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CHILDHOOD TRAUMA & OUR ROLE IN ITS PREVENTION AND TREATMENT

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A I. por demostrar que debajo del silencio se esconde una carcajada.

A E. por todo.

"LOVE NEVER FAILETH"
"FORTIS IN ARDUIS"

ABSTRACT

This final dissertation focuses on the development of three topics; trauma, childhood trauma, and the role of educational professionals in its detection, prevention, and treatment. To complete the theoretical framework of the paper, we have introduced three themes; trauma, trauma-informed care, and trauma-informed practices. In this part of the paper, we define and explain these concepts from a clinical and educational context, focusing especially on the elements and practices that are relevant to children and/or can be carried over from one context to the other. We focus especially on the TIPE (Trauma-Informed Positive Education) model to analyze the application of trauma-informed practices in the classroom, in order to address not only the students directly affected but the group as a whole. Once this has been done, we move on to the practical part, in which, based on the data collected, we propose six strategies and resources that teachers can implement at the classroom level in their day-to-day work. To conclude the practical framework, we present a real situation in which, due to the context, the author of the work implements a trauma approach in her interactions with her students, and then comments on the results obtained.

Keywords: trauma-informed care, trauma-sensitive schools, TIPE, positive psychology, pedagogical strategies.

RESUMEN

Este trabajo de fin de estudios se centra en desarrollar; el trauma, la infancia, y el rol que jugamos los profesionales educativos en su detección, prevención y tratamiento. Para completar el marco teórico, nos hemos introducido en tres temas; trauma, atención con enfoque de trauma, y practicas con enfoque de trauma. En esta parte del trabajo, definimos y explicamos estos conceptos desde un contexto clínico y educativo, centrandonos especialmente en los elementos y practicas relevantes con la infancia y/o que puedan ser llevadas de un contexto a otro. Nos centramos especialmente en el modelo TIPE (Trauma-Informed Positive Education) para analizar la aplicación de practicas con enfoque de trauma en el aula, para atender no solo a los alumnos directamente afectados, sino al grupo en su totalidad. Una vez hecho esto, pasamos a desarrollar la parte práctica, en la que, basandonos en los datos recabados, proponemos seis estrategias y recursos que los docentes pueden implementar a nivel de aula en su día a día. Para concluir la sección, exponemos una situación real en la que por el contexto, la autora pone en practica un enfoque de trauma en sus interacciones con los alumnos, y posteriormente comenta los resultados obtenidos.

Palabras clave: trauma, TIPE, atención con enfoque de trauma, escuela, psicología positiva. estrategias pedagogicas.

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INTRODUCTION: OBJECTIVES AND JUSTIFICATION

Cuando escuchamos o hablamos de trauma en nuestra sociedad en general y en los medios de comunicación, se suele relacionar con hechos muy concretos, dando a entender que una experiencia tiene que tener unas características muy específicas e inusuales para ser entendida como una experiencia traumática, y nada más lejos de la realidad.

Por otro lado, las nuevas generaciones se hacen eco de este tipo de términos más técnicos y los incorporan a su vocabulario, pero sin conocer realmente el alcance o las implicaciones que tienen, e incluso utilizando el término de forma banal, lo que nos hace restarle importancia real. Todos hemos escuchado -e incluso utilizado- frases como "oh, qué trauma" o "traumita" en conversaciones cotidianas. Pero, ¿ha sido este cambio beneficioso para desestigmatizarlo, o ha llegado al punto de banalizarlo?

En el contexto actual, en el que el mundo vive tiempos que podríamos calificar de convulsos; la crisis de COVID-19, la crisis económica, los conflictos bélicos y políticos en todo el mundo o la crisis climática, con los efectos adversos que todo ello está creando en la sociedad, hace que conocer y tomar cartas en el asunto haya dejado de ser una opción y se haya convertido en un deber para todos, incluidos los profesionales de la educación *“...it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education…”* (SAMHSA, 2014).

Para ello, los profesionales de la salud y la educación llevan años trabajando para proporcionarnos la información que ahora tenemos para poder abordar la prevención y el tratamiento de este problema de una forma profesional e informada. Esto se puede hacer a través de una lente sensible al trauma, que tiene la "Atención Informada por el Trauma" (TIC).

Para maximizar el impacto de estos esfuerzos, es necesario que se proporcionen en un contexto organizativo o comunitario que esté informado sobre el trauma, es decir, basado en el conocimiento y la comprensión del trauma y sus implicaciones de gran alcance (SAMHSA, 2014), por eso nosotros, como profesores, también tenemos que participar en este proceso.

Preguntarnos cual es el verdadero rol del docente en una situación habitual en el ambito educativo es algo muy común. Qué es lo que debemos conseguir de forma general está claro y consensuado. Podriamos decir, que nuestro deber para con los niños consiste en proporcionar una educación de calidad que fomente la igualdad, mediante practicas que den una respuesta lo más adecuada posible a las necesidades que presente.

Todo esto trabajando de forma activa en buscar las practicas más beneficiosas y trabajando de forma conjunta con todos los servicios y adultos que formen parte de la vida del menor ya sea de forma directa o indirecta.

Desgraciadamente, la realidad con la que nos encontramos en nuestro día a día difiere bastante de esa situación utópica y es lo que me ha llevado a hacer el trabajo de fin de grado sobre esto. Ver cómo un alumnos sufría y mostraba claros signos de un problema mayor, mientras que las docentes no tenían

Por una parte, es cierto que los docentes carecemos de formación profesional para poder hacer frente a un termino tán complejo como lo es el trauma, y esto no es un problema que solo afecte al campo de la educación , puesto que esta situación se da en otros muchos sectores, incluyendo en el campo de la salud. Pero eso no significa que que no tenerlo en cuenta esté justificado.

En 2015, la UNESCO celebró la Cumbre de Desarrollo Sostenible, en la que se elaboró lo que conocemos cómo “Agenda 2030” en la que se reuniaron un total de 17 Objetivos de Desarrollo Sostenible mediante los que aconsejan a los paises la dirección hacia la que deben mirar a la hora de trasformar la sociedad, incluyendo la educación que proporcionan a sus ciudadanos.

Los objetivos de este docuemtento son; (1) aclarar el concepto del trauma y sus diversos elementos, (2) presentar lo que se conoce como atención con enfoque de trauma (TIC) y su aplicacion en el campo educativo (TIP), (3) conocer el modelo TIPE como una posible herramienta de aplicación, (4) proponer estrategia prácticas para el día a día en el colegio y aportar mi expericencia en su uso. Todo esto para poder dar respuesta a las siguientes preguntas planteadas:

- ¿Tiene el trauma suficiente relevancia como para adaptar nuestras practicas educativas?
- ¿Debemos los docentes participar en la prevención y tratamiento del alumnado con historial traumatico? ¿En caso de sí hacerlo, es el modelo TIPE una opción viable?
- ¿Poseemos los docentes todos los recursos necesarios para implementar un modelo cómo TIPE?
- ¿Perjudicamos al alumnado general al implementar un enfoque sensible al trauma?

THEORETICAL FRAME

Trauma

As a result of extant research on the topic over the years and the complexity of the term, there is a wide range of ways in which trauma has been explained, therefore, providing a single definition of the concept is not possible. Due to that, for the completion of this document, different explanations of trauma will be taken into account to develop the topic as adequately as possible in the framework of trauma-informed care, trauma-informed practices, and education.

The Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States, an organization that has carried out extensive research around trauma, defined the concept as follows:

> *"Individual trauma results from an **event**, series of events, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." (SAMHSA, 2014)*

To add more information to what SAMHSA provides, Kimberg and Wheeler (2019) state that the most common form of transmission is through negative or adverse power dynamics, which we can understand as relationships in which someone - or something - dominant has power over a dominated person, creating inequality between the two and resulting in negative outcomes for the dominated person. This is a standard relational circumstance for doctors and patients, as well as, teachers and students.

Because of the fact that trauma can be transmitted through interpersonal relationships, some describe it as contagious, and as SMAHSA (2014) adds everyone can be affected by it: "Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation." (SAMHSA, 2014)

1. SAMHSA's three "E's" of trauma

As we have seen in the definition that SAMHSA provides, the organization underlines three terms and explains them through what they named "The three "E's" of trauma: (1) *event(s)*, (2) *experience of events(s)*, and (3) *effect*", which helps us understand the complexity of defining the concept of trauma in a generalistic way, as an individual's trauma results from the interaction of the three, creating a unique combination in each case.

(1) ***"Event(s)"***

Refers to any event, set of events, or circumstances that represent a potential or actual threat that can harm the person - or people - involved physically or psychologically. In the case of a child, it also includes the case of severe or life-threatening neglect from any of the caregivers that can result in a potential adverse outcome in their development.

(2) ***"Experience of event(s)"***

Refers to "how the individual label, assigns meaning to, and is disrupted physically and emotionally by the event" (SAMHSA, 2014), and plays a pivotal role in determining whether an event becomes traumatic and has negative or harmful

effect(s) or, on the contrary, the person has the capacity to overcome it without adverse outcomes. That “processing” of the event is dependent on a wide range of factors of the person themselves, as well as other external factors, that we will later analyze.

(3) ***“Effect”***

Refers to the adverse or negative consequences the event has had on the individual which, if long-lasting, SAMHSA (2014) mentions as “a critical component of trauma”. It would be impossible to list the effects as - once again - they are dependent on a number of factors and are different for each individual in a determined situation, which we will later discuss. What we can note now, in a general way, is that each effect the person is enduring - a traumatic stress reaction - as a result of the experience, can: (1) have an immediate or delayed onset, and (2) vary in duration - long-term and short-term -. Furthermore, as humans are social beings and, therefore, have interpersonal relationships, these adverse effects not only affect the person who has directly endured trauma, but also their families and communities, and society overall.

From this description that SAMHSA provides of the three “E’s”, we can discern that; (1) two individuals who experience the same event or series of events, do not have to consequently experience it/them the same way and/or have the same effect.

Example: two siblings who experience abuse from one of their main caretakers. One of the siblings might be able to overcome the adverse situation wiithout developing long-lasting effects, while the other one becomes addicted to substances as a result of untreated complex post-traumatic stress disorder.

And, conversely, (2) an individual who experiences the same or similar event at two different times in his/her lifespan, the way in which he/she will react - the effects - may not necessarily be the same, as the context or the resources available to him/her may have varied over time, creating a different experience of the event.

Example: A girl was neglected by her caregivers during childhood and developed cPTSD (complex post-traumatic stress disorder) and was placed in foster care. Once she grows up attends therapy and resolves the trauma history of her childhood and decides to reconnect with her biological family. She encounters the same family dynamics she suffered during infancy but is now able to confront the situation through the positive coping skills she has developed.

2. Types of trauma

It is virtually impossible to enumerate the existing forms of trauma because of the number of ways of classifying and describing it; according to age, according to what provoked it, where it happened, whether it was individual or communal, whether it happened once or multiple times, etcetera.

This results in an infinite number of ways of labeling or identifying it. Because of this, in this case, we are going to explain more in-depth two types of trauma that are of vital importance in the development of the work and which will be mentioned repeatedly throughout the document, so it is important to understand what we are referring to when we mention them: "Vicarious Trauma" and "Childhood Trauma".

Vicarious trauma (VT)

As we have previously mentioned, trauma can happen directly, when we experience it first-hand, but it can also happen indirectly when we are exposed to (or narrated) the trauma that others have experienced, which receives the name of “Vicarious Trauma” or “Secondary Traumatization”. It has been defined as: *“the negative transformation in the helper that results from empathic engagement with trauma survivors and their trauma material, combined with a commitment or responsibility to help them.”* (Saakvitne and Pearlman, 1996)

It is a very common type of trauma for frontline workers - police officers, healthcare workers, social workers, child protective services, or teachers to mention a few - as they are exposed to others’ negative life events, and can, understandably, connect with them and be affected by it. That “transformation” will depend - like in any other form of trauma - on the combination of the factors in each specific situation, that will determine the way in which a person processes the exposure, resulting in “Vicarious Trauma”, or “Vicarious Resilience” - if the exposure to the trauma results in a positive outcome -.

Childhood trauma

It encompasses any form of trauma that someone may undergo during childhood, which constitutes a critical period in a person's development. This event or circumstances create negative effects on the child's overall well-being - psychological, physiological, etcetera - resulting in an overload and consequent dysregulation of the person's nervous system.

Even though a minor can become a victim of any kind of trauma during this stage of their development; natural disasters, wars or terrorist attacks, everyday accidents

that can put their life at risk, some kind of structural violence, etcetera; when we talk about childhood trauma, there are several types that are more common than others; neglect and abuse - sexual, physical, psychological -, violence within the family (in any of its forms including vicarious trauma), school violence, medical trauma, discrimination, poverty, untreated mental illnesses of the caregivers, to name a few of the sources.

When talking about childhood trauma it is also important to be familiar with the term "Complex Trauma" or "Complex Psychological Trauma" which has been explained as: *"resulting from exposure to severe stressors that (1) are repetitive or prolonged, (2) involve harm or abandonment by caregivers or other ostensibly responsible adults, and (3) occur at developmentally vulnerable times in the victims' life, such as early childhood"* (Courtois and Ford, 2009).

When we analyzed the "Es" of SAMHSA (2014), we mentioned that there are different factors to take into account in both "Experience of event(s)" and "Effect", and this is what we are going to develop below.

3. Factors: Harm or Protection?

In order to define the term "factors", we will approach the topic from an "Ecological approach" that understands that there are multiple levels of influence that interact with each other; individual, family, community, school, and culture.

This approach has been developed from Bronfenbrenner's (1979) model (Eriksson et al., 2018). In Bronfenbrenner's "Ecological Systems Theory" the influence levels on an individual are classified into; microsystem, mesosystem, exosystem, macrosystem, and chronosystem, which describes not only the different levels on their own but the interaction between them as well.

1. *Microsystem*: consists of the environment that has a direct relationship with the person. In a child's case, we could include their; nuclear family, school, or different peer groups.
2. *Mesosystem*: refers to the relationship between the different microsystems in the individual's life. In a child's case, this includes the family-school relationship, or the relationship between the nuclear family and the child's friends.
3. *Macrosystem*: consists of all the indirect relationships with others - and circumstances - that have an impact on the individual. In a child's case, this includes the cultural, geographical, ideological, social, and political-economical context.
4. *Exosystem*: refers to the interaction between one of the elements of the microsystems with another that does not directly engage with the person. In a child's

case, this could look like the mother/father's relationship with their jobs or family friends the kid is unfamiliar with.

5. *Chronosystem*: analyzes the evolution of all the systems throughout a person's life. In a child's case, we could explain it as the system change that the divorce or death of the parents provokes for example.

Later, in 1994, the theory was actualized by Bronfenbrenner and Ceci and became "The Bioecological Systems Theory" (Center for child & family well-being, 2021) where the interaction and reciprocal effect of biological factors - genetics, age, sex, etcetera - and the environment are addressed. From the point of view of education, we could connect this to the "Nature and Nurture" concepts as we use both these terms to talk about the characteristics - and their interaction - a child has due to biological and genetic elements that are unchangeable by the environment (nature), and, the ones that are shaped by interactions with the environment and develop skills and strategies to transit life (nurture).

With this in mind, we can understand that every single element that forms a human's bioecological system is a factor. In regards to trauma, we can classify them as "Protective Factors" or "Risk Factors" according to the effect they produce. This effect will increase or decrease the probability of an event becoming traumatic.

1. *Protective factor*: any element of a person's bioecosystem that promotes resilience in case of adversity and positive development at any level (personal, social, economic, etcetera).
2. *Risk factor*: any element of a person's bioecosystem that has the potential to increase the likelihood of experiencing a traumatic event or an adverse effect from it.

We can picture the way factors work in trauma as a pair of scales: the more protective factors there are and the fewer risk factors there are, the less likely you are to be traumatized, and vice versa. The overall situation created by all the involved factors will determine "the side to which the balance tips".

It is important to note that:

1. Any factor can become protective or trauma-inducing, and that function can vary over time.
2. Even if all levels of the bioecosystem affect a person; when a human is in the early stages of development, the impact the factor has, increases the closer to the individual they are. In other words, for a child, it is more powerful the family situation they have than the political context they live in (even if we know that both are part of a person's support system).
3. The impacts of trauma can not only be prevented through the promotion of protective factors and avoidance of trauma-inducing ones but also mitigated when it happens.

4. Due to the fact that a power imbalance exists between adults and children - because they are fully dependent on their environment for survival, which is designed by the caregivers - the role the adults adopt is crucial.
    - Kimberg and Wheeler (2019) state that the most protective factor in the case of childhood trauma is: having a caregiver who is stable, reliable, nurturing, and whose presence is continuous in the child's life, sometimes referred to as an "Always Available Adult" (AAA).
    - On the same page, the most harmful factor is becoming a victim of any form of childhood trauma from a caregiver.

4. Effects

As we have analyzed in "three "E's" of trauma", it is unavoidable to talk about the effects that trauma has as part of the concept, and there are two aspects that can be important to consider for professionals: (1) the traumatized individual(s) do not necessarily need to be aware of the impact a certain event has had on them, which does not translate as the effect not existing, and, in addition to this, (2) the way in which the effect manifests is not always obvious or easy to connect to the event as the cause.

Alongside these, we need to understand that the effects of trauma do not stop in visible elements like behavior; trauma has a profound impact in a wide range of ways, which worsens in critical periods like - but not only - early years. Because of this, we can analyze the effects of trauma from the lens of childhood.

Minors who experience trauma have a higher chance of developing significant and lasting difficulties or problems in their development (De Bellis and Zisk, 2014; Enlow et al. 2013; Lieberman, 2004; NCTSN, 2003) in areas like; behavior, cognition, emotions, relationships, brain development, and physical and mental health, as J.D Bartlett and K. Steber (2019) show in their graphic [Attachment 1].

In that graphic we can see ways in which trauma can manifest in children, including; sleep and eating disorders, emotional dysregulation and difficulty with expressing and processing big emotions, low or negative self-esteem, problems and lack of skills in interpersonal relationships, hyperalert state etcetera.

From it we could extrapolate an important understanding of the effects of trauma in childhood: they - the effects - are so profound that can even neurologically impact a person and cause modifications in the anatomy of organs (Ortiz-Ospina, 2017; Romano et al., 2015) and alterations in their functioning by subjecting it to abnormal levels of stress. Romano et al. (2015) explain that when trauma is experienced in childhood, the brain can experience an absence of sensory input ("insufficient sensory exposure"), as well as, a continuous state of hyperalertness ("atypical activation of neurons"), resulting in that harmful stress exposure of

the child. We can see this reality in the image from Perry's *"Childhood experience and the expression of genetic potential: What childhood neglect tells us about nature and nurture"* (Perry, 2002) publication, where the brain scans of two 3-year-old children are compared to show the anatomical difference between a non-neglected brain, and the brain of a child who has been a victim of severe sensory-deprivation. [Attachment 2]

Given all this information about trauma, its factors, their interplay, and its possible outcomes, we can deduce that the negative or adverse effects that can be created by trauma will be significantly more devastating in situations in which the victim - or victims - have less influence or agency in making decision-making about themselves and their direct environment, and may even damage the physical structure of the organs and/or their functioning, resulting in the affected person's vital development being affected. This does not mean that trauma experienced in less critical phases cannot have these effects.

When we speak of trauma, we can only speak of the possibility - or not - that something can become traumatic. In other words, it is not possible to ensure that one event or another will result in trauma, only that it may enhance its creation or, on the contrary, serve to avoid it: the more we reduce risk factors and, in turn, promote protective ones, the smaller the probability of trauma will be. Similarly, the more risk factors a person experiences, and the fewer protective factors they have to cope with the event in question, the more likely they are to develop trauma.

We need to approach trauma from a flexible mindset, thinking that trauma is not a life sentence. But in order to be able to transform something potentially damaging into a useful and positive life skill or experience, we must understand what we are dealing with.

Trauma-Informed Care (TIC)

The idea of implementing a trauma-sensitive lens came from the realization that simply understanding trauma and carrying out individual interventions for traumatized people in the healthcare system was not enough. There needs to be a systemic approach that takes into account all the individuals of the ecosystem, and not only focuses on healing from trauma but also on promoting growth and well-being for all, to optimally target trauma.

This does not stop in the healthcare system and can be applied in other institutions, programs, and organizations across different fields, like education.

As we have seen in the previous section, trauma's effects cannot be attached to the individual who has endured it, but to the whole community and society. Therefore, the interventions must include them as well. We could understand it as "because trauma affects us all, implementing a trauma-sensitive lens benefits us all".

> *"A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.". (SAMHSA, 2014)*

To implement a trauma-informed approach, we must first define the mission and principles we want our practice to be based on. As SAMHSA stated, the ultimate goal is to develop *"a strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment." (SAMHSA, 2014; as seen in Kimberg and Wheeler, 2019)*.

Even if there are many ways in which we can aim at this goal, there has been a general adoption of the "key" assumptions and principles that SAMHSA developed in 2014, which are based on an understanding of; (1) trauma and its effects on a personal and interpersonal level, and (2) healing occurring when we experience stable, safe, dependable, collaborative, empowering, and compassionate relationships that are focused on promoting resilience rather than only mitigating the adverse outcomes of trauma. Because of this, we will center our description of trauma-informed care on them.

The four "R's": SAMHSA's key assumptions

In the first definition, we have provided of what a trauma-informed approach is, SAMHSA underlined four words that represent the key assumptions any organization needs to take into account to implement a trauma-sensitive lens; "Realize", "Recognize", "Respond", and "Resist re-traumatization".

1. *Realize*:

   Every person who is part of the system that implements this approach needs to have a basic understanding of what trauma is, the effects it has on the person who endures it, as well as the society the individual is part of.

   This includes connecting a person's experience of the events and reaction, as dependent elements of the person's available coping skills and resources to survive the situation that is overwhelming their nervous system in any way.

   This results in understanding negative behaviors and reactions to regular situations as a possible maladaptive coping skill a person has developed due to trauma. It also involves taking into account that trauma can result not only from living the event first-hand but also from being exposed to secondary traumatization.

Most importantly, it gives us the perspective that a trauma-informed approach should be adopted in as many systems as possible to maximize the effectiveness, and improve the outcomes in their work.

2. *Recognize*:

   All the participants need to be able to recognize the signs and symptoms of trauma, and the way they might vary according to factors like age, gender, type of trauma, duration of the exposure, or context. Not only in the case of the person who is being treated but anyone who is part of the system (relatives, other professionals, etcetera) around them.

   This will help in detecting traumatization victims and providing treatment as soon as possible, giving higher chances of positive outcomes, as well as, avoiding vicarious traumatization of the rest of the community.

3. *Respond*:

   By applying the principles of TIC in their performance standards, and adapting the answer to the situation to avoid unwanted triggers and promote positive outcomes for everyone involved; resilience for the individual, and vicarious resilience for the community.

   The adaptation in performance will include changes in the (1) language they use with the person and others about the topic, (2) behaviors, and (3) policies, to take into account the experiences of traumatized individuals at all levels.

   The implementation of these changes will require ongoing evidence-based training for all staff members - and a budget to support it -, and leadership that actively promotes this change and provides the needed aid for it.

   By doing this, the community will aim to:

   - provide a psychologically and physically safe environment
   - create a work environment of trust, fairness, and transparency

4. *Resist re-traumatization*:

   A vital part of adopting and implementing a trauma-sensitive lens is actively working to avoid the re-traumatization of any of the participants; patients and staff members alike. This includes creating an environment that aligns with the mission of the organization and promotes the well-being of all members.

   It also involves teaching staff members at all levels to recognize the triggers an individual might have and avoid practices that might make a person relive any aspect of their trauma. For example, staff will avoid leaving a patient alone with a male staff member if they have a history of sexual trauma from a male figure because they understand that this might trigger an adverse reaction from the patient and worsen their current state.

The four “R’s” in child-serving systems

Based on the four assumptions we just described, Barlett and Steber (2019) created their adaptation of them for child-serving systems, which they reflected in a figure. Through it, they re-explain the concepts - realize, recognize, respond, and resist re-traumatization - to suit the context of childhood and childhood trauma. [Attachment 3]

1. *Realize*:

   “the widespread nature of childhood trauma and how it impacts the child’s emotional, social, behavioral, cognitive, brain, and physical development, as well as their mental health.” (Barlett and Steber, 2019). As well as pointing out that the adults around the affected child must be familiarized with the effects of being exposed to someone else’s trauma, and take them into account when planning an intervention.
2. *Recognize*:

   The signs and symptoms of trauma and its variations, while making adults understand that “a child’s challenging behaviors are normal, self-protective, and adaptive reactions to highly stressful situations, rather than viewing that child as intentionally misbehaving.” (Barlett and Steber, 2019). This is a pivotal element to take into account when discussing childhood trauma since a child does not have the same cognitive capacity as an adult to inform us that something is wrong.

   This is consistent with the idea expressed by psychologist Regalado Fernandez during the "Jornadas JO" of the Government of Navarre, in which she states that a child will under no circumstances intentionally act to put the bond they have with an adult at risk. (Oroz and Regalado, 2022)
3. *Respond*:

   By implementing practices that promote recovery and resilience through changes on a personal and institutional level.
4. *Resist re-traumatization*:

   By actively shaping the interventions and physical environment to avoid triggers of their trauma history and prevent new trauma. For example, if a child has suffered sexual abuse where darkness was used as a weapon, teachers will avoid activities that include the sensorial experience of darkness or using a blindfold.

SAMHSA’s six key principles

As SAMHSA (2014) declared and we have mentioned, in a trauma-informed approach there are no fixed intervention instructions, but rather a set of principles that serve as general guidance and can be adapted to different fields.

1. *Safety*:

Providing a sense of physical and psychological safety for all individuals in the system regardless of their position is a priority when implementing a trauma-informed approach. This sense needs to be addressed through (1) the design of the physical space, as well as (2) the interpersonal relationships of all members.

2. *Trustworthiness & Transparency*:

   The institutional steps the organization takes must align with the information they provide their staff and clients, creating transparency in their governance, to create and sustain a sense of trust in all the members of the system.

3. *Peer support*:

   Just as we understand inter-disciplinary work promoting teamwork and support-nets are core elements of professionalism, creating a sense of mutual self-help and peer support from other trauma survivors is vital. This will help in avoiding the dangerous sense of loneliness that many individuals express when processing their experiences exclusively in 1:1 sessions (Oroz and Regalado, 2022).

   In the case of children, the term “peers” differs and includes family members and other adult figures in the life of the child who play a role in their healing.

4. *Collaboration & Mutuality*:

   The goal is to practically demonstrate that healing from trauma happens through meaningful relationships - regardless of the hierarchical position or type of relationship - that create a sense of agency and avoid adverse power dynamics in which the survivor lacks a voice or capacity to participate in decision-making aspects. Every member of the organization is important and plays a different role in the healing of the individual in their own way.

5. *Empowerment, Voice, and Choice*:

   Every member’s experiences and strengths have to be recognized and used as growth tools. The system acknowledges the primacy of the trauma survivors, resilience, and the community’s recovery and healing chances.

   The organization understands trauma as a unifying element for all individuals, and consequently, the management actively works in fostering empowerment in all members.

   Empowerment plays a key role in the design of achieving a trauma-informed approach because it balances the power dynamics that are oftentimes used as a coercive tool for victims by removing the sense of agency in decision-making. This switch creates an environment that allows members to be part of their treatment plan and restore the voice they lost. Staff members and patients become “teammates” rather than hierarchically organized individuals.

6. *Cultural, Historical, and Gender Issues*:

The organization actively works to overcome cultural stereotypes and biases based on gender, ethnicity, sexual orientation, etcetera. While, at the same time, acknowledging the importance those factors might have had in the individual's trauma history. And, due to this, they adapt their service to match the person's specific context, taking into account; culture, gender, ethnicity, race, etcetera, and the historical trauma that these factors can carry.

For the application of these principles to be effective for all members and sustainable over time, SAMHSA (2014) states that they need to be implemented in ten different domains of the system - regardless of the field -; (1) Governance and Leadership, (2) Policy, (3) Physical Environment, (4) Engagement and Involvement, (5) Cross-Sector Collaboration, (6) Screening, Assessment, Treatment Services, (7) Training and Workforce Development, (8) Progress Monitoring and Quality Assurance, (9) Financing, and (10) Evaluation.

An important idea to note is that becoming trauma-informed needs to be understood as a journey that will evolve throughout time and experiences, and give us the capacity to adapt the practices we implement - based on the mentioned principles- to the unique context we find ourselves in to achieve the mission as effectively as possible. The cognitive distortion of all-or-nothing thinking should be avoided; it is always better to do little than nothing at all.

"The four C's": a practical application of trauma-informed care

Based on the principles and components of trauma-informed care that SAMHSA (2014) provided, Leigh Kimberg (Kimberg and Wheeler, 2019) developed a practical approach to implementing it into the clinical field; "The 4C's". This paradigm provides an easy rubric for professionals to create and sustain a calm, supportive, non-judgmental, and resilience-promoting environment for all.

Even if it was created for the healthcare context, the guidance it provides can be applied in the educational field as well. We simply need to adapt the practical examples, to fit our specific needs following the theory Kimberg provides for each "C"; *Calm, Contain, Care, and Cope*.

1. *Calm*:

   Based on the fact that humans have the capacity to biologically "co-regulate" (Reed et al., 2015; Isobel and Angus-Leppan, 2018), professionals can transmit the sense of calmness through modeling and putting calming exercises together to activate the parasympathetic system. This is especially important when working with severely traumatized individuals and children, as their regulation capacities have been affected, and as a result, can develop negative coping skills like dissociating to face stressful situations.

To transmit a sense of calmness, we need to first be in that state, because the clues are not only verbal but non-verbal as well. Therefore, the two lines of communication need to send the same message to avoid a cognitive dissonance that can exacerbate the dysregulation. At the same time, the physical environment plays an important role in this process and should be flexible in adapting the sensory input (noise levels, smells, visual stimulation, etcetera) to the needs of the situation.

2. *Contain*:

   The person should have the agency to decide; when, to whom, and how much of the trauma they want - and feel safe - to share with others. We must never oblige a person to disclose aspects of their trauma history they don't feel ready to talk about.

   As professionals we should; respect each person's timing, show closeness, and let them know you are available for them when they feel ready to talk. In the case of teachers, we must also understand that we do not have the need to know details of a student's trauma history, to provide adequate care to them.

   For educators, this can look like this: " I see that you have big feelings that you don't want to share. That is okay. I want you to know that I am here for you. We can find another teacher (the school counselor) you feel good with if you want.". It also includes letting them talk without asking for further details but giving mindful verbal and non-verbal feedback.

   A pivotal point in this area is to not make a promise we are not 100% sure we will be able to keep because it can worsen the student's trust in adult figures around them, which we should promote.

3. *Care*:

   Having space for self-care and compassion is crucial when taking care of others, for the system to be sustainable over time. If our interventions result in vicarious traumatization, we will not be able to provide adequate help for others without harming ourselves in the process.

   Caring for each other can look like creating a support net, practicing cultural humility, and approaching adverse coping tactics (substance abuse, self-harm, etcetera) from a place of understanding rather than judgment, as we know that the person tried to achieve self-protection from the threat through the tools they had available.

   This can be pictured as changing the question from "How could you do X?" to "It must have been so hard for you to do X". Instead of lecturing the person, we try to show compassion for them and their situation.

4. *Cope*:

Work on developing and promoting the use of positive coping skills, relationships, and professional interventions, that will help in the healing process and promotion of resilience and celebrate their usage.

Coping also involves an understanding that healing from trauma is a long, slow, and rocky process that will not produce big changes, but rather small steps that involve repetition to incorporate into our everyday life.

Trauma-Informed Practices in the education context: TIPE

Trauma-informed schools answer the need to implement systemic changes, practices, and care for students and other members of the community who have been exposed to trauma, which as we have seen is almost a universal experience for humans and affects every aspect of our lives, including school life and academic performance.

As in the case of trauma-informed care in clinical settings, schools that adopt a trauma-sensitive lens base their intervention on SAMHSA's (2014) four key assumptions; (1) the *realization* of the widespread prevalence and impact of trauma, (2) the *recognition* of the signs of trauma exposure, (3) providing a *response* grounded in evidence-based practices, that will be used to(4) *resist re-traumatization* of the members.

As Overstreet and Chafouleas (2016) declare, this allows teachers to implement a trauma-sensitive lens, even when the organizational-level changes are not being implemented, as it does not necessarily involve a curricular adaptation, and can be implemented through a change in the type of relationship a teacher establishes with staff members, students, and their families. But will affect the effectiveness of the implementation as a system-level change is needed to ensure optimal outcomes.

Cole et al. (2013) understand a trauma-sensitive school as one where all its students have a sense of safety and support, and feel welcomed as they are.

Trauma-Informed Teaching

There are different ways to apply the general bases that trauma-informed care provides and can be challenging to explain. To help us with this, we have an outline that provides an overview of the elements of trauma-informed teaching [Attachment 4], and our explanation of the topic will be based on it.

Within trauma-informed education, we can find two different perspectives; the "deficit perspective" (healing), and the "strengths perspective" (growth).

In the first one, the goals are (1) to repair regulatory abilities, and (2) to repair disrupted attachment as well. It understands the intervention from a healing point of view that focuses on the shortcomings students have as a result of experiencing trauma. (Brunzell et al., 2015)

On the other hand, a strengths-based approach takes into account those two domains, and adds a third one; (3) increase psychological resources. This perspective

understands that the students have certain shortcomings due to their trauma history, but doesn't stop there, and also acknowledges the psychological resources available to achieve future success and well-being. (Brunzell et al., 2015)

In other words, from this point of view, the role of the school is not only to aid in the healing process of its students but to also assist in their growth to achieve success and well-being.

TIPE: Trauma-Informed Positive Education

Trauma-informed Positive Education can be defined as a strengths-based approach that combines trauma-informed teaching practices with Positive Education - Positive Psychology applied in the educative context - to provide opportunities for healing and psychological growth. Brunzell et al. (2019) explain that TIPE consists in integrating strategies from trauma-informed education and positive education to educate students who struggle with school as a result of trauma history in their lives.

When implementing a strengths-based model like TIPE into our teaching practices, Brunzell et al. (2015) provide 6 key assumptions:

1. Have developmentally informed high learning expectations and aspirations for students.
2. Provide students with access and opportunities that help them build and increase positive psychological resources. (Keyes, 2002; Seligman et al., 2005, as seen in Brunzell et al., 2015)
3. Understand that the classroom can be the most stable and consistent location for trauma-affected students and can be used as a therapeutic tool. (Perry, 2006, as seen in Brunzell et al., 2015)
4. Well-being can and needs to be taught in school (Seligman et al., 2009, as seen in Brunzell et al., 2015)
5. For the interventions to succeed, students must be developmentally prepared in other affective, interpersonal, and physiological competencies that can be affected by trauma (Schore, 2012, as seen in Brunzell et al., 2015)
6. Positive education is not only useful for *healing* and *growth* of traumatized students but can also help in the development of regulation and healthy attachment if applied through synergetic interactions of upward spirals of well-being.

Positive Psychology in TIPE

1. Two-Factor theory

The need for working on increasing psychological resources came from Keyes' two-factor theory which understands well-being and mental health as separate but related elements as we can see in the graphic Bruzell et al. (2015) provided us with. [Attachment 5]

Through it, Keyes explains that creating mental health is not enough to work on the deficits but to provide students with psychological resources and build on their strengths to access well-being. (Keyes, 2002; Keyes and Annas 2009). From it we can understand that:

a. We cannot promote well-being from a healing approach and need to take a growth mindset that takes into account that there are two different continuums.
b. Individuals who suffer a mental illness can work towards well-being because mental health - where well-being belongs - and mental illness are part of different continuums.

2. *Upward Spirals of Well-Being*

This theory also supports the idea that domain 3 needs to be taken into account when implementing a trauma-informed approach in school, and has been shaped based on a "*self-reinforcing upward spiral of amplifying psychological resources*" that Fredrickson (2001), Lindsley et al. (1995) and Wender (1968) proposed. (Brunzell et al., 2015) [Attachment 6]

It helps us understand the way in which the three domains in a strengths-based approach interact creating not only a cycle but a spiral that grows as the three domains are implemented, furthering their effect over time and increasing the well-being the individual experiences. As Brunzell and his colleagues (2015) state, "*the concept[...] helps to better understand how increases in a student's classroom competency can reciprocally amplify psychological resources such as goal striving or perceived efficacy when facing the challenge of learning within trauma-informed classrooms.*". (Brunzell et al., 2015)

3. *Broaden and Build theory of Positive Emotions*

Following the same line as the previous theory, Fredrickson (2001) added that what fuels the upward spiral is growth in exposure to situations and circumstances that have the capacity of triggering positive emotions.

The first action that will set off a chain reaction is: increasing the regulatory and relational abilities of students (Maruyama, 1963), which need to be sustained adequate learning opportunities for students (Brunzell et al., 2015).

Once we have targeted those two domains, we can work on increasing the psychological resources (Brunzell et al., 2015) through pedagogical goals that include; creating self-awareness of strengths in students (Seligman et al., 2009), and working with activities that promote gratitude (Howells, 2012).

Brunzell et al. (2015) state that if these ideas are taken into account, teachers can consider integrating a strengths-based approach in an explicit manner into their curricular content.

The three domains in the eyes of TIPE

Brunzell et al. (2015) point out that the three domains should be implemented sequentially because they are organized in the same order as the brain's development; regulatory skills, relational capacities, and psychological resources. But without forgetting that the effects will be maximized when the three interact in a synergistic way as we can see in the graphics by Brunzell et al. (2105). [Attachment 6]

1. *Repair regulatory abilities*

   An individual's ability to self-regulate can be affected as a result of trauma exposure. In order to repair them and provide children the capacity of thinking before acting rather than following impulses, we need to create an environment that provides; co-regulatory experiences, opportunities to work on their self-regulating capacities, as well as, situations that promote the identification of difficult and negative emotions, and management of classroom behavior (Brunzell et al., 2015)

   These interventions need to be adapted to the children's specific situation and allow as much practice as possible, increasing the difficulty as children progress.

   This domain can be challenging for teachers, as we are exposed to constant disruptive behavior and need to have the ability to de-escalate a situation in collaboration with the students. To do this in an effective manner, teachers should: avoid punishment and use natural consequences, set and communicate clear limits, and give attention to positive behavior instead of negative. At the same time, teachers should adapt their verbal and non-verbal language to help de-escalate the situation and model calmness for students.

2. *Repair disrupted attachment styles*

   APA (2022) defines attachment as "the emotional bond between a human infant [...] and its parent figure or caregiver" which "is developed as a step in establishing a feeling of security and demonstrated by calmness while in the parent's or caregiver's presence.", and adds "Attachment also denotes the tendency to form such bonds with certain other individuals in infancy ...". It can be understood as our first contact with socialization and the base for our future interpersonal relationships. For students who have a history of childhood trauma, this bond where their caregivers are seen as a "safe haven" is oftentimes broken and individuals lose opportunities to emotionally regulate.

   Crittenden (2008) mentions three key tasks for the development of healthy development; (1) protect and comfort children when they are not able to do so themselves, (2) guide children towards being able to do it themselves, and (3) provide children with opportunities to take developmental responsibility.

Following this idea, our classroom should be *relationship-based* so that when students display challenging behaviors, “teachers can employ attachment principles to continuously present a consistent, proactive, and welcoming invitation to stay in the teacher-student relationship in order to create safe opportunities for learning.” (Brunzell et al., 2015). This connects with the concept of *“unconditional positive regard”* that allows teachers to understand that we should not equal a behavior or emotional state with the value a student has as a person.

3. *Increase psychological resources*

   To work on this area that other deficit-focused trauma-informed approaches don’t elaborate on, Brunzell et al. (2015) opted for Martin Seligman’s well-being theory; PERMA (2011) as a possibility for school settings.

   PERMA consists of 5 domains that contribute to the creation of well-being separately but gain value when implemented as a group. The domains are; (P) positive emotions, (E) engagement, (R) relationships, (M) meaning, and (A) accomplishment.

   1. Positive emotions:

      When working with trauma-affected individuals, we need to put focus on encouraging the prevalence of positive emotions through the proposed experiences, while understanding that they might have a hard time interacting and experiencing them because they are not capable “*of savoring or capitalizing the on the on-flow benefits from resulting positive emotions*”. (Brunzell et al., 2015)

   2. Positive engagement:

      Creating an environment that allows children to concentrate, enjoy and sustain attention with a task will help us immerse students in the learning process. For this, it is important to take into account their interests, and character, while ensuring that students; can complete the task with the skills they currently have, know the goals of what they are doing, know the criteria through which their work will be valued, and receive ongoing and helpful feedback during the process. (Csikszentmihalyi, 1990, as seen in Brunzell et al., 2015)

   3. Relationships:

      Creating positive and nurturing interactions with our students will help us create a positive environment in which children will feel safe, valued, and cared for. In the case of traumatized students, this gains even more relevance as it will act as a tool to re-design their relational skills and provide them with a positive model on which to base their future interpersonal relationships to repair their disrupted attachment.

4. Meaning:

   Rather than looking for a life-changing situation that will provide meaning, we need to see it as an everyday little step towards the recognition of resilience as the mindset to adopt. Teachers will need to give positive feedback to students about it to encourage practice.

5. Accomplishment:

   This idea comes from the thought that all students can succeed, even those with difficulties. This needs to be experienced on a daily basis and can promote hope for traumatized individuals who often struggle to identify their positive outcomes and focus on their mistakes.

   This requires adopting a "*growth mindset*" that understands that everyone can grow and improve with practice and experience, instead of a "*fixed mindset*" that frames students and their abilities as static. This fixed understanding can be seen in common phrases like: "maths is not your thing", "I'm so stupid I made a mistake", or "I will not study for the exam because I will not pass".

   This is another reason for teachers to be mindful about the language used around and with students; our voice becomes their inner voice.

   Failure has to be part of the process and an opportunity to learn, not a dead end.

Pedagogy strategies in Trauma-Informed Positive Education

It is difficult to implement any kind of change in the way we teach. Even more so if we do not have a clear structure of how to introduce the changes in a way that achieves a positive result.

Kennedy (2015) says that teachers need to think about the goals they want to pursue through their work, to decide which pedagogies are most appropriate in their context. He also adds that we should understand our interventions as opportunities to respond to universal and unavoidable practice challenges that all teachers face;

(1) *portraying the curriculum* through meaningful - and comprehensible - experiences and questions.
(2) *enlisting student participation* by ensuring students understand the content, see it as relevant, and can accommodate it in their previous mental schemes.
(3) *exposing student thinking* to know what they understand, don't, and have a wrong understanding of.
(4) *containing student behavior* in a nurturing and positive way.
(5) While *accommodating the personal needs* of the teacher to address the previous four aspects through practices that align with their values, needs, and personalities to create a sustainable practice.

In order to give an answer to these 5 challenges within a trauma-informed positive education approach, Brunzell et al. (2019) created a general guide to allow teachers to implement changes in their practices from a TIPE model. [Attachment 7]

With this graphic, Bruzell et al. (2019) explain that the first step is to introduce TIPE to the staff who will be involved in the change. Once they are familiar with the model, we enter the "DISCOVERY" stage where teachers become familiar with their group and see "*what it currently is"*. Once they know the characteristics of their group, teachers can jump to "DREAM & DESIGN" where they imagine "*what it might be*" (dream) and plan their actions in accordance with TIPE ideas to complete the content of the curriculum; "*what it should be*" (design). After this, in the "ACTING AND OBSERVING" stage, teachers analyze the changes the practices have provoked in their class and collect information for the next stage. Lastly, in "DESTINY & PLAN FORWARD" teachers gather again and reflect on the actions they have implemented and propose more changes for future implementation. And the cycle begins again.

PRACTICAL FRAME

In this case, it was not possible to carry out an intervention based on TIPE in a sequential way due to the circumstances that arose during the practical training at the school. However, it was possible to implement some strategies that could be framed within this model on a personal level. Therefore, in this section we will; (1) describe strategies and techniques that can be implemented in our daily sessions with our students, and, once we know these practices, (2) talk about two experiences lived in the school and the results observed after implementing a trauma-sensitive point of view.

Strategies & resources for our day-to-day practice

1. **De-escalating a situation through the "Triune Brain"**

It is important to note that the theory that Paul MacLaren proposed has been extensively criticized and rejected by the scientific community due to incongruences (Carrillo, 2019), but from an educational perspective, it can be useful to understand and learn how situations can be de-escalated in three steps.

In this theory, MacLean explains that the human is like a combination of three interconnected different brains that follow a specific developmental order and builds up in layers; (1) the reptilian brain or primitive brain, (2) the limbic system or paleomammalian brain, and (3) the neocortex or neomammalian brain. (Kheper, 2020)

1. The "primitive brain" is in charge of our survival skills and takes control of a situation if it is perceived as a threat hijacking the emotional and rational capacities. It triggers the freeze, fight and flight responses.

2. The limbic system is the part of the brain that controls emotions and controls the emotional connections with others. It needs the “primitive brain” to be under control to function, and allows the neocortex to be in charge of our action-taking if regulated.
3. The neocortex is the part of the brain that is responsible for our rational thoughts and decisions, and depends on the other two being stable to be “in charge”.

Even if this is not the scientifically correct explanation, we can follow this three-step technique to de-escalate a relational problem that has arisen in our class. In some cases we will be able to control the situation with the third step, or the second and third, while in others the three steps will be needed. In order to decide this, the teacher will need to recognize the state in which each of the participants of the conflict are.

De-escalation steps:

1. *Remove threat*:
   Remove the children involved from the element that is triggering the fight, flight or freeze response if possible; go to a different space, separate the students if the conflict is between them, etcetera.
2. *Create an emotional bridge with the child*:
   Once the trigger is not there anymore, connect with them on an emotional level to regulate their nervous system; “I am here for you”, “I saw that you didn’t like when X did that to you”, “It’s okay to feel sad/angry because of it”, offer them physical proximity if they want (and respect their space if they don’t)... Model the calmness they have lost in the situation and act as a “safe haven” for them.
3. *Reason with them to look for solutions through natural consequences*:
   When the child is back in a normal state, we can start reasoning with them taking into account their developmental stage; “we can go and talk with X about what happened”, “It was not okay to hit X, what could we do now to make him feel better?”, “what can we do differently if this happens?” and provide positive resources for future situations. Don’t look for blames or enforce punishments, instead, work with logical consequences to solve the problem. “You hit X and she is sad now, what can we do for her to feel better?”.

2. Triangle view

Often when we encounter a student who has reactive behavior, we equate that behavior or problem with the student, understanding them as synonyms, which they are not, and it introduces us into a fixed mindset that we must avoid.

Instead, by applying the "triangle view" we are able to visualize the situation as composed of three independent elements; teacher, student, problem. And thanks to this we can make a change of mindset from "the child *is* a problem" to "the child *has* a problem" and what we have to do is to join with the student to help them to solve it.

This is a simple but effective exercise to put into practice a growth mindset because it allows us to imagine the concept in a visual way and can be helpful when a situation is triggering us as teachers. [Attachment 9]

3. **Mindset change**

Just as with the “triangle view” this is a very simple but effective technique to implement when facing a tough situation in class where we might be getting triggered by the behavior the child is displaying. Instead of thinking “they are *giving me* a hard time”, think “they are *having* a hard time”.

It helps us to stay in a rational position when our buttons are being unintentionally pushed, and it reminds us that children don’t have the same capacity as an adult to communicate what is happening and use what is wrongfully understood as “misbehavior”. It is the way a child has to tell us “hey, I’m not feeling good”, “I am having big emotions and it is scary”, “I need you”. This is particularly important in the case of students with trauma-history as they will be more prone to display these type of behaviors.

4. **Natural consequences vs. punishments**

Following a Positive Psychology approach mistakes should be understood as part of the learning process and an opportunity for an individual to learn. Because of this, replacing punishments (P) with natural consequences (N.C.) into our practice is a logical change to implement.

Natural consequences should be understood as “something that happens as a result of our actions or behaviors” and can look like:

- Spilled some juice during the snack break → takes a piece of paper and cleans it (N.C.) instead of sitting in a corner in silence (P)
- Doesn’t eat the snack → feels hungry (N.C.) instead of not going to the playground for not eating (P)
- Refuses to put the coat → feels cold in the playground (N.C.) instead of not being allowed to play with friends for not following an order (P)

5. **Literature as a resource for teaching emotions from a positive perspective**

Books are an excellent and already used resource for learning. It is a resource that, if properly used, can attract and sustain the attention of children to transmit a message.

In the case of early years, it combines a written message that is complimented by images to allow children to follow the story more easily. It also requires the adult’s ability to verbally transmit the written message and control the child’s attention through it. Because of

this, it can be a comfortable resource for teachers to use and introduce emotions positively and constructively to children.

The characteristics we should take into account when designing or choosing a book for our Early Years students are having; (1) clear and direct iconotext connection, (2) short and simple text - if there's any - with useful/relevant words for the kids to interiorize and use, (3) solid colors that create a big contrast and separated by clear and thick lines, as well as (4) a solid/plain color for the background that is going to help maintain children's attention in the content. And, if we focus on the characters or objects of the images, we should see that; (1) most of them don't portray movement and are static, and (2) don't maintain the size proportion with the real live version of the objects, and (3) have as few details as possible.

With this in mind, two years ago I created a prototype for a children's book that introduced emotions from a positive perspective and based it on "the wheel of emotions" where emotions are not classified into positive or negative and explained that all emotions can be felt; "MY EMOTIONS & I" [Attachment 8]

We first present a relatable character that introduces what the book is going to be about. After that, the structure the book follows for each emotion is:

1. Present an emotion and a situation that triggers it
2. Provide children with an activity to do to experience it. In the case of what we wrongfully understand as negative (anger, sadness, etcetera) provide examples of positive coping strategies (taking deep breaths or looking for comfort in reliable adults)
3. As an interactive element, ask "what about you?" at the end to start the conversation about the student's emotions.

Lastly, the character reinforces the idea that all emotions are valid and we have to take care of all of them.

Many things should be changed for the book to be used in class but it does give us an idea of what a book we create could look like. Creating our own stories - or adapting them - is an option when we cannot find a literature piece that completely suits our needs, and there is a wide range of free tools available online.

6. Flow principle questions for designing activities

When deciding on whether an activity is suitable for our class, there are some questions we can ask ourselves to evaluate it following the flow principles (Brunzell, 2019):

a. Do my students have the skills the completion of this activity requires? Is the activity appropriate for their current developmental stage?
b. Are the goals of the task clear and motivational for our students? Do our students know what they are doing the activity for?

c. Are the rules of the task fair and clear? Are our students aware of them from the beginning?
d. Can the activity capture and sustain our students' attention? Is it attractive to them? Does it take their interests into account to achieve intrinsic motivation?
e. Have I planned specific moments throughout the activity to provide personal feedback?

These questions can help us evaluate the activities we have proposed and provide guidance on; (1) what changes, and (2) in what direction we need to make them. [Attachment 10]

Personal school experiences with a trauma-sensitive lens

Even if I did not have the opportunity to carry out a systemic application of trauma-informed practices during my internships, I did adopt a trauma-sensitive lens when interacting with my students due to the context of the group.

To respect the privacy of the students I will address them as; student 1 and student 2, and will only provide information that is required to understand the context in which the interventions took place.

Description of the initial situation:

- *Student 1*:

  A 4 year old male non-identical twin who did not interact with other students. His body posture was eye-catching as he avoided any eye-contact, had his head down constantly and transmitted the feeling of wanting to take as little space as possible. His facial expression also matched the rest of the body language and expressed sadness. He did not voluntarily talk and when asked questions by the teachers barely emitted any noise; there was no communication. He oftenly had panic attacks when facing normal situations in the school context and did not trust the adults and avoided physical proximity. He never laughed or smiled and did not participate in games with others. He only interacted with his twin during the breaks, and even then, did not interact with anyone else.

  His family situation was harmful as the parents were immersed in a divorce and custody process with allegations of gender-based violence, which had a direct effect on the children.

  The two tutors showed preference for the father and made continuous negative comments about the mother in front of me and with other teachers. Their ultimate goal was “que el juicio se acabe ya”. They did not implement any specific interventions with him. The school’s “solution” for the situation was to propose a school-change to the family.

- *Student 2*:

A 4 year old student who is battling cancer and started coming to school in March 2022. He had to keep his mask on at all times unlike the rest of the students. He was shy and needed encouragement to play with others, but when done, he would interact with them happily in small groups.

As his treatment was still on, he had a permanent tube inserted on the left of his chest, so we had to be mindful of that.

As his energy levels were affected the schedule he followed was flexible, he started staying until the snack break was over (11.45am) and later decided he wanted to stay until the end (2pm). He had control over this and could ask us to call his mother if he was too tired to stay until lunch time. His family was extremely supportive and were in constant contact with the school.

Specific intervention techniques with Student 1:

- Greeted him 1:1 every day even if he didn't reply.
- Stayed close in case he needed me but never entered his personal space.
- When having panic attacks where he would become frozen and tensed his body, I got close to him and sat on the floor to be at his level so that he did not perceive me as a threat.
- In the beginning he would escape and refuse my help. I did not negatively react and stayed as an available figure for him.
- Started interacting with him during the P.E. sessions by introducing myself in the game the kids were playing to gain his trust.
- After interacting with him as part of the group, I carried a 1:1 english activity that allowed me to connect with him more
- Once he started talking, I followed up the conversation without interrupting him and allowing him to talk as much as he wanted, even if this meant that the task took a secondary role.
- Used the 3 steps de-escalating technique to calm him down when a problem arose.
- Provided multiple choices during the activities for him to choose from for him to start having a sense of agency.
- Respected his timing and never pressured him to do things faster.
- When he disclosured delicate information with me; (1) I maintained the same body language and avoided over-reacting, (2) didn't ask him specific questions and only used open questions, and (3) never forced him to share more than what he wanted.
- To avoid a sense on unpredictability, I verbally explained what we were going to do beforehand, and repeated each step before doing it, especially during stressful situations like wetting his pants.
- Applied the "Triangle View" strategy.

- Avoided using punishments and used natural consequences instead.

Specific intervention techniques with Student 2:

- Always got down to his level when interacting with him.
- Flexibilized the classroom rules until he became familiar with them like the others.
- Provided options and respected his choices even if he later changed his mind.
- Aided him in the beginning of his social interactions until he felt comfortable with the other students to play by himself.
- Offered physical contact when asked for.
- Respected his timing and did not pressure him when completing tasks. While also adapting the content as he was behind the rest of the class in some areas like Mathematics.
- Instead of following the booklets, games were introduced when working in areas like English or Mathematics.

Results of the intervention:

Student 1 was still suffering a lot due to the situation he was living and the inaction of the school when alerted about posible sexual abuse, but I managed to create a safe space for him and started seeing improvements in his social skills, trust in adults, and confidence.

He started smiling, laughing and communicating his needs when he wanted help. He also started accepting physical contact from trusted adults and independently played with other students during class and the snack break. His body language oftentimes expressed the sadness of the beginning, but could change throughout the day.

Student 2 was able to independently interact with other students and connected especially well with one of them, so he always had someone to interact with. He started asking to stay until 2pm even if he was tired because he was comfortable and happy in the group. He relied less in the presence of an adult and was able to handle some situations on his own. His language skills improved and was now able to repeat some words and phrases in Basque instead of Spanish. The games we used motivated him to learn and would ask his friends to play with him by saying “Es muy chulo….te enseño a jugar”.

These two students showed me the need to implement a trauma-sensitive approach and the results we can obtain from it. It would have been a good aspect to have the other teachers apply the same perspective but it was not possible to do it in the work environment. This also showed the importance of working on a system level, to not only help students, but also help teachers to manage the situations we might come across.

CONCLUSIONS: A TEACHER'S REFLECTIONS

Una vez analizado la bibliografía obtenida, queda constatado que el trauma es un elemento practicamente universal, que nos afecta a todos, independientemente de quien seamos, ya sea de forma directa o indirecta.

De la misma forma, también ocurre en el caso de los efectos adversos que esta experiencia provoca, pues tienen un impacto directo en el bienestar emocional y físico de nuestro alumnado. Lo que repercute en sus capacidades de aprendizaje, y por consecuencia, en sus resultados académicos, y se traduce en la necesidad de actuación por parte de los profesionales del campo de la educación tanto en su prevención, como en su tratamiento en colaboración con los científicos.

Es necesario que se empiecen a tomar mediadas urgentes a todos los niveles para hacerle frente. Desgraciadamente, como ya sabemos, los cambios a nivel institucional requieren la presión de cambios desde la sociedad, por lo que los cambios a nivel personal son importantes.

Los niños son el futuro, son las personas que formarán parte de la sociedad en el futuro y es nuestro deber como docentes, trabajar para crear una sociedad mejor en la que el bienestar psicologico y fisico de las personas tenga más relevancia que la que tiene ahora a la hora de tomar decisiones.

Ya no es debatible si el trauma tiene la suficiente relevancia para que los docentes - y las instituciones - intervengamos. La respuesta es sí. Si queremos cumplir los Objetivos de Desarrollo Sostenible marcados por la UNESCO, en este caso; salud y bienestar, educación de calidad, y paz, justicia e instituciones sólidas (Educo, 2019), debemos hacer frente al trauma de forma tajante.

La falta de actuación por parte del personal docente frente a esto podría considerarse una forma de negligencia, ejerciendo así un tipo de violencia sobre los menores por la situación de desprotección y vulnerabilidad, e incumpliendo los deberes y obligaciones profesionales que tenemos al permitir que siga sucediendo mediante un silencio complice.

Teniendo esto en mente, el modelo TIPE podría ser una opción viable para implementar en los centros educativos para crear un contexto óptimo que garantice el bienestar de todos para poder así experimentar al máximo las propuestas educativas llevadas a cabo. Como bien afirman Kimberg y Wheeler (2019) "Because trauma affects all of us directly and indirectly, "trauma-informed care" benefits us all".

Pero, para que esto pueda suceder, debe de haber un apoyo a nivel institucional y social que sostenga a las personas de forma colectíva, actuando cómo red de apoyo. Las instituciones deben trabajar para proporcionar medios que permitan poner en marcha y

sustentar estos cambios. Tiene que haber más y mejores servicios publicos para atender las necesidades de las personas de forma efectiva. El construir el mañana se hace ahora.

En futuros trabajos, podría resultar interesante llevar a cabo un estudio y evaluación de practicas que los docentes pueden aplicar a su trabajo para adoptar un enfoque de trauma en el aula. Así como evaluar la posibilidad de crear equipos a nivel de centro que puedan servir de apoyo en estos casos tanto para los menores como para los docentes que esten en contato con ellos, y así reducir las probabilidades de sufrir traumatización secundaria.

REFERENCES

- Substance Abuse and Mental Health Services Administration (2014, July). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. Retrieved from SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach
- Reed RG, Barnard K, Butler EA. (2015). *Distinguishing emotional co-regulation from co-dysregulation: an investigation of emotional dynamics and body-weight in romantic couples*. Emotion (Washington, DC).
- Isobel S, Angus-Leppan G. (2018). Neuro-reciprocity and vicarious trauma in psychiatrists. *Australias Psychiatry*.
- Kimberg, L., Wheeler, M. (2019). *Trauma and Trauma-Informed Care*. In: Gerber, M. (eds) Trauma-Informed Healthcare Approaches. Springer, Cham.
- Courtois CA, Ford JD (2009). *Treating complex traumatic stress disorders: an evidence-based guide*. New York: The Guilford Press.
- Saakvitne KW, Pearlman LA (1996) *Transforming the pain: a workbook on vicarious traumatization.* New York: W. W. Norton and Company.
- De Bellis, M. D. & Zisk, A. (2014). The biological effects of childhood trauma. *Child and Adolescent Psychiatric Clinics of North America*, 23(2), 185-222.
- Enlow, M., Blood, E., & Egeland, B. (2013). Sociodemographic risk, developmental competence, and PTSD symptoms in young children exposed to interpersonal trauma in early life. *Journal of Traumatic Stress*, 26(6), 686–694.
- Lieberman (2004). Traumatic stress and quality of attachment: Reality and internalization in disorders of infant mental health. *Infant Mental Health Journal*, 25(4), 336–351.
- National Child Traumatic Stress Network. (2003). *Complex trauma in children and adolescents: White paper from the National Child Traumatic Stress Network Complex Trauma Task Force*. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress. Complex Trauma in Children and Adolescents
- Ortiz-Ospina, E. (2017, December 17). *Child maltreatment and educational outcomes*. https://ourworldindata.org/child-maltreatment-and-educational-outcomes
- Romano, E., Babchishin, L., Marquis, R., & Frechette, S. (2015). Childhood maltreatment and educational outcomes. *Trauma, Violence, & Abuse*, 16(4), 418-437.
- Perry, B. D. (2002). Childhood experience and the expression of genetic potential: What childhood neglect tells us about nature and nurture. *Brain and mind*, 3(1), 79-100.

- Eriksson M., Ghazinour M., & Hammarström A., (2018). *Different uses of Bronfenbrenner's ecological theory in public mental health research: what is their value in guiding public mental health policy and practice?.* Soc Theory Health (2018) 16:414-433. https://doi.org/10.1057/s41285-018-0065-6

- The Center for Child & Family Well-Being (2021). *The Bioecological Model. Exploring how children's relationships and environment interact to help them thrive*. Psychology Department of the University of Washington. https://ccfwb.uw.edu/about-us/the-bioecological-model.

- Save the Children España (2019). *"Más me duele a mí. El maltrato que se ejerce en casa"*. Save the Children España: "Más me duele a mí. El maltrato que se ejerce en casa".pdf

- Oroz L. and Regalado E. (2022). *JO! Jornadas Bienestar Emocional SI ME JUZGAS, NO ME VES Lidia Oroz y Estefanía Regalado*. Juventud INJ - NGI Gazteria . YouTube. https://youtu.be/HbPMDAsFfAQ

- Overstreet, S., Chafouleas, S.M. (2016). Trauma-Informed Schools: Introduction to the Special Issue. *School Mental Health* 8, 1–6 (2016). https://doi.org/10.1007/s12310-016-9184-1

- American Psychological Association (2022). *Apa Dictionary of Psychology*. American Psychological Association. https://dictionary.apa.org/attachment

- Crittenden, P. M. (2008). *Raising parents: attachment, parenting, and child safety*. Abingdon, UK: Routledge/Willan.

- Seligman, M. (2011). *Flourish*. London: Nicholas Brealey Publishing.

- Keyes, C. (2002). The mental health continuum: from languishing to flourishing in life. *Journal of Health and Social Behavior*, 43(2), 207–222.

- Keyes, C., & Annas, J. (2009). Feeling good and functioning well: distinctive concepts in ancient philosophy and contemporary science. *Journal of Positive Psychology*, 4(3), 197–201.

- Fredrickson, B. L. (2001). The role of positive emotions in positive psychology: the broaden-and-build theory of positive emotions. *American Psychologist*, 56, 218–226.

- Seligman, M. E. P., Ernst, R. M., Gillham, J., Reivich, K., & Linkins, M. (2009). Positive education: positive psychology and classroom interventions. *Oxford Review of Education*, 35, 293–311.

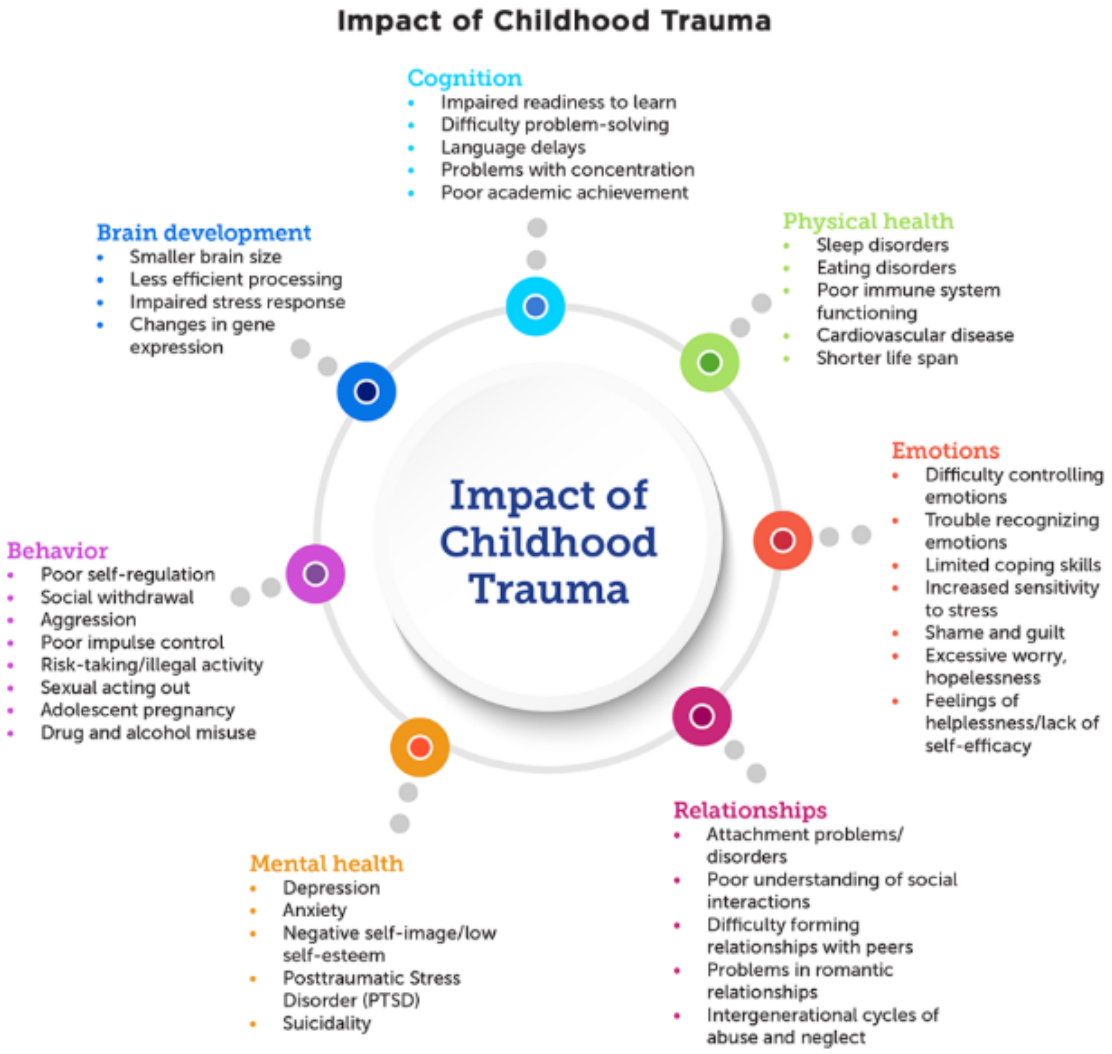
- Howells, K. (2012). *Gratitude in education: a radical view*. Rotterdam: Sense Publishers.

- Brunzell T., Stokes H., Waters L. (2019). Shifting Teacher Practice in Trauma-Affected Classrooms: Practice Pedagogy Strategies Within a Trauma-Informed Positive Education Model. *School Mental Health* (2019) 11:600–614 https://doi.org/10.1007/s12310-018-09308-8

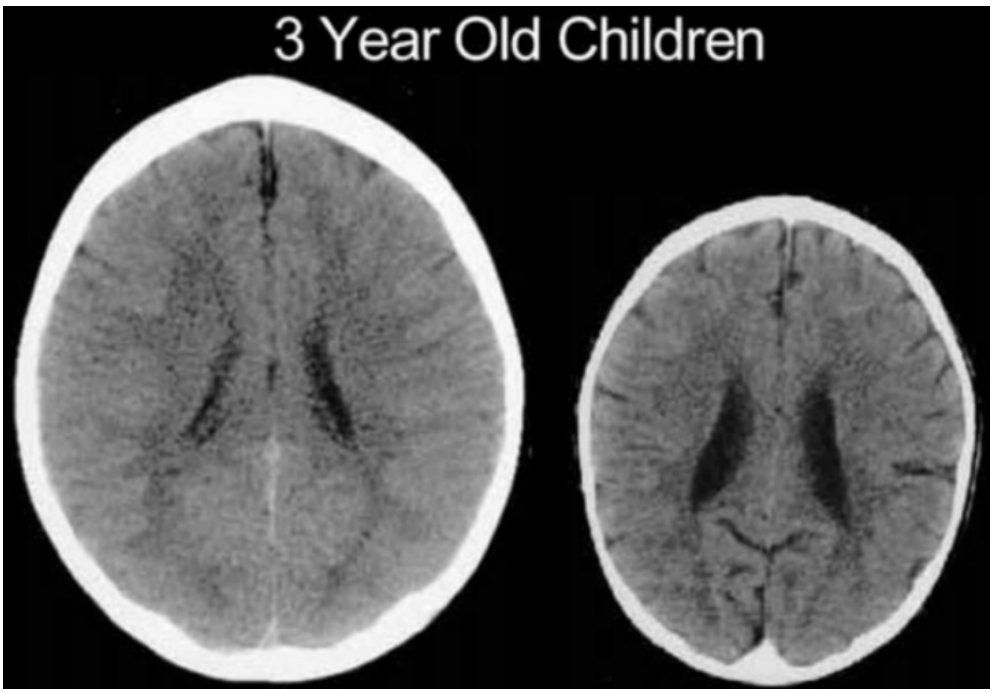
- Kennedy, M. (2015). Parsing the practice of teaching. *Journal of Teacher Education*, 67(1), 6–17.
- Kheper (2020). *The Triune Brain*. https://www.kheper.net/topics/intelligence/maclean/
- Carrillo A. (2019). *La teoría del cerebro triuno de MacLean: qué es y qué propone*. Psicología y Mente. https://psicologiaymente.com/neurociencias/teoria-cerebro-triuno-maclean
- UNICEF (2018). *10 derechos fundamentales de los niños, por Quino*. UNICEF America Latina y El Caribe. https://www.unicef.org/lac/historias/10-derechos-fundamentales-de-los-ni%C3%B1os-por-quino
- Educo (2019) *Qué son los 17 Objetivos de Desarrollo Sostenible y la Agenda 2030*. https://www.educo.org/blog/Que-son-los-17-Objetivos-de-Desarrollo-Sostenible?utm_source=google&utm_medium=cpc&utm_campaign=educo_brand_dsa&utm_term=kw&utm_content=text&tc_alt=64115&n_o_pst=n_o_pst&n_okw=___c_103267085027&gclid=EAIaIQobChMInOvVueiA-gIVa49oCR1PBAI5EAAYASAAEgJ-pvD_BwE

ATTACHMENTS

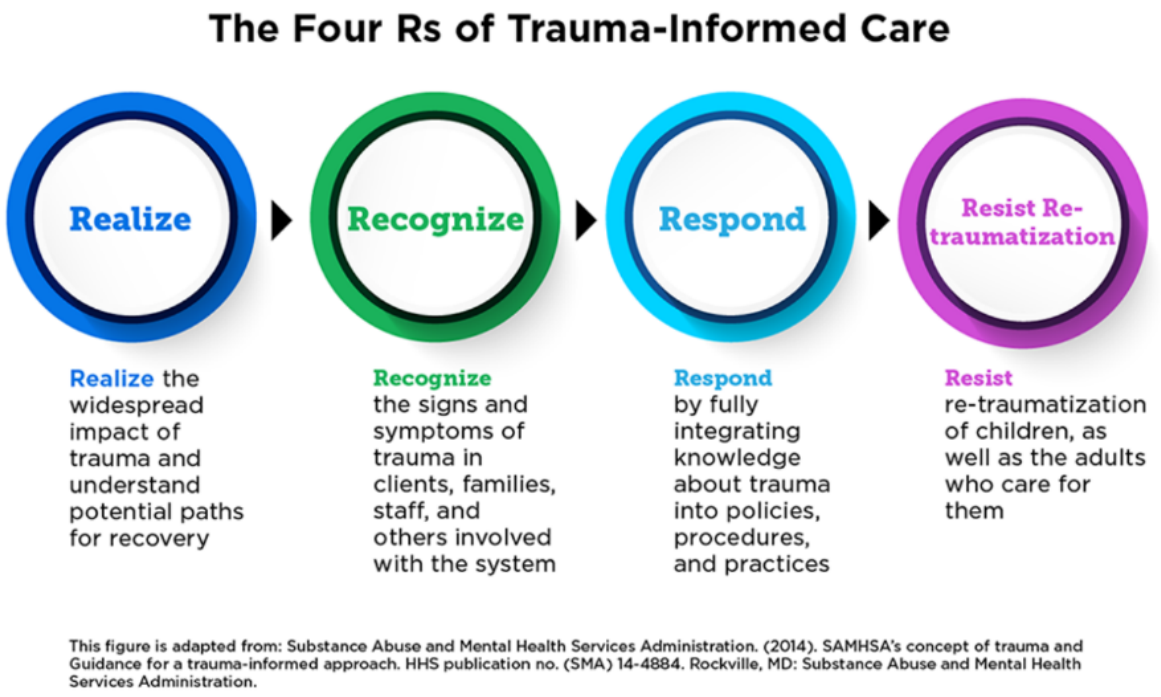
1. The Impact of Childhood Trauma



2. CT Scan (Perry)

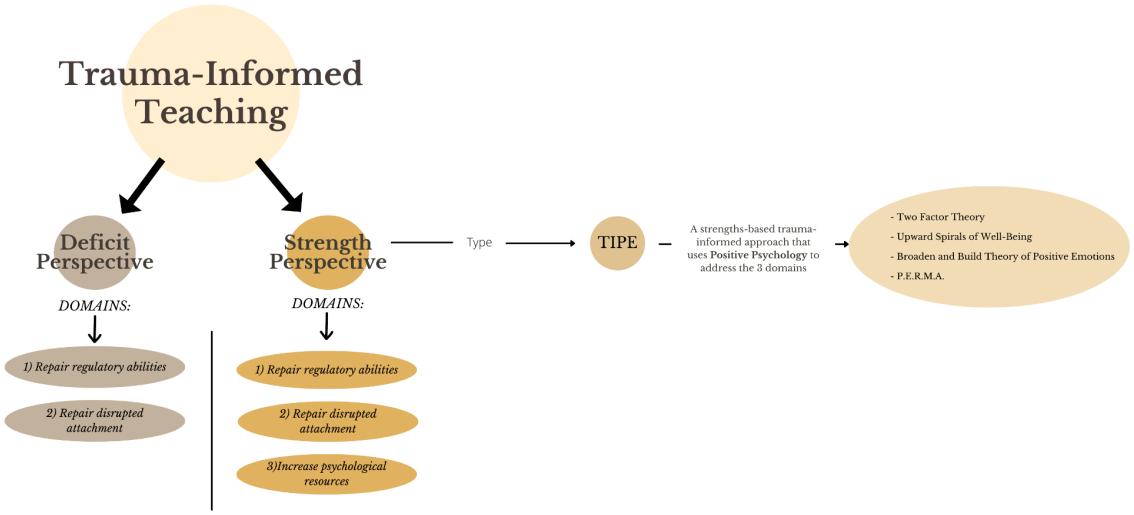


3. **The four Rs of Trauma-Informed Care in child-serving systems**

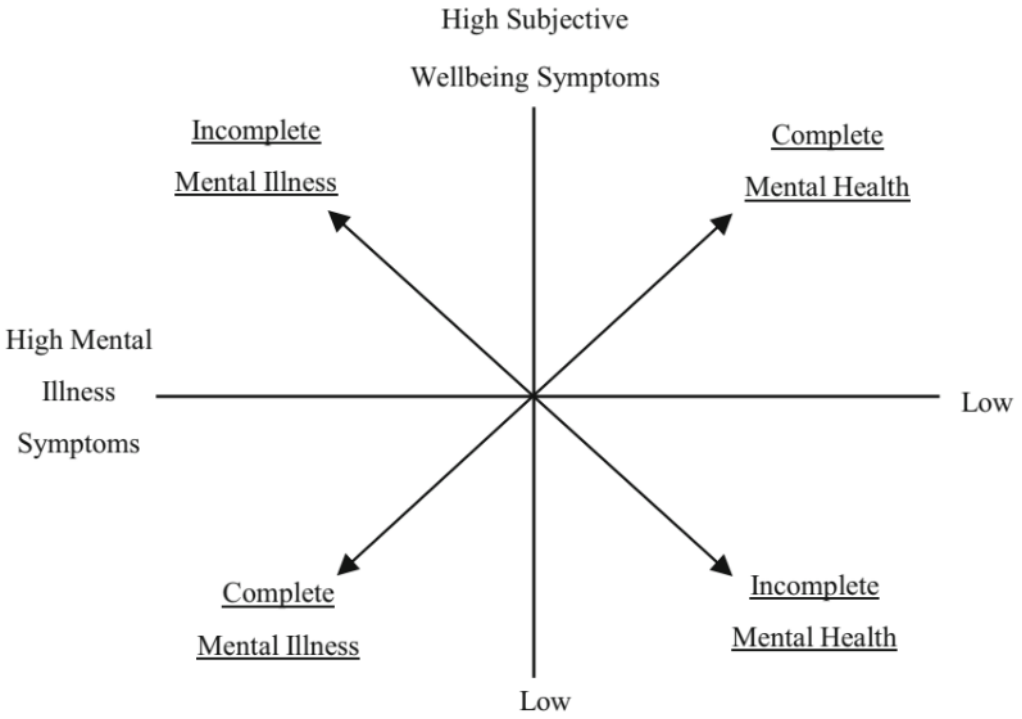


This figure is adapted from: Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's concept of trauma and Guidance for a trauma-informed approach. HHS publication no. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration.

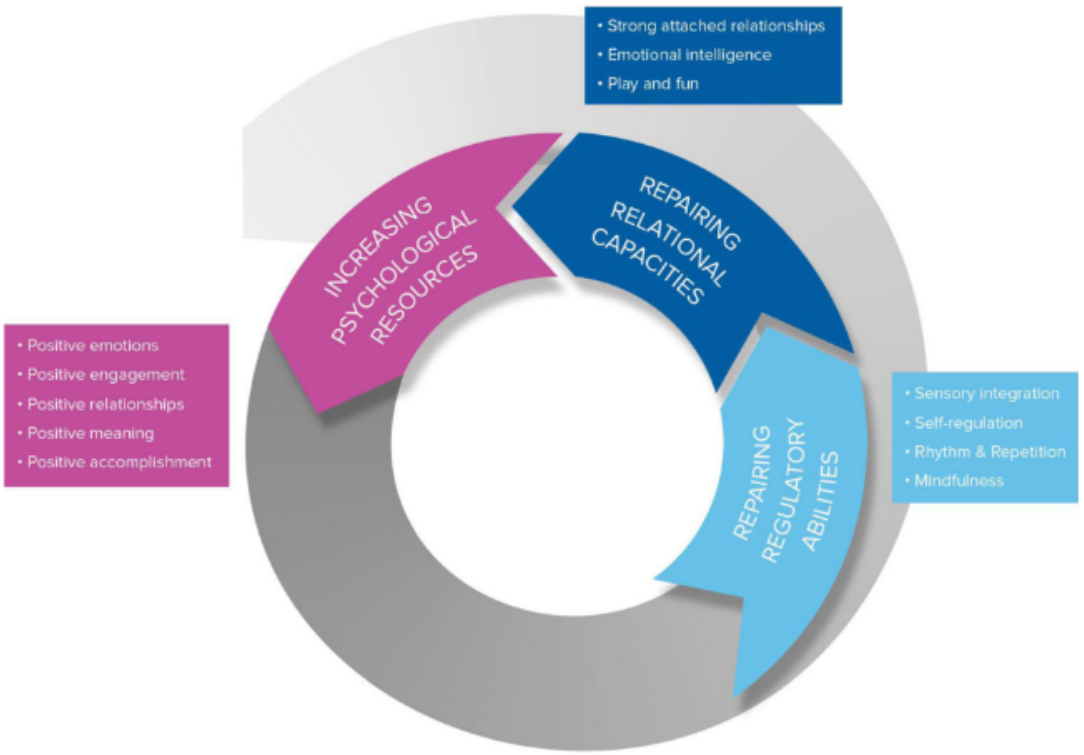
4. **Trauma-Informed Teaching**

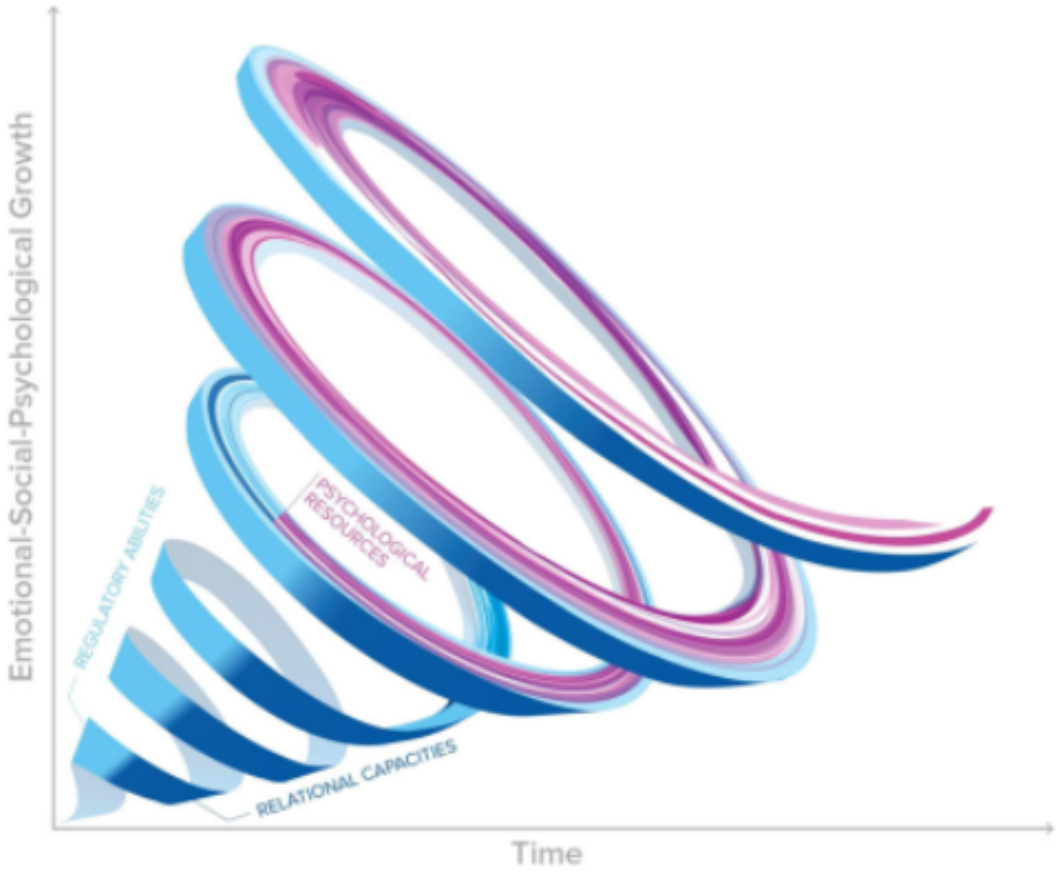


5. The mental health and mental illness: the complete state model

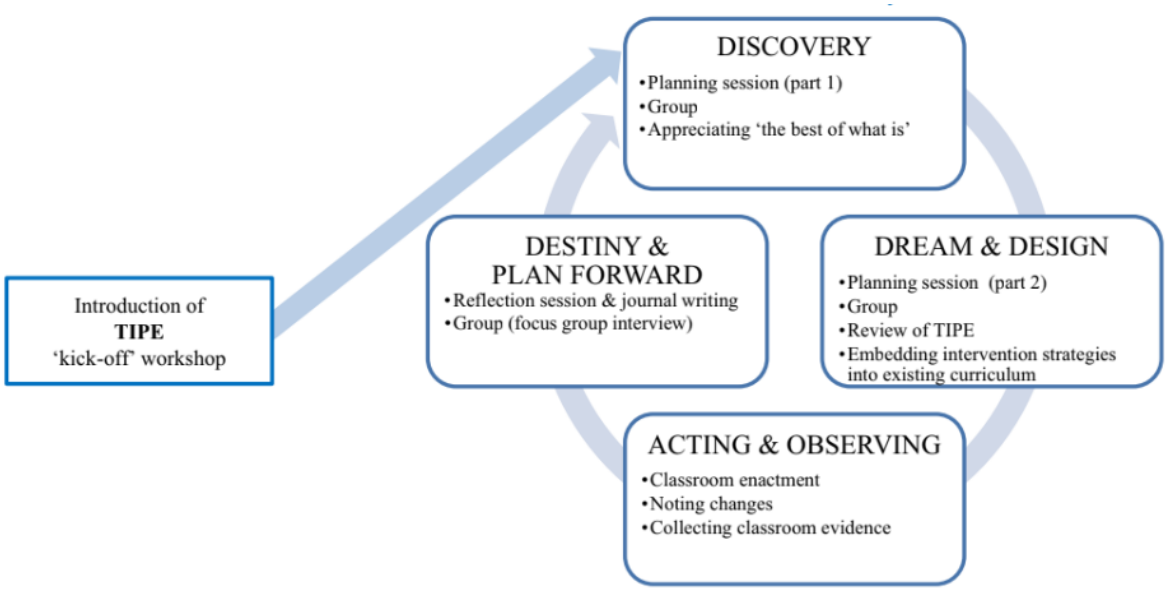


6. The 3 domains and their synergistic interaction in TIPE



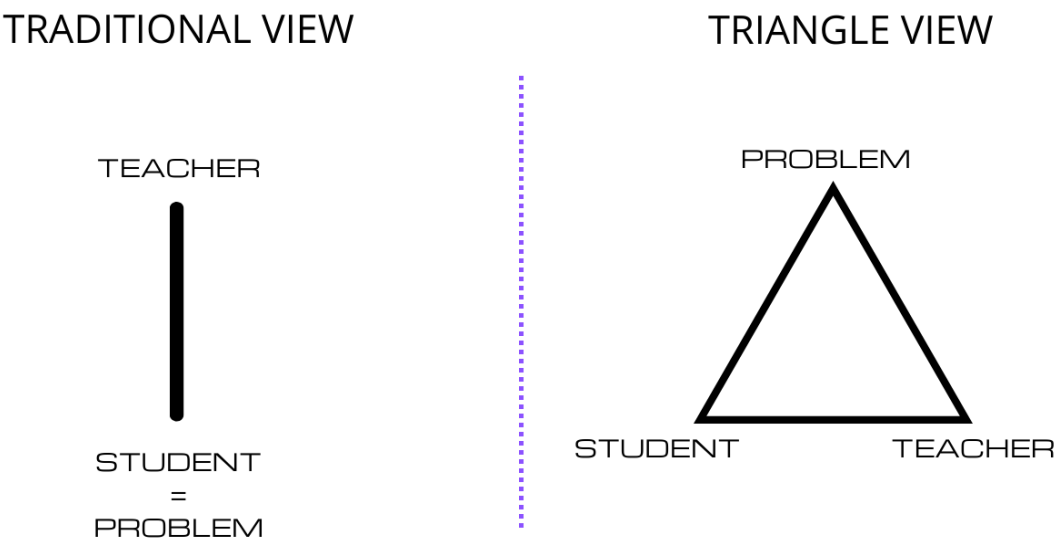


7. Action reflection research cycle

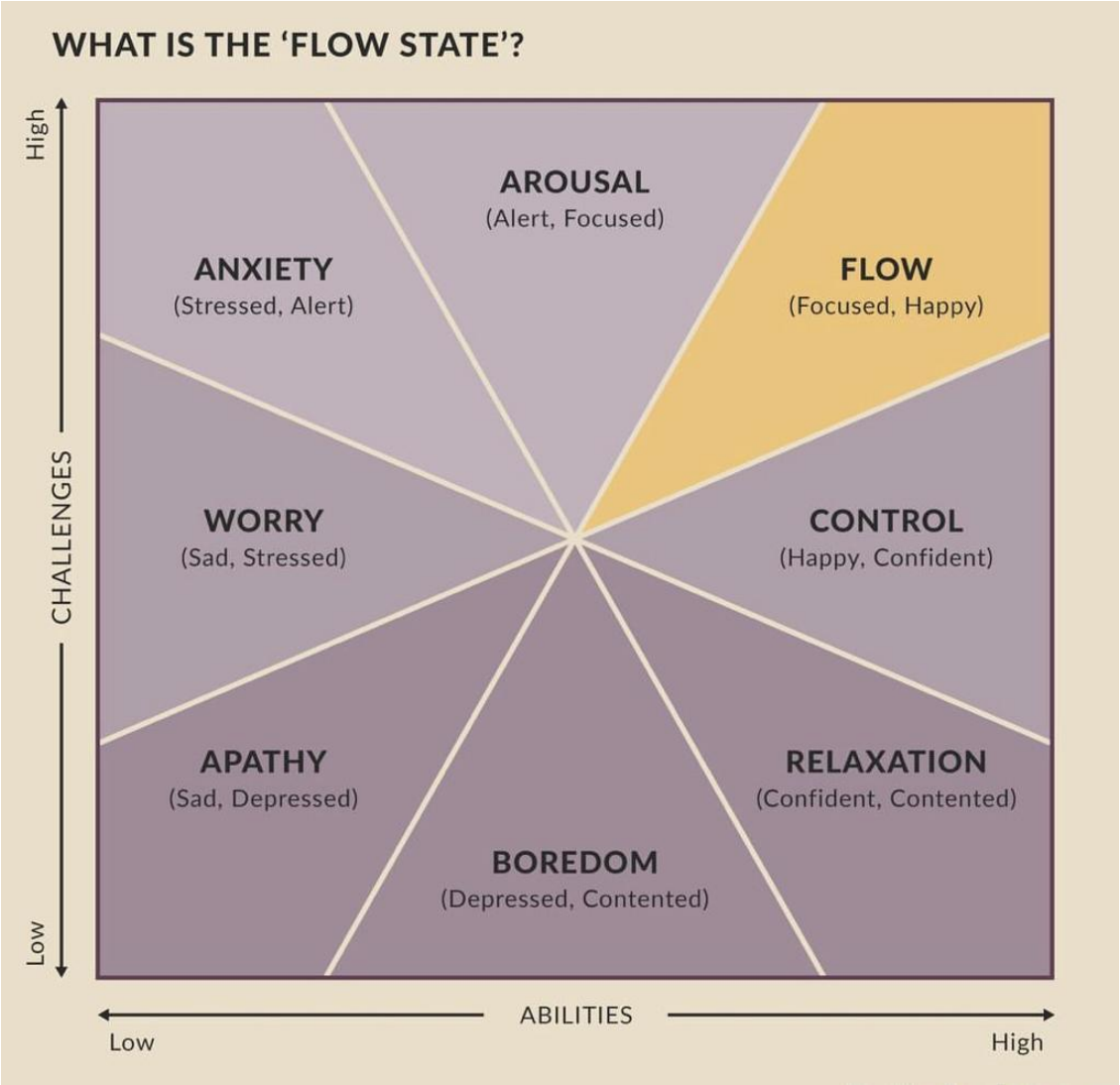


8. **Action reflection research cycle "MY EMOTIONS & I" book**
   [My emotions & I - Irantzu Ezpeleta Isaba]

9. **The triangle view**



10. **Flow state graphic (www.positivepsychology.com)**


WHAT IS THE 'FLOW STATE'?
High
CHALLENGES
Low
AROUSAL
(Alert, Focused)
ANXIETY
(Stressed, Alert)
FLOW
(Focused, Happy)
WORRY
(Sad, Stressed)
CONTROL
(Happy, Confident)
APATHY
(Sad, Depressed)
RELAXATION
(Confident, Contented)
BOREDOM
(Depressed, Contented)
ABILITIES
Low
High