: Do you have any, like, obviously without giving away identifying information, like, examples where you've had to deal with that?

Shana: One of my roles here, I work with some of the truancy, doing, like, student attendance improvement meetings. And I feel like there can be a lot of, it's hard to get leeway from certain staff about, like, where there's an attendance issue and you understand that there's a lot of mental health reasons behind the attendance and so, kind of a hard line of no, this is a no, this is the rule we have to follow it. Where my leaning would be like, that rule doesn't, it doesn't fit with this kid. Like, that kid doesn't, you know, what looks like successful attendance in school for, you know, maybe the average student is not what's going to look like successful for this kid. And I think that, that can be an area where, you know, and then they lose out on benefits at the school or any, you know, they lose out on school dances or other things and so, once again they're pushed out of the community and away whenever, their best looks like and actually doing well their version of well. You came three days this week- that's maybe fantastic for one kid and it's not for someone else. I think that's a big area where the, it's very evident that it's, there's a line drawn.

Jill: Jessica I have an example of that. We had a student who had a really rough week last week.

He was, he's not a typical, he's a 5th grader, typically a good kid. Just had some, like, minor behaviors, but definitely not his normal. And last year, in the spring his father was shot and killed by another father in our building. The incident happened outside of our building, obviously, but, it was two fathers in the neighborhood. And last week his family moved from one

unit in the Section 8 housing development into another unit. So I'm sure there was packing up belongings, there was finding things had been put away. So I'm, my understanding of his behavior last week was he, last week was a rough week for him, we need to show some grace and forgiveness and not look at the behavior as just behavior but as communicating that he had a rough week. And we had a substitute that was in his classroom who really did not understand that or, you know, she did not have the background. So when I pulled her aside and said, “listen we need to give him some more grace and some more breathing room", she was very focused on what he had done and how disrespectful his behavior was. And when I explained the situation to her, her reaction was, "well, how was I supposed to know?" So, I explained, well, just, you can ask or let us know and maybe one of us can give him a break or give him the attention he's seeking rather than just dealing with the behavior at its face value, right? And looking a little bit beyond the why. So just, I think, sometimes time is the reason that trauma-informed practice isn't always everyone's go-to because you need to to meet with that student or talk to with that student or pull that student aside instead of just saying "hey, cut that out," right, because his behavior was different than the last time this substitute was in for him. So, time, I think, time is a big barrier.

Jess: So, just an off-shoot of that is overall in your district settings, you know, what do you perceive the climate to be, what are the overall, like, beliefs and attitudes toward trauma-informed practice and, you know, being able to use it with your students and families?

Joy: I think, for me, there's a discrepancy between what people think are trauma-informed practices and what they actually are. So, there's a building that I work in that administratively they've said that, okay, when the students enter your classroom, you have then give you a thumbs up if they're having a good day or a thumbs down if they're having a bad day because we're trauma-informed. And I'm like, mm, yeah, that's great, but that is not, you can’t call yourself trauma-informed simply by a thumbs up or a thumbs down. There's so much more to, and we know there's a continuum, right, of of having that support in terms of trauma, so for me, I feel like there's a, there's a discrepancy there between what you think you're doing and that you're having an impact. Are we actually implementing trauma-informed interventions across the board and keeping those things in mind when we're working with with students. So, it becomes more than just a quick, you know, two second things as you're entering a classroom. I think it's important to do those kinds of things as just kind of a temperature check, but, okay, if a student gives you a thumbs down, then what? Right, so there has to be more than just that really quick interaction. And teachers being prepared on knowing what to do and how to intervene and that being trauma-informed isn't something that only a school counselor or a social worker can do, that these are techniques that teachers can implement in their classrooms regularly throughout the day.

Jill: I think once teachers are in the grind it becomes harder to find those moments to get to know students at a deeper level. I think at the beginning of the school year building relationships,

building relationships, building connections, building connections, is all, all they hear, and then when the curriculum, oh yeah, that's right, we gotta teach that, comes into play. And I'm in an elementary building, so the 1st grade teachers are "we gotta get 'em ready for 2nd, we gotta get 'em ready for 2nd," all the way up to our 6th grade teachers that, you know, "oh, we gotta get 'em ready for middle school, we gotta get 'em ready for middle school." So, how do we find those pockets of time, whether it be morning meeting or check, check outs at the end of the day. To continue to connect with students; to know their stories beyond that opening event, those opening, gotta get to know them, gotta get to know them- what are their favorite colors, what are their favorite activities, who's in sports? To know all those about those students but continue those activities throughout the course of the entire school year and not make "relationship-building" a beginning of the school year thing.

Shana: We've been working on becoming, we started a team here for trauma skill, call it the Trauma Skill School Model and I think it's even just, I think the, overall, everyone kind of wants to be trauma-skilled. I think it's, once you get it settled, it's finding the time and the ability to be able to be consistent with it. And even when we started ours starting from the top down was kind of our model, like, it needs to be coming from administrative, administration needs to be acting like that towards their staff and then the staff needs to treat themselves in a, in their own trauma-informed trauma-skilled way. And the best example is we took two hours out of an in-service day and we said you have to sign up for a mindfulness or wellness activity and people were doing things like, they brought, we brought dogs in, like one room was just set up to pet dogs and hang out or read a book or have coffee and people threw their hands up and were like "I have things to do" and we were like "if you can't stop and think of yourself for, like, a minute then you, what are you doing for your kids?" Like, what are we teaching our kids if we can't teach ourselves to stop. We, we're paying you, we'll pay you to pet a puppy, like, and they were "aah!" and then they did it and everyone was, like, "that was so awesome." And we've tried to build those back in where it's, like, and and we have it staff-led, too. Staff will sign up to lead a pottery class, or walk around the building, or go for a run, and everyone play, I think they like to play pickleball. But now it's kind of gotten better after doing it several times, but I think just even getting people going and the buy-in, like, stopping and being kind to ourselves first so that we have it to give to our, other, others around us can be a difficult place to start with.

Jess: You already started as a group talking about how you're seeing it, trauma-informed practices being used in your school by, like, non-mental health staff. Do you have anything else to add, like, more specifically about how you are or are not seeing it being used, like, more than a general concept but actual examples before I move onto something else?

Joy: Are you looking for specific situations or specific student, like, situations?

Jess: Something, yeah that, or "I have seen this in general being used"- however you feel. Or even just the idea, is it common, is it not common?

Joy: For me it's common that we talk about it, it's common that we say that we're trauma-informed but me as someone who has experience with trauma-informed supports, isn't really seeing the concrete examples of these people actually doing it, right? So you have, and I can't even say it's newer staff versus tenured staff, I just think it depends on the particular staff member. You're either in it and you embrace it and it's something that you try to implement in your classroom regularly or it's, or it's not. And then sometimes you hear the things like, "well, I am not a mental health professional, I am not a therapist so I, this should not be my responsibility," without seeing the benefit of just being able and willing to listen and knowing we're not asking you to do anything about it. We're just asking you to, you know, develop those relationships and if there is a student who comes in and they're super off, just maybe saying something to someone else, "hey, can you pull them and talk to them for a minute 'cuz they just don't seem like their normal, their normal selves." And, you know, I've had multiple situations at the middle school level this year where it's like you get SAP referrals, right, "this kid, I just don't know what it is, but they seem off" and I'm able to pull the student and find out, like, yeah, there's an anniversary that just happened or, or whether it's, you know, a move as Jill mentioned or something's going on. But, just having that awareness to say something's off with this kid and allowing the "mental health professionals" to then take it and be able to intervene. So, like I said, I couldn't say that it's newer staff versus you know, tenured staff, it just really depends on that particular person and their willingness to, to be trauma-informed without maybe even necessarily knowing that they're doing it.

Shana: I would say one of, like, for specific examples we've been trying to go through with the trauma skilled school process and that model and breaking it down through the different levels of things like acceptance and what does it feel, what does it mean to be accepted. We're making into topics that we present to, and we're going very slow with it, presenting it through the year to the staff. Applying it to ourselves and trying to make it where we're not, this is not just a new concept, we're not just, we're not, not one more thing, you know, you go, you go to an in-service and there's one more thing and you do it for a month or two and then you learn about the new thing you're doing now. And just trying to focus on tangible things we're already doing and making them in the model they call purposeful practices. So it's like, hey, you're already greeting kids at the door, is there a way, like using the thumbs up, thumbs down, is there a way that we can tweak what we're already doing to be purposeful and just be aware of the fact that we're not asking you to do anything necessarily different, we're just being more mindful and purposeful about what we're already doing to fit into all these categories of what does it mean to be accepted, what does it mean to belong. That was our latest one, just asking kids about belongingness and making it part of our morning meeting, about how do you belong here at the school, what does that look like? (Jess: heads up on time with reminder how to re-access Zoom link when the meeting is ended by Zoom time limits)

Jess: So, I heard a couple mentions of different ways that, you know, you're working with families, staff are working with families, and sometimes, like being trauma-informed without even realizing you're trauma-informed. So, and this is sort of just a blanket question, there is no right or wrong answer, what are you using with your students and families, whether it is trauma-informed practices or not, that you are finding to be effective in various situations? So this is just putting out, if we could create this magical school social work database of effective practices for different situations, like, what would you suggest goes in there?

Jill: So, Shana had talked earlier about attendance. We, we have found that with SAIP meetings- Student Attendance Improvement Plan meetings- that sometimes information comes out in those meetings that has nothing to do with our students' attendance. For example, we met with one mom and her daughter had, you know, is missing school probably, like, once a week. And her, the mom came in, she met with us. She was very open to what's going on in her home and she said "I think it's because she sees my son who has graduated not doing anything." And so the conversation then became, with this mom and my principal and myself, "well what does he want to do or how did this happen or talk us through this," and she said "I just don't know where to start, he wants to work with computers." So my principal literally picked up the phone and called someone, a connection he has at a community college and got this, this boy and interview at our community, our local community college but it, it had nothing to do with her, with the, with the 5th grader's attendance. It did, but that, when you think, when you think of student attendance plans, how can we help the 5th grader? It really became, how can we help the family? So, I don't know how we would put it in a school social work manual but listening to stories, listening to the families' stories, and digging deeper than, you know, the 5th grader's supposed to be here Monday through Friday, what does the family need to make, to make their environment better so that our, so then they're coming to school? And since we met with this mom, she, her communication with us has been so improved and just more connected to us. The daughter has not missed anymore school. The son went for the interview, he'll be starting, he, he started in January at the community college in a program that he was interested in. Now, yes, I am 23 years of experience, I know that's not gonna be the case for every SAIP meeting we sit through. We're gonna find the magic solution, but I think in this case, listening to her story, being heard and taking the time, taking the time to, to make another connection to a resource. So just, listening and, you know, the example I gave earlier. Listening to that boy's story and hearing him say we had to pack my dad's clothes and they're gonna stay in boxes now because he's gone. So hearing, just hearing stories and listening and making those connections.

Joy: I was gonna say right before you spoke, like, it needs to be student-led. Right?

Like, we need to be willing to listen to what our students are telling us, whether it's through their behavior or just by giving them a voice. Right? We can, cannot, and I know, some adults have this impression that I'm the adult and you will respect me and I don't think that that's the way kids

work nowadays, right? They wanna be shown respect and they deserve to be shown respect and so, just allowing the time to kinda talk about their stories and what works for them and what doesn't work for them and while, yes, there are going to be academic demands, I think just being willing to, to listen to them and allowing them to be part of the decision-making process as much as then can be is, is something that certainly would be helpful and, you know, families as well. You know, I come to my buildings and I'll tell people all the time, these are, these are my customers. Right? If they're not here, we're not here, so I treat my kids like they are my customers and I do my best to be able to provide the best customer service that I can, whether it's, you know, showing up when I say I'm going to show up or doing something I said I was going to do to develop that trust in them. And, you know, sometimes they don't have that and so to be able to be that person who's going to be there for them and is going to be dependable I think helps to develop that relationship and then they're going to share that information with us and they're going to know that we're here for them regardless of, of their story, of, of what's going on with them. And so I just think being willing to allow them to have a voice that's not contingent upon them respecting us every single time because we don't know what's going on. And that doesn't necessarily mean it's a personal attack on us, you know, if a kid's cussing me out, it doesn't mean it's a personal attack on me, it's the stuff that he's got going on. And being willing to say, okay tomorrow's a new day, or hey, maybe today I'm not your person, that's okay, I'm not offended by that, who is your person, let's find your person. Maybe today it's not me, that's okay. But being able to just listen to them.

Shana: I think, kind of piggy-backing off that, the the model that I like to use, and I think it's great, is Ross Greene's, like, Collaborative and Proactive Solutions Model. Like, he, because it has all that stuff, it's all about collaboration learning what it is people want or need and learning when to kind of, you kind of back off a demand, you shelve it for a time. I know that's really hard for some people 'cuz they feel like, they feel that they're, they're giving in, they're in a power struggle with the kid and then when they give in. But, I mean, the great thing about it is it that, even one of the ways he puts it is, they're not meeting the expectation anyway, so, you, like, can keep, you can keep on with it, they're not meeting it right now anyways, so how do we get there, get to being able to say this route is not the route. And the more proactive you are with it, the less likely you are to need to, to get into this bigger blow-up kind of situations 'cuz you can kind of head it off beforehand.

Jess: And then before we move on, I didn't know if you had anything to add, Tim, because you have such a unique population? Have you found anything successful working with them?

Tim: I do agree with the comment about listening to the stories. And I know that's hard to do when you have, like, district policies and rules because, you know, if you bend for one family then, you know, the word gets around and so then people will say "oh, well you didn't send this kid to the magistrate when they had so many absences but yet you're sending me to the magistrate

and I have the same as them, so what's, what's up with that?" But, you know, it is I, I think, as much as you can try to be flexible with those kinds of things, I know, I thinks Shana was talking about attendance and I thought about how I know for homeless students through McKinney-Vento, I believe it states in there attempting to be flexible with, you know, filing truancy in those cases, but, like, I'm not sure, you know, how many people even know about that stuff honestly. So that's, like, we're running out of time here. (Zoom time ran out)

Jess: So we were just talking about the practices that we're using. Any final thoughts on that before we move on? Okay, great. So jumping back to trauma-informed practices more specifically. How did you, like, stumble upon this concept, learn about this concept, like, when did trauma-informed practices first fall into your life and how did it get there?

Shana: As I said before I came from the clinical field so I worked with a lot of kids that experienced trauma. The agency that I worked for is a smaller local agency. We did, when I was a TSS, we had a summer camp and half the camp was for, it was the trauma camp, so my entire population I worked with was trauma. My, the person I interned with, was a, is a, specialized in trauma, and so it just naturally I became, just, I got all the trauma kids. It was all the RAD kids when they were little and, you know, a lot of trauma-specialized therapies is kind of what I focused my training and my work on. So that kind of, it kind of came naturally through that.

Jill: Training through the district and our IU.

Joy: I'm trying to think back.

I feel like it was the first in-service that I attended back in 2018 when we talked about ACEs and I first watched the Nadine Burke-Harris video which I have since watched a hundred times and could probably recite. I think that was, not that I had never heard about trauma, but that was the first time I think I connected, wow this is something that a lot of our students experience. And I remember the Director of Student Services at the time saying "okay, we're not gonna run out and give all the kids the ACE survey now, we're going to assume that all of our kids have experienced some type of Adverse Childhood Experience." So, just kind of that kind of shifted my mindset. Like, don't worry about what it is, let's just treat all of the kids, and assuming they've experienced something, whether it's super traumatic big T trauma or, like, little t trauma. Let's just assume, as a baseline, that we're going to support all students as if they may have experienced something. And so I think that was the first time that I remember really starting to think about trauma and then having attended some of the Lakeside specific trauma trainings and then having attended, having going into a second master's degree program that was specific for trauma-informed practices. Just having all of that then formal education around trauma. And really gravitating toward emotional support students for some reason, like, I really enjoy being able to get in there and really work with the and figure out what makes them tick and just starting to know some of

their histories and being like "wow, like, this is such, such a high population of these ES kiddos who have experienced those big traumatic events." So just being willing to and being interested in being able to help them.

Tim: Yeah, I agree with a lot of what's been said. I think I'm struggling to remember exactly, like, how I came into contact with it. But just trying to think about those key components, like, the it's not what's, you know, what's what's wrong with you but, like, what happened to you, like that kind of thing. And then, I did in my, before I came to this Southwest Region School District I did work at a specialized school with an IU, three, and I was the emotional support social worker and it's so interesting how, like, that was such a culture shock coming from, like, a reg, you know, a big public district to, like, a small school with, like, all ES kids and you see, like, there's how much trauma they've had and trying to not only just understand it all but then, you know, figure out how you can be trauma-informed with all of those different kids who have had a ton of different types of trauma and how to, like, you know, differentiate and all those things. So, that's kind of probably the best answer I can give there.

Jess: So thinking back to when you first were exposed to trauma-informed practices up through now, what has your overall experience been with professional development opportunities, trainings, and all of those sorts of experiences?

Jill: I feel like a lot of times at trainings they talk about what is trauma-informed practices but they don't get down to what you can put in your toolbox to take away. And when they do kind of get into what does it look like, how can we do it, it's things that a lot of staff or myself stay "well, we do that, we do that, of course we do that, why wouldn't we do that for our kids, why wouldn't why wouldn't we show grace and space for students?" So, I think everybody is looking for that secret of what, what they can do with students. But I think it goes back to building relationships, listening to the stories, and pausing before those reactions happen. And so, sometimes, you know, the latest and greatest thing isn't something new, it's something you're already doing. So I think sometimes telling staff we have to go to another trauma-informed practices or trauma training, everyone's like, "oh they're going to give us this new, new strategy" but it's, it's not. It's, it's what they're doing.

Shana: I have found in particular, I, 'cuz I do some of the trainings for the district and even in my position prior to this I would do, I tried to train for teachers on trauma, and I feel like when I incorporate information on how the brain works, on even just a simple level and keep bring it back to the fact that we're just, you know, a chemical reaction that's occurring in time and space right now; that we are just a bunch of cells in, like, a reaction. And trying to humanize it in that kind of way, it helped them understand it on a different level. That, I think, that helps with the depersonalizing aspect of it, too, of the behaviors, like, hey when the amygdala, you know,

hijacks your brain you can't get to your prefrontal cortex, what do you want a kid to do? Like, just kind of, really helping them understand why we're doing it. I don't like being told to do things without understanding the reason why so I think when we go under, if we go sublevel with it at times to help them understand why am I telling you to, like, what you feel like is coddle a kid when actually I'm just trying to get their prefrontal cortex back online because you're talking to and emotional brain that's not gonna learn anything right now anyways. You know, like, that's why they're gonna keep doing it. When we kinda put it in context, I feel like I get a better response and also whenever it, I think the trainings that are really good is whenever it's, like Jill was saying, actual tools that they can use and use for themselves. Like I have them do things where they, they practice, you know, different ways to engage their, like, their vagus nerve. You know what I mean, where they're practicing things and seeing how it feels in their body. And if it works for you, that's how it, that's why we are doing it to work with the kids. I think that tangibleness of it and, like, practicality of it, putting it into practice really makes a difference over just the concept of it, 'cuz we can talk about trauma trauma trauma all day but what does that look like everyday?

Joy: I would agree. And I think sometimes we as school social workers assume that teachers know what we know, like, as if I would be able to go into a classroom and talk about all of the acronyms that teachers do. I can't do that, so I can't assume that the skills and strategies that I use regularly are regular and comfortable for them to use. So, I, I agree without overwhelming them with the brain parts, because that, for me, I'm like, it has taken me several times to kind of learn about the parts of the brain. But you do need to know that, you need to know that some of these things are out of a student's controls. So, I think, you know, trauma's such a buzz word, too.

you say, "oh, we're going to do trauma training" and everyone's like "oh, here we go again," but being able to, like Jill said, come out of that professional development with practical skills that you can implement easily without teachers feeling like it's something else that they have to add onto their plate, because they're overwhelmed as well as we know and they are not solely responsible for the mental health needs of these students, but like, there are things that you can do easily in your classroom or just little adjustments and tweaks you can make that will be able to have a student be better able to respond especially if they are regulated.

Shana: When I like to, it needs to fit for that teacher, too. Remembering that, like, when we're learning about trauma-informed and trauma-skilled practices we need to, like, everyone's gonna look different and play to our own strengths. So it, a lot of times it's just, kind of, a generic overview, but like, how do we get to where we're going to be more examples that play to various strengths 'cuz it looks different for everyone.

Joy: But like, here's a huge toolbox and you take out of here what it is you like and toss the stuff you don't, that's okay.

Jess: So as we move forward, if you were able to go to a professional development session about trauma-informed practices for yourself what would you like to see in that? Are there any specific areas that you would like to see covered, any specific type of professional development you'd like, or is there anything that would be specific, anything that would be more useful or interesting or preferable?

Tim: I think kind of, like, what was just mentioned in terms of things that we can use as school social workers but that also are able to be shared with our, you know, teaching colleagues in a way that they don't feel like "oh, here we go again trauma, trauma trauma." And so, you know, I think that's important because otherwise it, it is gonna feel like more of the same where we feel like we're have this uphill battle with, you know, getting the message out in a way that's willing to be accepted by, you know, the teachers and other staff.

Joy: If we have PD on buy-in, right, like how to create buy-in for staff who maybe don't feel like it's something that they need to do or don't see the benefit of it or, so maybe that's not specific to trauma, 'cuz buy-in's a big thing, you know, for a lot of different topics. But how to create buy-in on a teacher level, on an administrative level, on a district level? Whether that kind of includes advocacy as well, in terms of what is needed, I don't know how to categorize that. But there you go.

Shana: No, but I think it's good, I think buy-in is a good idea 'cuz it's almost to me, when you were saying that I was thinking about, like, how can I approach those that I know are resistant in a way that's also trauma-informed towards them as well. You know, like, how can I be understanding of like, if I'm understanding of resistant students I need to be understanding of resistant teachers and how do I, what do I, what do I need to know to connect with them? Like, how do we bridge that gap between that? I think you used it earlier, the word, like, grace. I talk, a lot of people, but the difference between grace and accountability, like, is such a, is such a interesting thing. So I guess, you know, that, how'd the, how do we work in grace and accountability. You know, and when does holding a boundary, what does holding a boundary look like? Because I think boundaries are safety too, I think, like, in trauma you need to have boundaries but it looks different in how we each choose to hold them. So, I think, you know, those kind of trainings would me, you know, what different boundaries can look like.

Jess: Everybody looks really deep in thought. Okay. Alright, so is there anything else before we wrap up, that you feel that you'd like to add that I might have missed with my questions that you think is really important, that you, now that you've been sitting here you're like oh my gosh I really wanna add this from earlier? Any final thoughts?

Joy: Just along the lines of advocacy, like, there are standards for math, and there's standards for English, and there's standards for all of that stuff, right? But are there standards for social emotional care? And maybe, if there were something like that, then it would be more of a consistent thing that we're all doing. And there would maybe be a little more emphasis placed on dollars, right, to be able to implement these types of things and just to create that common language that, you know, everybody's using. So, I don't know if it's, if it's worth talking about, like, on a much bigger level in terms of school social work advocacy and just having that as part of the curriculum. So that it's not something we're adding in, it's something that we create time for automatically, that it's an expectation, just the same way any of your other classes would be.

Jess: Alright, if there's nothing else then. Thank you again for your time and your insight. I'm going to stay available through this link for about another 10 minutes for anybody who would like to meet with me individually and then I can also be reached through my e-mail address, which you all have access to. So, don't hesitate to reach out at any point. I check it with decent frequency. So, other than that, have a great day and I hope your students are good to you today. Take care and thank you!

Appendix L- Research Question #1: Additional Information

Table 15

Survey Participants' Time Licensed

	N	%
0	4	1.7
1	8	3.3
2	13	5.4
3	16	6.7
4	17	7.1
5	16	6.7
6	7	2.9
7	8	3.3
8	9	3.8
9	9	3.8
10	9	3.8
11	9	3.8
12	8	3.3
13	9	3.8
14	8	2.1
15	8	3.3
16	4	1.7
17	7	2.9
18	5	2.1
19	4	1.7
20	12	5.0
21	9	3.8
22	5	2.1
23	3	1.3
24	3	1.3
25	6	2.5
26	3	1.3
27	4	1.7
28	3	1.3
29	2	.8
30	6	2.5
31	1	.4
35	2	.8
36	1	.4
40	1	.4
Did Not Respond	3	1.3

Table 21

Perceived Preparation by Certification Courses to Use Trauma-Informed Practices

	N	%
0- Not At All	6	2.5
1- Very Little	12	5.0
2	7	2.9
3- Somewhat	60	25.1
4	45	18.8
5- Very Much	46	19.2
N/A- Not Applicable	22	9.2
Did Not Respond	41	17.2

Table 22

Perceived Preparation by New Staff Induction/Formal Mentoring Programs to Use Trauma-Informed Practices

	N	%
0- Not At All	50	20.9
1- Very Little	56	23.4
2	17	7.1
3- Somewhat	37	15.5
4	11	4.6
5- Very Much	13	5.4
N/A- Not Applicable	15	6.3
Did Not Respond	40	16.7

Table 23

Perceived Preparation by Professional Experience/On-the-Job Experience to Use Trauma-Informed Practices

	N	%
0- Not At All	3	1.3
1- Very Little	2	.8
2	1	.4
3- Somewhat	39	16.3
4	62	25.9
5- Very Much	110	46.0
Did Not Respond	22	9.2

Table 24

Perceived Preparation by Professional Development Opportunities to Use Trauma-Informed Practices

	N	%
0- Not At All	1	.4
1- Very Little	6	2.5
2	8	3.3
3- Somewhat	59	24.7
4	65	27.2
5- Very Much	75	31.4
Did Not Respond	25	10.5

Table 25

Perceived Preparation by Professional Conferences to Use Trauma-Informed Practices

	N	%
0- Not At All	3	1.3
1- Very Little	7	2.9
2	5	2.1
3- Somewhat	47	19.7
4	81	33.9
5- Very Much	61	25.5
N/A- Not Applicable	8	3.3
Did Not Respond	27	11.3

Table 26

Perceived Preparation by Independent Study to Use Trauma-Informed Practices

	N	%
0- Not At All	6	2.5
1- Very Little	7	2.9
2	3	1.3
3- Somewhat	45	18.8
4	62	25.9
5- Very Much	68	28.5
N/A- Not Applicable	14	5.9
Did Not Respond	34	14.2

Table 27

Perceived Preparation by Professional Supervision to Use Trauma-Informed Practices

	N	%
0- Not At All	29	12.1
1- Very Little	29	12.1
2	14	5.9
3- Somewhat	45	18.8
4	36	15.1
5- Very Much	33	13.8
N/A- Not Applicable	22	9.2
Did Not Respond	31	13.0

Appendix M- Research Question #2: Additional Information

Table 41

Survey Participants' Number of Reported Job Tasks- Raw Data

	N	%
1	5	2.1
2	14	5.9
3	19	7.9
4	31	13.0
5	46	19.2
6	45	18.8
7	26	10.0
8	30	12.6
9	16	6.7
10	7	2.9
11	2	0.8

Table 43

Survey Participants' Reported Caseload Size

Students on Caseload	N	%
8	2	0.8
9	1	0.4
10	3	1.3
12	1	0.4
13	2	0.8
14	1	0.4
15	1	0.4
18	3	1.3
20	4	1.7
22	1	0.4
23	1	0.4
25	3	1.3
28	1	0.4
29	1	0.4
30	5	2.1
33	1	0.4
35	8	3.3
36	1	0.4
40	9	3.8
41	1	0.4
45	7	2.9
48	1	0.4
50	17	7.1
60	3	1.3

Students on Caseload	N	%
62	1	0.4
65	3	1.3
68	1	0.4
70	3	1.3
75	1	0.4
80	3	1.3
85	2	0.8
100	8	3.3
105	1	0.4
110	1	0.4
120	2	0.8
125	1	0.4
132	1	0.4
150	2	0.8
161	1	0.4
180	1	0.4
200	4	1.7
250	3	1.3
260	1	0.4
270	1	0.4
300	5	2.1
350	4	1.7
400	3	1.3
450	1	0.4
470	1	0.4
500	12	5.0
564	1	0.4
570	1	0.4
600	7	2.9
650	3	1.3
680	1	0.4
700	3	1.3
715	1	0.4
800	5	2.1
850	1	0.4
900	1	0.4
1000	4	1.7
1005	1	0.4
1059	1	0.4
1200	3	1.3
1300	2	0.8
1350	1	0.4
1400	1	0.4
1500	5	2.1
1700	2	0.8

Students on Caseload	N	%
2000	1	0.4
2050	1	0.4
2200	1	0.4
2300	1	0.4
2400	1	0.4
2500	2	0.3
3000	4	1.7
3100	1	0.4
3400	1	0.4
4800	1	0.4
7000	1	0.4
Total	204	85.4
Missing/No Caseload	35	14.6

Table 46

Cross-Tabulation: Participants' Caseload & Use of Trauma-Informed Practices

	0 or 1 Types Used/Reported		2 Types Used/Reported		3 Types Used/Reported		4+ Types Used/Reported		Total	
	N	%	N	%	N	%	N	%	N	%
< 45 Students	13	24.5	13	22.4	13	26.0	12	27.9	51	25.0
45 to < 115 Students	11	20.8	21	36.2	10	20.0	10	23.3	52	25.5
115 to < 600 Students	15	28.3	11	19.0	14	28.0	4	9.3	44	21.6
600+ Students	14	26.4	13	22.4	13	26.0	17	39.5	57	27.9
Total	53	100.0	58	100.0	15	100.0	43	100.0	204	100.0

Table 48

Cross-Tabulation: Teachers' Use of Trauma-Informed Practice & Participants' Use of Trauma-Informed Practices

	0 or 1 Types Used/Reported		2 Types Used/Reported		3 Types Used/Reported		4+ Types Used/Reported		Total	
	N	%	N	%	N	%	N	%	N	%
Yes	13	29.5	28	52.8	25	53.2	28	60.9	94	49.5
No	14	31.8	13	24.5	9	19.1	10	21.7	46	24.2
Do Not Know	17	38.6	12	22.6	13	27.7	8	17.4	50	26.3
Total	44	100.0	53	100.0	47	100.0	46	100.0	190	100.0

Table 50

Cross-Tabulation: Administrators' Use of Trauma-Informed Practice & Participants' Use of Trauma-Informed Practices

	0 or 1 Types Used/Reported		2 Types Used/Reported		3 Types Used/Reported		4+ Types Used/Reported		Total	
	N	%	N	%	N	%	N	%	N	%
Yes	18	40.9	34	64.2	22	46.8	30	65.2	104	54.7
No	13	29.5	9	17.0	15	31.9	9	19.6	46	24.2
Do Not Know	13	29.5	11	18.9	10	21.3	7	15.2	40	21.1
Total	44	100.0	53	100.0	47	100.0	46	100.0	190	100.0

Table 52

Cross-Tabulation: Administrators' Support of TIP & Practice & Participants' Use of Trauma-Informed Practices

	0 or 1 Types Used/Reported		2 Types Used/Reported		3 Types Used/Reported		4+ Types Used/Reported		Total	
	N	%	N	%	N	%	N	%	N	%
Somewhat or Less	18	40.9	15	28.3	19	40.4	15	32.6	67	35.3
More Than Somewhat	12	27.3	20	37.7	11	23.4	12	26.1	55	28.9
Very Much	14	31.8	18	34.0	17	36.2	19	41.3	68	35.8
Total	44	100.0	53	100.0	47	100.0	46	100.0	190	100.0

Table 54

Cross-Tabulation: Participants' Sense of Physical Safety in the Work Setting & Practice & Participants' Use of Trauma-Informed Practices

	0 or 1 Types Used/ Reported		2 Types Used/ Reported		3 Types Used/ Reported		4+ Types Used/ Reported		Total	
	N	%	N	%	N	%	N	%	N	%
Somewhat or Less	9	20.5	12	22.6	9	19.1	4	8.7	34	17.9
Between Somewhat & Very Much	14	31.8	15	28.3	17	36.2	16	34.8	62	32.6
Very Much	21	47.7	26	49.1	21	44.7	26	56.5	94	49.5
Total	44	100.0	53	100.0	47	100.0	46	100.0	190	100.0

Table 56

Cross-Tabulation: Participants' Sense of Emotional Safety in the Work Setting & Practice & Participants' Use of Trauma-Informed Practices

	0 or 1 Types Used/Reported		2 Types Used/Reported		3 Types Used/Reported		4+ Types Used/Reported		Total	
	N	%	N	%	N	%	N	%	N	%
Somewhat or Less	14	31.8	18	34.0	14	29.8	10	21.7	56	29.5
More Than Somewhat	14	31.8	13	24.5	19	40.4	21	45.7	67	35.3
Very Much	16	36.4	22	41.5	14	29.8	15	32.6	67	35.3
Total	44	100.0	53	100.0	47	100.0	46	100.0	190	100.0

Appendix N- Research Question #3: Additional Information

Table 58

Cross-Tabulation: Level of Preparation Provided by BSW Programs & Practice & Participants' Use of Trauma-Informed Practices

	0 or 1 Types Used/Reported		2 Types Used/Reported		3 Types Used/Reported		4+ Types Used/Reported		Total	
	N	%	N	%	N	%	N	%	N	%
Less Than Somewhat	12	40.0	13	46.4	10	37.0	8	30.8	43	38.7
Somewhat	11	36.7	7	25.0	12	44.4	9	34.6	39	35.1
More Than Somewhat	7	23.3	8	28.6	5	18.5	9	34.6	29	26.1
Total	30	100.0	28	100.0	27	100.0	27	100.0	111	100.0

Table 60

Cross-Tabulation: Level of Preparation Provided by MSW Programs & Practice & Participants' Use of Trauma-Informed Practices

	0 or 1 Types Used/Reported		2 Types Used/Reported		3 Types Used/Reported		4+ Types Used/Reported		Total	
	N	%	N	%	N	%	N	%	N	%
Less Than Somewhat	11	20.8	12	20.0	8	16.0	8	17.0	39	18.6
Somewhat	22	41.5	21	35.0	16	32.0	13	27.7	72	34.3
Between Somewhat and Very Much	10	18.9	18	3.0	14	28.0	10	21.3	52	24.8
Very Much	10	18.9	9	15.0	12	24.0	16	34.0	47	22.4
Total	53	100.0	60	100.0	50	100.0	47	100.0	210	100.0

Table 62

Cross-Tabulation: Level of Preparation Provided by DSW/Ph.D. Programs & Practice & Participants' Use of Trauma-Informed Practices

	0 or 1 Types Used/Reported		2 Types Used/Reported		3 Types Used/Reported		4+ Types Used/Reported		Total	
	N	%	N	%	N	%	N	%	N	%
Less Than Somewhat	1	16.7	1	16.7	1	33.3	2	33.3	5	23.8
Somewhat	4	66.7	3	50.0	1	33.3	2	33.3	10	47.6
More Than Somewhat	1	16.7	2	33.3	1	33.3	2	33.3	6	28.6

Total	6	100.0	6	100.0	3	100.0	3	100.0	21	100.0

Table 66

Cross-Tabulation: Level of Preparation Provided by New Staff Induction/Formal Mentoring Programming & Practice & Participants' Use of Trauma-Informed Practices

	0 or 1 Types Used/Reported		2 Types Used/Reported		3 Types Used/Reported		4+ Types Used/Reported		Total	
	N	%	N	%	N	%	N	%	N	%
Not At All	13	31.0	19	35.2	9	19.1	9	22.0	50	27.2
Less Than Somewhat	19	45.2	17	31.5	24	51.1	13	31.7	73	39.7
Somewhat or More	10	23.8	18	33.3	14	29.8	19	46.3	61	33.2
Total	42	100.0	54	100.0	47	100.0	41	100.0	184	100.0

Table 68

Cross-Tabulation: Level of Preparation Provided by Professional Experience/On-the-Job Experience & Participants' Use of Trauma-Informed Practices

	0 or 1 Types Used/ Reported		2 Types Used/Reported		3 Types Used/Reported		4+ Types Used/Reported		Total	
	N	%	N	%	N	%	N	%	N	%
Somewhat or Less	12	22.2	15	24.6	11	21.2	8	16.0	46	21.2
Between Somewhat & Very Much	14	25.9	23	37.7	11	21.2	13	26.0	61	28.1
Very Much	28	51.9	23	37.7	30	57.7	29	58.0	110	50.7
Total	54	100.0	61	100.0	52	100.0	50	100.0	217	100.0

Table 70

Cross-Tabulation: Level of Preparation Provided by Professional Development Experiences & Participants' Use of Trauma-Informed Practices

	0 or 1 Types Used/ Reported		2 Types Used/Reported		3 Types Used/Reported		4+ Types Used/Reported		Total	
	N	%	N	%	N	%	N	%	N	%
Somewhat or Less	23	42.6	20	33.3	16	31.4	15	30.6	74	34.6

Between Somewhat & Very Much	15	27.8	22	36.7	15	29.4	13	26.5	65	30.4
Very Much	16	29.6	18	30.0	20	39.2	21	42.9	75	30.5
Total	54	100.0	60	100.0	51	100.0	49	100.0	214	100.0

Table 76

Cross-Tabulation: Level of Preparation Provided by Professional Supervision Experiences & Participants' Use of Trauma-Informed Practices

	0 or 1 Types Used/ Reported		2 Types Used/Reported		3 Types Used/Reported		4+ Types Used/Reported		Total	
	N	%	N	%	N	%	N	%	N	%
Less Than Somewhat	21	52.5	21	39.6	17	35.4	13	28.9	72	34.6
More Than Somewhat	19	47.5	32	60.4	31	64.6	32	71.1	114	30.4
Total	40	100.0	53	100.0	48	100.0	45	100.0	186	100.0

Table 78

Cross-Tabulation: Beliefs About Ongoing Professional Development Related to TIP & Participants' Use of Trauma-Informed Practices

	0 or 1 Types Used/ Reported		2 Types Used/Reported		3 Types Used/Reported		4+ Types Used/Reported		Total	
	N	%	N	%	N	%	N	%	N	%
Less Than Very Much	13	24.5	13	21.0	9	17.3	5	10.2	40	18.5
Very Much	40	75.5	49	79.0	43	82.7	44	89.8	176	81.5
Total	53	100.0	62	100.0	52	100.0	49	100.0	186	100.0

Appendix O- Research Question #4: Additional Information

Table 84

Cross-Tabulation: Perceived Administrators' Support of Professional Development & Participants' Interest in Further Professional Development About TIP

	Interested		Not Interested		Total	
	N	%	N	%	N	%
Somewhat or Less	62	45.9	30	42.3	92	44.7
Between Somewhat & Very Much	37	27.4	14	19.7	51	24.8
Very Much	36	26.7	27	38.0	63	30.6
Total	135	100.0	71	100.0	206	100.0

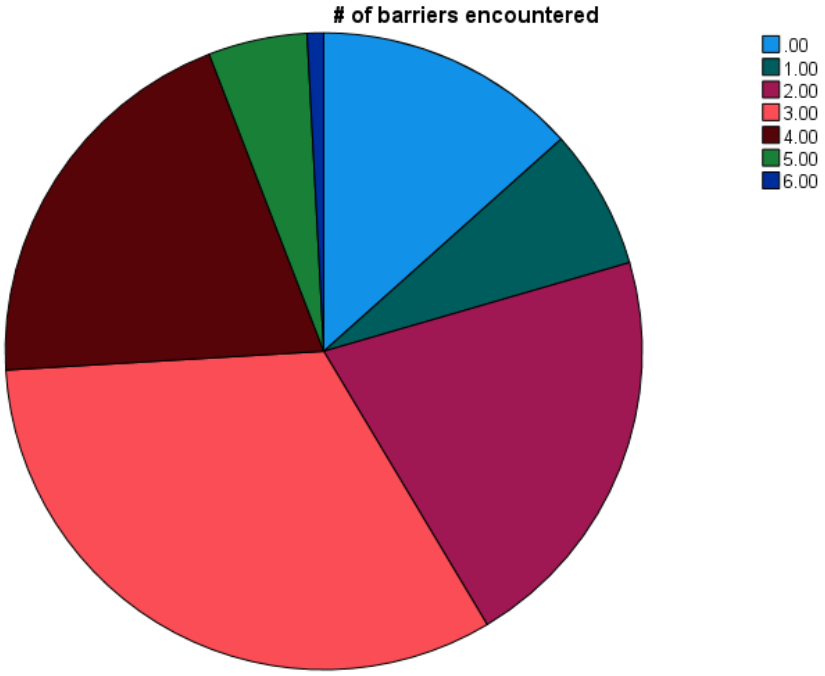
Table 86

Number of Barriers to Engaging in Professional Development Participants Reported Encountering

	N	%
0	32	13.4
1	17	7.1
2	50	20.9
3	78	32.6
4	48	20.1
5	12	5.0
6	2	0.8

Figure 7

Number of Barriers to Engaging in Professional Development Participants Reported Encountering



Appendix P- Institutional Review Board Approval

INSTITUTIONAL REVIEW BOARD
110 Old Main, PO Box 730, Kutztown, PA 19530
(484)-646-4167

DATE:	October 2, 2023
TO:	Jessica Schoonmaker Dr. John Vafeas Department of Social Work
FROM:	Jeffrey Werner, Chairperson Institutional Review Board
STUDY TITLE:	Pennsylvania School Social workers' Trauma Informed Practices: Status and Future Needs
IRB NUMBER:	IRB03092023
SUBMISSION TYPE:	Initial Application
REVIEW TYPE:	Expedited
EXPEDITED CATEGORY:	6 & 7
ACTION:	Approved
APPROVAL DATE:	October 2, 2023

The Kutztown University IRB has approved the initial application for your research study. Your research study has been assigned the IRB Number IRB03092023. This number must be referred to in any future communications with the IRB.

In addition, the following language must be added to the consent form, "This research has been approved by the Kutztown University IRB – approval #03092023."

This research approved as Expedited will have no expiration date. However, any revisions/changes to the research protocol affecting human subjects may affect the original determination therefore must be submitted for review and subsequent determination.

Research must be conducted in accordance with this approved submission. You must seek approval from the IRB for changes and ensure that such changes will not be initiated without IRB review and approval, except when necessary to eliminate apparent immediate hazards to the subjects. You must submit the Application for Revisions / Changes form to the IRB, prior to making changes.

It is your responsibility to report all adverse events / unanticipated problems to the IRB. You must report adverse events that are unanticipated, regardless of seriousness, or report events that are more serious or more frequent than expected.

Records relating to the approved research (e.g., consent forms), must be retained for at least (3) three years after completion of the research. Refer to the IRB procedures regarding records.

Please go the IRB's website to review procedures and to obtain forms as needed. If you have any questions, please contact the IRB at 484-646-4167.