Resilience in the Context of Emotional Trauma

Among Elementary-Aged Children

Caroline Hart

Saint Michael's College

Author Note

Caroline Hart, Department of Psychology, Saint Michael's College

Honors Program Independent Research under the guidance of Dr. Renee Carrico, Associate

Professor of Psychology

Contact: chart2@mail.smcvt.edu

Abstract

Families, schools, communities, and cultures all play a role in promoting and sustaining positive development in children. Any one of these systems also has the potential to cause harm to individuals and lead to maladaptive outcomes in children. Caregivers and teachers are among the most influential people in the lives of young children, and therefore provide substantial influence over whether or not a child enjoys a happy, successful life. Unfortunately, it is quite common for many children to experience trauma in a variety of contexts, which is often perpetuated by a lack of a stable or healthy home life. These experiences of complex trauma can negatively affect several aspects of child development that manifest in the form of maladaptive behaviors across contexts, including school. The present study examines the effects of emotional trauma among children in an elementary school setting, as well as what internal characteristics and external resources are most predictive of resilience. The findings expand on current knowledge regarding resilience in children and adolescents by looking at important links between complex trauma and competency across multiple domains of expected achievement, which shed light on numerous implications for future practice and policy.

Literature Review

Throughout childhood, development is fundamentally dependent on one's environment and relationships, which lay the foundation for potential success and efficacy across all domains. When trauma is a central and persistent feature of one's early experience, development is inevitably disrupted, and the cascading effects can be damaging. However, the incredible capacity for human resilience is evident in research, as well as personal stories of successful triumphs following unbelievable hardships. Resilience can be defined as a capacity to overcome adversity. It is important to note that resilience is not the absence of trauma-related symptoms. Instead, it can be seen as a range of positive adaptations that individuals make "regardless of the presence of disordered thoughts, feelings, and behaviors" (Ungar, 2013, p. 255). The behaviors of children who have experienced trauma nearly always make sense, given the context in which they developed. For example, children who appear emotionally withdrawn as a result of neglect have effectively adapted to a failure of caretaking by minimizing their access to emotional experience. "Ultimately, though, our goal is for children to do more than physically survive; we want them to adapt successfully to a world that goes beyond the context of danger and deprivation" (Blaustein & Kinniburgh, 2010, p. 19). Resilience is multifaceted and varies from individual to individual. However, what we can learn from those who prove to be more resilient in the face of extremely harsh circumstances can ultimately help increase the odds that other children will be successful as well. If we can identify what factors matter most in facilitating resilience, we can apply the proper resources to children who are struggling.

Researchers typically measure positive adaptation in terms of success in age-salient developmental tasks, which can be universal or culturally-dependent. "Developmental tasks typically include observable achievements, such as talking or academic achievement, but they

also may include internal achievements, such as happiness or a sense of identity” (Masten, 2014, p. 17). For elementary-aged children, which ranges from five to eleven years-old, common developmental task expectations include attending school and behaving appropriately; learning to read and write the language of the community; getting along with other children and making close friends; and respecting and obeying adults. In normative development, children in this age range begin to expand their world beyond the family circle, increasing their ties to school, the community, and peers. They have a strong investment in personal accomplishments and individual competency. Their own strengths and achievements help to build the filter through which they will later interpret experience. While abstract thinking begins to develop at the end of this stage, they generally continue to rely on concrete information for making meaning.

When there has been an impact of trauma, development in this age range can look quite different. As school and peers become increasingly important, children who have experienced trauma tend to struggle with competence in this area. If there have been impaired caregiver relationships, children will likely have difficulty forming relationships with peers and teachers since early attachment styles tend to be replicated in future relationships. These children usually approach others with a basic sense of mistrust, and their behavior may prevent them from receiving positive attention. “In this way, the cycle is perpetuated: The child retains and solidifies a belief that others are rejecting, while the system develops a belief that the child is disinterested in relationships” (Blaustein & Kinniburgh, 2010, p. 15).

In addition, a failure to develop a sense of agency earlier in development may impact children’s potential to perform well in school. School performance not only relies on cognitive ability, but also the capacity to concentrate, modulate arousal levels, regulate behavior, control impulses, tolerate frustration, and build interpersonal relationship skills. Children who have

experienced trauma may fall behind in any or all of these domains and experience feelings of failure, which they might generalize to other areas, causing them to overestimate their lack of competence. In this way, beginnings of negative self-concept and self-blame are internalized. Due to limitations in their skill set, children who have experienced trauma tend to cope with and express emotional and physiological experiences at this age through their behavior and interactions. They may become aggressive or bully others; may appear hyperactive, silly, or have difficulty managing behavioral arousal; or may withdraw and shut down (Blaustein & Kinniburgh, 2010).

There has been extensive research focused on evaluating and predicting resilience in high-risk populations. Such risks may involve low socio-economic status, harsh or neglectful parenting, homelessness, terrorism, and family displacement. “A risk factor could be highly specific to a particular outcome, but many of the most common risk factors of childhood predict multiple problems of behavior, health, and growth” (Masten, 2014, p. 14). While behavioral, social, and cognitive dysfunction are highly likely as the result of trauma, there is potential for positive adaptive behaviors to be developed which lead to greater resilience. Resilience is not an individual trait, but rather a process of development that enhances one’s ability to function across contexts. Positive functioning can be measured in various domains, but the cascading effect of functioning across domains and settings is what is usually most pertinent to resilience research. Conduct problems have been shown to undermine academic achievement, social competence, and psychological well-being (Masten, 2014). Therefore, in order for a child to be considered truly resilient, their positive functioning must be evident across all domains and settings.

“Resilience in young people is associated with a set of attributes of child, context, or their relationships that turn out to be well-established general predictors of positive

development” (Masten, 2014, p. 149). Included in this “short list” of protective factors are attachment and close relationships; intelligence and problem-solving skills; self-regulation and self-direction; self-efficacy and motivation to succeed; belief that life has meaning; effective schools; and effective neighborhoods (Masten, 2014). When measuring positive adaptive outcomes in the context of trauma, it is important to look at the intersection of individual and environmental factors. Researchers, as well as those who are involved in providing education or mental health services to trauma-exposed children, should examine how the social structures surrounding a person or community support or hinder positive development. Without easy accessibility to resources that facilitate psychological well-being, it can be extremely difficult for an individual to seek out and attain the support that will ultimately help them flourish. “Though personal motivation to adapt is still an important factor in positive development after exposure to traumatic events, the social ecology is responsible for constraining or liberating people’s choices with regard to coping strategies that result in prosocial behavior or pathological adaptation” (Ungar, 2013, p. 256). Families, schools, communities, and cultures interact in various ways to impact a child’s development and help shape resilience in direct and indirect ways. “The more the environments make available and accessible the resources that promote well-being, the more likely the individuals are to engage in processes associated with positive development such as forming secure attachments, experiencing self-esteem, engaging in expressions of personal agency, and meaningful employment” (Ungar, 2013, p. 258).

Ungar posits that there is no individual trait that is so fixed that it cannot be changed by an environmental intervention. One example of a longitudinal study that provides evidence for the malleability of individual characteristics through a facilitative environment is the work of Beckett et al. (2016) with Romanian orphans. While researchers found a substantial difference in

cognitive abilities among orphans who had been exposed to varying amounts of institutional deprivation, there was evidence of an ability to catch up between the ages of six and eleven no matter what age they were adopted into families. The reason for this improvement was thought to be related to extra individual assistance in school, as well as additional attention at home. This research illuminates the potential for individuals who have been severely emotionally deprived to still succeed later in life. In this study, researchers found that the window for opportunity in cognitive improvement is wider than previously believed. “The evidence is far too sparse for firm conclusions, but it seems that it may be possible for later experiences to alter some of the neural effects of early deprivation” (Beckett et al., 2016, p. 706).

One important system to analyze when discussing individual childhood trauma is the family, which serves as the primary structure and context in which a child develops. Children biologically inherit genetic vulnerabilities from their parents, which interact with external adversities to cause intergenerational transmission of risk. Problems within a family system that pose the greatest risk for child development include economic hardship, interparental conflict, neglect, and maltreatment. In cases of maltreatment and neglect, the overwhelming stress of these situations can cause toxic and persisting effects on brain development and adaptive function, including cognitive skills, the stress response systems, and the capacity for close and secure relationships. Sometimes neglect is a byproduct of mental health problems in parents, such as depression or addiction, which can impede parental quality and family function. (Masten, 2014). Families play a crucial role in facilitating positive development in their children by establishing effective roles and routines that maintain balance; training self-regulation through secure, responsive interactions; buffering the effects of adversity; and reaching out to community resources for additional support. “For a family to fulfill these crucial roles in protecting and

promoting resilience in children, the family itself must have the capacity for resilience” (Masten, 2014, p. 212). Therefore, community systems should work together to provide extensive support to families that are struggling. Services such as mental health care, financial and housing assistance, and education on effective parenting can help families who cannot adequately protect development for children threatened by adversity.

In cases of children who are deprived of an emotionally stable family and experience abuse or other forms of chronic stress in the home, schools have the opportunity to play an extremely important role in counteracting the effects of trauma in children. Intervention strategies in school-based settings, especially when implemented early with elementary-aged children, can make a significant difference in an individual’s overall quality of life. While a teacher can never replace the vital role of a loving parent, he or she can still create a positive classroom environment and be a source of comfort and support for a child who is facing adversity at home. “Schools nurture many of the adaptive systems in the individual that generate capacity for resilience over the course of development, while also affording opportunities for relationships with adults and peers beyond the family” (Masten, 2014, p. 218). Researchers suggest that schools should meet at-risk children with a trauma-informed approach. Trauma-focused practices in school settings include preventing adverse events that could re-traumatize children and fostering self-regulation skills.

One approach that has been proven to be effective is school-wide positive behavior interventions and supports (SWPBIS). Practices involved in this strategy include fostering social, coping, anger management, and relaxation skills, as well as having check-in periods with faculty mentors and forming meaningful relationships with adults. “Building positive adaptive systems’ by targeting school climate and students’ social problem-solving abilities, coping skills, and

growth mindset may be commonly fostered by SWPBIS strategies” (Zakszeski, Ventresco, & Jaffe, 2017, p. 316). There are challenges involved in implementing trauma-focused practices in schools, such as competing priorities related to academic achievement, as well as limitations of schedules and training time. In addition, when implementing these strategies, it is important to remain culturally sensitive by taking the population of the school community into account. However, the positive outcomes of creating a trauma-informed school setting far outweigh the challenges involved.

“The lives of children are deeply embedded in cultural contexts and their development is influenced by the traditions, values, rituals, practices, and beliefs shared by groups of people across families” (Masten, 2014, p. 240). It is especially important for mental health professionals and educators to remain culturally sensitive when addressing trauma and promoting resilience. Cultural ideas regarding expectations for behaviors, rearing children, and dealing with adversities in life can differ greatly. “Expectations about what it means to do well in life, the criteria for evaluating positive adaptation or competence in any given period of development, are deeply influenced by culture” (Masten, 2014, p. 246). In addition, children who are members of racial, ethnic, or religious minority groups in a particular area often face discrimination, which can have severely damaging effects. Immigrant and refugee children also face difficulties when entering a new culture and environment where the norms may clash with their family’s expectations and culture of origin. “Successful immigrant youth often appear to find a way to navigate comfortably across their cultural contexts, preserving ties to both cultures” (Masten, 2014, p. 249). In addition to biculturalism, fluent bilingualism has also been found to be a protective factor among immigrant youth. Their ability to bridge cultural and linguistic gaps for themselves and their families allows access to a broader network of cultural and community

resources. In addition, bilingual learning is associated with better cognitive abilities, such as executive functioning skills. “Language fluency is associated with greater success in school, as well as fewer PTSD symptoms in studies of war refugees” (Masten, 2014, 133).

At the level of individual characteristic differences, there seems to be a unifying set of attributes that consistently predict resilience across various types of trauma. These include self-efficacy, self-esteem, self-regulation, and intelligence (Masten, 2014). Self-efficacy is the belief that one possesses the ability to successfully complete a task and produce a favorable outcome on their own. When children are provided opportunities to master the environment around them, they gain a sense of control and agency, and are more likely to overcome challenges. Caregivers and teachers play key roles in promoting this development in early childhood. However, in cases where motivation or self-efficacy has been lost due to chronic exposure to trauma, promoting this mastery motivation system, especially during the elementary-age period, is vital in the promotion of resilience. The ability to self-regulate, which includes managing one’s own attention, emotions, and actions, also plays a key role in resilience. In a study of preschoolers in Kenya who had experienced political violence, those who displayed self-regulation skills prior to an outbreak of conflict later showed less aggression and more prosocial behaviors (Masten, 2014).

The attachment system is a powerful indicator of resilience because it plays an important role in the development of self-regulation skills, as explained by developmental theory. “Responsive and sensitive caregiving contributes to high-quality, secure attachment relationships between caregiver and child that are then carried forth into future relationships” (Masten, 2014, p. 152). Before a child can regulate his or her own emotions, sensitive caregivers play the key role of co-regulators who aid a child’s biological functioning, emotion, arousal, stress, and

behavior. An insecure attachment between child and caregiver is associated with decreased self-regulation, as well as other adaptive skills associated with executive function, in the future.

While children in these situations do have the potential to later form close bonds with others, such as teachers and friends, an abusive or neglectful parent is one of the greatest threats to child development (Masten, 2014).

While extraordinary intelligence is not necessary in the development of resilience, average and above-average cognitive abilities, including effective problem-solving skills, are linked to resistance to adversity and better overall functioning. “These capabilities likely reflect a human brain ‘in good working order’ combined with knowledge to understand what is going on, what to expect, and what to do or how to get assistance from others who do know” (Masten, 2014, p. 155). Toxic stress as a result of ongoing trauma can severely impede cognitive development by releasing high levels of glucocorticoid hormones for too long, affecting brain structure and function, particularly in the hippocampus, which is involved in cognitive functions such as memory. “Thus, a young child who is unprotected from stress by an effective parent, or, worse, assaulted with stress by an abusive parent is at risk of suffering cognitive consequences to learning and intellectual capacity.” (Masten, 2014, p. 183). Personality and temperament are also considered, but these factors are slightly more complex due to cultural differences of valued traits and their functions in particular contexts. “The most consistent evidence of protective effects for personality appear to be for the role of conscientiousness and effortful control (or constraint) for school or work success in the context of high risk or adversity” (Masten, 2014, p. 166). Humor is another complex factor that may be linked to resilience. Because it is a multifaceted concept that changes over time and across contexts, humor is difficult to study. However, it can be used in adaptive ways to connect with peers and cope with stress, and it tends

to be associated with various cognitive skills, intelligence, and social competence.

“Understanding, appreciating, and generating humor all appear to require high-level integration of cognitive and emotional processes, and humor often involves arousal modulation, reframing, or cognitive control” (Masten, 2014, p. 169). When used maladaptively though, humor can be used to demean or bully others, which can in turn distance children from peers because they may be perceived as hostile.

Internal and external systems of adaptation are always interacting – no one factor acts alone in the development of resilience. That is why it is important to look at all aspects of an individual, as well as the many protections or risks in his or her environment, that lay the foundation for the capacity to develop resilience. “Recovery from trauma is not an individual capacity alone but a function of the individual’s social ecology to facilitate recovery and growth” (Ungar, 2013, p. 258). Therefore, efforts for intervention with children should include clear, informed communication between family, school, and community systems that aim to foster positive individual development.

Method

The following case studies are based on two students in an alternative classroom program for children with official diagnoses of emotional disturbance. As defined by the Individuals with Disabilities Education Act (IDEA), emotional disturbance is “a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child’s educational performance: an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings under normal

circumstances; a general pervasive mood of unhappiness or depression; a tendency to develop physical symptoms or fears associated with personal or school problems” (Information about Emotional/Behavioral Disorders). The purpose of the alternative program is first and foremost to provide access to education for children who have not been able to learn effectively in a traditional classroom setting, due to emotional trauma and varying developmental and/or intellectual disorders that have evolved partially as a result of their trauma. While the background of each student varies, all cases involve complex trauma, which means that there has been exposure to multiple traumatic events, as well as wide-ranging, long-term effects of this exposure (Complex Trauma). Traumatic experiences among the students in this classroom include physical and/or emotional abuse; neglect; homelessness and poverty; and experiences with war and terrorism. The students in the alternative classroom typically struggle with emotional and behavioral regulation, social interactions, and academics. This program is designed to prepare students with the skills they need to enter or re-enter a mainstream classroom. The alternative program is in a self-contained classroom within a public elementary school in Vermont. The school district serves an ethnically diverse population, and many students come from low-income and/or immigrant households.

The researcher’s role within the alternative classroom was as an intern who provided behavioral and academic support to students. Through classroom observations and reading psychological evaluations, as well as interviews with teachers, a school-based social worker, and a clinical psychologist, I intended to assess the differences that exist in the background and development of two students of interest. The goal of this study was to determine what factors influence resilience in the context of emotional trauma, and in particular, why some children display more positive adaptive behaviors than others, even when trauma is a common

denominator between them. The study also sought to examine what resources and trauma-informed approaches promote optimal social-emotional and cognitive development.

The topics included in this investigation of resilience centered around the trajectory of each child's protective and risk factors. Through behavioral observations and interviews with clinical team members, as well as knowledge gained from individual psychological evaluations, the items that were assessed included: behaviors each child exhibited upon entering the alternative classroom; how each child behaves presently; and what the predicted outcome is for each child. There was a focus on both positive adaptive behaviors that appear to help each child resist the effects of their individual trauma, as well as the negative behaviors that need to be addressed in an effort to improve functioning. There was also an investigation into the specific trauma-focused practices that have been tested with each child, as well as how school-based implementation of these practices has proven to be effective or ineffective. Lastly, there was an evaluation about the next steps for each child in the effort to transition them into a mainstream classroom, if that is an option in the foreseeable future. It was hypothesized that the most insight would be gained from the interviews with the teachers who interact with these children on a daily basis, as well as the clinical psychologist and school-based social worker who also have regular contact with each child. In addition, researcher observations were used as supporting or opposing evidence. By focusing on these topics of investigation, considerable evidence was obtained about the factors that promote or impede resilience in the context of emotional trauma among elementary-aged children. The following accounts are based on behavioral observations, interviews with teachers and clinicians, and psychological evaluations. All names and identifying information have been changed to protect the identities of the individuals mentioned.

Case Studies

Case Study 1 – Adam:

Adam is a 9-year-old boy who was born to a family with generations of trauma and poverty. There is also a family history of mental illness. Adam's mother, Dana, suffers from depression, and there is a family history of both bipolar disorder and ADHD. Dana, who gave birth to Adam as a teenager, has a long abuse history, starting when she was a child. From birth, Adam witnessed his mother being abused by his father, who also physically abused Adam on multiple occasions. The most recent incident occurred over a year ago when Adam was sent to the hospital for abuse-related injuries. Sometime after this incident, his father was sent to prison for domestic violence. However, he was recently released and is actively seeking visitation rights to see his children, which has put a strain on the entire family, especially Dana. Adam lives at home with his mother and brother in the same apartment they have lived in for several years, which is filled with their trauma history. Dana is a single parent working a part-time job. She has very limited skills in parenting and struggles with mental illness, which makes raising two children very difficult for her. She has a lot of support available to her, including therapeutic family services and psychiatric help, but she has been rejecting those services recently. The home is reported to be very chaotic, and there is constantly a lot of yelling and physical aggression. Recently, Adam reported that his mother hit and pushed him and his brother, which Dana confirmed, admitting that she took her actions too far. Adam often comes into school upset or angry because of events that have happened at home. As a result, very minor things can easily trigger Adam, causing him to escalate and lose control of his emotions. He gets very frustrated when given corrections or reminded to follow certain directions, and it takes him a long time to settle down and calm his body once he starts to escalate. Adam's brother also struggles with

emotional regulation, and he receives one-on-one behavioral support in his mainstream classroom. Adam's grandfather assists with care when he can. While limited in his capabilities due to physical health problems, the grandfather seems to be a positive influence on Adam. When he comes into school following an extended visit with his grandfather, Adam is emotionally regulated.

Adam started exhibiting aggressive, impulsive behaviors in preschool, which then escalated from kindergarten on. He spent his kindergarten year in a mainstream classroom, but was not able to function well there. He only spent about ten percent of the day in the classroom, and the rest of the time regulating himself in another room due to erratic behaviors that interrupted academics. Such behaviors included throwing chairs, standing on desks, and running throughout the hallways. He had a one-to-one behavioral interventionist with him during that time, who helped him co-regulate. However, his behaviors interfered with the learning of others in the class and resulted in impaired peer relationships because the other students feared him. Upon entering the alternative program in first grade, Adam was performing very low academically. Because of concern from his psychiatrist regarding his cognitive development, Adam was given multiple IQ tests, on which he always scored close to 70. His scores indicate a significant limitation in intellectual functioning. Other test results have shown that Adam has low levels of self-esteem, self-regulation, social awareness, and learning, as well as very low processing speed and poor verbal skills, which impacts his ability to process oral directions. He is developmentally far behind on reading proficiency and has a lot of difficulty understanding the concept of time. Adam has been diagnosed with ADHD, combined type, as well as Oppositional Defiant Disorder. He has been prescribed medication for his ADHD, which he is supposed to

take at home, but there is speculation that his mother does not always comply with medication management.

Throughout the past year and a half in the alternative program, Adam has made significant academic and social-emotional improvements. He has developed a close relationship with the lead male teacher, Steve. While it does take a while to develop trust with adults, he seems to crave positive adult attention. Academically, he has made great gains, including learning the alphabet, being able to read short words, adding and subtracting, and generally getting more schoolwork done. He is a problem-solver and always wants to try to figure things out on his own. He is also very persistent and displays motivation to try his best when he is learning something he is very interested in. Once he is on task with something he likes, he is able to zone in and accomplish the task. This is evident in both academic work and mindful activities, such as completing puzzles or building with Legos, which seems to help him cope with emotional triggers. Socially, Adam is able to play with other children appropriately and contribute to a group when he is emotionally regulated. While he seems to be engaged in group activities, Adam struggles to pick up on certain social cues, which can make it difficult to develop peer relationships. He will often blurt things out without an awareness that he has hurt another child's feelings, and struggles significantly with social thinking activities. He does not appear to have much internal awareness unless he is completely calm and emotionally regulated. When he is not regulated, he often resorts to violence instead of asking for help. Lately, his escalations have been increasing in frequency and severity, which started following an extended stay at a residential treatment center for children experiencing acute mental health emergencies. He has expressed to his teachers that he wants to go back to the residential center because he does not want to be at home with his mother. When asked why he has become more violent at

school, he stated that his teachers are the only ones that can help him. While he had displayed violent behaviors before, it always appeared to be impulsive and not directed towards others. Recently, his violence has become directed at peers and teachers in a deliberate effort to hurt someone so that he can be taken to the residential center.

During his most recent outburst, Adam became angry after he was told he could not join a group activity since he was not cooperating with directions. He then started to throw things and tear apart the room. The other students were evacuated from the classroom, and Adam proceeded to break classroom supplies, throw things at the teachers, and hit and kick them. He became so violent that two police officers had to come into the classroom and de-escalate him, which included mild restraint. Adam was brought to the emergency room, where he was evaluated and then sent home. As a result of his most recent violent outbursts, he has been temporarily removed from the alternative classroom out of concern for the safety for others, and he has been attending two-hour tutoring sessions in another area of the school every day.

Case Study 2 – Ahmad:

Ahmad is an 9-year-old boy who moved to the United States two years ago from a refugee camp. His family fled a war zone after their home was bombed. The whole family was at home during the incident, but only the mother suffered serious injuries as a result. She is still recovering from severe burns and has many health problems that interfere with her daily life and prevent her from working. In addition to experiencing significant trauma at the time of the bombing and being displaced from their home country, the family has also experienced trauma as a result of their long, arduous journey as refugees, as well as their resettlement in the United States and subsequent food instability and poverty. Ahmad struggles with intergenerational

trauma and has been diagnosed with Posttraumatic Stress Disorder and Oppositional Defiant Disorder. He has also been diagnosed with ADHD, for which he receives medication management at school as directed by his pediatrician.

Ahmad lives with his mother and father, as well as his sister who is close in age to Ahmad. They are a very tight-knit, loving family, and Ahmad and his sister are well taken care of at home. Ahmad's sister is able to function well in a mainstream classroom and is not on an Individualized Education Plan (IEP) like Ahmad. The father, Nadim, is described as a protective parent and is seen by teachers as a great advocate for his son, Ahmad. However, because Nadim has not received adequate mental health care for his own trauma, he demeans providers and can inadvertently get in the way of treatment and educational opportunities for Ahmad. It took a considerable amount of time and effort on the part of the teachers and school psychologist to even get Ahmad into the alternative classroom because Nadim was refusing to acknowledge that Ahmad's behavior was a result of trauma. Nadim has also been known to cause a lot of conflict within the community where they live, which has isolated the family and made it difficult for Ahmad to create friendships with other children in the community.

Prior to entering the alternative classroom program, Ahmad was unable to remain in his mainstream classroom because he displayed aggression, ran away from adults who tried to help him, and was never fully engaged in learning. Upon entering the program, his behavior quickly improved. He is now able to stay in class and complete academic work. He is a lot more visibly calm, participates in group activities, and has been able to make friends with other students in the class. While he still struggles slightly with English language learning, Ahmad has made considerable progress, especially considering the fact that he and his family only speak their native language at home. Ahmad is a noticeably friendly, caring child who works very hard and

shows a strong desire to please his parents and teachers. He appears to have a genuine interest in learning, and it does not take him long to understand concepts. He is a quick learner and is able to stay on task without much direction from adults. However, he is also unafraid to ask for help when he needs it. He has developed strong relationships with the teachers in the classroom and looks to them for guidance in academic work, as well as navigating peer relationships. Ahmad struggles in dealing with unfamiliar situations on his own and displays anxious behaviors when he is unsure of what is going on. Often times, when he is in an environment where he feels anxious, he will stay close in proximity to his teachers and seek comfort from them. Within the classroom, he also constantly seeks out adult attention and praise, which seems to be his way of gaining reassurance that they are there for him. Occasionally, he will outwardly express his anxiety by yelling or becoming physically aggressive towards other children. While he is usually very kind, and often uses humor in an appropriate manner, Ahmad sometimes teases other students. However, Ahmad does display many positive social behaviors. He can recognize emotions in himself and others, and tries to comfort other students with encouraging words and kind actions. He is also able to play well with other students in the class, and actively participates in group activities.

Ahmad has been slowly re-entering a mainstream classroom setting by participating in “morning meetings,” an interactive group check-in activity between teachers and students, in which Ahmad has proven to be successful. He attends these class activities in the morning for about thirty minutes each day, along with an adult from the alternative program. By working up to a full transition into the mainstream setting slowly and in small increments, rather than suddenly putting Ahmad in an uncomfortable, threatening environment without much support, he is able to develop social skills and build confidence without becoming overwhelmed. Overall,

Ahmad appears to be a child who is engaged in learning, follows the class routine, and is generally very happy at school.

Qualitative Analysis

There were several themes of resilience that appeared throughout the conduction of the present case studies. As expected, the most enlightening evidence arose from interviews with teachers and clinicians, which was supported by periodic behavioral observations. The main findings, discussed below, highlight the most significant factors that predict resilience in the context of emotional trauma among elementary-aged children.

Effective Caregiving and Parenting Quality

There appears to be strong, clear links between the attachment system and resilience, which is evidenced in the present case studies. In the case of Adam, there is not much of an emotional connection between him and his primary caregivers due to repeated neglect and abuse from both his mother and father. In particular, Adam's insecure attachment with his mother, which is void of the nurturing and responsive qualities in a typical secure attachment, has resulted in impaired relationships with others, as well as a general lack of feeling safe at home. As explained by one of his teachers, "It's just Mom at home – very limited skills in parenting. She's admitted to not having a very close connection with him like a mother and son should have." Around the time that Adam's father was released from prison and began seeking visitation rights, the mother's mental health was reported to decline, and Adam began to exhibit more violent behaviors in school. According to one of his teachers, "Mom's mental health would be the biggest issue – depression. And there's concerns about how much help she's receiving for

her own mental health, which has a big effect on Adam.” Another teacher stated, “If he had a home where he felt loved and had consistency, like he does at Grandpa’s house, it might change the way he is at school.” In the case of Ahmad, there appears to be a much more stable, healthy attachment system in place. When asked about Ahmad’s family, one teacher concluded, “It’s a really loving family – they take care of each other. He’s well taken care of at home.” The clinical psychologist seemed to agree, stating, “That kid is loving and attached...I think [Ahmad] has felt a lot of love, and it’s developed into much more appropriate relationships.” The common thread between home life and positive adaptive behaviors appears to be a healthy attachment system. However, there are other factors within a family system that can result in impaired development. While Ahmad has had the extremely important protective factor of healthy caregiver attachment, the trauma his family has experienced and continues to struggle with still has a direct negative impact on him. He has experienced a series of chronic chaos, as well as food instability and poverty. With regard to the bombing of his home, one of his teachers stated, “It’s unclear how much [Ahmad] actually witnessed or remembers from that. But clearly his dad obviously knows a lot about it and is very traumatized himself, and he projects a lot of that onto [Ahmad].” While seen as a positive influence on Ahmad, as well as a strong advocate for his education, Ahmad’s father had a difficult time accepting that his son is emotionally disturbed and needed to be on an IEP. The alternative classroom teachers and clinical psychologist report that he fought them on this until he finally agreed to enroll Ahmad in the program. The father also makes it difficult for Ahmad to engage with other children in the community due to his hostile behaviors, which seem to be a result of his own trauma. The clinical psychologist explains, “I worry about the family system. In a school, the kid’s getting all the identified services, but it’s a traumatized family. So, Dad’s getting therapy through the pediatrician’s office because he doesn’t feel that he needs it,

but it's done in the spirit of supporting his son, and that's how we got dad to agree to come in."

In both cases, one must look beyond just the student's behavior as a function of individual trauma, and examine it in terms of emotional disturbance that is embedded in the trauma of the family. In both cases, there appears to be a strong need to extend more supportive mental health services to the parents in an effort to reduce the trauma exposure on the children. Ultimately, however, the existence of a healthy attachment system with caregivers seems to be a significant predictor of resilience.

Close Relationships with Other Adults

Another connection between attachment and resilience appears to be in the form of close relationships with other supportive, caring adults who are not primary caregivers. Despite a lack of healthy attachment with his mother or father, Adam shows interest in social relationships and displays a capacity to form those relationships. His consistent positive behavior following visits with his grandfather indicate that he shows Adam much more love and attention than he receives from his mother. One of his teachers stated, "His grandfather has a really strong relationship with him – probably the closest thing to a father figure he has." It is also clear that the lead male teacher, Steve, has had a significant positive influence on Adam by providing consistent support and giving him individualized attention based on his needs and abilities, which has improved his overall development. While discussing the relationship between Adam and Steve, the clinical psychologist stated, "[Adam] is very, very guarded. But given that he's experiencing so much emotional neglect from his mom, he really has attached to at least one person here. He's targeting him and trying to hurt him now, but he really loves him and trusts him." While Ahmad does have the presence of healthy caregiver attachment, he also benefits greatly from positive

adult relationships within the classroom. Both of his teachers concluded that he has a strong desire to please them by doing a good job. He also seeks them out for guidance, which can manifest in both positive and negative ways. One teacher explained, “If he’s not sure about a situation that’s going on, say if he has a conflict with another student, he’ll come tell an adult right away – sometimes too much I guess.” Another teacher stated, “He needs constant adult attention and praise...I would like to see him less dependent on adults all the time; not be so focused on getting attention from everybody; just feel part of a group.” While he often seeks out excessive adult attention, his capacity to form and engage in these relationships allows him to feel safe and cared for, which in turn helps him function well in school.

Intelligence and Problem-Solving Abilities

While he has made some considerable progress in reading and math during his time in the alternative classroom, Adam struggles greatly with academics. His poor cognitive functioning can be partially attributed to his traumatic experiences with abuse, as well as an unstable home life. His constant state of arousal, combined with ADHD, seems to make it very difficult for him to focus on academic work for a sustained amount of time or process directions and information quickly. As one teacher explains, “He has the capability to learn; he’s picking stuff up in his own little way. He’s got to learn how to read and write – his writing is so limited. But until he’s able to be emotionally regulated and not so fragile...he’s not going to be learning.” However, he does display an innate ability to solve problems to reach an end goal. If he is regulated, Adam is able to zone in on a task or subject that he has showed strong interest in. If a teacher frames a set of math problems around the topic of baseball, for example, Adam shows a much greater interest and ability to work through the problems because he enjoys playing baseball and has familiarity

with the subject. The clinical psychologist noted, “He’s got great visual-spatial skills. I’ve seen him use Legos and puzzles, and I think he can really regulate with that.” While not necessarily an academic task, his interest in putting objects together to build or create something displays that he has some innate cognitive abilities. One teacher also explained, “He’s a problem-solver. It’s really hard to teach him the traditional way; he wants to figure things out.” Ahmad does not struggle as much with academics, and he shows a genuine interest in learning no matter what the subject is. One teacher explained, “He has a passion to learn; loves math; likes to read books; and he’s a quick learner.” It does not take him long to process information or figure out a problem, and if he does not understand something, he will ask a teacher for help. While he is exceeding in math, he is far behind in reading. The clinical psychologist explained, “He has a lot of holes in his learning. He’s still an ELL [English Language Learner], so he still has a lot of language-based learning to do, and they don’t speak English at home.” He receives English Language services in school, which seems to be helping significantly with his reading. His ability to speak two languages fluently implies that he has innate cognitive capabilities that serve him well in other areas as well. While both students are behind other peers their age in academics, the progress that they have made within the alternative classroom show that they have the capacity to learn within a therapeutic environment that is tailored to their needs and abilities. However, what is unknown is whether or not they would function well academically in a mainstream classroom without the same kind of support.

Self-Regulation and Executive Function

Executive function capability, which includes skills such as working memory, flexible thinking, and self-control, appears to be a significant indicator of resilience. When children can

manage their internal state, they are able to attend to outside activities, such as learning and social relationships. Adam has been able to develop some self-regulation strategies during his time in the alternative program. Often times when he is feeling overwhelmed, he is able to take “time and space” away from the group without having to be directed by a teacher. However, in many instances, he is unable to regulate himself, which leads to a significant overreaction involving heightened emotions and erratic behavior. Due to an overstimulation of his stress response system as a result of ongoing trauma, there is often a big physiological response to very small triggers, which he is unable to identify and understand. As explained by the clinical psychologist, “The neurological development is inside out, so it impacts his cognitive development, his executive functioning, his ability to learn...He’s not even developed the ability to regulate his basic body functions. I think his heart’s pounding, he’s sweating, and his pupils are dilated – constant fight or flight. And he comes in that way. So, he gets here, on a scale of one to ten, he comes in a nine.” He exhibits aggressive behaviors as a response to certain triggers, such as minor peer conflicts, directions from adults, or transitions between activities. He lacks the ability to plan ahead and anticipate changes, which creates a lot of challenges for him throughout the day. The clinical social worker noted, “He has no internal awareness, unless he’s calm. So, he’s able to list strategies for anger management and impulse control, and tell you why he gets mad, but he can’t actually use those strategies in the moment.” One of his teachers explained, “Processing with him can be done, but very, very basic. You can do a quick little teaching of a replacement behavior just so he knows it, but he doesn’t really reflect on his behavior too much.” It is clear that he needs significant assistance in identifying triggers and managing his emotions when escalated. Ahmad presents with generally good executive function skills, including the ability to self-regulate in most situations. However, he can sometimes

become aggressive in response to situations that cause him to feel an overwhelming sense of anxiety. One teacher explained, “He seems to have anxiety when he’s not sure what’s going on and it leads to some maladaptive behaviors.” Large crowds and unfamiliar people or environments can be especially triggering for him, and cause him to react with physical or verbal aggression, which is usually short-lived and easily de-escalated. Generally, though, he seems to understand links between certain triggers, his emotions, and resulting consequences of his behaviors. One of his teacher explained, “When he’s displaying maladaptive behaviors, if you talk to him about it, he appears to be really genuine and reflective on it, and you can teach him how to handle similar situations in the future. It takes him a long time to learn it, but he does it and puts effort in.” His anxiety in situations that he perceives to be unsafe or unmanageable seems to be an adaptive response to his trauma, which involves chronic chaos and frequent instability in his environment. With enough support and guidance, he seems to possess the capability to overcome this obstacle, which can often get in the way of building social relationships and engaging in learning.

Coping Skills and Ability to Seek Help

A child’s ability to cope with stressors and reach out for help when they cannot do it alone also appears to be a strong indicator of resilience. Adam is a child who struggles greatly with self-regulation. While his erratic and violent behaviors can be seen as an adaptive response to a history of trauma and a chaotic home life, his actions are ultimately maladaptive because they prevent him from learning and forming social relationships. As explained by one of the classroom teachers, “He can take a break and walk away from things where he couldn’t before, but now he seems to know how to use his behavior to manipulate other people’s reactions as

well.” While he has developed a particularly close relationship with this teacher and trusts him, Adam has recently started to target his violence towards this teacher. When asked why he has outbursts at school, Adam explained that his teachers are the only ones that can help him. The clinical social worker explained, “Right now, we know that he’s trying to reach out for help, but he doesn’t know how to do it appropriately. So, it is a strength – he wants help.” The clinical psychologist also noted, “That’s his coping skill now because he’s seeing that as how to get his needs met...The only way to get his needs met are violence, and he’s headed down a conduct disorder path.” Recently, his violence escalated to a point where he was removed from the classroom and placed on a tutoring schedule. While he has been succeeding on this plan, he is missing out on the social aspect of school and regressing in terms of moving towards a mainstream classroom. Ahmad appears to be on the opposite end of the spectrum in terms of asking for help. He is constantly seeking attention and guidance from teachers within the classroom, and looks to them for comfort in unfamiliar situations. Most of the time, this is an asset to Ahmad, as it allows him to attain the help that he needs and feel safe and secure. However, when it becomes excessive, this behavior can prohibit him from engaging in activities or completing tasks on his own. One of the classroom teachers noted, “I see him going into a general education class and if he’s struggling with something, he’s going to kind of be shy and not ask for help, whereas he would with us, so he needs to generalize those skills more.” Ultimately, however, a child’s ability to ask for help can be seen as one type of coping skill that allows access to opportunities for guidance and learning, which will serve that child well in many aspects of life, especially within an educational setting.

Self-Efficacy

Self-efficacy stems from an internal motivation to overcome challenges, which is fostered early in childhood when a child is allowed opportunities to see how their actions influence the world around them. If a child is not given much positive encouragement to try new things and make mistakes, they will likely remain stagnant in their efforts to overcome challenges. Children develop self-efficacy when they are given reasonable challenges and provided support from parents and teachers. This attribute is linked to a better ability to think productively by applying positive thinking skills to a perceived challenge, as well as a lower vulnerability to stress and depression. When he first entered the alternative classroom, Adam was very far behind in academics, and did not display much of a capacity or willingness to learn. However, over time, with plenty of positive encouragement and manageable challenges within the classroom, he has developed self-efficacy, which has allowed him to access education when he is regulated. One teacher noted, “He’s persistent. When you teach him something he really likes, he really tries to do his best at it.” What is unfortunate about this situation is that, while the internal motivation is present, his unstable home life does not allow for this ability to transfer across contexts, and his dysregulation of emotions and behaviors prevent him from utilizing this capacity to learn. The clinical social worker explained, “If we can’t get the systems in place to address the trauma, or whatever he’s identifying as the trauma, then I don’t see how he’s going to be able to be successful moving forward. He’ll be successful, but it will be in an alternative setting type of way. I do think he’ll always need to have some kind of intervention in his life, even if he was in the mainstream.” Ahmad also displays a capacity for self-efficacy within the classroom. One teacher explained, “He’s calm; he stays in class; he works; he’s made friends. He participates in everything and really wants to do well. He stays on task. I think having a small classroom with

people he really knows is really beneficial to him.” The therapeutic classroom environment seems to work really well with Ahmad because it allows him to feel a lot less overwhelmed and he knows what to expect. While he does display an ability to complete work without much direction, he constantly seeks out validation from teachers and thrives off of praise. This can be seen an effective motivation tool, but it may also prevent him from developing an internal motivation to do well in a mainstream classroom setting. The school psychologist explained, “I think he doesn’t have the confidence because academics are so hard for him and he notices when he can’t do something. Because he really has big holes, and part of it is not speaking enough English.” In a mainstream classroom, there are far more students and usually only one teacher who cannot provide the same amount of attention and guidance as there is available in the alternative classroom. Ahmad will need to build up his self-efficacy in order to succeed in that type of setting. However, the school psychologist goes on to say, “He certainly has plenty of barriers, but here’s a kid who’s happy at school; who’s engaged in learning; who follows the routine.” Ultimately, fostering children’s self-efficacy through positive reinforcement and opportunities for manageable challenges appears to be one of the most effective ways to instill confidence and a motivation to learn independently.

Social Awareness and Close Friendships

Another factor that appears to correlate with resilience is a capacity for good social skills and peer interactions. When children display an ability to read social situations correctly and develop close relationships with other children, they appear to function well across contexts. Children are usually drawn to other children who show social reciprocity, meaning they engage in interactions appropriately by picking up on social cues and responding in a predictable

manner. Regarding Adam, one classroom teacher noted, “He doesn’t have many social skills. “He’s not able to just ask a teacher for help or deal with a peer issue. He’ll just lose it and start yelling at kids.” Adam appears to be triggered by very minor peer conflicts, even if the other child or children are well-intentioned. The clinical social worker stated, “He’s a rule follower in terms of games and activities with other kids, so he gets really mad easily because he thinks you cheated, but he doesn’t know how to play, so he cheats anyway.” He does not read situations or others’ emotions well, and often responds in an aggressive manner. This ultimately distances him from his peers, which isolates him and further prevents him from developing social skills. While he occasionally acts out his emotions in aggressive ways, Ahmad generally appears to be socially adept. The clinical psychologist noted, “He’s got a wide range of friends; he’s well-liked by staff; and he’s got some innate social reciprocity – he can recognize when someone’s sad or hurting. He has good social intuition.” He is able to read a situation and act in appropriate ways. He is also able to process his emotions and reflect on his behaviors, which helps him to respond in better ways when he encounters future conflicts.

Agreeable Personality and Sense of Humor

Lastly, personality and humor seem to be somewhat related to resilience. Personalities are complex, and their qualities play out differently across contexts. Generally, though, it appears that having a pleasant, agreeable disposition is more closely linked to resilience when compared with a disposition that is emotionally reactive and aggressive, especially within a classroom setting. If a child is hostile and resistant to help or social relationships, teachers and other children are less likely to engage with that child, which distances them further from the resources they need to succeed. Speaking about Adam, one of the classroom teachers noted, “He comes in

upset and triggered – violence is his biggest barrier. If he’s upset with somebody or something he’s asked to do, he’ll throw things.” The other children in the class usually remain distant from Adam because they do not know when he is going to have another outburst, and they have come to see him as emotionally reactive and aggressive due to his behaviors. This perpetuates his inability to engage appropriately in peer relationships and build his social skills. Ahmad is an extremely friendly child who shows an innate ability to understand and engage in humor. One teacher stated, “He’s funny. He’s a really caring, gentle kid. He wants to please people.” While he usually engages in humor appropriately, he sometimes uses it to tease others, which can create peer conflicts. This usually happens in the presence of older children, and he immediately shows remorse after adult intervention, indicating that he is seeking attention and validation in a maladaptive way. One teacher explained, “It seems like he’s teasing other kids to try to fit in or impress other students – trying to be funny more so than trying to be mean.” Generally, though, he is pleasant to be around, which is evident in his positive daily interactions with teachers and peers.

Trauma-Informed Approaches to Intervention

Therapeutic Crisis Intervention (TCI) and the ARC Model are two trauma-informed approaches that have proven to be effective within the alternative classroom in the present study. TCI, which was developed by Cornell University, uses techniques that are non-coercive and non-aggressive to de-escalate a crisis and lead to the child’s own emotional regulation and growth. In TCI, the successful resolution of child’s crisis depends on the environment of care, such as the classroom, as well as responses from the therapeutic team, which includes teachers and clinicians. TCI also assesses children’s behaviors as expressions of needs (Therapeutic Crisis

Intervention). Often times, a child may be trying to ask for help, but cannot do it appropriately, so he or she acts out in violence and aggression at school, as was evident in the case of Adam. TCI relies on time and space to allow the child to self-regulate emotions, followed by a conflict cycle resolution once the child is regulated. If a child is clearly beginning to escalate, the teachers in the alternative program may ask or encourage the child to take time and space away from the group to regulate themselves. Sometimes children remove themselves from a stressful situation without any direction, which shows that they are in tune with their emotions and behaviors. The dividers in the room allow teachers to set up “cubicles,” or private spaces, where a child can be alone and regulate themselves without distractions. Once the child is regulated, the teachers start by discussing the stressful situation or incident with the child, then evaluate the child’s feelings, analyze the child’s behavior, and finally respond in an appropriate way. This cycle helps the student connect their emotions, behaviors, and consequences of their actions, which in turn helps build self-regulation and executive function skills. In the TCI approach, physical interventions are only used as a safety intervention to contain a child’s acute aggression and violence.

The ARC Model is an evidence-based practice developed by Margaret Blaustein and Kristine Kinniburgh that focuses on attachment, self-regulation, and competency. It works flexibly across contexts and aims to identify key targets of intervention for trauma-exposed youth and their caregiving systems. Starting with the concept of attachment, the therapist focuses on building attunement by engaging in reflective listening skills, which includes reading children’s cues and responding appropriately; responding consistently with positive reinforcement and praise, which enforces a clear understanding of rules and predictability in adult responses; and building routines and rituals. In an effort to promote self-regulation skills, the therapist focuses on

building a feelings vocabulary; normalizing the experience of mixed emotions; connecting emotions to body sensations, thoughts, and behaviors; helping children to understand links between their internal states and external factors; and encouraging children to share their emotions with others. Lastly, focusing on competency, the therapist targets feelings of efficacy and success in children by promoting the development of problem-solving skills, which include evaluating situations, inhibiting responses, and making thoughtful decisions; helping children to understand the difference between acting and reacting; targeting aspects of self and identity; and promoting a positive self-concept. Through the use of these approaches, teachers and clinicians are trained to understand how trauma can affect children, which then aids them in responding sensitively and appropriately.

Conclusion

Ultimately, what seems to be most effective in fostering resilience in children who have experienced trauma is the combination of trauma-informed practices within a school setting, along with a family systems approach to treatment. Schools can apply extensive intervention strategies to treat trauma in children, but these efforts will not be enough if the issues within the child's home are not addressed as well. By working together to understand how a child can best be supported both at home and in school, teachers, clinicians, and social service providers can offer the best possible care for a child who is struggling. Including parents in their child's treatment is also crucial to the effectiveness of intervention. When parents are supported and valued as key players in their child's development and learning, they will likely be more motivated to build their parenting skill set and reach out for help if they need it. While it is well known that there is a strong correlation between early trauma and vulnerability to stressful

experiences later in life, building resilience from an early age can help resist many of the harmful effects of trauma. Understanding the key factors of resilience mentioned and how they relate to the adaptive systems in a child's life can help inform researchers, teachers, clinicians, and families in the ways that they can support the healthy development of children who have experienced emotional trauma.

References

- Beckett, C., Maughan, B., Rutter, M., Castle, J., Colvert, E., Groothues, C., Kreppner, J., Stevens, S., O'Connor, T., G., & Sonuga-Barke, E. J. S. (9 May 2016). Do the Effects of Early Severe Deprivation on Cognition Persist Into Early Adolescence? Findings From the English and Romanian Adoptees Study. *Child Development*, 77(3), 696-711.
- Blaustein, M. E. & Kinniburgh, K. M. (2010). *Treating Traumatic Stress in Children and Adolescents: How to Foster Resilience through Attachment, Self-Regulation, and Competency*. New York, New York: The Guilford Press.
- Complex Trauma. (n.d.). Retrieved from <https://www.nctsn.org/what-is-child-trauma/trauma-types/complex-trauma>.
- Information about Emotional/Behavioral Disorders. (n.d.). Retrieved from <http://community.cec.sped.org/ccbd/about/ebddefinition>.
- Masten, A. S. (2014). *Ordinary Magic: Resilience in Development*. New York, New York: The Guilford Press.
- Therapeutic Crisis Intervention (TCI). (n.d.). Retrieved from <https://www.cebc4cw.org/program/therapeutic-crisis-intervention/detailed>.
- Ungar, M. (2013). Resilience, Trauma, Context, and Culture. *Trauma, Violence, & Abuse*, 14(3), 255-266.
- Zakszeski, B. N., Ventresco, N. E., & Jaffe, A. R. (9 October 2017). Promoting Resilience Through Trauma-Focused Practices: A Critical Review of School-Based Implementation. *School Mental Health*, 9, 310-321.