

SCHOOL COUNSELORS' PERCEPTIONS OF TRAUMA-INFORMED APPROACHES IN
SCHOOLS

by

Elizabeth Burkhardt

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

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School of Behavioral Sciences

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APPROVED BY:

Suzie Johnson, Ph.D., Committee Chair

Kelly Gorbett, Ph.D., Dissertation Reader

ABSTRACT

Adverse childhood experiences affect millions of children and adults on a daily basis and this results in many people who are unable to effectively navigate the pathways of life to lead a productive life. Schools are in an ideal position to intercede and provide trauma-informed care to children who are experiencing academic or behavioral problems by providing programs aimed at decreasing the effects of these adverse experiences. One such program being implemented is the multi-tiered support system (MTSS) programs, which is incorporated into the entire school day of all students. Interventions are provided in tiers which correspond to the needs of each student. Evidence-based interventions are provided while the results are monitored and used to provide further assistance. School counselors are an integral part of the MTSS team, which includes PBIS and RtI components, but often they do not receive the necessary training. When school counselors are adequately trained, they function as a team member and this increases the amount of time counselors can spend on other important activities.

Keywords: trauma; school counseling; trauma-informed care; training

Dedication (Optional)

I would like to thank the Lord my God for providing me with the tools necessary to complete this dissertation. Without him, I am nothing.

I would also like to thank my wonderful husband for his constant support and unwavering love during this process. God know what he was doing when he joined us together. Forever and always, Don!

Acknowledgments (Optional)

I would like to thank my chair, Dr. Suzie Johnson, PhD for her guidance and boundless encouragement throughout the dissertation process. I would also like to thank Dr. Kelly Gorbett, PhD for serving as my reader and cheerleader. You were both handpicked by the Lord to serve in these capacities and I will forever be thankful for all you have done. God bless!

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List of Abbreviations and Terms

The following definitions are provided to ensure the uniformity of these terms as they were used in this particular study. These definitions were developed to reflect the manner in which the terms are used specifically in this study, keeping in mind the way the terms are used in the professional literature.

Adverse Childhood Experiences (ACES) - Adverse Childhood Experiences (ACES) is the term used to describe all types of abuse, neglect, and other potentially traumatic experiences that occur to people under the age of 18. Adverse Childhood Experiences have been linked to risky health behaviors, chronic health conditions, low life potential, and early death.

American School Counselor Association (ASCA): A professional organization that provides support and professional development for school counselors (ASCA, 2017).

ASCA Mindsets & Behaviors for Student Success: New standards that replaced the ASCA National Standards (ASCA, 2004) and are aligned with U.S. academic standards for better standard overlap (ASCA, 2014).

ASCA National Model: A framework that provides guidelines for a systematic, data-driven set of programs (i.e., individual counseling, classroom counseling, groups, college planning) that are designed to enhance the educational experience of all students. The framework 15 contains four main parts: foundation, management system, delivery system, and accountability (ASCA, 2012).

ASCA National Standards: A set of standards and indicators that are intended to guide school counselors in their development of comprehensive school counseling programs, focused on the academic, social/emotional development, and career domains (ASCA, 2004).

Certified school counselor: An individual with a master's degree in school counseling and who is certified by his or her state department of education to work as a school counselor (ASCA, 2015).

Closing the gap action plans: Plans school counselors develop to assist in closing the achievement gap of an identified population (ASCA, 2012).

Closing the gap action plan results report: A report that illustrates the impact and outcome of closing the gap action plan (ASCA, 2012).

Comprehensive school counseling program (CSCP): A systematically developed combination of services (i.e., classroom guidance, individual counseling, group counseling, response services, and college planning) school counselors provide for students. These services are driven by data and are based on the ASCA National Standards (ASCA, 2017).

Indirect student services: These services consist of activities (i.e., advocacy, consultation, collaboration) performed by school counselors on behalf of students. These services might include advocacy, consultation, and collaboration with teachers, administrators, or families (ASCA, 2017).

Individual student planning: A set of ongoing systematic activities coordinated by school counselors designed to help students develop goals and prepare for their future (ASCA, 2017).

Multi-tiered System of Support (MTSS): A Multi-Tiered System of Supports (MTSS) is a systemic, continuous improvement framework in which data-based problem-solving and decision making is practiced across all levels of the educational system for supporting students.

Positive Behavior Intervention and Supports (PBIS): The broad purpose of PBIS is to improve the effectiveness, efficiency, and equity of schools and other agencies. PBIS improves

social, emotional, and academic outcomes for all students, including students with disabilities and students from underrepresented groups.

Responsive services: Activities (i.e., individual counseling, small groups, or crisis intervention) performed by school counselors that meet the immediate needs of students (ASCA, 2017).

School district: A set of schools in a geographical area governed by a local board of education (Your Dictionary, n.d.).

State school counselor association: A state-level branch of ASCA that provides support and professional development for school counselors within a given state (ASCA, 2015).

State department of education: The state-level government department that provides support and leadership for students, parents, and educators with a given state.

Trauma-informed care (TIC) - 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)

CHAPTER ONE: INTRODUCTION

Overview

Adverse childhood experiences (ACEs) are an all too common phenomenon in society today. A strong relationship exists between the number of adverse childhood experiences and adult health risk factors for the leading causes of death. The more trauma endured, the higher the number of chronic conditions, and the lower the quality of life and life expectancy (Felitti et al., 1998). Children affected by trauma have equally debilitating issues in school. Researchers reported early exposure to ACEs in infancy and before children attend school has an adverse effect on their ability to achieve academically. ACE's before the age of three shows a increased need for an IEP by first grade, therefore, the earlier interventions for toxic stress start, the better the outcome for the child (McKelvey, Connors Edge, Mesman, Whiteside-Mansell, & Bradley, 2018). School is an optimal setting to address childhood trauma because educational staff members consistently interact in the lives of students. Baweja et al. (2016) found training school personnel to deliver trauma-informed focused programs achieved better outcomes for children affected by trauma

Background

According to the National Child Traumatic Stress Network (2017), children who suffer from one or more traumatic events can experience long-lasting reactions affecting their daily lives. Some of these reactions include intense and ongoing emotional upset, depressive symptoms, anxiety, problems with behavior, self-regulation, trouble relating to others, forming attachments, nightmares, and other somatic symptoms. They may also struggle with focusing on tasks causing academic difficulties. Nationally 13% of all children are survivors of abuse or neglect, while the lifetime prevalence is one in four children (Finkelhor, Turner, Shattuck, Hamby & Kracke, 2015). Given these

statistics, it is important to be aware of the prevalence, to assist in providing interventions to lessen the severity of symptoms and the issues that follow.

Trauma-informed care (TIC) has become a widely accepted approach in the area of human services and counseling. Strand, Popescu, Abramovitz, and Richards (2016) determined the need to develop a specific conceptual framework to help guide implementing TIC initiatives in communities and schools. Not all schools identify and treat trauma in the same manner and some schools may not even be aware of nor address this rampant and devastating dilemma of childhood trauma. School psychologists, school counselors, and school social workers seek concrete ways to provide service delivery options for students who survived trauma, however, there are barriers to employing trauma-informed care in schools.

Lokeman (2011) specifically discussed the role of school counselors in providing trauma-informed care in schools. The author suggested conducting more research to determine the extent graduate programs of school counselors include trauma response training. Furthermore, additional studies can reveal the importance school counselors assign to providing trauma-informed care given their frequent interactions with children adversely affected by childhood experiences.

Problem Statement

Potentially **injurious** childhood experiences can deleteriously influence every aspect of human life, thereby requiring increased public awareness to lower the incidence rate and detrimental outcomes of victims (Metzler, Merrick, Klevens, Ports, & Ford, 2017). One third to one-half of the children exposed to trauma demonstrated impairments in self-regulation areas such as affect dysregulation, information processing, attention/concentration, self-conceptualization, and behavior (Spinazzola, Ford, Zucker, Bessel & van der Kolk, 2005). This highlights the need to address the negative effects of trauma, however, minimal empirical literature exists. The dearth of systemic and

ecologically focused conceptualizations underscores exigent circumstances requiring further investigation. Holistic interventions target all aspects of a child's life, including education, medical care, and other mental health services. They would also include paying special attention to safety in the home, social and community settings (Soleimanapour, Geierstanger, Claire & Brindis, 2017).

Children feel the influence of adverse experiences early throughout their lives. The effects experienced instantaneously during childhood can result in long-term effects, realized well into adulthood. Bethell, Gombojav, Solloway, and Wissow (2016), underscored the far-reaching effects of childhood experiences. Nearly half of the total population of children in the United States experience an adverse childhood experience and approximately 22% encounter more than one. Given the associated negative outcomes of ACE's and the vast, far-reaching influence they can have, researchers felt it prudent to identify affected children and secure the needed assistance and interventions to mitigate the long-term effects.

Another problematic barrier children face when exposed to adverse childhood experiences is developmental difficulties caused by atypical brain development (Blick & Nelson, 2016; Perry, 2002). Specifically, the developing child may have a smaller brain volume, changes in the structure of the brain, and differences in the development of the amygdala and the hippocampus (Blick & Nelson, 2016; Perry, 2002). When these brain difficulties occur, children, display emotional and cognitive deficits.

While analyzing the 2011-2012 National Survey of Children's Health, Bethell et al. (2014) found children with adverse experiences during their developmental processes had lower levels of school engagement and higher rates of chronic diseases. The more ACE's a student experienced lower the attendance rates, along with less success in reading, writing, and math. Poor educational and behavioral outcomes resulted in populations of children dealing with ACE's (Porche, Costello, &

Rosen-Reynoso, 2016; Romano, Babchishin, Marquis, & Frechette, 2015). Blodgett and Lanigan (2018) purported awareness of students' adverse childhood experiences was important in helping children succeed in multiple aspects of their lives. Traditionally, educational systems focused on academics, and did not address the role of mental stability in the lives of the students. With vast amounts of research delineating the deleterious effects of childhood trauma, the systems perspective of treating trauma expanded to include school as an important element requiring redress.

Purpose Statement

I intend to explore professional school counselors' training and attitudes/self-efficacy toward trauma-informed practice/care utilizing quantitative methodology. Using a descriptive research design, I will investigate two research questions. I pose the first question to allow me to explore the type and amount of trauma-informed care/practice training professional school counselors participated in during and after their graduate studies. The second research question I targeted to examine professional school counselors' perceived attitudes/self-efficacy toward providing trauma-informed care in school settings. Using a predictive correlation design, I will probe to what extent, if at all, years of experience as a school counselor, trauma-informed care training in graduate school, and participation in trauma-informed practice professional development activities or in-service experiential activities predict professional school counselor's perceived attitudes/self-efficacy toward providing trauma-informed care in school settings.

Significance of the Study

I intend to unveil factors related to treatment modalities for the vast number of children who suffered various traumas but for numerous reasons, have not benefitted from previous interventions. Crosby, Howell, and Thomas (2018) found awareness of trauma triggers for students and trauma training for staff are both important parts of a school trauma-informed program. The researchers'

rationale included capturing evidence of the children's experiences as they attend school regularly for 6-8 hours a day, 10 or more months a year. School counselors can be invaluable assets in providing trauma-informed programs, given their knowledge in administering to traumatized populations. However, Lokeman (2011) found they exclude them as part of multidisciplinary teams. As many school counselors are trauma-informed trained facilitators, they are also familiar with the curriculum making it possible to lessen the achievement gap for students who have been traumatized (Day et al., 2015). Baweja et al. (2016) conferred children affected by trauma demonstrated better outcomes when all school personnel receives training to deliver trauma-informed focused programs. They suggested their consistency in the students' lives contributed to improved academic achievement (Baweja et al., 2016).

Research Questions

RQ1: What training do professional school counselors' have trauma-informed care in a school setting?

RQ2: What are the professional school counselor's attitudes toward providing trauma-informed care in a school setting?

RQ3: What are professional school counselors' levels of self-efficacy in using trauma-informed care in a school setting?

RQ4: To what extent are (a) years of experience as a school counselor, (b) participation in trauma-informed care training in graduate school, (c) participation in trauma-informed practice professional development activities, and (d) participation in trauma-informed practice in-services predictive of professional school counselors, perceived attitudes toward providing trauma-informed care in a school setting?

RQ5: To what extent are (a) years of experience as a school counselor, (b) participation in trauma-informed care training in graduate school, (c) participation in trauma-informed practice professional development activities, and (d) participation in trauma-informed practice in-services predictive of professional school counselors' self-efficacy in providing trauma-informed care in a school setting?

Summary

The goal of this study is to understand school counselors' perceptions about their role in treating childhood trauma to mitigate the effects of adverse childhood experiences. Different programs attempt to meet the needs of these students such as school-based groups (Thompson & Trice-Black, 2012), school-based psychological evaluations (Wong, Rosemond, Stein, Langley, Kataoka & Nadeem, 2007), bounce back initiative (Santiago et al., 2018) social-emotional learning (Taylor, Oberle, Durlak, & Weissberg, 2017) and engaging parents (Santiago Pears, Baweja, Vona, Tang, & Kataoka, 2013). However, those implementing trauma-informed care initiatives overlook involving key school personnel. School counselors are well-positioned to identify children struggling with traumatic experiences who do not seek help (Fryman & Mayor, 2017). They can provide key individualized services to affected student populations (Fryman & Mayor, 2017). Although often excluded, well positioned school counselors advocate for and provide information to multidisciplinary teams concerning students affected by ACEs.

Using an ecological approach embraces including all the systems in a person's or child's world because they act together in formulating collective life-long experiences (Crosby, 2015). Researchers determined a holistic focus can be useful when attempting to infuse trauma-informed approaches in school settings. They found it necessitated all staff to become aware of trauma and how it evidences in students' lives (Crosby, 2015). Being aware of trauma triggers for students and trauma

training for staff are important parts of school trauma-informed programs. School counselors are invaluable assets for providing trauma-informed interventions (Crosby et al., 2018). Viewing school systems through a social injustice perspective lens can illuminate the suffering of groups of students often neglected and do not feel empowered to make changes in their lives. Implementing a different approach gives them access to social, emotional, and academic interventions to better support them (Crosby et al., 2018).

School counselors can be helpful by providing effective counseling, which can also serve as a protective factor for students (Lapan, Wells, Petersen, & McCann, 2014). However, school counselors received less training in working with trauma than counselor educators, even though school counselors were significantly more likely to report that it was an important part of what they do (Lokemon, 2011). RB-Banks and Meyers (2017) believed it was important to open the doors of the schools to mental health professionals to form a collaborative response to the adverse childhood experiences of the students. Mental health professionals can help school personnel understand trauma, along with strategies to use in identifying and addressing the multiple levels of disabling conditions, which emerge from the deleterious experiences. When all systems work in a united fashion, adaptation of trauma interventions for programs such as multi-tiered systems of support (MTSS), response to the intervention (RTII), and school-wide positive behavior support (SWPBIS) programs can work towards the common goal of assisting students currently enduring the effects of adverse childhood experiences. School counselors can contribute to the body of knowledge directed towards helping to shape and define trauma-informed care practices in educational environments.

CHAPTER TWO: LITERATURE REVIEW

Overview

Childhood trauma has become a frequent occurrence in our society. In a recent study completed by Blodgett and Lanigan (2018), almost half of the children in the study reported having at least one adverse childhood experience (ACE). The more adverse childhood experiences a student suffered, the lower their rate of attendance at school, along with noted behavioral challenges. The authors also expressed how ACEs experienced by students lessened achieving academic progress, specifically in the core subjects of reading, writing, and math. I aim to explore the perceptions of school counselors in their self-efficacy in mitigating the effects of trauma by using evidence-based programs. My intent includes exploring if evidence-based programs reduce the time school counselors spend attending to individual mental health issues. Another goal is to ascertain whether school counselors receive adequate training on programs designed to moderate the effects of trauma.

Conceptual/Theoretical Framework

Bronfenbrenner's ecological systems theory is the most broadly implemented theoretical framework for studying individuals in their organic environmental circumstances (Neal & Neal, 2013). When completing a study based on the factors of human development, investigators found it prudent to discuss the ecological system based on Bronfenbrenner's research. The approach centers on the premise people do not exist or operate in a vacuum but are instead influenced by all systems in their world. The theory places the person at the center; however, it depicts systemic involvement as flowing to and from their environmental encounters. Bronfenbrenner visualized people as a part of interrelated systems, which resemble layers of an individual's life experience. It is in this context they

realize their ability to shape and alter the course of their future, as each person is a functioning agent in their personal development.

Bronfenbrenner (1979) described the ecological system as being comprised of four interrelated mechanisms. The first relevant element is the developmental process, which involves the relationship of the individual to the environment. Secondly, the theorist postulated the integral interplay between individuals, their biological, cognitive, emotional, and behavioral qualities, and systemic involvements. Bronfenbrenner delineated the importance of the context in understanding human development and the interrelationship with environmental experiences. The last integral mechanism also characterized as time, which is the chronosystem moderating changes in human life. The elements, collectively known as the process-person-context-time model (PPCT), constitutes a method for conceptualizing the integrated developmental system. Bronfenbrenner conceptualized how the model provided the breath of the human experiences necessary to investigate the role of each component to comprehend how people experience their lives.

Bronfenbrenner (1979) offered another important theoretical framework in designating four environmental levels: the micro, meso, exo, and macrosystems. Each system is unique and influences the development of individuals differently. Level 1 or the microsystem is comprised of the immediate environment where a person closely interacts with others such as a classroom, playground, home, or church. The level 2 mesosystem identifies the interaction of two or more settings the person is part of such as schools, organizations, and institutions. The exosystem, level 3, included one or more settings not directly influencing a person, government agencies, for example. The last system, level 4, also known as the macrosystem, encompasses culture, society, and community, indirectly affecting people's lives. Although interconnected, researchers typically focus on one of the systems as their primary target (Onwuegbuzie, Collins, & Frels, 2013).

Reviewing research through the lens of Bronfenbrenner's ecological systems theory creates opportunities to identify the different factors contributing to people's perceptions and experiences. Hannaway, Steyn, and Hartell (2014) used this approach to study the perceptions of teachers of Black students and the education system to delineate the interactions and mutual relations between the systems. Using the ecological model assist researchers to take into account intrinsic personal experiences, while also integrating the interactions of the other systems such as school, home, and community. They can create a circumstantial map outlining the different aspects contributing to how people discern and define their reality.

Viewing studies through the lens of Bronfenbrenner's ecological theory helps us understand the intersectionality between ourselves and systems in our society and communities. Scrutinizing the interactions between and within the systems can provide recommendations useful in guiding public mental health care professionals (Eriksson, Ghazinoour, & Hammarstrom, 2018). Adequate and effective public mental health care relays on the ability to understand the ecological systems approach effectively incorporate findings, inform treatment strategies, and steer public policies.

School systems can benefit from integrating Bronfenbrenner's ecological systems theory in multiple aspects of educating students. Children in learning environments interact with people who can have a profound influence on their development. Ecological systems theory positions the child in the center of this system while scrutinizing the outcomes of relationships and experiences (Hayes, O'Toole, & Halpenny, 2017). Including school as a critical component helps inform our conceptualization of personalized learning by recognizing significant characteristics in students. The framework assists in highlighting important social connections and frameworks affecting students' social, emotional, and physical well-being. They provide an inclusive conceptual basis establishing how prevalent social contexts in a child's life interrelate and influence central outcomes, including

social and emotional adjustment along with how they function in school. Bronfenbrenner contended human development takes place through multifaceted collaborations between human beings, persons, and objects in their proximate environment, namely school staff in this instance.

Bronfenbrenner's ecological systems theory has important implications for schools. First, it is necessary for all school staff to realize they are part of students' microsystems, which means each staff member has contextual interactions with students and there exists the possibility to create encouraging relationships. An effective approach to provide necessary support is to function as a positive role model, which includes the role of an active listener. Bronfenbrenner's ecosystems theory affects how educators consider children who struggle in the classroom and pinpointing the environmental influences affecting a child's development and learning. Evoking Bronfenbrenner's ecosystems theory and applying it to the school system, the microsystem represents individuals and entities with whom the student directly connects within the classroom. Another important microsystem the student dependably interacts with is their family. This theory is important for educators to comprehend because it encourages the educator to build essential relationships with their students and create a communication-rich classroom that involves the parents. This is essential because many students experience adverse childhood experiences and early intervention is key to assisting them. Baweja et al. (2016) suggested improved outcomes result from training school personnel to recognize and assist adversely affected children.

The frequency of children subjected to trauma exposure is disturbing. Approximately 25% of an established group of otherwise healthy children from suburban and urban populations reported experiencing one or more traumas by the time they were 2 to 3 years old (Briggs-Gowan, Ford, Fraleigh, McCarthy, & Carter, 2010). Children exposed to these traumatic events suffer from a broad range of social-emotional consequences, which compromise their ability to flourish. Traumatic

experiences potentially result in poor mental health in children, along with their ability to achieve in school.

Adverse childhood experiences (ACE) are stressful or traumatic occurrences having strong associations with the development and prevalence of numerous undesirable health problems throughout a person's lifespan. These experiences can include abuse, neglect, and domestic abuse, substance abuse in the household and family members with mental illness. Other qualifying events include the divorce of parents and the incarceration of a family member. According to Finkelhor et al. (2015), additional adverse experiences should be considered for inclusion with previous assessments and treatment strategies.

One of the first notable studies to shed light on the effects of childhood trauma was a joint effort between Kaiser Permanente (San Diego, CA) and the CDC (Atlanta, Georgia) which undertook a study on the long-term effects of adverse childhood experiences. One of the most important findings of this study is the relationship of adverse childhood experiences to the negative physical effects throughout a person's lifespan. Another important finding involved the proportional relationship of adverse childhood experiences to the number and severity of physical ailments. Accordingly, the more reported ACE's, correlated with more severe health problems, stress-related diseases, and deaths (Felitti et al., 1998).

The incidence rate of adverse childhood experiences is widespread and pervasive. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 40% of the sample of the Kaiser study stated they had endured two or more adverse childhood experiences and 12.5% reported four or more adverse experiences. Saunders and Adams (2014) reported exposure rates of 20% to 48% of all children to more than one type of trauma or

victimization, leading to concluding there is a high incidence of people who experienced multiple traumas during their childhood.

The notable Kaiser and CDC study completed on childhood trauma in the United States brought much-needed recognition to the topic of trauma and its role in negative physical outcomes. Adverse childhood experiences can activate the stress response systems causing an overreaction of the body's fight, flight or freeze response, typically protective mechanisms. This constant overreaction causes physical harm and increases the chances of developing stress-related diseases and sometimes death (Felitti, 1998). Szilagy and Halfon (2015) considered this occurrence a physical crisis and state necessary for pediatricians to assess children. They advised screening for adverse childhood experiences before the damage is unrepairable. These experiences left untreated, cause physical and emotional effects detrimental to children as they grow and mature into their adult years.

DeBellis and Zisk (2014) reported how common stress systems affected by trauma-related to organic changes in affected individuals, accounted for the negative biological consequences. Ehlert (2014) discussed the association between negative childhood experiences and a lack of glucocorticoid. The researcher found resulting dysregulation of the immune system and cascading created deleterious consequences for the human body (Ehlert, 2014).

Researchers determined negative psychopathology in childhood trauma victims was widespread and undeniable in the delineation of maladaptive manifestations (Read, Morrison, & Ross, 2005). Read et al. (2005) suggested various mental illnesses result from adverse childhood experiences, such as psychosis and schizophrenia. ACEs can also significantly increase externalizing symptoms and emotionality, which cause difficulty in affect regulation and understanding social circumstances while increasing incidents of negative conduct (Price, Higa-

McMillan, Kim, & Frueh, 2016). Another area negatively affected by adverse childhood experiences is behavior. According to Spinazzola et al. (2005), one third to one-half of children exposed to trauma had impairments in self-regulation areas such as dysregulation, information processing, attention/concentration problems, self-concept, behavior, and relationships. Teachers reported children who live in urban settings suffer more adverse childhood experiences and display proportionately more academic and behavior problems (Jimenez, Wade, Lin, Morrow & Reichman, 2016). In one study, an assessment for post-traumatic stress disorder (PTSD) revealed 49% of the students assessed presented with moderate to high symptoms (Hoover et al., 2018). The negative outcomes often viewed as early as kindergarten and many of these children receive an incorrect diagnosis of attention deficit disorder by age nine (Jimenez, 2016; Jimenez, 2017).

Children who suffered adverse childhood experiences and did not receive effective treatment demonstrated a propensity to negative outcomes (Metzler et al., 2017). Not only can ACE's affect a person physically, mentally, behaviorally, and academically, adverse childhood experiences can deleteriously influence education, employment, and income in adulthood (Metzler et al., 2017). Researchers corroborated other undesirable consequences such as negative pregnancy outcomes (Smith, Gotman, & Yonkers, 2016), health risks and chronic health diagnosis (Downey, Gudmunson, Pang, & Lee 2017), asthma and COPD in women (Remigio-Baker, Hayes, & Reyes-Salvail, 2015), substance abuse, including alcoholism (Guzman, 2015; Fang & McNeil, 2017) and an increased risk of suicide (Roy, 2011; Hadland, 2012). A proportionate number of victims become serious, violent, and chronic juvenile offenders, which increased the certainty of negative results. The effects of childhood trauma and adverse

childhood experiences are voluminous and far-reaching, affecting a significant portion of the population.

Approaches to Healing Childhood Trauma

Bethell et al. (2014) discussed the high number of adverse childhood experiences and the need to address the children affected by traumatic pasts. In order to provide better health, stability, and overall positive outcomes, it is necessary to have a coordinated effort, while encouraging the use of new research and advances in the trauma field. Interventions should be available from all areas of a child's life, including school, medical care, and other mental health services. Safety in the home, schools, and community agencies should receive special attention (Soleimanapour, Geierstanger, Claire & Brindis, 2017). This is essential because children who have at least two ACEs show less resilience, are less likely to live in a safe and protective environment and have less access to adequate healthcare (Brown & Shilling, 2017).

Szilagyi and Halfon (2015) called on pediatricians to assess children for adverse childhood experiences to reduce the detrimental outcomes if left untreated. Pediatricians are in an advantageous position to help prevent, diagnose, and treat children and refer adults exposed to ACEs to treatment providers. There is a need for all systems of society that are part of a person's life to become part of the solution (Burke et al., 2017). A systemic approach assures the involvement of multiple sources in identifying trauma survivors. This includes identification, assessment, and treatment in every component of the societal systems.

Adolescents subjected to adverse childhood experiences display distinctive developmental needs, which must be addressed from a holistic perspective, including health, education, and social systems. Left untreated, traumatic events can lead to academic and behavioral difficulties, as well as suicidal ideation. A systemic approach can provide a

comprehensive approach to treating children, adolescents, and adults who many times suffer in silence, without understanding how trauma pervasively affects their lives. Accessible information about the effects of trauma can contribute to lowering the incidence rates and mitigating the effects (Soleimanpour, Geierstanger, & Brindis, 2017; Metzler et al., 2017).

Because of youth support systems advantageous position, they can become involved in children's lives in a personal way (Brown & Shillington, 2017). ACE's demonstratively produced negative effects, creating a need for training on early identification for professionals who work with young people (Boullier & Blair, 2018). Early detection can lessen the negative physical and mental health effects of adverse childhood experiences, thereby providing the potential for better outcomes for the affected population. Adults can provide protective relationships, positively affecting children coping with traumatic events.

Trauma in School Settings

Hoover et al. (2018) found 49% of the students they assessed presented with moderate to a high level of symptoms of post-traumatic stress disorder (PTSD). Almost half of these students simultaneously deal with problematic symptoms creating detrimental consequences not only academically, but also behaviorally and socially. Their findings highlight the need to provide trauma services to school-aged children. According to Paccioine-Dyszlewski (2016), schools are in a unique position to provide support to students, and it is incumbent upon schools to address social and emotional issues.

McKelvy, Edge, Mesman, White-Mansell, and Bradley (2018) identified how early exposure to adverse childhood experiences in infancy and before a child attends school has undesirable effects on their ability to achieve academically when they reach school-age. Also relevant is the increase in behavioral difficulties in children exposed to traumatic events.

Children who experience ACEs before the age of three show an increase in the need for an individualized education plan (IEP) before first grade. The researchers highlighted the need for earlier interventions than previously thought. They discussed how intervening during early developmental stages contributes to better outcomes for the child (McKelvy et al., 2018).

Although the idyllic scenario is to identify children with traumatic pasts before they arrive at school, this practice is the exception and not the norm. Schools are in an ideal position to advocate and encourage children and parents to seek needed help when academic and behavior issues become problematic. Many school personnel has the training necessary to realize there is a problem and this early identification can be crucial in beginning the process to understand obstacles standing in the way of achievement and success. The effects of experiencing trauma or possibly ongoing traumas can be the culprit, highlighting issues requiring redress (Walker & Walsh, 2015).

Recently researchers showed how schools are an invaluable asset in providing trauma-informed care. Trauma training for staff includes the identification of triggers as an important part of a school trauma-informed approach (Crosby et al., 2018). Along the same lines, Martin et al. (2016) concurred with this finding pointing out the importance of schools in providing trauma-informed approaches. The authors specifically point to the unique position schools can play in providing support. It is imperative to acknowledge that school is an effective way to reach those students who need trauma care.

Ridgard, Laracy, DuPaul, Shapiro, and Power (2015) underscored the importance of providing mental health services in schools as it offers opportunities to reach and locate services for children living in high-risk, hard-to-reach areas. Developers of best practices for this population indicated in addition to schools, interventions for trauma experiences should be

available in those reaching them from various aspects of their lives including the medical arena and mental health agencies (Solemanpour et al., 2017). There is also a need to remove barriers such as lack of transportation, lack of services in the area and time restraints on parents so children will be in a better position to access needed care and support.

Another advantage of providing trauma-informed approaches in schools is the ability to provide long-term care given children attend school five days a week for most months in a year. Encouraging students to attend school after traumatic events can provide them with support over a length of time (Perfect, Turley, Carlson, Yohanna, & Saint Gilles, 2016). Researchers noted the benefit of offering support over extended periods. Attending school offers the ability for professionals to consistently intervene, even during summer months when programs operate during summer break. They have the time needed to realize gains by maintaining their stability and encouraging the development of students.

Trauma-informed care in school can begin in early intervention programs designated to assess for deficits in multiple areas of a child's life. Adverse childhood experiences in children aged 0-2 have subsequent negative health outcomes beginning with the trauma and continuing throughout adulthood if not mitigated by trauma-informed programs (Melville, 2017). For children who are not assessed or deficits identified, preschools can also be pivotal in providing trauma-informed care. Researchers determined trauma-informed approaches as applicable and beneficial for children when administered as early as possible (Holmes, Levy, Smith, Pinne, & Neese, 2015; Loomis, 2018; Milot, Ethier, St. Laurent, & Provost, 2010).

Reinberg and Fefer (2018) reported how schools are in a good position to provide trauma-informed care, however, the care needs to be evidence and data-based. They also recommended providing interventions using school mental health professionals. School mental

health professionals can be a vague term when determining exactly which professional should be overseeing the trauma care. School mental health professionals can include mental health personnel engaged by the school district but working for outside agencies. Conversely, schools typically employ teachers, supplemental staff, social workers, and school counselors. They can also delegate trauma-informed care to a specific job class. Another option would be to assign multiple personnel to work together for the best possible outcome, such as an outside agency working with school mental health professionals.

Baweja et al. (2016) found the most common method of providing trauma-informed care is by someone outside the school community and not school employees. One of the advantages of utilizing personnel from an outside agency is the ability of that person to work specifically with affected young people without having to attend to other responsibilities in the school. Mental health professionals can enter schools to help students affected by trauma while they also assist the school staff and teachers to learn appropriate responses. This approach incorporates more people and supports the goal of providing a holistic strategy to address student's needs (RB-Banks & Meyers, 2017).

Baum et al. (2013) articulated the importance of teachers as a component in the implementation of trauma-informed approaches in schools. Teachers are uniquely positioned to influence their students given they spend the majority of the school day with their pupils. To help alleviate symptoms of PTSD and anxiety in their students, teachers can receive training on programs such as Building Resilience Intervention. Regardless of which program the school establishes, a systems approach inclusive of all personnel, especially teachers, has the potential to produce positive results.

One of the advantages of designating teachers to provide trauma-informed care is the majority possess the relational assets of maintaining open and candid interactions with their students. Their ability to provide sincere and dependable communication to students helps create feelings reflective of safe and supportive environments. These characteristics and conditions can make a difference when working with students affected by trauma (Morgan, Pendergast, Brown, & Heck, 2015). Brunzell, Walker, and Stokes (2015) concurred and underscored how teachers can increase psychological resources in their students, helping them feel safe and able to take the risks needed to learn and achieve academically.

Baweja et al. (2016) expanded the idea of only providing information to teachers through studying achieving better outcomes for children affected by trauma through training all school personnel to deliver trauma-informed focused programs. Instead of relying solely on teachers, it may be best to include all school personnel who are in the lives of the students consistently. Crosby (2015) advanced an ecological approach, which stated that all systems in a person's world act together to affect change in a person. Therefore, I intend to discover whether it is necessary to have all staff trained in trauma symptoms and triggers to better identify the students who need assistance. Crosby et al. (2018) shared the importance of being aware of trauma triggers for students and offering trauma training for staff as part of a school trauma-informed program. Researchers recognized schools as an invaluable asset for providing trauma-informed care to those children who struggle and may choose to suffer in silence.

Administrators can designate other school personnel receive training on how to provide or oversee trauma-informed approaches. Fryman and Mayor (2017) discussed how social workers are in an advantageous position to be aware of those students who are struggling and in need of help. Not all students who need assistance ask for it, however, social workers who

receive training can recognize the silent calls of a child in need. Social workers are pivotal in providing individualized services to students who are struggling academically, behaviorally, and maybe responding to resultant outcomes of traumatic experiences. Another essential role of the social worker is one of teaching prevention and educating students to recognize unsafe situations, thereby helping them to avoid experiencing additional traumas.

Support from the administration team in the school is an essential component of successful trauma-informed programs. Without buy-in from the principal and district administration, programs cannot get off the ground, which makes it virtually impossible to sustain achieving goals and objectives. School counselors need the time to learn and incorporate individualized counseling and small groups into the school day without administrative support (Sitler, 2009). Sustainability rests beyond good intentions and initial buy-in for beginning programs to help students affected by trauma. However, the ability to continue diminishes as a result of leadership changes, financial feasibility, and competing priorities (Nadeem & Ringle, 2016).

Schools may not be willing to add another initiative to the many programs receiving support however, trauma-informed care may already be a part of what is already happening in schools. Many schools already endorse the federally sanctioned MTSS program, which provides tiers of academic achievement and tiers to assess behavior (Baweja et al., 2016). Chafouleas, Johnson, Overstreet, and Santos (2016) contended that trauma interventions are a natural fit for MTSS, RTII, and SWPBIS programs, which are federally mandated initiatives implemented in schools. The authors asserted much of trauma-informed care is already happening in schools and it would require a small amount of effort and work to provide a sustainable trauma-informed

care program. I intend to incorporate inquiries concerning the perceptions of school counselors in determining whether trauma-informed care is achieving the intended goals.

Professional School Counseling

School counseling evolved in the 1800s in response to the industrial revolution and the vocational guidance necessary to focus on jobs created using emerging techniques (Gysbers & Henderson, 2001). The movement focused on providing vocational counselors whose primary responsibilities were to help students prepare for industrial jobs created during the initial boom. School counselors helped students who were failing by giving them support and encouraging them to stay in school. They were charged with developing strategies to avert students from failing while preparing them to work when they graduated. The role of the school counselors was to assist in acquiring a work card needed for employment in the newly found industries.

The National Vocational Guidance Association formed in 1913 to encourage school counseling as a viable career. Several years later, the position of school counselor began to evolve to include other aspects of the students' needs. It was during the early 1920s, the social and emotional needs of the students became considered as important, thereby requiring counseling. Almost simultaneously, the Great Depression caused many to struggle to survive, which led to determining programs such as school counseling as unnecessary.

Since this time, the school counseling profession has not been considered essential by numerous decision-makers and as of the early 2000s was not viewed as a vital profession (Cervoni & DeLucia-Waack, 2011). In the beginning, school counselors were referred to as guidance counselors and their job was to provide vocational guidance (Lambie & Williamson, 2004). Teachers initially executed the job of a school counselor even though they did not receive training or have a model to guide them (Gysbers & Henderson, 2001). In the 1920s, Carl Rogers

developed his conception of the client-centered approach, which built upon the premise that humans move through predictable stages of development. Although Rogers' approach was not new, the emphasis on the cognitive, social, moral, and personal development of each person academia considers seminal. The school counselors in this era agreed with this approach and utilized the concepts to expand the role of vocational guidance to include offering information and bring together knowledge to effectuate change and motivate students. This philosophical difference also brought about name designation change based on the new focus and the formerly designated guidance counselor became known as a school counselor (Lambie & Williamson, 2004).

Later in the 1950s era, school counseling became a more respected career choice. The American School Counselor Association implemented standards and began to provide training (Bauman et al., 2003). The association began providing research into relevant counseling issues, developmental strategies, and most importantly, advocacy to promote the professionalism of the school counselor (Lambie & Williamson, 2004). In 1957, the passing of the National Defense Education Act (NDEA), provided funding for colleges to recruit students who excelled in sciences to further advance the United States to surpass other country's scientific contributions. Colleges used financial support to begin preparing school counselors to identify gifted students in science and technology along with guiding them into appropriate curriculums. Counseling duties continued to multiply and with the funds provided by NDEA, training for school counselors improved and the profession burgeoned (Baker, 1996.)

Another significant period for school counseling was in the 1960s when the baby boomer generation was reaching a peak. As the baby boomers became school-aged, the number of students grew exponentially. The student enrollment numbers continued to grow, and

simultaneously the need for more school counselors became evident (Baker, 1996). Even with these changes, the role of the school counselors was not well defined, and they functioned similar to teachers. During this time, the responsibility of a school counselor was to work as an advocate for individual students, but without any guide or knowledge of social or emotional development. This lack of understanding of how to meet student needs contributed to the role ambiguity the profession has struggled with and had difficulty overcoming (Arbuckle, 1976).

The school counselor's role significantly developed during the last half of the twentieth century, and counselors received additional duties in the name of accountability. Gysbers (2004) determined the 1960s began the accountability movement and counselors were unduly relied upon to meet this initiative. In the 1970s and '80s, school counselors tasked with duties not falling under the scope of school counseling but lacked the ability to advocate for themselves allowing school administrators to wield to determine their roles (Baker, 1996). Gysbers (2004) acknowledged the need for accountability during this time demanded school counselors develop an organizational structure that would define their responsibilities.

The 1980s and 90s did not bring any clarity to the role of the school counselor and the focus on accountability only became more intense. The era also ushered in the testing of students, with the results used to make administrative, funding, and state decisions (Gysbers, 2001; Lambie & Williamson, 2004). The practice of adding additional nonjob-related duties to the school counselor position continued at an alarming pace. The continual addition of duties created stressful situations as school counselors became responsible for a disproportionate number of students' needs (Lambie & Williamson, 2004). Without a clearly defined role and the extreme expectations of school administrations, school counselor positions became overworked, overburdened; creating the inability for them to meet the needs of the students.

The shifting needs of students in the United States prompted restructuring in the educational system, predominantly in the role of the school counselor (Bardhoshi & Duncan, 2009). In 2000, the American School Counselor Association (ASCA) began to advocate for school counselors by developing the first edition of a national model, which they continued to enhance and update in 2012 and 2017 (ASCA, 2004, 2012, 2017). The ASCA National Model was developed to further delineate the role of the school counselor, to bring uniformity, and to position school counselors in a leadership position within their respective school systems.

The ASCA National Model is a framework for developing a comprehensive school counseling program (CSCP) that concentrates on the “how” of school counseling (ASCA, 2012, 2017). The ASCA National Model is comprised of four major components: the foundation, management, delivery, and accountability systems (ASCA, 2012; Erford, 2010; Wittmer & Clark, 2007). The model presented the question of “How are students different as a result of the school counseling program?” (ASCA, 2012, p. 99). This question remains the impetus guiding and inspiring the work of 21st-century school counselors (Erford, 2010). When implemented as proposed, the ASCA National Model has the capacity to augment student success and provide job security and role certainty for school counselors amidst educational reform and budget cuts (Erford, 2010).

The ASCA National Standards (2004) adopted the mission, “to prepare today’s students to become tomorrow’s adults”. The National Standards highlight three domains, social/emotional development, academic, and career. The social/emotional development domain emphasizes students’ personal and social development and encompasses topics such as decision making, social skills, and self-care (ASCA, 2004). The academic domain supports students’ academic development, such as learning about study skills, organization, or attending a transition group (ASCA, 2004). The career domain focuses on helping students to develop career interests, workplace skills, and to become

knowledgeable about different professions and vocations (ASCA, 2004). According to the standards, school counselors should create programs for students inclusive of each of these domains (ASCA, 2004).

In 2014, ASCA established new content for the ASCA National Standards, termed ASCA Mindsets and Behaviors for Student Success (ASCA, 2014). The new emphasis represented a move toward aligning school counseling standards with initiatives of districts and states. The three original domains of academic, social/emotional development and career development continue to be part of this latest guideline. The principal modification is a decrease in the number of standards. In 2014, ASCA CSCP now includes only 35 standards, which consist of six mindsets and 29 behaviors, a diminution from the original set of nine standards, each with several sub-standards and indicators (adding up to more than 100 specific standards to address). The current standards are still applicable to all three domains, which greatly streamlines aligning curriculum with standards for school counselors (ASCA, 2014). The new standards meld with the national educational standards and simplicity allows the school counseling standards to readily coincide with academic standards (ASCA, 2014)

Many states have also modified their state CSCP models to align with the ASCA National Model (Lapan, 2012). For example, the South Dakota Department of Education (Bardhoshi & Duncan, 2013) revised its comprehensive school counseling program model in 2013 to align with the latest revision from ASCA. Gysbers (2006) amassed 60 years of school counseling research and reported, “strong leadership at the state level is a key to developing effective and accountable comprehensive guidance and counseling programs at the local level” (p. 247). Although it is commonly recognized how guidance and counseling programs should be established at the state level, a review of the department of education and association websites from various states revealed nearly

no special supports or initiatives directed at helping school counselors with model implementation (Dahir & Stone, 2009). A few states, Oregon, Utah, Wisconsin, Tennessee, and North Carolina, are omitted from this list because they created a professional development plan (Dahir & Stone, 2009).

Some states conducted research on the effectiveness of CSCP. By way of example, Carey and Dimmitt (2012) showed high school graduation rates increased when CSCP is fully implemented. The completed study advanced the development of CSCPs within schools (Carey et al., 2012). Another study conducted among Wisconsin schools assessed challenges to implementation and found student-to-counselor ratios and non-counseling duties were barriers to implementation of CSCPs (Burkard, Gillen, Martinez, & Skytte, 2012). Wisconsin offers an array of training opportunities and reported an approximate rate of implementation of 60% among high schools statewide (Burkard et al., 2012). Continuing support remained unstudied in relation to the implementation of CSCPs. Dahir and Stone (2009) found professional development proposals, such as those approved for teachers, would also be advantageous for school counselors in the implementation of CSCPs. The systematic assessment would be a beneficial method to better understand the professional development needs of school counselors (Dahir & Stone, 2012).

A lack of knowledge precludes understanding what state assistance is most useful for school counselors during CSCP model implementation (Burkard et al., 2012). Some schools function without CSCPs, and differences create variations from school to school in the services students receive (Burkard et al., 2012; Erford, 2010; Lapan, 2012). Studer and Oberman (2006) reported school counselors who have local or state decision-makers buoying their efforts are more efficacious with implementation than are those without such support. There are other states whose mandates guide the development of CSCPs. Therefore, there is a need to understand what categories of state-level supports are most advantageous in promoting CSCP implementation (Gysbers, 2006).

A noteworthy factor that impacts school counselors and their ability to complete implementation of CSCPs is the need to respond to non-counselor duties. These obligations use valuable time that could otherwise be spent with students. Non-counselor duties defined as the requirement to complete tasks deemed as inappropriate for the school counselor should be excluded as part of a school counselor's role (ASCA, 2017). These obligations might include supervising classrooms or common areas, disciplinary duties, coordinating cognitive achievement tests or aptitude tests, and maintaining student educational records (ASCA, 2012). Killip, Rawls, and Barry (2012) reported excessive student-to-counselor ratios along with time spent on non-counselor duties takes away time from completing activities outlined in the ASCA model. Researchers found student-counselor ratios and relationships with administrators have a major effect on school counselor job satisfaction (Wilkerson & Bellini, 2006). Furthermore, low job satisfaction is correlated with low implementation of CSCPs (DeMato & Curcio, Wilkerson & Bellini, 2006). Researchers underscored how stress, non-counselor duties, and the relationship with administration have an unfavorable influence on school counselors' level of job satisfaction. ASCA (2004) also specified how delineated school counselor roles may have a direct positive effect on the implementation of the ASCA's National Model.

Many factors contribute to the ability of the school counselor to perform their duties. If there is a lack of support from decision-makers, it is difficult to support essential programs, assist with program concerns and collaborate with the essential components of a CSCP. It is essential for counselors to have the training and professional development in what constitutes a beneficial school counseling program and how to achieve the various components. Non-counseling duties assigned to school counselors take away valuable time that could be used to conduct student activities and strengthen other programs. When administration, staff, school board members, and parents consider

and give scrutiny on providing for the students' needs, they contribute to creating an environment where the essential components positively influence each student's life.

Professional school counselors work with students from elementary school through the senior year of high school. Some of the work counselors accomplish with students is based on developing social, emotional, and academic goals. Mandates require school counselors to attain a master's degree, and in most states, it is mandatory to have a license or certificate issued by the state department of education. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards for school counseling preparation programs directed school counselors receive training in mental health and education (CACREP, 2011). Specifically, a professional school counselor must comprehend the fundamental areas of the ASCA National Model and be able to utilize it to implement a school counseling program. Most importantly, it is incumbent for professional school counselors to become aware of the multiple factors influencing a student's health and well-being (CACREP, 2009).

As student needs have changed with society, school counselors are also shifting to meet their various requirements. The Surgeon General found students who do not experience a sense of trust or feel welcomed by counselors, may be reluctant to seek needed help (U.S. DHHS, 2001). Effective counselors can build rapport with students by elucidating their role as a school counselor, making students aware of the limits of confidentiality, and by establishing a welcoming environment where they validate students' emotions (Harris, 1995). It is vital for school counselors to connect with families as this crucial role provides the opportunity for systems in a student's world to work together to effectuate positive change. This can sometimes be challenging as some families feel unwelcome in schools or necessary for their children, making it difficult to establish a working rapport (Lee, 2001).

Collaborating with trusted community leaders, such as pastors, can break down the trust barrier between a counselor and members of different cultures, ethnicities, and family of origins.

Viewing individual counseling delivered by school counselors as an act of advocacy and accountability helps to eliminate barriers, such as access, opportunity, and achievement gaps (Eschenhauer & Chen-Hayes, 2005). When children begin their school career, they bring with them a history of positive and negative experiences. It is these experiences that professional school counselors consider as they seek to provide support and assistance. Without appropriate intervention, students will not receive the needed support to work through harmful incidents and without mitigation of the negativity, children will not flourish.

Related Literature

Multi-Tiered Systems of Support in Schools

There has been an increasing interest in providing mental health services in schools to help address non-academic issues. To overcome well-documented barriers, school personnel make attempts to mediate the challenges for students affected by adverse childhood experiences. One of the ways schools provide help is through the multi-tiered systems of support initiatives. The goal of multi-tiered systems of support is the early identification of at-risk students who need appropriate interventions, not only for academics but also for behavioral difficulties (Hawken, Vincent, & Schumann, 2018). This early identification is important in providing students support before the struggles become advanced and more challenging to alleviate.

Multi-tiered system of support is a program school districts incorporate into their everyday school activities. According to the Pennsylvania Training and Technical Assistance Network (PATTAN), two commonly used initiatives fall under the umbrella of MTSS: positive behavior support and response to intervention. Fletcher and Vaughn (2009) documented the

common themes of both programs focus on the implementation of evidence-based interventions in tiers or levels of need. Tier one, or the primary intervention, also referred to as the universal tier, consists of activities designed for all students. This tier is typically the only intervention necessary for 80 % of the students, however, the other 20% require more assistance. Tier two, or secondary tier, focuses more on an intervention designed to assist students who need intense and individualized assistance, which is approximately 15% of a student population. In comparison, tier three, or the tertiary tier, represents 5% of the students who are in most need of academic and behavioral interventions.

Schools are in an inimitable position to be able to assist students in dealing with adverse childhood experiences and subsequent mental health issues because of their ability to provide programs grounded in empirical research and evidence-based practices. August, Piehler, and Miller (2018) delineated the progress of MTSS in schools and suggested building upon the accomplished advances to provide better care for affected students.

School Counseling and MTSS

The role of the school counselor in the MTSS initiative is still unclear. Goodman-Scott, Betters-Boubon, and Donahue (2015) determined the roles and responsibilities of school counselors when compared to the widely accepted American School Counselors Association (ASCA) comprehensive model and framework. The authors showed a correlation between the MTSS program of positive behavioral interventions and supports (PBIS) and the ASCA model in the areas of leadership, such as the need to communicate with all stakeholders, the use of data to make effective decisions, and the creation of interventions to help increase positive outcomes.

Goodman (2013) suggested PBIS is an asset to school counselors in lieu of creating additional roles and responsibilities. It is possible for school counselors to integrate the roles of a

PBIS program into the existing counseling program, thereby, creating less work, more efficient use of time, and better interventions. Parents are a part of the PBIS initiative and need to be willing to support the program, an area where school counselors have existing relationships. An additional component of the PBIS program is a bully prevention program, however, professionals may view it as additional responsibility for school counselors, already burdened with increasing demands on their time. In comparison, Cressey, Whitcomb, McGilvray-Rivet, Morrison, and Shander-Reynolds (2015), stated there is no extra workload for a counselor as a part of the PBIS team, but instead the type of work changes to better serve the students.

Equally important as the demands on counselors' time is the necessity of training for school counselors confronting the expectation of involvement in MTSS programs. Curtis, Van Horne, Robertson, and Karvonen (2010) determined the effectiveness of the PBIS program in reducing behavioral problems, training in PBIS for school counselors became a factor in the outcomes. Improved training for all team members, including school psychologists, teachers, and administrators could produce better results (Chityo & Wheeler, 2009; Eagle, Dowd-Eagle, Snyder, & Holtzman, 2015). Feuerborn, Tyre, and Beaudoin (2018) suggested providing training for the entire school staff and including them as integral members of the MTSS program.

Freeman et al. (2016) agreed implementation of an MTSS program produces positive outcomes in behavior and attendance, the authors supported emphasizing an initial and ongoing training component throughout the program. Implementing and maintaining an MTSS program requires unique skills and knowledge learned through training and professional development opportunities (Tyre, Feuerborn, & Woods, 2018). The authors advocated for specific detailed training, which also addressed staff concerns thereby increasing the support and subsequent

success of the program. Training in MTSS programs is necessary to realize the potential positive outcomes for affected students (Tyre et al., 2018).

Programs

School administrators reviewed studies regarding other trauma-informed care programs. One such program is the sanctuary model, which is a method of trauma care developed for use in inpatient settings, based on the S (safety) E (emotions) L (losses) and F (future) acronym. Blitz and Lee (2015) found the model is adaptable for use in schools by providing a common language to encourage healing. Blitz, Anderson, and Saastamoinen (2016) discussed adjusting the sanctuary model to work in schools showed promise in mitigating some negative outcomes of trauma by advancing a school-wide approach. Other approaches to trauma-informed care in schools use the Stanford CTT manual, and RAP program, which focuses on positive education. Carrion and Hull (2010) studied the Stanford CTT approach and determined its effectiveness in schools attempting to assist students affected by trauma. The program RAP uses cognitive-behavioral and mindfulness strategies implemented in the classroom with the entire class versus a pull-out individualized or small group approach (Mendelson, Tandon, O'Brennan, Leaf, & Ialongo, 2015). By incorporating positive education, which allows for building skills of self-regulation and increasing their relational qualities, it is possible to facilitate student's success in the classroom (Brunzell et al., 2015).

Summary

Many schools are unprepared to deal with the number and extent of traumatic incidents students experience. Being aware of the effect of trauma on students is an essential element in educational environments. Absent from addressing these issues, students may not learn or succeed in the classroom. When students misbehave, it is important to not automatically assume they are only behavioral problems and deem them unfixable. Attending to the trauma in the lives of students can

not only help decrease physical maladies, but the focus also increases academic and personal achievement. A receptive learning environment responds to students who experienced injurious events by incorporating trauma-informed approaches in schools.

School personnel, teachers, mental health providers, social workers, and school counselors attempt to provide trauma care. Without a unified methodology, the separate pieces may be somewhat helpful, but with a unified school-wide approach, they may not realize positive outcomes. I intend to survey school counselors to understand their perceptions about the importance of incorporating a trauma-informed approach through the use of a multi-tier support system (MTSS), and more specifically, their designated role and how it affects their time management. Often school counselors do not receive the required training to serve as an effective member of a MTSS initiative, including RTII and positive behavior support. Although required to complete a master's degree level program to work in their capacity, they receive minimal training regarding trauma, its effects, symptoms, and manifestations while attending graduate programs. Including school counselors in the implementation of MTSS approaches, is making a difference in reaching students who need help. The number of adverse childhood experiences in the lives of our students requires effective training to elevate school counselors, to perform essential services to this vulnerable population.

CHAPTER THREE: METHODS

Overview

To execute this investigation, I will collect data from professional school counselors regarding their training in trauma-informed care, feelings of self-efficacy, and attitudes towards the use of trauma-informed care in a school setting. I will also examine how factors, including years of experience as a professional school counselor and training in trauma-informed care, predict professional school counselors' students' self-efficacy and attitudes towards using then intervention strategy in educational environments. To investigate research questions one and two, I will employ a descriptive research design. My goal in posing question one is to query the type and amount of trauma-informed care/practice training professional school counselors participated in during and after their graduate work. Responses to the second research question will assist me in examining professional school counselors' perceived attitudes/ self-efficacy toward providing trauma-informed care in their work setting. Using a predictive correlation design, asking the third question will contribute to exploring to what extent, if at all, are (a) years of experience as a school counselor, (b) trauma-informed care training in graduate school, and (c) participation in trauma-informed practice professional development activities, and (d) trauma-informed practice in-services predictive of professional school counselor's perceived attitudes/ self-efficacy toward providing trauma-informed care in a school setting.

Design

My purpose in conducting this descriptive nonexperimental quantitative survey study is to identify whether the training school counselors receive in their graduate-level programs and professional development is adequate in helping them to recognize and address mental health issues of the students in elementary, middle, and high school levels using a trauma-informed approach. Also, I designed the study to assess the perceptions of professional school counselors in their self-efficacy and attitudes in using a trauma-informed approach. The data I collect will focus on counselors' perceptions of the evidence-based programs implemented in schools and whether they feel they are effective for students' mental health concerns.

Research Questions

Research Question 1: What training do professional school counselors' have trauma-informed care in a school setting?

Research Question 2: What are the professional school counselor's attitudes toward providing trauma-informed care in a school setting?

Research Question 3: What are professional school counselors' levels of self-efficacy in using trauma-informed care in a school setting?

Research Question 4: To what extent are (a) years of experience as a school counselor, (b) participation in trauma-informed care training in graduate school, (c) participation in trauma-informed practice professional development activities, and (d) participation in trauma-informed practice in-services predictive of professional school counselors, perceived attitudes toward providing trauma-informed care in a school setting?

Research Question 5: To what extent are (a) years of experience as a school counselor, (b) participation in trauma-informed care training in graduate school, (c) participation in trauma-informed practice professional development activities, and (d) participation in trauma-informed

practice in-services predictive of professional school counselors' self-efficacy in providing trauma-informed care in a school setting?

Participants and Setting

The population for this study will be comprised of K-12th-grade professional school counselors certified by their state to practice in a school setting. The sample will align with Bruce and Bridgeland (2012) findings, which stated professional school counselors are predominately female, White, and between the ages of 25 and 65. The sampling frame I utilized included school counselors recruited from two professional school counselor websites: The American School Counselor Association (ASCA) and the Pennsylvania School Counselors (PSCA). I simplified the designated parameters for submitting my survey to the members of ASCA because I am a member of ASCA. The only requirement is to post information about the research to the ASCA Scene, an online area designated for professional discussion, and invite members to respond. The ASCA organization suggests posting the relevant information first, including information on the focus of the study. Once the information is available, I will invite fellow school counselors to participate. Assuring compliance with PSCA guidelines requires a more in-depth approach. To have research considered, it is necessary to submit three items to the leadership of PSCA for consideration: an explanation of the research and the support this researcher is requesting, a copy of Liberty University's IRB approval, and a copy of the informed consent documents.

The setting for this study is initially unlimited since there are many school counselors in the United States, but also many professional school counselors who practice internationally and are part of the American School Counselor Association. The membership of this group crosses many boundaries and could provide glimpses into school counselor perceptions from other

countries and subgroups. Agencies representing schools overseas in other countries recruit school counselors trained in the United States and their unique experiences will provide additional and valuable information.

Instrumentation

Table 1

Variable	Measurement
Attitudes toward providing trauma-informed care in a school setting (Variable in RQ 2 and Criterion variable in RQ4)	The Attitudes Related to Trauma-Informed Care Scale (ARTIC-45)
Level of self-efficacy in using trauma-informed care in a school setting (Variable in RQ 3 and Criterion variable in RQ 5)	School Counselor Self-Efficacy scale (SCSE; Bodenhorn & Skaggs, 2005) Modified for Trauma-Informed Care
Years of experience as a school counselor (predictor variable in RQ4 and 5)	How many years have you worked as a school counselor? (Potential responses: This is my first year, 1 to 4 years, 5 to 9 years, 10 to 14 years, 15 to 19 years, 20 to 24 years, 25 to 29 years, 30 to 34 years, 35 or more years)
Professional school counselors' training in	How, if at all, did you participate in trauma-informed care training in graduate school? (Potential responses: no

trauma-informed care training, a topic covered in one, a topic covered more than
 (Variable in RQ 1 and one courses, a course, more than one course)
 predictor variable in RQ4 and 5) How much, if any, trauma-informed care professional
 development training (do not include school-sponsored in-
 service training) have you participated in? (Potential
 answers: none, a one-day training, a multi-day training,
 multiple training) –*this could also be formulated as the
 one below*
 How many, if any, trauma-informed care school or
 district-sponsored in-service training have you participated
 in? (Potential answers: none, 1, 2, 3,4, 5 ,6,7,8,9,10, more
 than 10)

**School Counselor Self-Efficacy Scale (SCSE, Bodenhorn & Skaggs, 2005) Modified
 for Trauma-Informed Care in Schools**

The instrument used to measure the dependent variables of school counselor’s self-efficacy for implementing Trauma-Informed Care (TIC). I will utilize a modified version of the School Counselor Self-Efficacy Scale (SCSE), (Bodenhorn & Skaggs, 2005). The School Counselor Self-Efficacy Scale is a 45-item instrument, developed to provide a psychometrically sound instrument to evaluate school counselors’ self-efficacy. The scale consists of five subscales including, the Personal and Social Development scale containing 12 items; the Leadership and Assessment scale containing 9 items; Career and Academic Development (scale containing 7 items; the Collaboration scale contains 11 items; and the Cultural Acceptance scale containing 4 items).

The original School Counselor Self-Efficacy Scale exhibited good construct validity (citation); explain. Cronbach's α indicated good reliability for the entire scale (.add), which is within the accepted threshold of 0.70 to 0.95 (citation). Each subscale demonstrated good reliability, Personal and Social Development (.91), Assessment (.90); Career and Academic Development (.85); Collaboration (.87); and Cultural Acceptance (.72).

I summed together the five-point Likert-type scale ratings for item for the entire scale to indicate a school counselor's self-efficacy. Per the developers, the lower the score, the lower the self-efficacy. Possible score ranges for each of the entire scale and each subscale include: Personal and Social Development (12-60) Assessment (9-45); Career and Academic Development (7-35); Collaboration (11-55); and Cultural Acceptance (4-20).

I modified the School Counselor Self-Efficacy Scale to focus on school counselor's self-efficacy with providing trauma Informed Care (TIC) as part of a comprehensive school counseling plan. Informed by an extensive literature review, I worked with an expert who has practiced trauma care and holds a Ph.D. in Counselor Education and Supervision to modify each item to focus on TIC. For example, the item the original item, "Advocate for the integration of trauma-informed care to promote student academic, career, and personal development into the mission of my school academic, career, and personal development into the mission of my school." I included the original scale and the modified scale in Appendix B and C.

To establish face and content validity of the modified School Counselor Self-Efficacy Scale, I provided the instrument to a panel of three expert reviewers for content validity, face validity, clarity, conciseness, and reading level (Worthington & Whittaker, 2006). Each reviewer met, at minimum, the following criteria: hold a graduate degree in counseling; hold professional school counseling

certification; be a trained/practice TIC; published/ presented on the topic of TIC; and have practiced as a school counselor for at least three years.

Each reviewer received an emailed copy of the instrument and given one week to review the instrument and complete an item analysis survey. I used item analysis to “evaluate the extent to which questions are consistently understood and answered by individuals” (Dray et al., 2011, p.33). For the purpose of this study, I asked the reviewers to rate each item on a 5 point Likert type scale (5 = Excellent, 1= Poor) using a rubric (Appendix D) to assess the items content validity, face validity, clarity, conciseness, and reading level (Worthington & Whittaker, 2006).

The Attitudes Related to Trauma-Informed Care Scale (ARTIC-45)

The ARTIC provided the first psychometrically reliable and valid tool to help stakeholders—researchers, practitioners, policymakers, and consumers—evaluate TIC and its outcomes. The ARTIC is the first measure of its kind to attempt a comprehensive representation of TIC-relevant attitudes, and it is held the ARTIC can be the catalyst the trauma field needs to “drill down” to what is, and what is not, trauma-informed, and thus to move beyond what are currently important foundational principles with unclear operational definitions. Due to the widespread relevance of TIC to educational, human service, corrections, and medical settings, the ARTIC has vast potential uses. Schools and organizations can use the ARTIC as a baseline measure to determine the extent to which their culture is trauma-informed, and the findings can then inform data-driven decision making about the need for trauma training and other TIC interventions. Schools and organizations that implemented TIC, the ARTIC can provide a way to engage in an ongoing evaluation of system-wide TIC practices, hypothesized as linked to safe and supportive environments and associated with better outcomes. Specialists in trauma-informed system change contended while TIC challenging to full implementation, it becomes

difficult to maintain due to wider system pressures, which act as a gravitational “pull toward the punitive” (Morgan, Salomon, Plotkin, & Cohen, 2014). Researchers can use the ARTIC both to monitor regression and to serve as an “assessment-as-intervention” to battle against the retributive pull.

The scale has 5 main subscales and 2 additional:

1. Underlying Causes of Problem Behavior and Symptoms. Emphasizes behavior and symptoms as adaptations and malleable versus behavior and symptoms as intentional and fixed.
2. Responses to Problem Behavior and Symptoms. Emphasizes relationships, flexibility, kindness, and safety as the agent of change versus rules, consequences, and accountability as the agent of behavior and symptom changes
3. On-The-Job Behavior. Endorses empathy-focused staff behavior versus control-focused staff behavior.
4. Self-Efficacy at Work. Endorses feeling able to meet the demands of working with a traumatized population versus feeling unable to meet the demands.
5. Reactions to the Work. Endorses appreciating the effects of secondary trauma/vicarious traumatization and coping by seeking support versus minimizing the effects of secondary trauma/vicarious traumatization and coping by ignoring or hiding the impact.

Researcher Developed Questions

1. Did you receive training in trauma-informed care evidence-based practices during your graduate degree program?

2. How many courses, if any, did you take on trauma-informed care during any of your counseling degree program? (0,1,2,3,4,5,6,7,8,9,10, more than 10- numbers or range)
3. How many courses, if any, did you take in which trauma-informed care was taught during a lecture or unit during your counseling degree program? (0,1,2,3,4,5,6,7,8,9,10, more than 10- numbers or range)
4. If yes, please check/type the training you received [course, one-day workshop...]
5. Have you participated in school district sponsored, in-service trauma-informed care training? (yes/no) or How many school district sponsored, in-service, if any, have you participated in on trauma-informed care/practice? (0,1,2,3,4,5,6,7,8,9,10, more than 10- numbers or range)
 - If any, please check the type of training you received [.....]
 - Have you participated in professional development (aside from in-service) on trauma-informed care training? (yes/no) or How many professional developments, if any, have you participated in on trauma-informed care/practice? (0,1,2,3,4,5,6,7,8,9,10, more than 10- numbers or range)

Procedures

The first procedure was obtaining IRB approval from Liberty University. Researchers must receive IRB approval prior to collecting data. The procedures for placing the survey online in the ASCA and PSCA professional websites, which I previously outlined, also required approval. Once the deemed appropriate for these communities, I could disseminate the survey and begin the informed consent process, followed by collecting data.

I used Qualtrics as the collection tool. When probable participants click on the link, they reviewed and memorialized the informed consent and agreement of the terms before receiving permission to continue. After agreeing, the participant could view and complete the surveys and submit the forms as data for collection. Maintaining the highest standards of data collection required continued analysis of the structure of the survey and the effect on school counselors. After two weeks, ASCA Scene and the PSCA received a follow-up email to encourage more counselors to participate. The surveys closed four weeks after the inception of the invitation and all data was uploaded to SPSS.

Data Analysis

Reported descriptive statistics answered the first three research questions. I conducted two standard multiple regression analyses to answer research questions 3 and 4. Table 2 summarizes the analyses used to answer each research question.

Table 2

Question	Analysis
Research Question 1: What training do professional school counselors' have trauma-informed care in a school setting?	Frequencies for each response to all three questions are reported: <hr/> How, if at all, did you participate in trauma-informed care training in graduate school? (Potential responses: no training, a topic covered in one, a topic covered

more than one courses, a course,
 more than one course)
 How much, if any, trauma-
 informed care professional
 development training (do not
 include school sponsored in-service
 training) have you participated in?
 (Potential answers: none, a one-day
 training, a multi-day training,
 multiple trainings) –*this could also
 be formulated as the one below*

How many, if any, trauma-
 informed care school or district-
 sponsored in-service trainings have
 you participated in? (Potential
 answers: none, 1, 2, 3,4, 5
 ,6,7,8,9,10, more than 10)

Research Question 2: What are the professional
 school counselor's attitudes toward providing
 trauma-informed care in a school setting?

Means and standard deviations for
 scores on the following scale and
 its subscales: The Attitudes
 Related to Trauma-Informed Care
 Scale (ARTIC-45)

<p>Research Question 3: What are professional school counselors' levels of self-efficacy in using trauma-informed care in a school setting?</p>	<p>Means and standard deviations for scores on the following scale and its 5 subscales: School Counselor Self-Efficacy scale (SCSE; Bodenhorn & Skaggs, 2005)</p>
<p>Research Question 4: To what extent are (a) years of experience as a school counselor, (b) participation in trauma-informed care training in graduate school, (c) participation in trauma-informed practice professional development activities, and (d) participation in trauma-informed practice in-services predictive of professional school counselors, perceived attitudes toward providing trauma-informed care in a school setting?</p>	<p>Standard Multiple Regression</p>
<p>Research Question 5: To what extent are (a) years of experience as a school counselor, (b) participation in trauma-informed care training in graduate school, (c) participation in trauma-informed practice professional development activities, and (d) participation in trauma-informed practice in-services predictive of professional school counselors' self-</p>	<p>Standard Multiple Regression</p>

efficacy in providing trauma-informed care in a school setting?

I used the null hypotheses for RQ 4 and 5, two separate standard multiple regression analyses with a significance level set at $p = .05$ to analyze the data. According to Gall et al. (2007), standard multiple regression utilizes “research participants’ scores on two or more predictor variables to predict their performance on the criterion variable” (p. 345). As both RQs 4 and 5 contain multiple predictor variables (e.g. years of experience and participation in training) and one criterion variable each as well as the aim to examine the possible predictive relationships between the predictor variables and the criterion variable, standard multiple regression analyses were the most appropriate.

Prior to conducting any regression analysis, I conducted the following assumption tests: (a) independence of observations; (b) homoscedasticity; (c) the presence of a linear relationship between the predictor variables and the criterion variable; (d) absence of multicollinearity; (e) no significant outliers; and (f) approximately normally distributed random errors (residuals). In assessing the assumptions, I used the following methods: the assumption of independence of observation (no autocorrelation) assessed and interpreted using Durbin-Watson’s original values (Field, 2000). In examining homoscedasticity and linearity, I employed the use of scatterplots (Warner, 2013), and partial regression plots using studentized residuals were used to further check linearity (Field, 2005). Cook’s distance will also be calculated using the formula $4 / (n - k - 1)$, where n is the number of cases and k is the number of independent variables to determine the “effect of a single case” (such as any outliers) on the model (Field, 2005, p. 165). A value greater than one was considered to be an extreme outlier.

According to Field (2009), multicollinearity is a “situation in which two or more variables are very closely linearly related” (p. 790). Multicollinearity the method I used to evaluate using variance influence factor (VIF), the correlation matrix, and tolerance values (Field, 2005; Warner, 2013). A value of 10 or higher on the VIF is the threshold used to determine multicollinearity. A correlation matrix was also used to present the analyzed bivariate relationships between the individual predictor variables and the criterion variable (Gall et al., 2007). The relationship among the predictor variables was analyzed using correlation in order to help determine if there were any strong relationships among the predictors. Each correlation coefficient was checked for significance ($p < .05$) with an established cutoff correlation coefficient of .7 (Field, 2005; Warner, 2013). Ideally, the predictor variables should have a strong relationship with the criterion variable, but not with other predictor variables (Mundfrom et al., 2006). I considered tolerance values with a value of less than .1 interpreted them as being problematic (Field, 2005), yet I found no such values. To test for normality, a histogram (including a normal curve superimposed) I used “examine the shape of the distribution of scores” (Warner, 2013, p. 550). A P-P Plot determined the tenability of this assumption; a relatively straight, diagonal line indicates normality (Warner, 2013).

In addition to the assumption testing following Morgan, Reichert, and Harrison’s (2002) recommendations, the following statistics I reported for the analysis:

- descriptive statistics (M, SD),
- number (N),
- degrees of freedom (df),
- multiple R or effect size (R²),
- observed F (F),
- significance level (p).

Also, for each predictor, the following information is reported: “unstandardized regression coefficient (B), standardized regression coefficient (β), observed t-value (t), significance level (p), and semi-partial correlations (variance accounted for per variable)” (Morgan et al., 2002, p. 69).

The F-test determined whether to reject the null hypotheses for RQ 4 and 5. To analyze the individual contributions of each variable, I examined t-tests to see if any of the regression coefficients were individually significant (Field, 2005). Adjusted R² (coefficient of determination) was used to report the effect size and measure the amount of linear association between attitudes and self-efficacy (the y variable) and the four predictor variables.

CHAPTER 4: FINDINGS

Overview

Ninety-nine participants responded to the survey; however, twenty-two did not complete the survey. Thus, I analyzed the responses of seventy-seven professional school counselors. Most of the school counselors who participated in the survey were Caucasian ($n=66$, 85.7%). Five (6.5%) reported their race as Black, 3 (3.9%) as Hispanic, and 3 (3.9%) as other. The professional school counselors reported having licenses and practicing across 38 of the 50 states, with years of experience ranging from 1 to over 30 years (see Table 3). The size of the school and number of students each professional school counselor was responsible for varied (see Table 3).

Table 3

Descriptive Statistics for Professional School Counselor's Experience ($N=77$)

	<i>n</i>	%
Years of Experience		
First-year	10	13.0
1-5 years	20	26.0
6-10 years	12	15.6
11-15 years	15	19.5
16-20 years	10	13.0
21-25 years	6	7.8
26-30 years	1	1.3
Over 30 years	3	3.9
Type of School		
Elementary School	31	40.3

High School	21	27.3
Middle School	16	20.8
Other	9	11.7
School size		
1-200	9	11.7
201-350	11	14.3
351-500	19	24.7
500-650	7	9.1
more than 650	31	40.3
Number of Students		
Responsible for		
0-100 students	5	6.5
101-200	14	18.2
201-300	14	18.2
301-400	22	28.6
401-500	11	14.3
501-600	6	7.8
601-700	1	1.3
701 or more	4	5.2

Research Question 1

Research Question 1 asked, what training do professional school counselors' have trauma-informed care in a school setting? I analyzed the survey questions using descriptive statistics to answer this research question. Forty-one (53.2%) professional school counselors (PSC) reported

receiving no trauma-informed care (TIC) training during their graduate programs; however, thirty-six (46.8%) did receive training. Of the 36 who received training, nineteen (52.8%) of the PSC reported taking at least one course focused on TIC and (8.3%) reported taking at least two courses focused on TIC. Others reported having attended a workshop focused on TIC for a course or taking one or more courses that addressed TIC. The majority of professional school counselors ($n = 56, 72.7\%$) also reported attending one or more school district-sponsored TIC training or choosing to participate in a professional development (not sponsored by the school district) focused on TIC ($n = 55, 71.4\%$) (see Table 4 for number of trainings and professional developments attended).

Table 4

Descriptive Statistics for Professional School Counselor's Training Experiences ($N=77$)

	<i>n</i>	%
School district TIC training attended		
0	21	27.3
1	13	16.9
2	16	20.8
3	10	13.0
4	3	3.9
5 or more	14	18.2
TIC professional developments attended		
0	22	28.6
1	19	24.7
2	7	9.1
3	15	19.5

4	1	1.3
5 or more	13	16.9

Research Questions 2 and 3

Research Question 2 asked, What are the professional school counselor's attitudes toward providing trauma-informed care in a school setting? and research question 3 asks, What are professional school counselors' levels of self-efficacy in using trauma-informed care in a school setting?

Instruments

The instrument used to measure the variable, professional school counselor's attitudes toward providing trauma-informed care in a school setting, for this study was the Attitudes Related to Trauma-Informed Care (ARTIC) (Baker et al., 2016)), one of the most widely used psychometrically valid measures of trauma-informed care (TIC). I calculated reliability for this scale based on the sample who responded to the survey. The ARTIC Scale demonstrated acceptable to good reliability with a Cronbach's alpha coefficient of .75.

The instrument used to measure the variable, professional school counselor's self-efficacy for implementing Trauma-Informed Care (TIC), for this study was a modified version of the School Counselor Self-Efficacy Scale (SCSE) (Bodenhorn & Skaggs, 2005). Development of the School Counselor Self-Efficacy Scale as a 43-item instrument was to provide a psychometrically sound instrument to evaluate school counselors' self-efficacy. The scale has five subscales including, the Personal and Social Development scale containing 12 items; the Leadership and Assessment scale containing 9 items; Career and Academic Development (scale containing 7 items; the Collaboration scale containing 11 items; and the Cultural Acceptance scale containing 4 items. The original School Counselor Self-Efficacy Scale exhibited good construct validity and reliability. Cronbach's α

indicated good reliability for the entire scale (.85), which is within the accepted threshold of 0.70 to 0.95 (Bodenhorn & Skaggs, 2005). Each subscale also demonstrated good reliability, Personal and Social Development (.91), Assessment (.90); Career and Academic Development (.85); Collaboration (.87); and Cultural Acceptance (.72). However, for this study I only a composite scale to measure school counselor's self-efficacy for implementing trauma-informed care.

A modified School Counselor Self-Efficacy Scale focused on school counselor's self-efficacy with providing trauma Informed Care (TIC) as part of a comprehensive school counseling plan (e.g., The School Counselor Self-Efficacy Scale for Trauma-Informed Care (SCSE-TIC)). Informed by an extensive literature review, I worked with an expert who has practiced trauma care and holds a Ph.D. in Counselor Education and Supervision to modify each of the 43 original items to focus on TIC. For example, the original item, "Advocate for integration of student academic, career, and personal development into the mission of my school" was modified to "Advocate for integration of trauma-informed care to promote student academic, career, and personal development into the mission of my school." For scoring, I used the original scale's five-point Likert-type scale format. To calculate the final score I summed together the entire scale to indicate a professional school counselor's self-efficacy when implementing TIC. The lower the score, the lower the self-efficacy. The higher the score, the higher the self-efficacy. Possible scores ranged from 43-215.

In order to establish face and content validity of the School Counselor Self-Efficacy Scale for Trauma Informed Care (SCSE-TIC), to a panel of two expert reviewers examined the instrument for content validity, face validity, clarity, conciseness, and readability (Worthington & Whittaker, 2006). Each reviewer held a Ph.D. in Counselor Education and Supervision, had a graduate degree in counseling and had taught a course focused on trauma-informed care; practiced as a school counselor for at least 3 years; and had published or presented at the national level on trauma-informed care.

Each reviewer received an emailed copy of the instrument and allows one week to review the instrument and complete an item analysis survey. I used the item analysis to “evaluate the extent to which questions are consistently understood and answered by individuals” (Dray et al., 2011, p.33). For the purpose of this study, the reviewers rated each item on the modified scale using a five-point Likert-type scale (5 = Excellent, 1= Poor) to assess each item for content validity, face validity, clarity, conciseness, and readability (Worthington & Whittaker, 2006). The reviewers also provided any recommendations for changes to each item as they saw appropriate. I calculated the mean scores of content validity, face validity, clarity, conciseness, and readability for each item and all exceeded 4.0. Therefore, I retained all items. In addition, I analyzed comments and suggestions analyzed using open coding of all written feedback to identify improvement themes (Creswell, 2013) and adjusted five items for grammar and readability purposes. After I completed the data collected, I calculated reliability, and for the modified SCSE was good with a Cronbach’s alpha coefficient of .975.

I included the original scale and the modified scale, The School Counselor Self-Efficacy Scale for Trauma-Informed Care (SCSE-TIC) in Appendix B.

Descriptive Analyses

Descriptive statistics for the professional school counselor’s attitudes toward providing trauma-informed care in a school setting and self-efficacy in using trauma-informed care in a school setting reported in Table 5. I used the ARTIC to measure attitudes about trauma-informed care and the potential range is 45-360, which dictated the mean would be 157.5. The mean for this study is 166.390 which signifies the participants held moderate attitudes in providing trauma-informed care. The range for the SCSE-TIC is 43-215 and the 154.207 mean for the study suggests a moderate level of self-efficacy.

Table 5 Descriptive Statistics for Professional School Counselor's Attitudes and Self-Efficacy ($N=77$)

	Range	Minimum	Maximum	<i>M</i>	<i>SD</i>
ARTIC	164.00	95.00	259.00	166.390	19.199
SCSE- TIC	144.00	69.00	213.00	154.207	30.789

Research Question 4

Research question four asks, “To what extent are (a) years of experience as a school counselor, (b) participation in trauma-informed care training in graduate school, (c) participation in trauma-informed practice professional development activities, and (d) participation in trauma-informed practice in-services predictive of professional school counselors, perceived attitudes toward providing trauma-informed care in a school setting?” I planned to use a multiple regression analysis but it was not conducted as the preliminary results of the pairwise correlation analyses were not statistically significant. Effect sizes demonstrated that the pairwise association between the ARTIC scores and each independent variable were very small; thus making the multiple regression analysis futile. The descriptive statistics for the independent variables and dependent variable, ARTIC, are reported in Table 6, and the results of the correlation analyses (e.g. Pearson's r and Spearman's ρ) in Table 7.

Table 6

Descriptive Statistics for Variables and ARTIC ($N=77$)

	<i>M(Mdn)</i>	<i>SD</i>
ARTIC	166.390	19.199

Years of Experience	3.42 (3)	1.80
Number of TIC courses taken during Graduate School	.32	.549
Number of courses that addressed TIC during Graduate School	.92	1.537
Number of School District sponsored TIC in-services attended	2.04	1.795
Number of School District sponsored TIC PDs attended	1.91	1.786

Results of the correlation analyses between each independent variable and the dependent variable, ARTIC

Table 7

Correlation Matrix

	1	2	3	4	5	6
1	-	.065	.019	-.024	-.013	-.037
2	-	-	-.320*	-.256*	.213	.366*
3	-	-	-	.530*	-.120	-.225*
4	-	-	-	-	-.042	-.036
5	-	-	-	-	-	.641*

Note. * $p < .05$. 1= ARTIC variable (dependent variable), 2= Years of experience variable, 3= Number of TIC graduate courses taken variable, 4= Number of graduate program courses where TIC was

addressed, 5= Number of TIC school district-sponsored In-services, 6= Number of TIC Professional Developments

Research Question 5

Descriptive Statistics

A multiple regression (MR) was conducted to examine question 5, To what extent are (a) years of experience as a school counselor, (b) participation in trauma-informed care training in graduate school, (c) participation in trauma-informed practice professional development activities, and (d) participation in trauma-informed practice in-services predictive of professional school counselors' self-efficacy in providing trauma-informed care in a school setting? The descriptive statistics for the independent variables and dependent variable, SCSE-TIC, reported in Table 8.

Table 8

Descriptive Statistics for Independent Variables and SCSE-TIC ($N=77$)

	<i>M(Mdn)</i>	<i>SD</i>
SCSE-TIC	154.207	30.789
Years of Experience	3.42 (3)	1.80
Number of TIC courses taken during Graduate School	.32	.549
Number of courses that addressed TIC during Graduate School	.92	1.537
Number of School District sponsored TIC in-services attended	2.04	1.795

Number of School District sponsored TIC PDs attended	1.91	1.786
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Table 9 is a correlation matrix demonstrating the association among the variables in the analysis, demonstrating several significant pairwise associations among variables.

Table 9

Correlation Matrix

	1	2	3	4	5	6
1	-	.055	.000	.065	.320**	.547**
2	-	-	-.320*	-.256*	.213	.366*
3	-	-	-	.530*	-.120	-.225*
4	-	-	-	-	-.042	-.036
5	-	-	-	-	-	.641*

Note. * $p < .05$. 1= TIC self-efficacy variable, 2= Years of experience variable, 3= Number of TIC graduate courses taken variable, 4= Number of graduate program courses where I addressed TIC, 5= Number of TIC school district-sponsored In-services, 6= Number of TIC Professional Developments

Assumption Testing

I conducted assumption testing prior to conducting the MR. There was independence of residuals, as assessed by a Durbin-Watson statistic. The value of 2.112 indicated the assumption of

independence of observations is tenable as the value is close to 2. Inspection of the scatterplot of the studentized residuals (SRE_1) against the (unstandardized) predicted values (PRE_1) and partial regression plots demonstrate no violation of the assumption of linearity (see Appendix D). Inspection of the scatterplot of the studentized residuals (SRE_1) against the (unstandardized) predicted values (PRE_1) also demonstrates no gross violations of the assumption of homoscedasticity (see Appendix E). The assumption of multicollinearity is not violated as tolerance values are greater than 0.1 (the lowest is 0.538) and VIF values are greater than 10 (highest is 1.858). Examination of casewise diagnostics indicated no extreme outlier. Evaluation of Cook's distance supported this conclusion as no case had a value that exceeded 1 (Cook, & Weisberg, 1982). Moreover, all the leverage values were less than .2. Finally, the examination of a histogram with superimposed normal curve and a P-P Plot demonstrates no gross violations of the assumption of normality (see Appendix F). As assumptions for the MR were not violated, the MR was used to examine the data to answer the research question.

Analysis

The results of the multiple regression demonstrated the model containing the combination of the following variables (a) years of experience as a school counselor, (b) participation in trauma-informed care training in graduate school, (c) participation in trauma-informed practice professional development activities, and (d) participation in trauma-informed practice in-services significantly predict professional school counselors' self-efficacy in providing trauma-informed care in a school setting, $R^2 = .323$ (adjusted $R^2 = .275$), $F(5,71) = 6.761$, $p < .001$. Based on the effect size, the explains 32.3 % ($.323 \times 100$) of the variability of the criterion/dependent variable, professional school counselors' self-efficacy in providing trauma-informed care.

One variable, number of TIC professional developments attended, made individual significant contributions. This demonstrated the more professional school counselors attend TIC professional developments, the more likely they were to have higher self-efficacy in implementing trauma-informed care as part of a comprehensive counseling program. None of the other variables made significant contributions (See Table 10).

Table 10

Contributions of Independent Variables (N= 77)

Variable	Zero-Order r	Partial r	β	SE B	B	t	p
Years of Experience	.055	-.088	-1.359	1.831	-.080	-.742	.460
Number of TIC courses taken during Graduate School	.000	.104	5.953	6.741	.106	.883	.380
Number of courses that addressed TIC during Graduate School	.065	.007	.142	2.353	.007	.060	.952
Number of School District sponsored TIC in-services attended	.320**	-.053	-.978	2.188	-.057	-.447	.656

Number of School District sponsored TIC PDs attended	.547**	.490**	10.868	2.296	.630	4.734	< .01
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Note. * $p < .05$, ** $p < .01$

Summary

The following Table 11 summarizes the findings

Table 11

Summary of Findings

Question	Analysis	Main Conclusions & Findings
Research Question 1: What training do professional school counselors' have trauma-informed care in a school setting?	Descriptive Statistics (frequencies)	A little over half ($n = 41$; 53.2%) professional school counselors (PSC) reported receiving no trauma-informed care (TIC) training during their graduate programs; However, over half of the PSC reported attending one or more school district-sponsored TIC training ($n = 56$, 72.7%) or choosing to participate in a professional development (not sponsored by the school district) focused on TIC ($n = 55$, 71.4%).

<p>Research Question 2: What are the professional school counselor's attitudes toward providing trauma-informed care in a school setting?</p>	<p>Means and standard deviations for The Attitudes Related to Trauma-Informed Care Scale (ARTIC-45)</p>	<p>PSC reported moderate attitudes toward TIC ($M= 166.390$ $SD=19.199$; potential range 45-225)</p>
<p>Research Question 3: What are professional school counselors' levels of self-efficacy in using trauma-informed care in a school setting?</p>	<p>Means and standard deviations for the modified School Counselor Self-Efficacy scale (SCSE; Bodenhorn & Skaggs, 2005), the SCSE-TIC</p>	<p>PSC reported moderate self-efficacy toward TIC ($M= 154.207$, $SD = 30.789$; potential range 43-215)</p>
<p>Research Question 4: To what extent are (a) years of experience as a school counselor, (b) participation in trauma- informed care training in graduate school, (c) participation in trauma-informed practice professional development activities, and (d)</p>	<p>Pairwise Correlation Analyses; planned multiple regression was not conducted</p>	<p>Fail to reject the null hypothesis; pairwise correlation analyses demonstrated no association($p >.05$) between years of experience as a school counselor, (b) participation in trauma- informed care training in graduate school, (c) participation in trauma-informed practice professional development activities,</p>

participation in trauma-informed practice in-services predictive of professional school counselors, perceived attitudes toward providing trauma-informed care in a school setting?

Research Question 5: To what extent are (a) years of experience as a school counselor, (b) participation in trauma-informed care training in graduate school, (c) participation in trauma-informed practice professional development activities, and (d) participation in trauma-informed practice in-services predictive of professional school counselors' self-efficacy in providing trauma-

Standard Multiple Regression

and (d) participation in trauma-informed practice in-services with professional school counselors' perceived attitudes toward providing trauma-informed care in a school setting.

Reject the null hypothesis ($R^2 = .323$ (adjusted $R^2 = .275$), $F(5,71) = 6.761$, $p < .001$). The model containing the combination of the following variables (a) years of experience as a school counselor, (b) participation in trauma-informed care training in graduate school, (c) participation in trauma-informed practice professional development activities, and (d) participation in trauma-informed practice in-services significantly predict professional school counselors' self-efficacy in providing trauma-informed care in a

informed care in a school
setting?

school setting. The model explains
32.3 % (.32.3 X 100) of the
variability of the professional school
counselors' self-efficacy in
providing trauma-informed care.

CHAPTER FIVE: CONCLUSIONS

Overview

Ninety-nine participants responded to the survey; however, twenty-two did not complete the survey. Thus, I analyzed the responses of seventy-seven professional school counselors. Most of the school counselors who participated in the survey were Caucasian ($n=66$, 85.7%). Five (6.5%) reported their race as Black, 3 (3.9%) as Hispanic, and 3 (3.9%) as other. The professional school counselors reported having licenses and practicing across 38 of the 50 states, with years of experience ranging from 1 to over 30 years. The size of the school and number of students each professional school counselor was responsible for varied.

Research Question 1 asked, what training do professional school counselors' have trauma-informed care in a school setting? According to the descriptive statistics calculated by SPSS, forty-one (53.2%) professional school counselors (PSC) reported receiving no trauma-informed care (TIC) training during their graduate programs; however, thirty-six (46.8%) did receive training. Of the 36 who received training, nineteen (52.8%) of the PSC reported taking at least one course focused on TIC and (8.3%) reported taking at least two courses focused on TIC. Others reported attending a workshop focused on TIC for a course or taking one or more courses that addressed TIC. The majority of professional school counselors ($n = 56$, 72.7%) also reported attending one or more school district-sponsored TIC training or choosing to participate in a professional development (not sponsored by the school district) focused on TIC ($n = 55$, 71.4%)

I developed research questions 2 and 3 to ascertain the attitudes with which professional school counselors view trauma-informed care and its role in schools and the self-efficacy professional school counselors purport when employing trauma-informed care. Specifically, research question 2 asks, what are the professional school counselor's attitudes toward providing trauma-informed care in a

school setting? In order to measure attitudes, the ARTIC was given to the participants. The range of the ARTIC is a minimum of 45 to a maximum of 315 since there are 45 questions with 7 answer choices. An average of 166.3896 demonstrated a moderate attitude in providing TIC in schools.

Alternately, research question 3 asked, what are professional school counselors' levels of self-efficacy in using trauma-informed care in a school setting? The range of scores used on the School Counselor Self Efficacy-TIC is 43-215; the lower the score, the lower and self-efficacy and the higher the score, the higher the self-efficacy. The average self-efficacy of 154.207 found in this study demonstrated a moderate level of self-efficacy.

Research question 4 attempts to delineate the variables that will be predictive of professional school counselors' perceived attitudes toward providing trauma-informed care in schools. Surprisingly, there was no association found between perceived attitudes and years of experience, number of TIC courses taken, number of courses where I addressed TIC, TIC school district-sponsored in-service opportunities, or the number of TIC professional developments. This finding suggested regardless of the type of training taken by the participant or the years of experience as a professional school counselor, attitudes about TIC were not influenced. So, based on these results, I concluded even though I planned a multiple regression analysis, it was not conducted as the preliminary results of the pairwise correlation analyses were not statistically significant. Effect sizes demonstrated the pairwise association between the ARTIC scores and each independent variable was very small; thus, making the multiple regression analysis futile.

The final research question five asked, To what extent are (a) years of experience as a school counselor, (b) participation in trauma-informed care training in graduate school, (c) participation in trauma-informed practice professional development activities, and (d) participation in trauma-informed practice in-services predictive of professional school counselors' self-efficacy in providing

trauma-informed care in a school setting? As in RQ 4, the goal was to ascertain if the five variables are predictive of professional school counselors' self-efficacy in providing trauma-informed care. By examining the models, it was evident experience and training significantly predict the self-efficacy of professional school counselors. The results of the multiple regression demonstrated the model containing the combination of the following variables (a) years of experience as a school counselor, (b) participation in trauma-informed care training in graduate school, (c) participation in trauma-informed practice professional development activities, and (d) participation in trauma-informed practice in-services significantly predict professional school counselors' self-efficacy in providing trauma-informed care in a school setting, $R^2 = .323$ (adjusted $R^2 = .275$), $F(5,71) = 6.761$, $p < .001$. Based on the effect size, this explains 32.3 % ($.323 \times 100$) of the variability of the criterion/dependent variable, professional school counselors' self-efficacy in providing trauma-informed care.

There was significant evidence to reject the null hypothesis related to research question 5. Especially pertinent was the finding one variable, the number of trauma-informed care professional developments made individual significant contribution. None of the other variables made significant contributions.

Discussion

Researchers documented the pervasive effects of adverse childhood experiences and the importance of trauma-informed care in a school setting (Bethell, Gombojav, Solloway, & Wissow, 2016; Metzler et al., 2017; Soleimanapour et al., 2017). Schools are invaluable assets in providing trauma-informed programs but not all school counselors receive training in trauma and sometimes excluded as part of treatment teams (Lokeman, 2011). There is a need for research to determine the extent to which trauma-informed care training is included in the graduate program of school

counselors. Furthermore, once counselors receive training, additional research can determine the school counselors' self-efficacy when providing trauma-informed care in schools. School counselors are involved in the lives of the students daily and can undoubtedly work with children affected by adverse childhood experiences to help lessen the negative effects.

The model containing the following combination of the following factors (a) years of experience as a school counselor, (b) participation in trauma-informed care training in graduate school, (c) participation in trauma-informed practice professional development activities, and (d) participation in trauma-informed practice in-services significantly predict professional school counselors' self-efficacy. Specifically, the most substantial conclusion of this study is the significant finding the more professional school counselors attend trauma-informed professional developments, the more likely they are to have higher self-efficacy in implementing trauma-informed care as part of a comprehensive counseling program. Participation in professional developments demonstrated the most important of the variables I studied. Professional development opportunities are trainings offered to appropriate staff and then each staff member is given a choice if they would like to participate. Having ownership and a say in participation may indicate professional school counselors who choose to attend professional developments may have a sincere interest in the topic and a stake in the implementation.

The two main constructs surveyed in this study were professional school counselors' attitudes towards providing trauma-informed care in schools and their self-efficacy or the belief that they are capable and have the knowledge to provide trauma-informed care in a school setting. It is interesting to note that although the attitude construct showed a moderate rating, it did not correlate with school counselors' self-efficacy, which was also a moderate rating. This result indicates that although professional school counselors may feel they have self-efficacy in providing trauma-informed care in

schools, their attitude about providing it may not be positive for various reasons. It is possible to have a high self-efficacy and have a negative view of providing trauma-informed care because of the many reasons inherent in schools.

When considering professional school counselors' ability to provide trauma-informed care in schools, it is necessary to discuss the factors limiting their effectiveness. Kim and Lambie (2018) identified relevant external and internal variables related to professional school counselors' propensity for burnout. Some factors shown to correlate with burnout included having non-counselor related duties, having assigned large caseloads, working in schools that did not meet adequate yearly progress, experiencing a scarcity of supervision, and having greater perceived stress. Of particular concern is burnout, which can be defined as a psychological phenomenon associated with job-related stress and usually occurs when counselors are unable to meet the clients' needs as well as their own due to a high-pressure environment (Maslach, 2017). Wachter (2006) found 20% of school counselors experience burnout that may limit their ability to provide ethical and effective services to students.

High caseloads of students remain a noted struggle in many schools across the United States. McCarthy et al. (2010) found the demands on school counselors are numerous but paperwork and a high number of students on caseload were the most stressful. Researchers found the number of students on a caseload 54.6% as extremely demanding. According to the American School Counselors Association, an acceptable ratio of students to counselors is 250:1 (ASCA, 2015). In this research study, 44 of the 77, or approximately 57% of the participants indicated they were responsible for 301 or more students. Four of the participants were responsible for 701 students or more, double the ratio recommended by the American School Counselor Association (ASCA, 2015).

Implications

School systems have historically implemented new initiatives, only to eliminate or change them every few years. Because of this practice, professional school counselors may feel like the new initiative is just the next “new thing” and they may be hesitant to fully embrace another initiative since it most likely will not be around long. A universal trend in education is to introduce a new methodology and subsequently spend many hours working towards implementation. Newly elected governors or school officials may have different priorities and the previous initiative may not be as important. I have been involved in public school education as a teacher and school counselor for 25 years and in my experience, a new direction is inevitable about every three years. Because of this reasoning, professional school counselors may view trauma-informed care in schools as the next “new initiative” and not as a best practice that will stand the test of time and they may not invest the time and energy required for implementation.

My findings reflect professional school counselors who completed professional development had higher self-efficacy, made individual significant contributions. This conclusion can help guide school districts on the best delivery system for implementing new initiatives within their district. Instead of mandatory in-service trainings, providing a choice to professional school counselors may yield a higher self-efficacy and raise their belief they have the requisite capabilities and the resources to provide trauma-informed care in schools. If schools want to increase professional school counselors’ self-efficacy, it may be advisable to provide a selection or menu of various opportunities

Limitations

One limitation is my inclusion of a new instrument designed to measure the construct of self-efficacy of school counselors when providing trauma-informed care. I recommend using complete factor analysis and test for construct validity for the School Counselor Self Efficacy Trauma-

Informed Care. This would provide more useful psychometric properties, which is the construction and validation of measurement instruments and assessment if the instruments to assure reliable and valid forms of measurement. A reliable scale consistently measures the same construct. This can occur across testing sessions, individuals, and settings. A valid measure measures what it says it is going to measure. The School Counselor Self Efficacy Scale is one of the few measures available for research involving professional school counselor and it became necessary to modify in order to be more useful in this study. The reported reliability for the modified SCSE-TIC reported at .975, which is not always desirable. It may indicate the items may be entirely redundant.

It is always pertinent to report an uneven characteristic found in the participants. Noteworthy in this study is 85.7 % of the participants reported their race as Caucasian. This percent included 66 participants out of the total N of 77 and therefore excludes the study for consideration as culturally inclusive. Many options offered as choices and a category of “other” provided the ability those who did not feel they fit into the designated labels, responses.

Lastly, a limitation often noted in research is the dependence on a self-report method of data collection. One of the advantages of utilizing a self-report method is the ease of data collection, which allows researchers to gather data quickly and cheaply. However, incorporating a self-report method in research is not without limitations. Fixed choice questions lack flexibility and force participants to answer. Another complication can be the social desirability bias in which people want to appear good, knowledgeable, and sometimes endorse choices to make themselves appear more proficient.

Future Research

Because this study was quantitative, follow up questions for some results were not possible. In the future, a qualitative study could better help delineate the reasons why professional school counselors participated in trauma-informed care trainings, professional developments, and in-service

opportunities. The only variable that showed an individual significant contribution to self-efficacy is the involvement in related professional development. It would be pertinent to survey the segments of the study population who did not have training, as well as those who did, chose other options to ascertain the factors contributing to their decision to participate. I would recommend research to further understand why professional school counselors choose to participate in professional development opportunities and what factors influence their choices.

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APPENDICES

Appendix A

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Appendix B

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Appendix C

Rubric One

The School Counselor Self Efficacy School Counselor Self-Efficacy Scale for Providing Trauma informed care (SCSE-TIC) is being developed to measure school counselor's self-efficacy with providing trauma Informed Care (TIC) as part of a comprehensive school counseling plan. The following pages contain the candidate items measuring the construct of the level of professional school counselors' self-efficacy delivering Trauma-informed Care. The purpose of Rubric One is to evaluate the content and face validity each candidate item for inclusion in the SCSE-TIC. Please review the provided definitions of Trauma-Informed care. Then review each candidate item and using the scale below, rate each item on the listed criteria by clicking on the word rate in the box below each criteria and selecting the appropriate rating from the drop-down box that appears. Then please provide feedback in the space provided on any rating of four (good) or below as well as suggestions for recommended changes, additions, or deletions, to improve both content and face validity. Scale: 5-Very Good; 4-Good; 3-Fair; 2-Poor; 1-Very Poor. Appropriate questions would be a) "How well does the statement assess the construct it purports to assess- school counselor's self-efficacy in using TIC?: (b) "When you provided your response, what was it you had in mind?"; (c) Did the item depict an element of TIC? If not, why? (d) "Would you reword the statement?" If so, how? For the purpose of this survey, the following definitions:

Trauma-informed care (TIC) - 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).

Adverse Childhood Experiences (ACES) - Adverse Childhood Experiences (ACES) is the term used to describe all types of abuse, neglect, and other potentially traumatic experiences that occur to people under the age of 18. Adverse Childhood Experiences have been linked to risky health behaviors, chronic health conditions, low life potential, and early death.

Domain: Trauma-Informed Care in Schools						
Factor: Personal and Social Development (1)						
1	8. Function successfully as a small group leader who provides Trauma-informed Care (TIC). (1)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
	Comments: Click to add text					
2	17. Evaluate commercially prepared material designed for Trauma-informed Care (TIC) school counseling to establish their relevance to my school population. (1)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
	Comments: Click to add text					
3	18. Using trauma- informed principles, model and teach conflict resolution skills. (1)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
	Comments: Click to add text					
4	19. Ensure a safe, trauma-informed care environment for all students in my school. (1)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
	Comments: Click to add text					
5	20. Change situations in which an individual or group treats others in a disrespectful or harassing manner, which could result in trauma. (1)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
	Comments: Click to add text					
6	21. Using trauma- informed principles, teach students to use effective communication skills with peers, faculty, employers, family, etc. (1)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
	Comments: Click to add text					

7	22. When providing Trauma-informed Care (TIC), follow ethical and legal obligations designed for school counselors. (1)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
	Comments: Click to add text					
8	23. Using trauma- informed principles, guide students in techniques to cope with peer pressure. (1)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
	Comments: Click to add text					
9	24. Adjust my communication style appropriately to the age and developmental levels of various students who have experienced trauma or Adverse Childhood Experiences (ACES). (1)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
	Comments: Click to add text					
10	25. Incorporate students' developmental stages in establishing and conducting a Trauma-Informed Care (TIC) component of a school counseling program. (1)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
	Comments: Click to add text					
11	27. Teach, develop and/or support students who have who has experienced trauma or Adverse Childhood Experiences (ACES) with their coping mechanisms for dealing with crises in their lives-e.g., peer suicide, parent's death, abuse, etc.(1)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
	Comments: Click to add text					
12	35. Help students who have experienced trauma or Adverse Childhood Experiences (ACES) identify and	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate

	attain attitudes, behaviors, and skills which lead to successful learning. (1)					
Domain: Trauma-Informed Care in Schools						
Factor: Leadership and Assessment (2)						
1	3. Analyze data to identify patterns of trauma-related achievement issues, symptoms, and behavior that contribute to school success (2)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
2	5. Develop measurable outcomes for a school counseling program that integrates Trauma-informed care (TIC) which would demonstrate accountability. (2)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
3	30. Help teachers improve their effectiveness with students who have experienced trauma or Adverse Childhood Experiences (ACES). (2)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
4	36. Select and implement applicable Trauma-informed Care (TIC) strategies to assess school-wide issues. (2)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
5	37. Promote the use of Trauma-informed care (TIC) counseling activities by the total school community to enhance a positive school climate. (2)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate

	Comments: Click to add text					
6	38. Develop school improvement plans that include Trauma-informed Care (TIC) based on interpreting school-wide assessment results. (2)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
	Comments: Click to add text					
7	39. Identify aptitude, achievement, interest, values, and personality appraisal resources appropriate for specified traumatic situations and populations who have experienced trauma or Adverse Childhood Experiences (ACES). (2)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
	Comments: Click to add text					
8	40. Implement a preventive approach to student trauma or Adverse Childhood Experiences (ACES). (2)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
	Comments: Click to add text					
9	41. Lead school-wide initiatives which focus on ensuring a positive learning environment for students who have experienced trauma or Adverse Childhood Experiences (ACES). (2)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
	Comments: Click to add text					
Domain: Trauma-Informed Care in Schools						
Factor: Career and Academic Development (3)						
1	11. Teach students who has experienced trauma or Adverse Childhood Experiences (ACES) how to apply	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate

	time and task management skills for daily life and school activities. (3)					
Comments: Click to add text						
2	12. Foster understanding of the relationship between trauma, learning, and daily life/work. (3)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
3	13. Offer appropriate explanations to students, parents, and teachers of how trauma or Adverse Childhood Experiences (ACES) affect school performance. (3)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
4	14. Deliver age appropriate Trauma-informed Care (TIC) programs through which students acquire the skills needed to successfully navigate the world. (3)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
5	15. Implement a Trauma-informed Care (TIC) program which enables all students to make informed academic, personal, and career decisions. (3)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
6	16. Teach students who has experienced trauma or Adverse Childhood Experiences (ACES) to apply problem-solving skills toward their academic, personal and career success. (3)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						

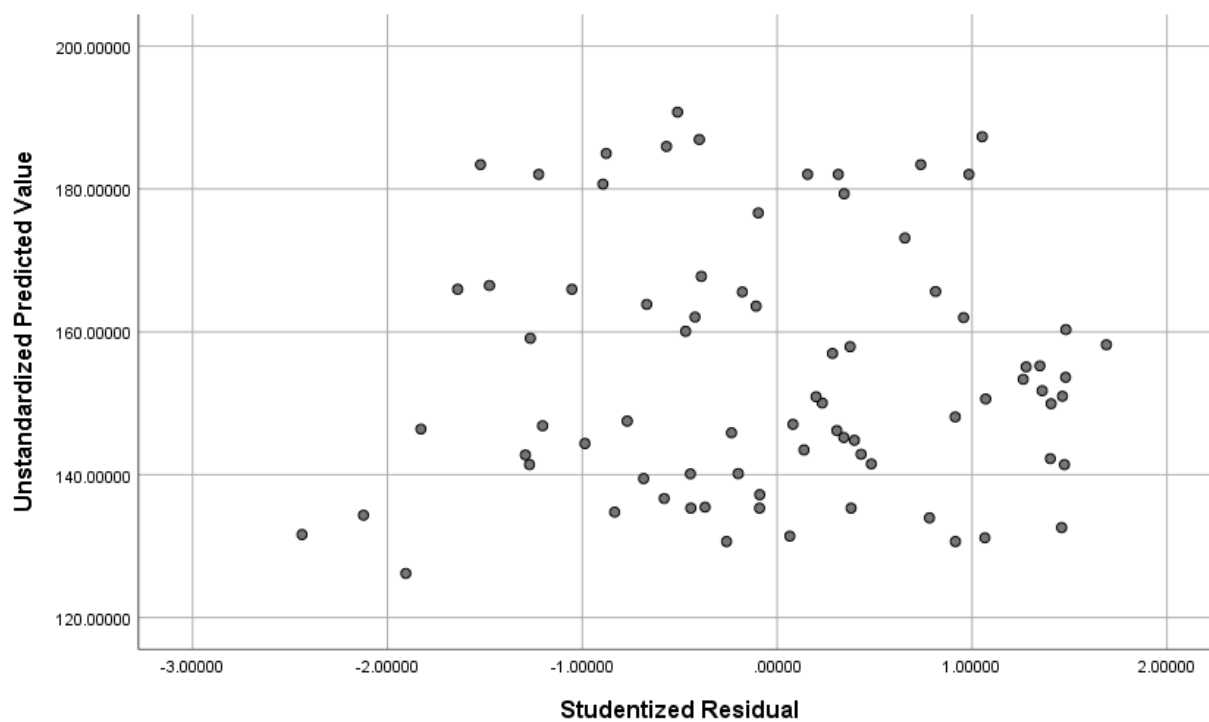
7	33. Use technology designed to support students who have experienced trauma or Adverse Childhood Experiences (ACES). (3)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
Domain: Trauma-Informed Care in Schools						
Factor: Collaboration (4)						
1	1. Advocate for integration of student academic, career, and personal development into the mission of my school. (4)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
2	2. Recognize situations that impact (both negatively and positively) student learning and achievement. (4)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
3	4. Advocate for myself as a professional school counselor and articulate the purposes and goals of school counseling. (4)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
4	6. Consult and collaborate with teachers, staff, administrators and parents to promote student success. (4)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
5	7. Establish rapport with a student for individual counseling. (4)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						

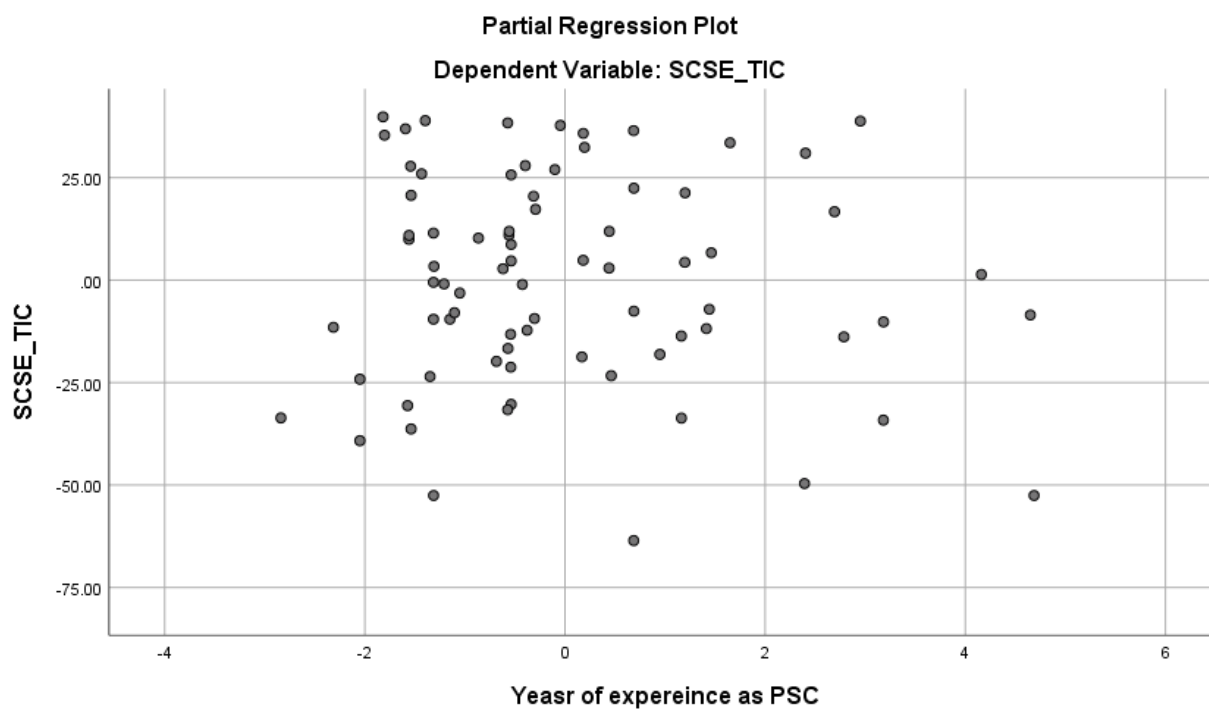
6	9. Effectively deliver suitable parts of the school counseling program through large group meetings such as in classrooms. (4)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
7	10. Conduct interventions with parents, guardians and families in order to resolve problems that impact students' effectiveness and success. (4)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
8	32. Speak in front of large groups such as faculty or parent meetings about Trauma-informed Care (TIC). (4)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
9	34. Communicate in writing with staff, parents, and the external community about Trauma-informed Care (TIC). (4)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
10	42. Consult with external community agencies that provide support services for our students who have experienced trauma or Adverse Childhood Experiences (ACES). (4)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
11	43. Provide resources and guidance to school population in the area of Trauma-informed Care (TIC). (4)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate

	Comments: Click to add text					
Domain: Trauma-Informed Care in Schools						
Factor: Cultural Acceptance (5)						
1	26. I can find some way of connecting and communicating with any student who has experienced trauma or Adverse Childhood Experiences (ACES) in my school. (5)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
2	28. Counsel effectively with students who have experienced trauma or Adverse Childhood Experiences (ACES) and their families from different social/economic statuses. (5)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
3	29. Understand the viewpoints and experiences of students who have experienced trauma or Adverse Childhood Experiences (ACES) and their parents who are from a different cultural background than myself. (5)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						
4	31. Discuss issues of sexuality and sexual orientation in an age appropriate manner with students who have experienced trauma or Adverse Childhood Experiences (ACES). (5)	CV	FV	CL	CON	RL
		rate	rate	rate	rate	rate
Comments: Click to add text						

Appendix D

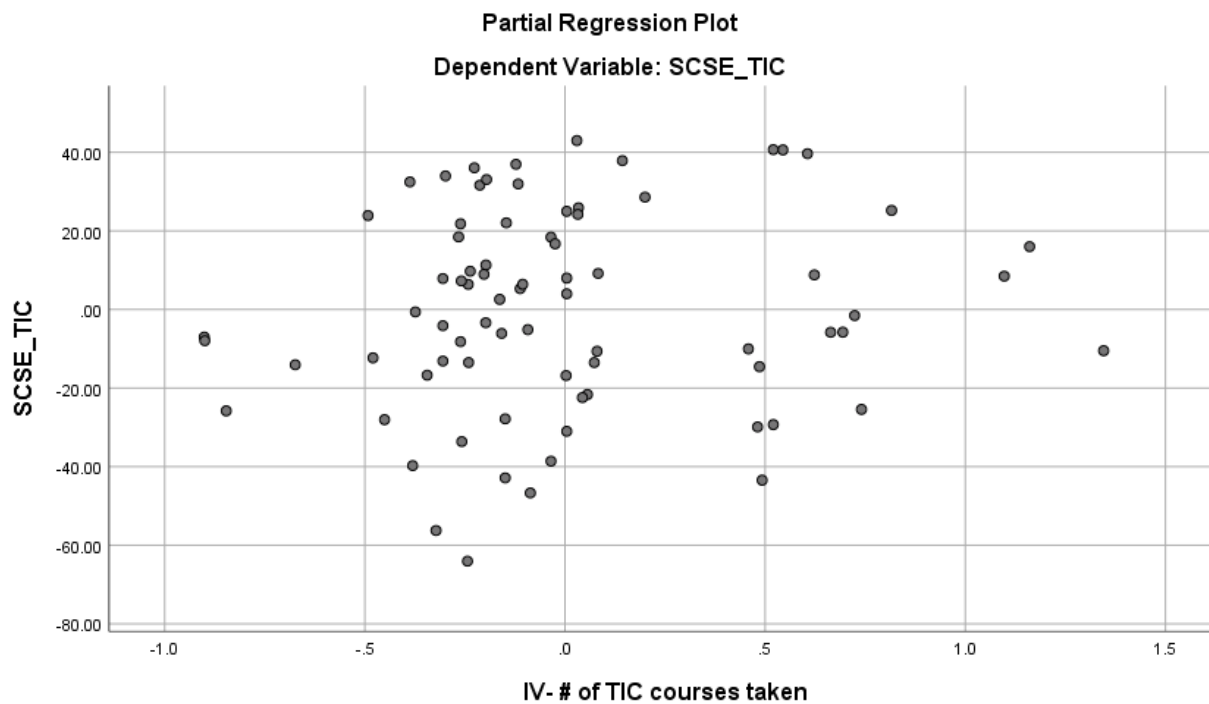
Studentized residuals against the (unstandardized) predicted values and partial regression plots

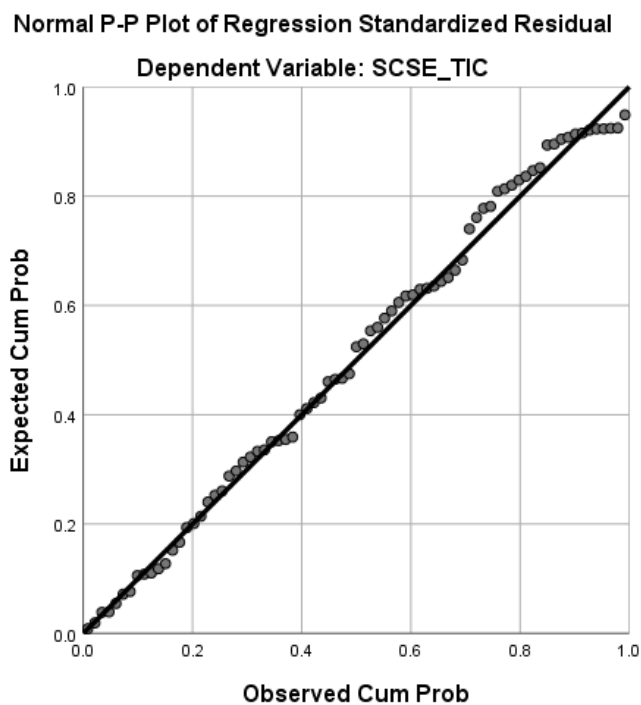




Appendix E

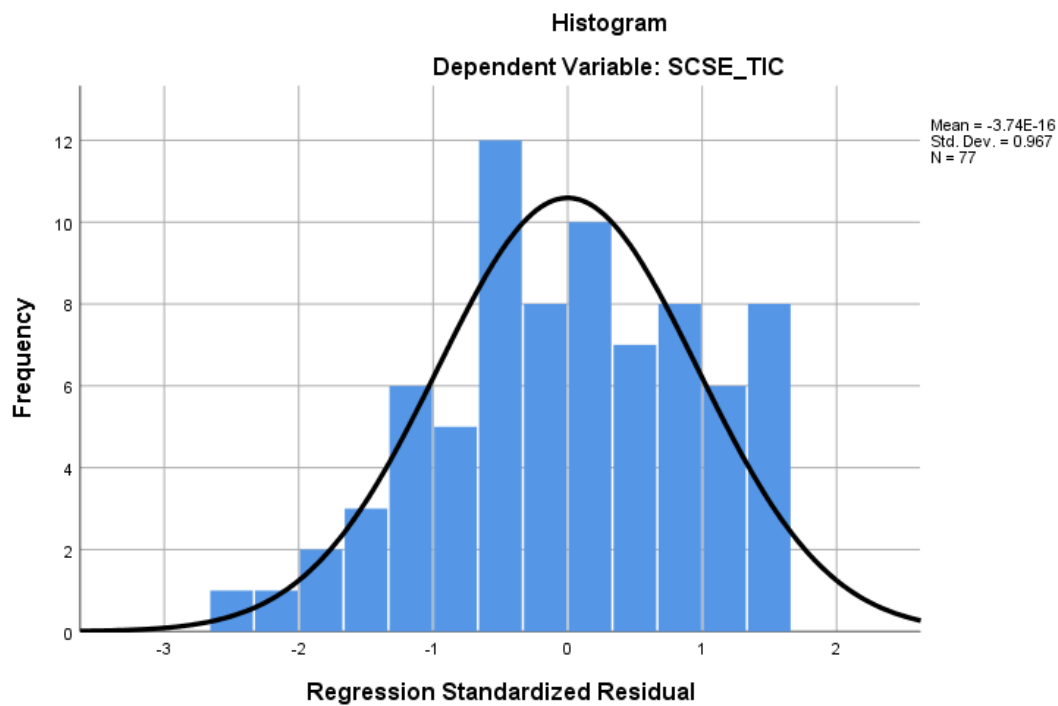
Studentized residuals (SRE_1) against the (unstandardized) predicted values (PRE_1)





Appendix F

Histogram with superimposed normal curve and a P-P Plot



Appendix G

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Board has approved this document for use from
12/9/2019 to --
Protocol # 4036.120919

INFORMED CONSENT

School Counselors' Perceptions of Trauma-Informed Approaches in Schools Elizabeth Burkhardt
Liberty University
School of Behavioral Sciences

You are invited to be in a research study that explores professional school counselors' perceptions of their self-efficacy, attitudes and amount of training in trauma-informed care. You were selected as a possible participant because you are a certified professional school counselor and a member of a professional organization for school counselors (ASCA and/or PSCA). Please read this form and ask any questions you may have before agreeing to be in the study.

Elizabeth Burkhardt, a doctoral candidate in the Community Care and Counseling department, School of Behavioral Sciences at Liberty University, is conducting this study.

Background Information: The purpose of this study is understand if professional school counselors are receiving the necessary training to participate in trauma-informed care in schools. It will also study the attitudes of professional school counselors towards trauma-informed care and the level of self-efficacy when participating in trauma-informed care.

Procedures: If you agree to be in this study, I would ask you to complete an anonymous survey. This survey will take approximately 10-15 minutes to complete.

Risks: The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

Benefits: Participants should not expect to receive a direct benefit from taking part in this study.

Compensation: Participants may be compensated for participating in this study. Participants may choose to be entered into a drawing to win one of five \$10.00 Amazon gift cards. Email addresses will be requested for compensation purposes; however, they will be pulled and separated from your responses by Qualtrics to maintain anonymity.

Confidentiality: The records of this study will be kept private. Research records will be stored securely, and only the researcher and the researcher's dissertation committee will have access to the records. Participant responses to the survey questions are anonymous. No names are collected. Data will be stored on a password locked computer and may be used in future presentations.

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12/9/2019 to --
Protocol # 4036.120919

Voluntary Nature of the Study: Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide

to participate, you are free to not answer any question or withdraw at any time, prior to submitting the survey, without affecting those relationships.

How to Withdraw from the Study: If you choose to withdraw from the study, please exit the survey and close your internet browser. Your responses will not be recorded or included in the study.

Contacts and Questions: The researcher conducting this study is Elizabeth Burkhardt. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at eburkhardt1@liberty.edu. You may also contact the researcher's faculty chair, Dr. Suzie Johnson, at sajohnson9@liberty.edu.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Please notify the researcher if you would like a copy of this information for your records.

Statement of Consent: I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.