2019

Trauma Sensitive Schools and the Psychoeducational Evaluation

Barbara Jordan
barbara_jordan81118@yahoo.com

Follow this and additional works at: https://mds.marshall.edu/etd

Part of the Disability and Equity in Education Commons, and the School Psychology Commons

Recommended Citation
https://mds.marshall.edu/etd/1228

This Thesis is brought to you for free and open access by Marshall Digital Scholar. It has been accepted for inclusion in Theses, Dissertations and Capstones by an authorized administrator of Marshall Digital Scholar. For more information, please contact zhangj@marshall.edu, beachgr@marshall.edu.
TRAUMA SENSITIVE SCHOOLS AND THE PSYCHOEDUCATIONAL EVALUATION

A thesis submitted to
the Graduate College of
Marshall University
In partial fulfillment of
the requirements for the degree of
Education Specialist
   In
School Psychology
   by
Barbara Jordan
Approved by
Dr. Conrae Lucas-Adkins, Committee Chairperson
Dr. Sandra Stroebel
Dr. Lanai Jennings

Marshall University
May 2019
APPROVAL OF THESIS

We, the faculty supervising the work of Barbara Jordan, affirm that the thesis, *Trauma Sensitive Schools and the Psychoeducational Evaluation*, meets the high academic standards for original scholarship and creative work established by the School Psychology Program and the College of Education and Professional Development. This work also conforms to the editorial standards of our discipline and the Graduate College of Marshall University. With our signatures, we approve the manuscript for publication.

Dr. Connae Lucas-Adkins, Department of School Psychology  Committee Chairperson  Date

Dr. Sandra Stroebel, Department of School Psychology  Committee Member  Date

Dr. Lanai Jennings, Department of School Psychology  Committee Member  Date
# TABLE OF CONTENTS

**LIST OF TABLES** ........................................................................................................................................... v

**ABSTRACT** .................................................................................................................................................... vi

**CHAPTER 1** .................................................................................................................................................. 1

**LITERATURE REVIEW** ................................................................................................................................. 1

Overview ......................................................................................................................................................... 1

Biological/Physical Impact ............................................................................................................................... 2

Impact on Children ......................................................................................................................................... 5

Implications for the Future ............................................................................................................................... 7

Protective Factors ......................................................................................................................................... 8

Trauma Sensitive Schools ............................................................................................................................... 10

Definition and Need ..................................................................................................................................... 10

Implementation ............................................................................................................................................... 12

Trauma and Special Education .................................................................................................................... 18

Current Study ................................................................................................................................................. 19

**CHAPTER 2** ............................................................................................................................................... 21

**METHOD** .................................................................................................................................................. 21

Participants .................................................................................................................................................... 21

Procedure ...................................................................................................................................................... 21

Data Analysis ................................................................................................................................................ 22

**CHAPTER 3** ............................................................................................................................................... 23

**RESULTS** .................................................................................................................................................. 23

**CHAPTER 4** ............................................................................................................................................... 26

**DISCUSSION** ............................................................................................................................................ 26

Limitations and Future Research ................................................................................................................ 30

**REFERENCES** ........................................................................................................................................... 31

**APPENDIX A: OFFICE OF RESEARCH INTEGRITY APPROVAL LETTER** .......... 36
LIST OF TABLES

Table 1  ACE Categories Identified.................................................................23
Table 2  Location of ACEs in Records..............................................................24
Table 3  Crosstabulation Between ACE Score and Outside Counseling Services.....25
ABSTRACT

Exposure to adverse childhood experiences, commonly referred to as ACEs, negatively impacts various physical and psychological aspects of the body and can result in a number of detrimental life outcomes including disease, mental health disorders, and even early death. The negative effects of ACE exposure begin long before adulthood, often resulting in academic and behavioral difficulties for school-aged children. Since school psychologists strive to advocate for the needs of all students, ensure correct special education categorization, and promote trauma-sensitive practices in schools, it is beneficial for them to have knowledge of ACEs and trauma that impact the students they serve. The current study examined ACE exposure in a sample of children receiving special education services in a small West Virginia school district. The majority of ACE information was found in psychoeducational reports, followed by outside evaluations and medical records. Data analysis revealed that 75% of students experienced one or more ACE, 45% experienced two or more, 28% experienced three or more, and 16% experienced four or more ACEs. Parental divorce was the most common ACE, followed by household mental illness, unstable home, and low income. No significant relationship existed between ACEs and LRE, behavioral goals, or counseling as documented on the IEP. A relationship did exist between ACEs and the likelihood of receiving outside counseling services. Implications for school psychology practice and the ethics of including trauma information in psychoeducational reports are discussed as well as the importance of incorporating trauma-sensitive practices into schools.
Overview

Recent research has highlighted the substantial impact that trauma, particularly childhood trauma, has on individuals throughout their lifespan. Trauma, defined by Oral et al. (2016) as negatively perceived situations that are outside of one’s control, impacts both physical and psychological aspects of the body and, in many cases, leads to a variety of negative life outcomes. These outcomes are due in part to the significant consequences of toxic stress that often results from trauma. Toxic stress is a chronic condition that overwhelms the body’s nervous and endocrine systems to the point of permanent disruption, malfunction, or alteration (Oral et al., 2016). Toxic stress leads to feelings of helplessness, fear, and loss of control over one’s life (Shonkoff, Boyce, & McEwen, 2009; Herman, 1992).

In their landmark study, Felitti et al. (1998) evaluated the long-term impact of various traumatic childhood experiences on disease risk in adulthood, overall quality of life, and age at death. Known as the adverse childhood experience (ACE) study, this project has been instrumental in shedding light on the long-term effects of trauma and toxic stress. Felitti et al. used a questionnaire to collect data from over 9,000 participants regarding ACEs in categories such as abuse, neglect, family violence, and parental mental illness. Two-thirds of the individuals surveyed reported one or more ACE and one-fifth reported at least three ACEs (Downey, Gudmunson, Pang, & Lee, 2017). Additionally, a positive correlation was discovered between ACEs and various medical diagnoses such as cancer, heart disease, and chronic obstructive pulmonary disease (COPD) and also between ACEs and risk of alcoholism, substance abuse, obesity, depression, suicide, and sexual promiscuity (Felitti et al., 1998). The effects are
cumulative, meaning that the more ACEs an individual has experienced increases their risk of one or more of these negative outcomes.

As shocking as the original ACE study results seem, it is likely that the number of ACEs reported is only a conservative estimate of the true number (Downey et al., 2017). Reasons for underreporting include repressed painful memories, cultural and generational differences, varying perceptions of severity or impact of personal experiences, or embarrassment. Additionally, circumstances other than those described in Felitti et al.’s original questionnaire are often considered adverse (Van der Kolk et al., 2015). Examples include poverty, bullying, community or school violence, transience, serious accidents, illness or injury, prostitution, natural disaster, war, and terrorism. All of these can have a negative impact on future educational socioeconomic, and criminal outcomes (Giovanelli, Reynolds, Mondi, & Ou, 2016) as well as personal mental and physical health. This impact is due in part to the development of negative or maladaptive coping mechanisms which in turn contribute to potential health risks associated with ACE exposure. However, it is important to note that maladaptive coping is only one reason for the negative effects of ACEs.

**Biological/Physical Impact**

Trauma and ACEs of all varieties impact more than mentality alone. In many instances, particularly those involving multiple or prolonged ACE exposure, physical changes occur in brain structure, the body’s regulatory system, and even DNA. Structural changes have been discovered in some brain regions including the corpus callosum and the prefrontal cortex, while functional alterations have been noted in other regions such as the amygdala and hippocampus (Downey et al., 2017; Teicher, 2000). The immune system, endocrine system, and several functions within the nervous system (e.g., autonomic nervous system, hypothalamic-pituitary-
adrenal (HPA) axis) are also sensitive to toxic stress (Shonkoff et al., 2009; Herman, 1992). Additionally, certain areas of chromosomes react to stress and over time this can lead to obesity, heart disease, and cancer (Drury, 2017).

Among the structures that are affected by toxic stress, the hippocampus, amygdala, prefrontal cortex, and limbic system are affected the most (Navalta, McGee, & Underwood 2018; Andersen & Teicher, 2008). The autonomic nervous system, for example, regulated in part by the limbic system, is commonly known as the body’s fight, flight, or freeze reaction to a real or perceived threat (Shonkoff et al., 2009; Herman, 1992). Typically, when a threat is recognized, the autonomic nervous system releases epinephrine to increase heart rate, increases blood flow to the brain and muscles while decreasing flow to the skin and digestive system, and releases glucose for extra energy (Sciaraffa, Zeanah, & Zeanah, 2018). This response enables the body to react to the threat by either fighting, fleeing, or freezing in place. After the threat has been removed, norepinephrine is released to return the body to a calm state. Toxic stress over time causes this process to malfunction, become more sensitive to environmental factors that are typically nonthreatening, and alter the way the individual reacts to a real or perceived threat. This level of stress, often experienced through trauma, leads to an overload of this system resulting in compromising an individual’s ability to cope (Shonkoff et al., 2009; Herman, 1992). In some cases, the individual eventually ends up not able to recover and experiences more detrimental health effects over time.

The body’s automatic stress response reaction also includes the hypothalamic-pituitary-adrenal (HPA) axis. When stress occurs, the hormone cortisol is released which helps provide the body with extra energy needed to fight or flee a threatening situation. If this stress response happens too frequently, however, a number of negative effects occur. Cortisol strongly affects
memory, attention, emotion regulation, the immune system, and metabolism (Teicher, 2000). In excess, cortisol can cause dysregulation in the cardiovascular and endocrine systems and also lead to learning, memory, and attention problems.

Overall, damage to the HPA axis, limbic system, and other brain structures involved in the stress response influences anxiety and mood dysregulation and increases the number of panic and affective symptoms noted in individuals who have experienced ACEs (Navalta et al., 2018). This increase occurs because over time toxic stress can cause irreparable damage to the nervous and endocrine systems that leads to disrupted or modified function of these systems (Shonkoff et al., 2009; Herman, 1992). For example, after a traumatic event, environmental situations can spark an unwarranted stress response in an individual forcing them to enter fight-or-flight mode when no real threat exists (Landsverk, Burns, Stambaugh, & Rolls Reutz, 2009). Eventually, the individual spends so much time in this heightened state that the autonomic nervous system, HPA axis, and other body systems become impaired.

Young, developing brains are especially sensitive to the effects of toxic stress and children who experience this level of stress often suffer from both physical and behavioral symptoms (Oral et al., 2016). The brain rapidly grows and builds connections during this time and flooding it with stress can cause alterations to the way these neuropathways develop. These pathways are then linked with anxiety, mood dysregulation disorders such as depression, and behavior problems later in life (Navalta et al., 2018). Toxic stress during certain critical or sensitive developmental periods has a particularly strong effect on the young brain and increases the chance of developing these issues (Sciaraffa et al., 2018). Alterations in brain structures due to stress and trauma are partially to blame for the development of negative or maladaptive coping
mechanisms mentioned in Felitti et al.’s original study, which in turn negatively influences health and contributes to potential health risks associated with ACE exposure (1998).

**Impact on Children**

Exposure to trauma and toxic stress affects an individual long before adulthood. Enlow (2013) found that experiencing domestic violence, one of the identified ACEs, before age two lowered IQ scores by age eight even when other factors are controlled for such as socioeconomic status, maternal IQ, and problems at birth. Further, Felitti et al. found that ACE exposure can cause anxiety, depression, and anger in children (1998). Psychological abuse in particular was found to be the best predictor of negative outcomes when compared to other types of abuse (e.g., physical, sexual) (Downey et al., 2017). After a traumatizing event, environmental factors may trigger a stress response in the child even if the situation does not seem aversive to adults.

ACEs can cause children to present with a plethora of problems including aggression, anger, withdrawal, under- or over-reactions, defiance, irritability, clingingness, blunted emotions, social withdrawal, loss of interest in pleasurable activities, mistrust, misinterpreted intentions of others, poor concentration, regression of skills (e.g., toileting, speech, self-confidence), changes in sleep or eating patterns, self-harm, or sexual overactivity (Sciaraffa et al., 2018). Many of these issues can occur when no trauma is present, thus any sudden onset should be considered a warning sign especially in children under the age of eight. The signs should be further explored to rule out or treat any medical problems or environmental factors that could be the cause.

Children who are or have been exposed to ACEs are more likely to struggle with attention, focus, self-regulation, and interpersonal relationships. If children spend much of their time focused on survival or in a perpetual state of fight-or-flight, they may miss out on certain developmental milestones and skills resulting in deficits that can impact them as adults.
(Landsverk et al., 2009). Further, ACEs can cause learning and behavioral problems, somatic concerns, and anxiety-related disorders (e.g., Generalized Anxiety Disorder, Obsessive-Compulsive Disorder). Alarmingly, children who have experienced four or more ACEs are 4.5 times more likely to suffer from depression and at least 12 times more likely to attempt suicide (Downey, Gudmunson, Pang, & Lee, 2017).

Certain populations of children are more likely to experience ACEs. For example, children in the foster care system almost always have experienced ACEs (Landsverk et al., 2009). Additionally, children with disabilities are over three times more likely than those without disabilities to endure neglect, physical, and/or sexual abuse (Marcal, n.d.). Further, Porche, Zaff, and Pan (2017) found that adolescents are more likely to experience ACEs than younger children because they often have added responsibilities, more peer influence, and less adult supervision. For these individuals, the experiences are more likely to have a negative impact into adulthood even when ACEs experienced during early childhood are taken into consideration.

At school, 51% of children with four or more ACEs experienced behavior and learning problems compared with only 3% of children with no ACEs (Burke, Hellman, Scott, Weems, & Carrion, 2011). These difficulties are partly due to children either consciously or subconsciously focusing on survival instead of on learning, exploring, and growing (Landsverk et al., 2009). Additionally, the more ACEs a child experiences the higher their risk for academic failure, retention, absenteeism, and low school participation even when school factors, age, gender and ethnicity are considered (Blodgett & Lanigan, 2018; Bethell, Newacheck, Hawes, & Halfon, 2014). Bethell et al. (2014) found that children with two or more ACEs were over two and a half times more likely to be retained compared to those with no ACEs. Additionally, Grevstad (2010) noted a correlation between ACEs and higher rates of school failure and suspension and Belfanz,
Byrnes, and Fox (2014) found that those with three or more ACEs are significantly more likely to perform below grade level, need special education, and either be expelled or drop out of school. However, a child need not be exposed to a high number of ACEs to experience problems in school. Even a single occurrence of an ACE can cause reading problems (Delaney-Black et al., 2002) as well as a number of behavioral or internalizing symptoms such as anxiety.

**Implications for the Future**

Individuals who experience ACEs are less likely to earn a high school diploma, go to college, or keep stable employment than those with no ACEs (Porche et al., 2017). Additionally, those with high ACE numbers are more likely to engage in health-risking behaviors such as substance abuse, self-injurious behavior, or other maladaptive coping mechanisms to deal with stress, resulting in a number of negative effects (Oral et al., 2016). Although maladaptive coping mechanisms are not the sole reason for these negative outcomes, they often play a vital role.

Multiple ACEs can cause poor emotion regulation resulting in mental health issues such as anxiety, depression, post-traumatic stress disorder (PTSD), dissociation, hallucinations, somatoform disorders, eating disorders, personality disorders, social withdrawal, and suicide attempts (Marcal, n.d.; Oral et al., 2016). Further, trauma exposure is closely associated with domestic violence, teen pregnancy, and overall poor quality of life (Downey et al., 2017). ACEs have such a strong impact that exposure to them is considered a “basic cause” of adult illness and death. Aside from the detrimental effect on mental health, ACE exposure is strongly related to several leading causes of death in adults including heart disease, cancer, COPD, liver disease, stroke, and diabetes (Felitti et al., 1998; Downey et al., 2017). Due to these potential negative life outcomes, it is imperative that children are equipped with protective factors to help mitigate the effect of ACEs.
**Protective Factors**

Despite the high number of people who experience one or more ACEs, many go on to lead normal, happy lives and do not suffer from excessive mental or physical health problems. This reality is likely due to the presence of protective factors that buffer the effects of ACE exposure. Personal traits such as hardiness, temperament, empathy, self-control, and self-efficacy all add to the likelihood that negative effects will be reduced (Buse & Burker, 2013). Additionally, external factors such as secure attachment with a loving caregiver, community support, spirituality, positive peer relationships and influence, family-school connections, high expectations, and school engagement can mitigate the effects of ACEs (Buse & Burker, 2013) and promote healthy development of essential skills such as self-regulation, emotional expression, and assertiveness (Sciaraffa et al., 2018). As a whole, these factors build and sustain resilience, or the ability to ‘bounce back’ in the face of adversity (Sciaraffa et al., 2018).

Resilience allows an individual to adapt to challenging life situations and effectively cope with the aftereffects. Bath (2008) proposed three “pillars” of resilience: safety, connections, and emotional management. Before healing can take place, individuals need to feel safe both physically and psychologically. Next, connecting with a trusted individual can create a sense of trust and alter precognitions such as “all people are bad,” or “everything I love gets taken from me.” Over time, modeling and other interventions can build emotional management or self-regulation skills in the traumatized individual which adds an important buffer for future adversity. Other elements important for building resiliency include supportive adults, problem-solving skills, goal setting, hobbies and interests, optimism, self-esteem, confidence, and a sense of belonging and feeling needed (Philadelphia ACE Task Force, 2016).
Many ACEs occur in family and home life, which unfortunately removes many of the potential sources of resilience-building. As a result, these protective factors should be and often are acquired from other sources, particularly from the community and the schools. For example, early childhood educators sometimes find themselves to be the person their students develop attachment to (Belsky & Fearon, 2002). Further, adolescents often secure mentors that, if formed with those who are a positive influence, can reduce the likelihood of later struggles and even reduce parenting stress (Porche et al., 2017). Educators are one of many sources of support for traumatized youth, and the connection is especially beneficial for those with abuse or neglect in their backgrounds (Porche et al., 2017). Community support is another protective factor and can be found through support groups, volunteer opportunities, access to continuing education or tutoring programs, community activities and celebrations, and access to health care.

Many protective factors can come from the school environment. Even community resources can come from the school in the form of building connections and providing information to students and families. Schools can build protective factors through providing students with a sense of choice over their learning, encouraging active participation in school and school events, explaining the “why” behind academic and social-emotional lessons, instilling a sense of belonging, and helping them reach their future goals (Office of Superintendent of Public Instruction, 2014). Over time, children and adolescents with high resiliency are less likely to engage in violence, school problems, substance abuse, antisocial behavior, and gambling and more likely to maintain good health, become involved in leadership and volunteer activities, resist danger, and be successful in school (Philadelphia ACE Task Force, 2016). Further, Porche et al. (2017) found that empowering traumatized youth and fostering resilience can have a two-
generational effect, meaning that the chances of poverty, divorce, parental death, incarceration, mental illness, and domestic violence are decreased and result in less ACEs in the future.

**Trauma Sensitive Schools**

**Definition and need.** In light of recent research regarding ACEs and the importance of protective factors, schools are increasingly implementing trauma-sensitive practices into their daily operations. These trauma-sensitive schools understand that a number of their students are experiencing or have experienced trauma and work to provide support, avoid re-traumatization, and create an environment that is sensitive to the individual needs of students (Berg, Osher, Moroney, & Yoder, 2017).

Some research suggests the incorporation of trauma screening in schools to identify children who may have been exposed to trauma and are potentially more likely to have emotional, behavioral, or academic problems. Gonzalez, Monzon, Solis, Jaycox, and Langley (2016), for example, suggested that identifying children with trauma history early may increase their chances of receiving support services in school as opposed to more traditional identification practices. Other studies found vast inconsistencies between screening measures that compromise their validity and question their ability to link trauma exposure to intervention (Eklund, Rossen, Koriakin, Chafouleas, & Resnick, 2018). In deciding whether to incorporate trauma screening into the school system, factors such as potential stigma, over identification of trauma, ethical considerations surrounding parental consent, and the tendency to move away from an overall trauma-sensitive school environment should be seriously considered (Cole, Eisner, Gregory, & Ristuccia, 2017; Rousseau, Pottie, Thombs, Munoz, & Jurcik, 2011).

Supporting this movement to trauma-sensitive school practices, Iachini et al. (2016) found that behavior changes in school were common among students who experienced ACEs
either before or during their time in school. Further, Sciaraffa et al. (2018) discovered that ACE-exposed children struggle more than their non-ACE-exposed peers in the areas of self-regulation, attention and focus, and interpersonal skills. As a result of these findings, teachers and other school personnel need to be aware that ACEs and trauma could likely be the blame for misbehavior or learning problems, especially since individuals experience trauma differently and may react in a number of ways (Buse & Burker, 2013).

Children spend a significant portion of their time within a school setting. Schools provide a safe, secure, environment where children find nutrition, structure, routine, rest, physical activity, and exposure to a number of interesting and educational opportunities (Sciaraffa et al., 2018). Additionally, children are more likely to take advantage of mental health services in school than through outside mental health clinics due to barriers such as transportation concerns, caregiver work schedules, etc. Rones & Hoagwood (2000) found that 70% of students that receive mental health services access them through the school. Barriers such as lack of transportation, not knowing where or how to seek services, restricted appointment availability, or location of facilities can keep students from receiving outside counseling (DeRigne, Porterfield, & Metz, 2009; Mendez, Carpenter, LaForett, & Cohen, 2009; Owens et al., 2002), further increasing the importance of school-based mental health. Even for those children not receiving these services, schools often are a source of protective factors. Many school staff develop personal relationships with the children in their care, which is vital to instilling a sense of safety and belonging particularly in early childhood (Bronfenbrenner, 2005; Sciaraffa et al., 2018). Additionally, professionals within the school including teachers, school psychologists, and school counselors can explicitly teach coping skills and regulation strategies to help children thrive when adversity is present (Wong, 2008).
Research to date shows promising results in schools implementing trauma-sensitive practices. In early childhood programs, these initiatives are found to decrease stress in children leading to improvements in attention, behavior, and overall gains in social and cognitive development (Holmes, Levy, Smith, Pinne, & Neese, 2014). During adolescence, trauma-sensitive schools have proven to increase student resilience overall and positively impact student support relations, problem-solving skills, and overall sense of optimism (Longhi, 2015). Further, these practices result in a significant reduction in violence during adolescence and early adulthood including dating and intimate partner violence, self-directed violence, youth violence, and sexual violence (Mikton & Butchart, 2009).

The goal behind trauma sensitivity in schools is to create an environment that promotes safety, connections, inclusion, support, healing, and acceptance for all students (Public Counsel, 2017). Doppelt (2015) found that trauma sensitive schools also include a commitment to social equity and justice, diversity, communication, trust, constructive criticism to encourage growth and challenge perceptions, and overall well-being. By consistently implementing and expanding such initiatives, trauma-sensitive schools build resilience in youth which results in a wealth of positive outcomes.

**Implementation.** The first step to trauma sensitive school practices involves a paradigm shift and viewing situations through a “trauma lens.” The goal of this mentality is to refrain from asking “what is wrong with you?” and instead ask “what happened to you?” (Philadelphia ACE Task Force, 2016). This change acknowledges the chance of ACE exposure and appreciates the role that exposure plays in the difficulties or misbehavior that presents at school (Philadelphia ACE Task Force, 2016). In order to create lasting change within a school, this shift involves not only school staff but also involves stakeholders at the systems level including administrators,
parents, and community agencies. Training and implementing programs that teach about ACEs, their impact on behavior, and ways to boost social-emotional skills is one of the most important non-academic ways to strengthen children (Porche et al., 2017).

One important factor in creating trauma-sensitive environments is to examine and adjust information at the policy level. For example, “zero tolerance” discipline policies that require suspension or expulsion are found to be detrimental to students and even to encourage inappropriate behavior and lack of student involvement in school (APA Zero Tolerance Task Force, 2008). In-school suspension (ISS) or other in-school methods of discipline that are fairly and consistently used along with trauma-informed school personnel and mental health professionals at school have a positive impact on behavior and help keep students included at school (Illinois ACE Responsive Collaborative, n.d.; Gregory et al., 2010). Other policy changes suggested include regular ACE professional development training for all school staff, restorative justice practices for discipline, mentor programs and other educational opportunities for parents, outreach to community support programs, and support for early intervention. Changes at the policy level not only add a layer of accountability and specificity to trauma-sensitive practices but also help maintain stakeholder support and funding to keep the initiative strong on a long-term basis (NASP, 2015).

At the district level, several key components support and help sustain the trauma-sensitive initiative (What is Trauma-Informed Care?, 2015). First, staff training and subsequent staff buy-in is essential to creating the paradigm shift needed to implement any new changes. Next, specific individuals designated as “leaders” support others within the system and ensure new school-wide programs are correctly implemented (Sonoma County Office of Education, 2017; Doppelt, 2015). These leaders work as a team and strive to assess the current school
climate, identify areas of strengths and weaknesses, work with staff to fill gaps in resources and construct plans for implementation and monitoring, and create a sense of collaboration and empowerment among all involved (Berg et al., 2017). Once the new initiative is put into place, leaders provide feedback to school personnel and review monitoring data to gauge effectiveness of the new program and make changes as needed (Doppelt, 2015). Leaders also provide support to staff affected by vicarious or secondary trauma and encourage open communication among all school personnel (What is Trauma Informed Care?, 2015). Over time, trauma-sensitive school practices become commonplace and result in positive outcomes for all students.

Individual schools can incorporate trauma sensitivity by first maintaining the commitment to awareness of the role trauma plays in academic, behavioral, and social outcomes. Awareness promotes a safe, supportive environment that allows healing, secure attachments, and learning to thrive. School staff can provide both students and their families with resources to empower and support positive connections (Johnson, 2016; Marcal & Trifoso, 2017). Examples include extracurricular activities, after school programs, wraparound services, and individual or family counseling. These family-school affiliations enable parents to play a more active role in their children’s education and model appropriate relationship behaviors (Sciaraffa et al., 2018).

Once the commitment is made, schools implement programs such as School-Wide Positive Behavior Interventions and Supports (SWPBIS or PBIS) to shift the focus from negative to positive behavior responses and teach students appropriate replacement behaviors (Van der Kolk et al., 2015). As students learn more appropriate behaviors and the expectations placed on them, a climate of positive behavior is created as students assume responsibility for their actions and learn accountability. Evidence-based social emotional learning (SEL) programs are also widely used in schools to teach students skills to regulate their emotions, develop empathy and
strong relationships, employ positive coping skills and problem-solving tactics, and handle tough situations in a positive manner (Public Counsel, 2017; Buse & Burker, 2013).

Another way schools can promote trauma sensitivity is to actively build connections with students and their families. These connections not only allow schools to maintain high academic expectations (Porche et al., 2017) but also to bolster the social and emotional learning of students. Discipline becomes an opportunity to explore challenges and problem solve as a team to teach students self-control, self-regulation, independence, and natural consequences (Sonoma County Office of Education, 2017). Rather than considering a child as “bad,” trauma-sensitive discipline practices focus on the “bad thing” the child has done and work with the child to teach them more acceptable ways to work through their problems. Further, particularly during high school, strong relationships often provide vital links to resources such as career programs, child care, GED classes, etc. to support those students who struggle to positively cope (Porche et al., 2017).

In the classroom, teachers can create a trauma-sensitive climate by setting clear behavioral expectations, establishing a structured schedule with daily routines, priming students before transitions or when changes to the schedule are expected, allowing students time to express themselves through creative means or mindfulness activities, and providing an outlet for students grappling with big emotions (e.g., a designated calm-down area, allowing students to sit quietly or put their head down when they need a break, permitting movement breaks, teaching deep breathing or other restorative techniques, etc.) (Sonoma County Office of Education, 2017). Teachers can also promote a positive, caring environment by modeling problem-solving strategies and verbal expression of feelings, opening lines of communication between themselves and each student, physically putting themselves on the same level as students, validating feelings
and experiences without judgment and respecting privacy, actively listening, teaching children to be appropriately assertive, affording students some degree of control, and, perhaps most importantly, maintaining their own emotions while keeping patience with struggling students (Sciaraffa et al., 2018; NASP 2015; Rodenbush, n.d.). Further, praising good behavior and effort toward the use of positive coping mechanisms empowers students and fosters continued motivation.

Despite the best effort of school staff, some students inevitably struggle with past or current trauma and do not immediately respond as expected to trauma-sensitive approaches. Additionally, children present with a wide variety of temperaments, personality traits, and coping skills which renders a “one size fits all” approach ineffective in some cases. For this reason, a tiered approach to school-wide positive behavior is often recommended to meet the needs of students at all levels of functioning (ACEs Public Schools, 2011). At the first tier, or the school-wide level, programs such as PBIS and overall high expectations for positive behavior provide all students with a structured, safe environment to learn the difference between good and bad behavior and how to regulate their own behavior to match expectations. The second tier utilizes small group lessons, role playing, and modeling to teach struggling students appropriate behavior, social skills, and coping skills. Next, for students who need additional support, a functional behavior assessment analyzes the driving force behind negative behaviors and a behavior plan is created to tailor interventions based on the students’ individual needs. Finally, if a student does not respond despite the tiered support system, special education is considered to determine the least restrictive environment in which the student can safely function at school and to specially design instruction. In the special education environment, students tackle one skill at a
time and are provided opportunities to practice, discuss, and reflect each skill before moving to the next one (ACEs Public Schools, 2011).

Although the bulk of trauma-sensitive practice implementation occurs at the individual school level, school psychologists play a vital role in supporting teachers and other school staff on the process and often act as consultants for students with significant behavioral concerns. Additionally, school psychologists conduct professional development trainings and serve as members of the teams that implement and support trauma-sensitive initiatives within the school. The National Association of School Psychologists (NASP) outlines the unique role school psychologists play in creating and maintaining trauma-informed schools (2015). School psychologists are committed to providing comprehensive mental health services to all students and use data-driven systems to implement interventions and monitor student progress. Further, school psychologists work with administrators and others at the district level to find and implement evidence-based programs for behavior and social-emotional learning, inform and support school staff members with trauma-sensitive initiatives, and help build connections between the schools, families, and community (NASP, 2015).

When considering special education eligibility, school psychologists work to ensure correct diagnosis and placement for all students. Given that the behaviors students exhibit as a result of trauma closely mimic those of common childhood behavioral and mental health disorders, it is imperative that trauma history be considered before labeling a student with a disability. School psychologists share this knowledge with the eligibility team and advocate for placement and instruction that supports this unique need.
### Trauma and Special Education

Before a child is identified as eligible to receive special education services, a comprehensive, multidisciplinary evaluation is conducted to assess all areas of suspected exceptionality as well as all areas of related need (Hass & Carriere, 2014). Sometimes the needs of the student are directly linked with their exceptionality but in some cases they occur alongside a diagnosis though are not directly related. Trauma, for example, can play a role in diagnoses such as Post-Traumatic Stress Disorder (PTSD), Acute Stress Disorder, Reactive Attachment Disorder, Disinhibited Social Engagement Disorders, dissociative disorders, and bereavement disorders but can also mimic common childhood disorders (e.g., ADHD, behavioral disorders) resulting in misdiagnosis in the educational environment. Additionally, factors such as lack of exposure, poor vocabulary knowledge, and compromised working memory or processing speed can cause misdiagnoses of specific learning disabilities or intellectual disability. Trauma sensitive practices in schools can reduce the severity of student behaviors and provide a strong network for resilience, ultimately reducing the chances students will be unnecessarily referred for special education evaluation and over identified with disabilities.

Given that ACE exposure often results in a variety of externalizing and internalizing behaviors in children, it is imperative that school multidisciplinary teams consider trauma when making eligibility decisions. However, mandates such as the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and professional ethics codes often discourage or prohibit the sharing of this information. Further, mandated reporting laws complicate the revealing of certain ACEs (e.g., abuse, neglect) since it can result in investigations on family safety and may cause drastic changes in the life of the child affected (e.g., removal from the home). Finally, the stigma attached to certain traumatic
experiences may keep some students or their families from revealing sensitive information. Such severe consequences as proposed by these elements likely reduce the number of ACEs reported by children and families, possibly to the detriment of the child’s education.

Psychoeducational reports, for example, include such information as background information, reason for referral, observation data, and testing results (Sattler, 2008). Background information typically reported includes birth and developmental history, prior special education services, medical and physical history, sibling and basic family makeup, and other information about the child’s life timeline. Due to laws and ethical principles regarding confidentiality and the disclosure of private information, ACE information is sometimes mentioned in conversation or alluded to but not mentioned in the report. However, teachers consider and incorporate many recommendations made in psychoeducational reports as well as reported background information (Lindelauf, Reupert, & Jacobs, 2018), especially in theme-based reports (Fletcher, Hawkins, & Thornton, 2015). School psychologists can support students by providing interventions specifically tailored to trauma exposure.

Current Study

Trauma exposure results in a variety of negative physical, social, behavioral, and emotional effects on children that impact both immediate and future functioning and success. School psychologists play a vital role in advocating for trauma-sensitive practices both in schools as a whole and during the special education eligibility process. The current study aims to determine how and where ACEs are reported in special education records within a single district in West Virginia. Relationships between ACE exposure and disability category, behavior/counseling minutes on the IEP, and the number of ACEs will be explored. It is hypothesized that there will be a low number of ACEs documented in the records but that there
will be a significance between number of ACEs and inclusion of special services on the IEP and possibly disability category. Research questions:

1. How many ACEs are identified in the special education records?
2. How are ACEs documented within the special education record?
3. Do IEP or outside behavior and counseling services vary by the derived ACE score?
CHAPTER 2

METHOD

Participants

The investigator conducted an archival review of 100 psychoeducational reports from a single district in southern West Virginia. Participants were comprised of 66 males and 34 females ages 6 through 21 ranging from kindergarten to twelfth grade who are currently receiving special education services as of the 2018-19 school year. Participants were 93% White/non-Hispanic, 4% Black, 1% Hispanic, and 2% Multi-Racial. This sample is proportionate to the ratio of males to females and to the ethnicity percentages of students receiving special education services within the district. Half of the students ranged from kindergarten to fifth grade (50%) and the second half were enrolled in sixth through twelfth grade (50%).

Procedure

The investigator reviewed special education records of students currently receiving special education services in the categories outlined in the Individuals with Disabilities Education Act. Records reviewed included student assistance team (SAT) documents, eligibility forms, prior written notices, individualized education programs (IEPs), medical and court records, psychoeducational reports, parent information reports, and other documents included in each individual file. All versions of every document were reviewed in the case of students with multiple evaluations.

Files were chosen by random sampling and represent approximately 10 percent of the district’s current number of students receiving special education. Each file was thoroughly searched for mention of each of the ten original ACE questionnaire items as well as additional life stressors that could potentially be considered ACEs for many children (e.g., transience, foster
care placement, etc.). A list of all identified ACEs can be found in Table 1. Additional information collected included the student’s age and category of initial special education eligibility, any changes in eligibility over the course of their academic career, and the source of the ACE item within the file (e.g., SAT file, IEP, psychoeducational report, etc.). Once the file review was completed, the data was anonymized by replacing each student’s name with a number and then entering these into a randomizer. Records containing student name and given number were then destroyed.

Data Analysis

The data recording sheet was completed in Microsoft Excel and then transferred to IBM Statistical Package for Social Sciences (SPSS) for analysis. The investigator utilized SPSS to generate a variety of basic statistics including frequency counts, mean comparisons, and standard deviations. The Kolmogrov-Smirnov Test of Normality provided evidence that data was not normally distributed. Therefore, the investigator selected nonparametric alternatives to independent samples t-test (Mann-Whitney U) and analysis of variance (Kruskal-Wallis). Additionally, the investigator used the crosstabulation function to generate contingency tables to compare total recorded ACE scores and both IEP and outside counseling services.
CHAPTER 3

RESULTS

**Research Question 1**: How many ACEs are identified in the special education records?

Out of the 100 file reviews conducted, 75% of students had documentation of at least one ACE, 45% had two or more ACEs, 28% had three or more, and 16% experienced four or more ACEs. The average number of ACEs experienced was 1.86 (range: 0 – 8, mode: 1; SD: 1.89). The most common ACE identified was parental divorce (30%), followed by household mental illness (24%), unstable home (15%), low income (14%), foster care (13%), medical issues – child (13%), and transience (12%). Remaining categories (household substance abuse, death of close family member, etc.) were reportedly experienced by 10% or less of the student sample.

Table 1

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Divorce</td>
<td>30%</td>
</tr>
<tr>
<td>Household Mental Illness</td>
<td>24%</td>
</tr>
<tr>
<td>Unstable Home</td>
<td>15%</td>
</tr>
<tr>
<td>Low Income</td>
<td>14%</td>
</tr>
<tr>
<td>Foster Care</td>
<td>13%</td>
</tr>
<tr>
<td>Medical Issues – Child</td>
<td>13%</td>
</tr>
<tr>
<td>Transience</td>
<td>12%</td>
</tr>
<tr>
<td>Household Substance Abuse</td>
<td>10%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
</tr>
<tr>
<td>Physical Neglect</td>
<td>9%</td>
</tr>
<tr>
<td>Death of Close Family Member</td>
<td>8%</td>
</tr>
<tr>
<td>Medical Issues – Household</td>
<td>7%</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>5%</td>
</tr>
<tr>
<td>Emotional Neglect</td>
<td>5%</td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>3%</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>3%</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>2%</td>
</tr>
<tr>
<td>Household Incarceration</td>
<td>2%</td>
</tr>
</tbody>
</table>
The Kolmogorov-Smirnov Test of Normality concluded that the total calculated ACE scores are not normally distributed. Based on the Mann-Whitney U test, no statistical differences occurred between number of ACEs and sex (p=.376), programmatic level (p=.484), category of exceptionality (p=.099), or LRE (p=.056).

**Research Question 2**: How are ACEs documented?

ACEs were found in a variety of locations within the special education file. The most common location for reported ACEs was the parent report (50%), followed by outside evaluations (21%), other sources of information (e.g., memorandums, Birth to Three records, etc.) (18%), IEP (17%), medical records (15%), psychoeducational reports (4%), and court documents (3%).

Table 2  
*Location of ACEs in Records*

<table>
<thead>
<tr>
<th>Location</th>
<th>0 ACEs</th>
<th>1 ACE</th>
<th>2 ACEs</th>
<th>3 ACEs</th>
<th>4 or more ACEs</th>
<th>Total ACEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Court Documents</td>
<td>97%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>IEP</td>
<td>83%</td>
<td>12%</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
<td>17%</td>
</tr>
<tr>
<td>Medical Records</td>
<td>85%</td>
<td>14%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>15%</td>
</tr>
<tr>
<td>Other</td>
<td>82%</td>
<td>13%</td>
<td>4%</td>
<td>1%</td>
<td>0%</td>
<td>18%</td>
</tr>
<tr>
<td>Outside Evaluation</td>
<td>79%</td>
<td>11%</td>
<td>4%</td>
<td>0%</td>
<td>6%</td>
<td>21%</td>
</tr>
<tr>
<td>Parent Report</td>
<td>50%</td>
<td>29%</td>
<td>13%</td>
<td>5%</td>
<td>3%</td>
<td>50%</td>
</tr>
<tr>
<td>Psychoeducational Reports</td>
<td>96%</td>
<td>4%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>4%</td>
</tr>
</tbody>
</table>

**Research Question 3**: Do IEP or outside behavior and counseling services vary by the derived ACE score?

Participants with zero or one IEP behavioral goals had an average of 1.5 reported ACEs. However, increased reported ACEs were revealed for participants with two (\( \bar{x} =3.2 \)) or three (\( \bar{x} =1.9 \)) behavioral goals on the IEP thereby resulting in a significant Kruskal-Wallis value (p=.009).
Although very few participants in the study received in-school counseling services as documented on the IEP, students with counseling had on average 0.7 more reported ACEs as compared to students without counseling on their IEP. This mean difference was not statistically significant (p=.256). Conversely, there was a significant mean difference between counseling services and recorded ACEs (p=.006) but this was primarily due to mean difference between outside counseling and recorded ACEs (p=.002). Crosstabulations in Table 3 illustrate that none of the participants with an ACE score of zero received outside counseling services whereas 43.8% of participants with an ACE score of four or higher received outside counseling services.

Table 3
Crosstabulation Between Reported ACE Score and Outside Counseling Services

<table>
<thead>
<tr>
<th>Total ACEs Recorded</th>
<th>Outside Counseling</th>
<th>No Outside Counseling</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>Expected Count</td>
<td>Percent</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>4.3</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>20.8</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>25</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>5.1</td>
<td>16.70%</td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>24.9</td>
<td>83.30%</td>
</tr>
<tr>
<td></td>
<td>30</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>2.9</td>
<td>23.50%</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>14.1</td>
<td>76.50%</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>2</td>
<td>8.30%</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>91.70%</td>
<td>100%</td>
</tr>
<tr>
<td>4+</td>
<td>7</td>
<td>2.7</td>
<td>43.80%</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>13.3</td>
<td>56.30%</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>83</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>83</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>17%</td>
<td>83%</td>
<td>100%</td>
</tr>
</tbody>
</table>
CHAPTER 4
DISCUSSION

The purpose of this study was to determine how and where trauma-related incidences are reported in special education records. The investigator reviewed 100 current special education files for children ages 6 through 21 receiving services in a rural West Virginia school district and noted the type of ACEs found, their location within the file, the special education category of each student, and the existence of behavioral or counseling services both inside and outside of school.

Data analysis determined that 75% of the students experienced one or more ACE, 45% experienced two or more, 28% experienced three or more and 16% experienced four or more ACEs. These percentages are higher than those among West Virginia adults and children as a whole, where 55.8% of individuals reported at least one ACE, 33.2% reported two or more, 21.5% reported three or more, and 13.8% reported four or more ACEs (ACE Coalition of WV, 2018) and than national averages where 61.5% reported at least one ACE, 38% reported two or more ACEs, 24.6% reported thee or more, and 15.8% reported four or more (Center for Disease Control, 2019). The most common ACE in the current study was parental divorce (30%) followed by household mental illness (24%), unstable home (15%), low income (14%), foster care (13%), child medical issues (13%), and transience (12%). West Virginia adults and children reported household substance use as the most common ACE (28.8%) followed by parental divorce (26.6%), verbal abuse (22.7%), household mental illness (17.0%), domestic violence (16.1%), and physical abuse (12.8%) (ACE Coalition of WV, 2018) and national data show the most common ACE as emotional abuse (34.4%), followed by household substance abuse (27.6%), parental divorce (27.6%), physical abuse (17.9%), and domestic violence (17.5%)
(Center for Disease Control, 2019). Although the West Virginia and national studies only included the original ten ACE items, the only similarity between those data and the results of the current study are the high rates of parental divorce. This finding suggests that students receiving special education services appear to have higher ACE scores than the general public in West Virginia as well as the overall national averages.

The majority of ACEs in the reviewed special education files were located in the parent report (50%), followed by outside evaluations (21%), other sources of information (18%), the IEP (17%), medical records (15%), psychoeducational reports (4%), and court documents (3%). No ACE items were found in Student Assistance Team (SAT) files. Although some incomplete or missing documents may render this an underreported number of ACEs, the majority of ACE items were found in sources stemming from parents or outside sources of information rather than documents from the local schools. The absence of information in school documentation is likely due to confidentiality concerns as well as lack of knowledge of ACEs experienced by the child, concerns regarding stigma for the child or family, or perhaps perceptions of redundancy with including the information in multiple areas.

Despite the number of ACEs found within the special education files, the true number of ACEs experienced by participants is likely higher due to factors such as underreporting, exclusion of the information from the student’s official record, or lack of knowledge regarding each student’s home life. For example, at least 25% of the files did not include a parent report which was found to be the most common place that ACEs were reported. Some files were also missing outside evaluations or medical records which also affected the number of ACEs recorded. Additionally, certain documents within the files (e.g., IEP, meeting memorandums) sometimes included mention of trauma or stress in the home but did not elaborate and therefore
could not be included in the data collection process. These discrepancies were expected, however, given that in almost every study of ACE exposure underreporting was listed as a limitation. This pattern is continued in the current study.

Since the original ACE study was published in 1998, research has highlighted the importance of intervention and the instilling of protective factors to mitigate the effect of ACEs on later life. Schools provide a unique arena to provide these buffers both to children and to their families. Additionally, children with ACE exposure present with a variety of academic and behavioral problems in school that can compound the chances of negative outcomes. School psychologists advocate for and strive to ensure correct educational placement for all students in their care and work as part of a team to promote learning and provide support children need to thrive. One way to ensure the correct service delivery to students is to take trauma history into account when determining special education eligibility. Inclusion of this information in psychoeducational reports notifies both the current eligibility team as well as others who read the report that the child has experienced one or more ACE and may exhibit academic or behavioral difficulties as a result. This knowledge can then be used to plan educational paths aimed at reducing the negative effects of trauma and potentially breaking the cycle for future adversity while reducing the chances that a student will be misdiagnosed with a disability.

Although the benefits to including ACE exposure in the psychoeducational report are many, certain ethical guidelines outlined by the NASP Principles for Professional Ethics may deter school psychologists from including such information in their reports. Standard I.2.5, for example, which states that confidential information should only be discussed or released to those with a legitimate need to know, is one such Principle that acts as a deterrent of trauma inclusion in psychoeducational reports (NASP, 2010). Standard II.4.3, which requires school psychologists
to only include documented and relevant information from reliable sources, may also cause hesitation for including ACE information. However, despite these warnings, school psychologists also have a duty to promote changes in schools that benefit both students and their families and also to advocate for practices that serve the best interests of children (Standard IV.1.2, NASP 2010).

Psychoeducational reports are confidential documents shared only with school personnel, parents, and in some cases the student. These reports can follow students throughout their academic career and beyond, influencing their educational setting and services for many years. Although removing trauma from reports may remove stigma and allow students the benefit of a fresh start in a new school setting, omitting information regarding trauma exposure can potentially hurt students over time by masking the true source of their difficulty and keeping school teams from tailoring interventions to the student’s true area of need. Additionally, not including recommendations for remedying the effects of trauma experienced can be considered out of compliance with NASP Standard IV.1.2 and could potentially help keep trauma-sensitive practices from becoming commonplace in schools.

Results of this study indicated that even though 16% of students experienced four or more ACEs, which was found to have a cumulative effect predictive of multiple negative life outcomes, few had at least one behavioral goal and even less received counseling services on their IEPs. Even if the specific traumatic experience is not included in the report, a general statement that alerts readers to ACE exposure can help ensure students who need these services have access to them and can promote overall trauma sensitivity in the school environment. Overall, implementing universal precautions and treating all children as if there was exposure to
ACEs ensures that children receive support regardless of whether ACEs are known to school personnel.

**Limitations and Future Research**

Limitations of this study included the small size of the sample (i.e., covers only one district in one state), the underreporting of certain ACEs, missing, inaccurate, or incomplete documents within special education files (e.g., parent reports, outside evaluations, medical records), and the exclusion of students ages three through five receiving special education services. Future research should expand sample sizes and include districts across multiple states and with varying populations. Additionally, a comparison study of psychoeducational reports or special education records between districts that have implemented trauma-sensitive practices and those that have not could help further determine the need for inclusion and overall trauma sensitivity efforts.
REFERENCES


APPENDIX A: OFFICE OF RESEARCH INTEGRITY APPROVAL LETTER

Office of Research Integrity
Institutional Review Board
One John Marshall Drive
Huntington, WV 25755

February 12, 2019

Conræ Lucas-Adkins, PsyD
School Psychology, MUGC

RE: IRBNet ID# 1381102-1
At: Marshall University Institutional Review Board #2 (Social/Behavioral)

Dear Dr. Lucas-Adkins:

Protocol Title: [1381102-1] Trauma Sensitive Schools and the Psychoeducational Evaluation

Site Location: MUGC
Submission Type: New Project APPROVED
Review Type: Expedited Review

In accordance with 45CFR46.110(a)(5), the above study was granted Expedited approval today by the Marshall University Institutional Review Board #2 (Social/Behavioral) Chair. An annual update will be required on February 12, 2020 for administrative review and approval. The update must include the Annual Update Form and current educational certificates for all investigators involved in the study. All amendments must be submitted for approval by the IRB Chair prior to implementation and a closure request is required upon completion of the study.

This study is for student Barbara Jordan.

If you have any questions, please contact the Marshall University Institutional Review Board #2 (Social/Behavioral) Coordinator Bruce Day, ThD, CIP at 304-696-4303 or day50@marshall.edu. Please include your study title and reference number in all correspondence with this office.

Sincerely,

[Signature]

Bruce F. Day, ThD, CIP
Director, Office of Research Integrity