Teacher Experiences Regarding a Trauma-Informed Care Model in a Residential Facility School

Tammy Allen

Concordia University - Portland

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Concordia University–Portland

College of Education

Doctorate of Education Program

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Teacher Experiences Regarding a Trauma-Informed Care Model in a Residential Facility School

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Concordia University–Portland
College of Education

Dissertation submitted to the Faculty of the College of Education
in partial fulfillment of the requirements for the degree of
Doctor of Education in
Transformational Leadership

Heather Miller, Ph.D., Faculty Chair Dissertation Committee
Jillian Skelton, Ed.D., Content Specialist
Brian D. Roland, Ph.D., Content Reader

Concordia University–Portland
2018
Abstract

This action research study examined the experiences of 12 teachers in a residential facility school in southern Colorado regarding the implementation of a trauma-informed care model. The analysis of the data provided evidence that the teachers’ experiences during the study transformed their perceptions concerning trauma-informed care. The study was guided by Herr and Anderson’s (2015) Action Research Cycle involving four phases: Develop, Act, Observe, Reflect. Participants were actively engaged in a focus group during the study. The focus group was guided by Schmuck’s (2006) Steps of Responsive Action Research. Using this cyclical action research approach, participants learned about trauma-informed care and contributed to the actions that took place in the study. They determined strategies through which to implement the trauma-informed care model. Participants experienced shifts in their perceptions and realized the viability of the trauma-informed care model in the residential facility school environment. Through the action research process, teachers participated in the development of shared interventions and improved their awareness of improvements and changes resulting from the process. They also identified challenges and concerns of using trauma-informed care in a residential facility school. This study demonstrated that the action research process is a viable option for increasing knowledge and understanding and that trauma-informed care is an essential component of assisting staff in working with traumatized youth.

*Keywords:* trauma-informed, action research, trauma-informed care in schools, teacher perceptions
Dedication

This dissertation is dedicated to the rarely recognized champions who choose to dare the trenches and work tirelessly to help youth who have experienced life-changing trauma. There are not many who have the heart to tackle this difficult population, and the world is a better place because of you. I am encouraged and amazed daily by your effort, dedication, and compassion.
Acknowledgements

I would like to thank Dr. Heather Miller, my department chair, for her meticulous efforts in helping me to complete this dissertation. I could absolutely not have completed it without her. She guided me through the most difficult of times and always provided feedback that was in my best interest. Thank you!

I would also like to thank my committee members, Dr. Skelton and Dr. Roland. Thank you for your time and feedback as I progressed through this journey.
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Chapter 1: Introduction

Introduction to the Problem

Exposure to trauma impacts children’s ability to focus and learn (Balaey, 2014; Goodman, Miller, & West-Olatunji, 2012; Lanius, 2015; Maikoetter, 2011; Perry, 2001). Students who have experienced trauma often struggle with brain development, learning, and social-emotional functioning (Dann, 2011; Ford, Chapman, Connor, & Cruise, 2012; Purvis, Cross, Jones, & Buff, 2012). Over 150,000 youth are placed in juvenile detention, correction, and residential treatment facilities each year (Sickmund, Sladky, Kang, & Puzzanchera, 2015). These facilities are required to educate youth who reside within them. Residential facility schools are faced with the challenge of educating students with severe emotional and behavioral needs. Management of students with severe emotional and behavioral issues can be taxing on the physical and emotional health of employees (Huges, Matt, & O’Reilly, 2015; Katsiyannis, Zhang, & Conroy, 2003; Koening, Rodger, & Specht, 2017; McLeskey, Tyler, & Flippin, 2003; Tehrani, 2007). Schools and classes supporting these types of youth are difficult to staff and often rely on alternative licensure programs to secure teachers (Fuller & Alexander, 2003; Parris, et al.; Saastamoinen, 2015).

Background, Context, History, and Conceptual Framework for the Problem

Residential facility schools struggle to retain teachers and support staff (Fuller & Alexander, 2003; Hughes, Matt, & O’Reilly, 2015; SRI International, 2001). The attrition rate for teachers of emotionally disturbed students is high (Borntrager et al., 2012; Hughes, Matt, & O’Reilly, 2015; Katsiyannis, Zhang, & Conroy, 2003; McLeskey, Tyler, & Flippin, 2003). A contributing factor in retaining teachers who work with students who have emotional and behavioral needs is referred to as secondary, or vicarious, trauma (Borntrager et al., 2012;
Tehrani, 2007). Secondary trauma is defined as a phenomenon whereby those within traumatized individuals’ immediate environment become swept up in the reenactment of past events (Borntrager et al., 2012; McCann, & Pearlman, 1990). Employees who experience higher levels of distress report lower levels of job satisfaction (Huges, Matt, & O’Reilly, 2015; Tehrani, 2007). Working in an environment with multiple youth who have experienced complex trauma and continue to reenact their experiences causes a phenomenon known as compassion fatigue. Compassion fatigue involves the impact of environmental pain and emotional discord on others (Bloom & Farragher, 2010; Cieslak et al., 2014; Tehrani, 2007). It has been shown to be a factor in care workers’ leaving their positions after comparably short periods of time (Katsiyannis, Zhang, & Conroy, 2003; McLeskey, Tyler, & Flippin, 2003). Compassion fatigue can affect a person’s view on the world, sense of hope, and emotional stability. Working with traumatized individuals day after day can negatively impact employees and contribute to high turnover rates (Katsiyannis, Zhang, & Conroy, 2003; McLeskey, Tyler, & Flippin, 2003; Tehrani, 2007). The problematic result is youth who have severe emotional needs, require highly skilled intervention, and need to learn to trust adults experiencing repeated feelings of loss and abandonment in the environments where they are supposed to be receiving help (Heron, & Chakrabarti, 2002; Tehrani, 2007).

**Constructivism**

The theory of learning that views the development of knowledge as directly associated with the evolution of experiences and reflection is known as constructivism (Kim, 2014). Individual views shaped by experiences make up the mental models through which staff members filter their perceptions of the world around them (Senge, 1990). It is important to address the assumptions through which employees experience the workplace so that
communication can be clear and false perceptions can be redirected (Bolman & Deal, 2014). Teachers of emotionally and behaviorally disordered students report significantly more pressure to address disruptive behavior and deal with physically aggressive behaviors than other teachers (McManus & Kauffman, 1991). Thus, the nature of working with youth who have severe emotional issues often elicits fear and anxiety in staff members. In addition, perceptions of caregivers can be negatively impacted through projection of clients’ perceptions (Bloom & Farragher, 2010; Cieslak et al., 2014; Tehrani, 2007). Constructivism can assist in understanding how the perceptual disposition of individuals impacts their behavior (Kim, 2014).

**Action Research**

This study was designed using action research. Herr and Anderson (2015) described action research as “inquiry that is done by or with insiders to an organization or community, but never to or on them” (p. 3). Action research assesses issues that are impacting current practice. This method is a critical approach to structured inquiry that aims to give voice and consideration to participants by including them in the process (Groundwater-Smith, 2007).

**Statement of the Problem**

Trauma-informed care has emerged as a viable option in treating youth who struggle with emotional and behavioral issues (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011; Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013; Jenson et al., 2014). More recently, trauma-informed care has also been implemented in schools (Oehlberg, 2008; Wiest-Stevenson & Lee, 2016). A missing link in existing research involves how or if these models might impact experiences with the secondary trauma by care workers, specifically teachers. The problem this study addressed is how or if implementation of a trauma-informed care model
changes teachers’ experiences of working with youth with social and emotional issues in a residential treatment center facility school.

**Purpose of the Study**

Through the framework of constructivism, this action research study was designed to better understand the experiences of teachers in residential facility schools. The purpose of this study was to investigate the experiences of teachers when implementing a trauma-informed care model in a youth residential facility school.

**Research Questions**

The primary research question this study sought to answer is: What are the experiences of teachers in a residential treatment center with regard to trauma-informed care?

Further subquestions follow:

- What are the experiences of facility school teachers regarding secondary trauma?
- What practices may lessen this impact?

**Rationale, Relevance, and Significance of the Study**

Benefits of the research include informing those in similar settings, such as facility administrators and teachers, of how trauma-informed care is experienced by teachers, improving practices for implementing a trauma-informed model, and demonstrating the collaborative process for teachers. I chose this research because I was interested in improving the workplace environment for facility school teachers and desired to examine the impact of the trauma-informed model’s implementation on their experiences.

**Definition of Terms**

*Action research* – a research design whereby “researchers authentically positioned themselves as insiders doing action research or self-studies, they focused more on individual,
organizational, and social transformations that resulted through actions taken within the setting” (Herr & Anderson, 2015, p. 58).

*Compassion fatigue* – the negative impact of working with individuals who experienced trauma can have on caregivers through projection of clients’ perceptions onto the beliefs and assumptions of caregivers, leading to higher levels of occupational burnout (Bloom & Farragher, 2010; Cieslak et al., 2014; Tehrani, 2007).

*Complex trauma* - exposure to adversities that are repetitive and prolonged, cause direct harm, neglect, or abandonment by caregivers, and occur at developmentally vulnerable times (Courtois & Ford, 2009)

*Parallel process* - the way thoughts, feelings, and actions are connected over time between people and within organizations (Smith, Simmons, & Thames, 1989)

*Organizational trauma* – when, due to employee reactions to feeling unsafe in the work environment, an organization becomes highly reactive, and the decision making of leaders becomes superficial or controlling (Bloom & Farragher, 2010)

*Sanctuary* – a framework developed by Bloom (1997) for addressing trauma and creating a trauma-informed culture

*Secondary, or vicarious, trauma* – phenomenon whereby those within traumatized individuals’ immediate environment become swept up in the reenactment of past events (Borntrager et al., 2012; McCann, & Pearlman, 1990)

*Toxic stress* - “strong, frequent, or prolonged activation of the body’s stress response systems in the absence of the buffering protection of a supportive, adult relationship” (Shonkoff et al., 2012, p. e236)
Trauma-informed care - perspective which holds that dealing with the effects of trauma as such, and not as stand-alone behaviors, improves outcomes (Bartlett et al., 2016).

Trauma theory – a “psychoanalytic poststructural approach that suggests trauma is an unsolvable problem of the unconscious that illuminates the inherent contradictions of experience and language” (Balaev, 2014, p. 1).

Assumptions, Delimitations, and Limitations

The design of this study, action research, has several limitations, including the sample size and the subjective nature of qualitative research analysis. Results from action research studies are not transferrable (Herr & Anderson, 2015). However, the collaborative process used in the study could be applicable to other similar settings (Herr & Anderson, 2015). In addition, the way trauma-informed care was used in the study could be helpful to others working in the residential care field. The instruments used in the study could also be used within similar contexts. These limitations are further discussed in the Methodology section.

Delimitations in the study, associated with action research, included the setting, instrumentation, researcher positionality, and context. These issues limit the transferability of the findings and may impact transferability of practices. Delimitations are further discussed in the Methodology section.

Chapter 1 Summary

Exposure to traumatic experiences has a profound effect on the lives of those who survive it (Dann, 2011; Ford, Chapman, Connor, & Cruise, 2012; Purvis, Cross, Jones, & Buff, 2012). Youth with these experiences often find themselves in treatment at residential facilities (Goodman, Miller, & West-Olatunji, 2012; Porche, Costello, & Rosen-Reynoso, 2016). Educators in the schools within residential facilities struggle to provide adequate educational
access to these students because of the severe nature of their social-emotional issues and the impact of the students’ previous trauma on the present environment (Katsiyannis, Zhang, & Conroy, 2003; McLeskey, Tyler, & Flippin, 2003; Tehrani, 2007). Trauma-informed care models have provided a possible model for addressing the problems exhibited by youth in these environments and have recently been introduced to school settings (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011; Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013; Jenson et al., 2014; Oehlberg, 2008; Wiest-Stevenson & Lee, 2016). The purpose of this action research study was to describe and understand the experiences of teachers working in a residential facility school and how those experiences are affected by the implementation of a trauma-informed care model.
Chapter 2: Literature Review

Introduction to the Literature Review

In recent years, the trauma-informed care approach has made a significant contribution to the treatment of youth with emotional and behavioral disorders (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011; Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013; Jenson et al., 2014), including treatment in schools (Oehlberg, 2008; Wiest-Stevenson & Lee, 2016). This study explored the experiences of staff members implementing a trauma-informed care model in an educational setting. In this chapter I review the literature on trauma-informed care, its impact on youth, and its importance to organizational development. I investigated several databases, including ERIC, ProQuest, JSTOR, Taylor and Francis, Sage Journals, and Google Scholar, for pertinent studies. Search terms included trauma-informed care, organizational trauma, trauma-informed care in schools, trauma and learning, trauma-informed staff, secondary trauma, and childhood adversity.

Researchers have examined the impact of a trauma-informed care model on students (Day et al., 2015; McInerney & McLindon, 2014; Mendelson, Tandon, O’Brennan, Leaf, & Ialongo, 2015), but little information has been documented on the effect of this type of framework on staff members (Crosby, Day, Baroni, & Somers 2015; Middleton, Harvey, & Esaki, 2015; Overstreet & Chafouleas, 2016). Working with students who have severe emotional and behavioral issues is physically, emotionally, and intellectually draining (Billingsley, 2004; Connor et al., 2003; Eastwood & Ecklund, 2008; Lakin, Leon, & Miller, 2008; Steinberg & Knitzen, 1992). These students’ teachers often struggle with isolation and feelings of ineptitude (Chang, 2009; Ekornes, Hauge, & Lund, 2013). Many of those willing to take on the challenge cannot sustain themselves for more than a few years, leaving facilities
whose mission is to help these students with an average yearly attrition rate of 46% (Connor et al., 2003).

Thus, schools serving youth who have emotional and behavioral problems struggle to retain teachers and support staff. In turn, many administrators must secure teachers from alternative licensure programs (Fuller & Alexander, 2003), which tend to produce teachers who are more likely to leave their positions (Fuller & Alexander, 2003). High turnover rates have been associated with higher rates of youth needing subsequent placements (Tremblay, Haines, & Joly, 2016).

As the leaders charged with providing meaningful treatment and education to students, residential administrators must address a way to reduce the impact of the environment created when youth with social-emotional challenges are placed together. Furthermore, improvement is needed in the resiliency of care workers and teachers who must address and correct behavioral problems while educating the child (Ekornes et al., 2013; Mitchell & Arnold, 2004).

**Conceptual Framework**

**Constructivism**

Constructivism is a theory of learning that views knowledge development as an ongoing evolution of experiences and reflection. The perspective is based on the work of Vygotsky (1994), who focused on learning as the interaction of people and their environments. Kim (2014) described social constructivism research as “discovering meaning and understanding through the researcher’s active involvement of the construction of meaning” (p. 539). Among researchers, social constructivist viewpoints are associated with knowledge generation as researchers are actively involved in constructing meaning (Kim, 2014). This theory is important
in understanding how research subjects perceive and interpret the world around them (Shank, 2002).

Social constructivism may explain the impact of a trauma-informed care model on employees. In a study of compassion fatigue and secondary trauma, Tehrani (2007) found caregivers with lower levels of distressing experiences reported higher levels of job satisfaction. In addition, working with individuals who experienced trauma can have a negative impact on caregivers through projection of clients’ perceptions onto the beliefs and assumptions of caregivers, leading to higher levels of occupational burnout (Bloom & Farragher, 2010; Cieslak et al., 2014; Tehrani, 2007). With consideration of these factors, social constructivism may assist in understanding shifts in teachers’ experiences when a trauma-informed care model is put into place.

**Review of Research Literature**

In this section I explore the foundation of trauma, as well as its extended impact on youth, staff members and child care workers, and organizations. Individuals’ personal experiences with trauma underpin many barriers created when working with youth who have social-emotional issues (Black, Woodsworth, Tremblay, & Carpenter, 2012; Ford, Chapman, Connor, & Cruise, 2012; Perry, 2009; Purvis, Cross, Jones, & Buff, 2012). Exposure to trauma affects children’s ability to focus and learn (Black et al., 2012; Maikoetter, 2011; Perry, 2001) and has been associated with maladaptive behavior in children and adolescents (Black et al., 2012; Hughes, 2004; Ford et al., 2012). In fact, many students in residential care are unable to access the educational environment without first addressing their treatment needs (Maikoetter, 2011; Perry, 2001). Thus, educating students with severe emotional and behavioral issues can be taxing on the physical and emotional health of employees.
Trauma Defined

According to results from the National Stressful Events Web Survey (Kilpatrick et al., 2013), 87% of people experience at least one event that fits with the DSM-5 criteria for PTSD in their lifetime. In a review of literature, Ford et al. (2012) found between 25%–43% of adolescents and children and up to 90% of youth in residential facilities have experienced at least one traumatic stressor in their lives. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2012) explained that “trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being” (p. 2). Complex trauma was further defined by Courtois and Ford (2009) as involving exposure to adversities that are repetitive and prolonged, cause direct harm, neglect, or abandonment by caregivers, and occur at developmentally vulnerable times. Mahoney and Markel (2016) also noted that complex trauma is associated with disturbances in emotional regulation, dissociation, somatic distress, and identity or relational disturbances. Approximately 35% of youth and children in residential facilities have been exposed to this type of trauma (Ford et al., 2012).

Individuals with four or more exposures to adverse experiences in childhood can be up to 12 times more at risk for alcoholism, drug abuse, depression, suicide attempts, and long-term psychological issues (Chartier, Walker, & Naimark, 2010; D’Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Felitti et al., 1998; Ford, 2012). These individuals also have a greater risk for smoking, self-rating of “poor” health, sexually transmitted diseases, inactivity, and severe obesity (Chartier et al., 2010; Felitti et al., 1998). The SAMHSA (2014) echoed these
concerns by noting the significance of trauma in the past of those who seek assistance for mental health-related concerns.

Theories Supporting the Research

**Trauma theory.** Caruth (1996) is credited with coining the term *trauma theory*. Balaev (2014) described trauma theory as a “psychoanalytic poststructural approach that suggests trauma is an unsolvable problem of the unconscious that illuminates the inherent contradictions of experience and language” (p. 1). In other words, trauma theory exerts that when experiences shock the brain beyond current comprehension and the ability to express this confusion through language, a problem is created. The theory holds that interpretation of events and the mind’s perceptions largely contribute to the severity of symptomology after experiencing a traumatic event (Balaey, 2014; Bloom, 1999). Exposure to trauma affects brain functioning, which, in turn, affects learning, decision making, and socialization.

Traumatic experiences change the way people view the world (Lanius, 2015; Van der Kolk & Ducey, 1989). Experiencing trauma leads to a release of chemicals in the brain, known commonly as the fight-or-flight response (Bloom, 1999; Lanius, 2015). When individuals repeatedly experience these types of situations the brain changes (Corrigan, Fisher, & Nutt, 2011) and perceives this state of hyperarousal as typical. Therefore, the individuals live with ongoing biochemical stressors that leave them constantly feeling on edge (Bloom, 1999; Corrigan et al., 2011).

Traumatic events typically involve a situation where some action is occurring over which an individual has little to no control. The individual’s ability to cope is overwhelmed by the experience, thus resulting in the experience being traumatic (Van der Kolk & Ducey, 1989). If individuals repeatedly experience this type of situation, they may come to believe they have no
power or control over things that happen. Bloom (1999) noted that becoming accustomed to trauma leads individuals to stop attempting to escape dangerous situations. The result is learned helplessness and a loss of hope. Corrigan et al. (2011) identified an inability to modulate arousal or regulate emotions in individuals who have experienced repeated trauma. This unregulated emotional state often causes individuals to overreact to seemingly minor situations and engage in socially inappropriate behaviors as a coping response (Corrigan et al., 2011; Cox, Resnick, & Kilpatrick, 2014). Table 1 shows the impact of trauma on individuals.

Trauma theory holds that exposure to trauma early in life, particularly ongoing trauma, impacts brain function (Lanius, 2015), which directly impacts memory, thereby affecting learning (Maikoetter, 2011). Youth with traumatic histories learn and respond differently to stimuli than those who have not experienced trauma (Cox, Resnick, & Kilpatrick, 2014; Lanius, 2015). Often, the symptoms of ongoing traumatic experiences mimic those of many behavioral and mental health disorders (Black et al., 2012; McInerney & McKlindon, 2014). In school systems, these behaviors can lead to further isolation of the youth from the academic environment through placements in separate classrooms, separate schools, and residential facilities (Black et al., 2012).

**Trauma-informed care.** The trauma-informed care perspective holds that dealing with the effects of trauma as such, and not as stand-alone behaviors, improves outcomes (Bartlett et al., 2016). Models of trauma-informed care are beginning to be implemented in schools across the country (McInerney & McKlindon, 2014; Oehlberg, 2008; Overstreet & Chafouleas, 2016). One such framework, the Sanctuary model (Bloom, 1997), demonstrates ways to integrate trauma-informed care concepts into social, community, and organizational environments.
Table 1

*Trauma, Systems, and Organizational Learning Theory*

<table>
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<tr>
<th>Impact on Youth</th>
<th>Impact on Staff</th>
<th>Impact on Leaders / Organizations</th>
</tr>
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<tbody>
<tr>
<td>Lack trust</td>
<td>Lack trust / confidence</td>
<td>Parallel process / Secondary / vicarious trauma</td>
</tr>
<tr>
<td>Feel unsafe</td>
<td>Feel unsafe</td>
<td>Collective history</td>
</tr>
<tr>
<td>Constant hyperarousal</td>
<td>Constant hyperarousal</td>
<td>Culture feels unsafe physically and emotionally</td>
</tr>
<tr>
<td>Defensive coping</td>
<td>Defensive coping mechanisms</td>
<td>Defensive coping mechanisms</td>
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<tr>
<td>mechanisms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deficient communication</td>
<td>Deficient communication</td>
<td>Deficient systems of communication</td>
</tr>
<tr>
<td>Reenactment</td>
<td>Reenactment</td>
<td>Defensive coping is a way of life</td>
</tr>
<tr>
<td>Resistant to treatment</td>
<td>Unable to impact youth behavior</td>
<td>Unable to retain staff or show growth</td>
</tr>
<tr>
<td>Drop out / Give up</td>
<td>Burn out / Give up</td>
<td>Organizational decline</td>
</tr>
</tbody>
</table>

*Sanctuary*. The Sanctuary model, developed by Bloom (1997), is one of four models found to be promising in terms of effectiveness (James, 2011). Sanctuary is a framework for addressing trauma and creating a trauma-informed culture (Esaki et al., 2013). The model is unique in that it embraces not only specific interventions with clients; it also addresses the aspects of parallel process and organizational trauma in its quest to create an entire culture that is trauma responsive (Esaki et al., 2013). Figure 1 shows how trauma operates within an organization.
Figure 1. How trauma operates in an organization. This figure illustrates the overlap of trauma, systems, and organizational learning theories in describing the impact of trauma on an organization.
The Sanctuary model is based on a framework consisting of four pillars: shared knowledge, shared values, shared language, and shared practices (Bloom, 1997; Esaki et al., 2013). Bloom and Farragher’s (2013) work, firmly grounded organizational learning and systems theory, discusses the trend of clients deemed “resistant to treatment” (p. 13) and the movement of care workers toward reliance on management and control tactics to maintain safety.

Suggested intervention involves dedication to seven commitments: nonviolence, open communication, democracy, growth and change, emotional intelligence, social learning, and social responsibility (Bloom, 1997; Esaki et al., 2013). The Sanctuary approach of utilizing the S.E.L.F. (safety, emotions, loss, future) format to process situations as they occur is a key component of addressing the trauma without reenacting it. The approach involves addressing feelings of safety and how they could be improved, identifying associated emotions, recognizing current and past losses, and planning for future change (Bloom, 1997). The Sanctuary approach is shown in Table 2.

Bloom and Farragher (2010) discussed organizations as living organisms that are vulnerable to the effects of trauma. The authors applied Smith, Simmons, and Thames’s (1989) premise of parallel process to describe the way thoughts, feelings, and actions are connected over time within an organization. Many social defense mechanisms, such as avoidance, coercion, and scapegoating, develop as a response to organizational trauma. In an environment that feels unsafe, individuals experience chronic hyperarousal (Bloom & Farragher, 2010). This study was designed to determine if the implementation of a trauma-informed care model can
improve employees’ feelings of safety in the environment and, in turn, decrease the sense of chronic hyperarousal experienced by staff members.
Table 2

Sanctuary Model

<table>
<thead>
<tr>
<th>Framework</th>
<th>Commitments</th>
<th>Approach</th>
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<tbody>
<tr>
<td>Shared knowledge</td>
<td>Emotional intelligence</td>
<td>Safety</td>
</tr>
<tr>
<td>Shared values</td>
<td>Growth and change</td>
<td>Emotion Management</td>
</tr>
<tr>
<td>Shared language</td>
<td>Democracy</td>
<td>Loss</td>
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<tr>
<td>Shared practice</td>
<td>Nonviolence</td>
<td>Future</td>
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<td></td>
<td>Social learning</td>
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<td></td>
<td>Open communication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Responsibility</td>
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</tr>
</tbody>
</table>

**Organizational trauma.** Bloom and Farragher (2010) described a bleak downward spiral of group dynamics that contributes to the eventual condition of organizational trauma. When an individual spends enough time in an environment that feels unsafe, behaviors that are effective for survival (but not necessarily socially appropriate or treatment focused) become a normative response (Corrigan et al., 2011; Cox et al., 2014). Staff members in this state of chronic hyperarousal experience the inability to control their emotional responses to variant levels (Bloom & Farragher, 2010; Hormann & Vivian, 2013). Bloom and Farragher further described how an organization becomes highly reactive, and the decision making of leaders becomes superficial or controlling. These issues lead to miscommunication, and, Bloom and Farragher contended, eventually issues that need to be discussed become taboo. As communication suffers, more errors occur, and reactive organizational leaders become controlling and authoritarian to maintain some semblance of order (Middleton, Harvey, & Esaki, 2015). Eventually, unresolved conflicts and grief lead to a system that is oriented completely around the nucleus of
trauma (Hormann & Vivian, 2013). Over and over, Bloom and Farragher explained, trauma is reenacted, largely unbeknownst to those living it.

Bloom and Farragher (2013) contended that becoming trauma responsive can move an organization forward from the demoralizing effects described above. Though most data collected regarding the Sanctuary model are focused on youth or student outcomes, some organizational impact has also been noted (Middleton et al., 2015; Rivard, Bloom, McCorkle, & Abramovitz, 2005). Implementation of the Sanctuary model has been associated with increased feelings of job competency on the part of workers and improved organizational culture (Stein, Kogan, Magee, & Hindes, 2011). Further study in this area is necessary to determine specific impact of implementing the Sanctuary model on the workplace environment.

Impact on Youth

Trauma interrupts brain development, which is particularly impactful during the beginning stages of life (Dann, 2011; Ford et al, 2012; Purvis, Cross, Jones, & Buff, 2012). According to Perry (2009), the brain organizes its development from brainstem to frontal lobe. The later, higher functioning components of the brain are dependent on the development of the earlier, more basic functioning elements. If development at the early stages is disrupted, the functions that develop later, such as reasoning, decision making, and empathy, are negatively impacted. Exposure to adverse childhood experiences has been found to impact school engagement and placement on Individual Education Programs (IEPs) (Goodman, Miller, & West-Olatunji, 2012; Porche, Costello, & Rosen-Reynoso, 2016). In addition, traumatic stress has been found to negatively impact reading, math, and science performance (Danese & McEwen, 2012; Goodman et al., 2012). As Dann (2011) stated, “Good teaching alone will be insufficient for these children unless it is accompanied by understanding something of the likely
underlying causes of and possible responses to their difficulties” (p. 457). Students who have experienced trauma in their lives are likely to need substantial additional academic, behavioral, and emotional supports (Dann, 2011).

Repeated exposure to trauma has been shown to lead to an eventual ongoing state of hyperarousal that can mimic the behavioral symptoms of attention deficit hyperactivity disorder and other mental health conditions (Corrigan, 2011; D’Andrea et al., 2012; Ford et al., 2012; Hughes, 2004; Lynch 2003; Purvis, Cross, Jones, & Buff, 2012). Living with hyperarousal as a state of normalcy makes individuals highly and inappropriately reactive to seemingly nominal situations because they are always in a state of fear. Maikoetter (2011) connected this feeling to school difficulties because of the need to be free of fear to learn. In addition, individuals in a state of hyperarousal become overly aggressive, socially inept, and lacking in trust of others, especially authority figures (Ford et al., 2012; Hughes, 2004; Lynch 2003; Perry, 2009). If a caregiver is absent or otherwise seriously compromised, the stress response and relational areas of the brain develop abnormally (Dann, 2011; Perry, 2009). Children who experience hyperarousal appear overanxious, impulsive, and dysregulated. Perry (2009) further found they will struggle with activities involving language, social skills, and reading.

Impact on Teachers/Staff Members

Lavian (2012) found that teacher burnout is greater in unsupportive climates and is related to the make-up of the student population. Shonkoff et al. (2012) discussed the devastating impact toxic stress can have on individuals. Adults working with students who have endured extensive trauma can experience toxic stress (Borntrager et al., 2012; Ekornes, 2016). Shonkoff et al. (2012) explained toxic stress can result from “strong, frequent, or prolonged
activation of the body’s stress response systems in the absence of the buffering protection of a supportive, adult relationship” (p. 236).

Mitchell and Arnold (2004) found that teachers often become disillusioned when they face the harsh realities of educating students, and they often leave their jobs early in their careers. This can be especially true of teachers working with students who have emotional and behavioral concerns (American Association for Employment in Education, 2004; Anderson & Bronstein, 2012; MacDonald & Speece, 2001). Those who do stay in their jobs tend to request different assignments and take more time off than their peers (Goddard & O’Brien, 2003). Cooper (2006) noted that some teachers may interact with students in a manner that puts them more at risk of being injured. Indeed, Van Leeuwen and Harte (2015) found that 67% of residential staff working with emotionally and behaviorally disturbed individuals reported being injured by a resident within the past 5 years. Tense interactions often lead to strained teacher-student relationships (Sutherland, Lewis-Palmer, Stichter, & Morgan, 2008). Chong and Ng (2011) addressed the importance of teachers needing extensive training in strategies that work with students who have emotional and behavioral issues. Feeling overwhelmed with duties, teaching needy students, and working with unmotivated youth also contribute to stress for teachers of emotionally and behaviorally disturbed youth (Richards, 2012).

Vicarious or secondary trauma is another environmental hazard of working with students who have experienced trauma (Tehrani, 2007). Teachers must address students’ extreme needs, which can, as noted in the parallel process discussion above, affect the surrounding atmosphere. Teachers respond in various ways to this emotional environment. Richards (2012) found one set of troubling responses of many teachers: becoming physically exhausted, developing physical ailments, losing enthusiasm about teaching, and suffering personal relationship problems. As
such, the attrition rate for teachers of emotionally disturbed students is high (Katsiyannis, Zhang, & Conroy, 2003; McLeskey, Tyler, & Flippin, 2003).

**Impact on Leaders and Organizations**

One documented organizational challenge is finding teachers who can successfully sustain their work with students who have emotional and behavioral problems (Adera & Bullock, 2010). Assisting individuals who have experienced extensive trauma can cause organizations to develop symptoms of vicarious trauma, resulting in an organizational culture riddled with stress, fear, and hopelessness (American Association of Children’s Residential Centers, 2014). An environment under these conditions is ripe for nurturing coercive, power-oriented, and hierarchal leadership tactics (Bloom, 2009; Middleton et al., 2015). The setting is not conducive to democratic, empathetic, or innovative perspectives associated with trauma-informed care. Leaders in this type of environment tend to be reactive and solicit little input from others in the face of their own stress responses to the unsafe feeling of the organization (Blitz, Yull, & Clauhs, 2016; Bloom, 2009).

In this circular and self-defeating manner, organizational context affects staff burnout in residential facilities. The result tends to be excessive bureaucracy, lack of autonomy and decision-making authority, few advancement opportunities, and rare use of positive recognition (Seti, 2007). Territoriality in the form of departmentalization and hostility toward anyone considered an “outsider” increases, and open communication suffers (Bloom, 2009). With each exposure to danger in the organizational environment, individuals become more sensitive to dangerous circumstances, resulting in a state of hyperarousal that is not dissimilar to that experienced by firsthand exposure to trauma (Bloom, 2009; Lynch, 2003). In contrast, Esaki, Hopson, and Middleton (2014) found respondents who felt administratively supported to have
more positive beliefs about the commitment of the organization, and employee loyalty was enhanced when workers understood the organizational need being met by an initiative or directive. Trauma affects everyone who is touched by it in the past, and it continues affecting people in the present, even if the initial trauma has long since elapsed. Thus, attention to the ways trauma impacts organizational entities has elicited interest on the part of researchers (Elwyn, Esaki, & Smith, 2016).

**Organizational Trauma-Informed Care**

Kusmaul, Wilson, and Nochajski (2015) noted, “Organizations become trauma-informed by engaging a lens that presumes everyone in the agency, from clients through management, may have a history of direct or indirect trauma exposure” (p. 26). The SAMHSA (2015) indicated trauma-informed care models must prioritize safety, trustworthiness, and transparency. Collaboration and mutuality are key principles as well. The SAMHSA suggested that employee empowerment, voice, and choice, as well as recognition of cultural, historical, and gender issues, are areas of significant importance. Transformational leadership approaches to the implementation of trauma-informed care models have been found to be successful (Middleton et al., 2015). Muskett (2014) found allocation of responsibility, shared commitment to the goal of becoming trauma-informed, and involvement of all organizational departments to be key areas of focus in becoming a trauma-informed organization. In addition, using multiple strategies can be more effective than subscribing to one strategy in particular (Muskett, 2014).

**Review of Methodological Issues**

Studies in trauma-informed care represent a variety of research methods, including qualitative, quantitative, mixed-methods, and action research (American Association of Children’s Residential Centers, 2014; Black et al., 2012; Dann, 2011; Ekornes, 2016; Kusmaul,
Wilson, & Nochajski, 2015; Maikoetter 2012; Muskett, 2014; SAMHSA, 2015; Shonkoff et al., 2012; Van Leeuwen & Harte, 2015). Quantitative methods, while broadly accepted, lack sufficient representation of the complexities associated with the instructional environment or the shared emotional valence experienced when working with trauma-impacted youth (Tehani, 2007). Survey data or questionnaires alone can be difficult to interpret, vague, and exclusionary toward some groups (Esaki et al., 2014; Kusmaul et al., 2015). Restraint reduction and the frequency of serious incidents can be easily demonstrated, but establishing a cause-effect relationship is difficult because of multiple circumstantial factors that could be involved (Rhineberger-Dunn, Mack, & Baker, 2016).

Researchers have noted the need for further attention on the impact of trauma-informed care models on care workers’ perspectives and organizational culture (Hodgdon et al., 2013). Overstreet and Chafouleas (2016) also noted the need for the impact of trauma-informed training on educational environments. Qualitative measures may be more apt to capture the intricacies associated with worker perceptions and workplace culture. The practice of face-to-face interviewing and focus group discussions yield more specific and in-depth information (Kusmaul et al., 2015). However, the educational environment of residential treatment centers is not conducive to certain forms of qualitative studies, particularly those that extend over long periods (Day et al., 2015). The student demographic, while sharing many similarities within the population, is constantly changing. Students present at the beginning of a study are unlikely to be present 6 months later, which, given high turnover rates, can also be true for staff members. In the field of residential facility education, studies focusing on long-term impact may struggle to maintain contact with participants (Day et al., 2015).
Action research methodology is conducive to educational research because it can address the complexity and organization of the educational environment (Sagor, 2011). Action research assesses issues that are impacting current practice. Herr and Anderson (2015) asserted, “When researchers authentically positioned themselves as insiders doing action research or self-studies, they focused more on individual, organizational, and social transformations that resulted through actions taken within the setting” (p. 58). There are, however, limitations of action research methodologies. Institutional review boards may not support the changing nature of action research studies (Herr & Anderson, 2015). Researcher objectivity may be questioned given the interconnected nature of researcher and participant relationships. Findings may be limited given the small sample size, and results may be less likely to be accepted by the academic community as holding the statistical relevance to constitute a reason for change beyond the immediate environment (Herr & Anderson, 2015).

**Synthesis of Research Findings**

A review of existing literature presents substantial evidence that experiencing trauma, particularly ongoing trauma in the childhood years, produces life-changing social, emotional, and behavioral symptoms (Goodman et al., 2012; Leichtman, Leichtman, Barber, & Neese, 2001; Maikoetter, 2011; McInerney, & McLindon, 2014; Porche et al., 2016; Perfect, Turley, Carlson, Yohannan, & Gilles, 2016). Patterns of behavior in individuals who have experienced trauma, such as reenactment, have been well documented (McCann & Pearlman, 1990; Substance Abuse and Mental Health Service Administration, 2014; Wiest-Stevenson & Lee, 2016). The impact of traumatic experiences reaches beyond the individuals who experienced trauma to those who are working to help them (Ekornes, 2016; Shonkoff et al., 2012; Smith et al., 1989). It is for this
reason that trauma oriented interventions in schools should be viewed as part of a universal system of supports (Blitz & Lee, 2015).

As trauma is reenacted by those who suffered it, the environment around those individuals is affected (Connor et al., 2003; Ekornes, 2016; McCann & Pearlman, 1990; Seti, 2007; Shonkoff et al., 2012). The effects reach from youth to workers supporting youth to supervisors and leaders. Eventually, an entire organization can become trauma-oriented and produce an environment that is counterproductive to treating the very individuals it is designed to help (Hormann & Vivian, 2013). This phenomenon has been documented in social service organizations (Rivard, Bloom, McCorkle, & Abramovitz, 2005). Past inquiries focused mainly on home and therapeutic environments (Hodas, 2006; Overstreet & Chafouleas, 2016), but a significant amount of a youth’s time is spent in school.

While the importance of addressing trauma in schools has been identified (Maikoetter, 2011; Perry, 2001; Porche et al., 2016), evidence specifically documenting how employing methods of trauma-informed care in schools affects those who work with traumatized students is lacking (Overstreet & Chafouleas, 2016). A supportive and therapeutic community is needed to help youth move beyond traumatic experiences they have suffered in a functional manner. Thus, it stands to reason researchers should focus on how to assist those who are a part of the youth’s immediate environment to develop and maintain the type of culture conducive to healing (Overstreet & Chafouleas, 2016).

Residential facility schools provide a heightened view of the vicarious, cultural, and organizational impact of working with traumatized youth (Leichtman et al., 2001). The positive impact of trauma-informed care models for youth has growing evidence, but references to the impact of these models on staff members is minimal (Overstreet & Chafouleas, 2016; Rolfsnes
Prevalent issues suffered by school staff who work with students exhibiting the characteristics of traumatic exposure have been documented, such as burnout, toxic stress, and decreased longevity in the field (Connor et al., 2003; Decker, Bailey, & Westergaard, 2002; Ekornes, 2016; Heron & Chakrabarti, 2002). Additional research is needed that addresses how school staff can be supported to develop and maintain a therapeutically supportive and trauma-informed environment.

**Critique of Previous Research**

**Traumatic Impact**

Researchers have repeatedly documented the impact of trauma, particularly complex trauma, on youth behaviors (James, 2011), learning (Goodman, Miller, & West-Olatunji, 2012; Perry, 2009; Porche et al., 2016), and perceptions (Balaey, 2014; Bloom, 1999; Lanius, 2015; Van der Kolk & Ducey, 1989). Thorough investigation has supported long-term effects as well (Ford et al., 2012), including abnormal brain development (Dann, 2011; Ford et al., 2012; Purvis, Cross, Jones, & Buff, 2012). Although past research has not shown how particular programs of trauma-informed care change youth behaviors, some results are promising (Ford et al., 2012; James, 2011). In addition, sample sizes in many studies are small and make generalization difficult (Day et al., 2015; Herr & Anderson, 2015).

**Impact on Teachers/Staff Members**

Despite the importance of student-teacher relationships in student growth and development (Spilt, Koomen, & Thijs, 2011), literature regarding trauma-informed care in schools tends to be focused on the establishment of interventions that impact youth and does not often address the impact of trauma-informed care models on staff members (Crosby, 2015; Esaki et al., 2014; Kusmaul et al., 2015). Historical theory supports the concept of vicarious or
secondary trauma as those within the traumatized individual’s immediate environment become swept up in the reenactment of past events (Borntrager et al., 2012). Reference is made to staff involvement with trauma-informed care models, but evidence revealing the impact on staff members is minimal (Middleton et al., 2015). More in depth understanding of staff members’ responses to survey items is necessary to clearly interpret results (Kusmaul et al., 2015).

**Trauma-Related Care in Schools and Organizations**

The importance of schools and human service organizations addressing the effects of adverse events is well-supported (Goodman et al., 2012; Leichtman et al., 2001; Maikoetter, 2011; McInerney & McKlindon, 2014; Porche et al., 2016; Perfect et al., 2016). However, small sample sizes in highly concentrated research environments makes generalization to larger populations difficult (Day et al., 2015; Herr & Anderson, 2015). Surveys are often used to measure growth. This method can be helpful in allowing for anonymity, but in-depth understanding of participant perspectives is necessary to fully interpret findings (Kusmaul, 2015).

**Chapter 2 Summary**

Trauma-informed care has been shown to be an important consideration when working with students, particularly those who have demonstrated a need to receive residential treatment services (Ekornes et al., 2013; Mitchell & Arnold, 2004). Research regarding the concept of trauma, its impact on youth, and its importance to organizational development was examined in the literature review. Databases such as ERIC, ProQuest, JSTOR, Taylor and Francis, Sage Journals, and Google Scholar were investigated for pertinent studies. Search terms included trauma-informed care, organizational trauma, trauma-informed care in schools, trauma and learning, trauma-informed staff, secondary trauma, and childhood adversity.
Research on childhood traumatic experiences has demonstrated their impact on youth (Dann, 2011; Purvis, Cross, Jones, & Buff, 2012), direct care workers (Ekornes, 2016; Shonkoff et al., 2012), and organizations (Adera & Bullock, 2010; American Association of Children’s Residential Centers, 2014; Bloom, 2009). Theories supporting peer-reviewed studies include trauma theory, trauma-informed care, and organizational trauma. Trauma theory holds that exposure to adverse experiences in a child’s early years negatively impacts worldviews and brain development (Dann, 2011; Purvis, Cross, Jones, & Buff, 2012; Van der Kolk & Ducey, 1989). One pertinent behavior resulting from exposure to trauma is hyperarousal (Hughes, 2004; Lynch, 2003; Purvis, Cross, Jones, & Buff, 2012). Individuals in a state of hyperarousal become overly aggressive, socially inept, and lack the ability to trust (Hughes, 2004; Lynch 2003; Perry, 2009).

Trauma-informed care is the concept of working with youth from the perspective of the trauma they have experienced (Bartlett et al., 2016). One such framework is the Sanctuary model, developed by Bloom (1997). The model places a strong focus on the impact of secondary, or vicarious, trauma via a parallel process (Smith et al., 1989) whereby the thoughts, feelings, and actions of people become connected over time. Gone unchecked, staff members develop their own state of hyperarousal (Bloom & Farragher, 2010). When the state of hyperarousal becomes chronic, it can permeate an organization leading to highly reactive decision-making by leaders who develop superficial or controlling traits to regain a semblance of safety and control (Bloom & Farragher, 2010). The social constructivist view may be helpful to understanding the impact of a trauma-informed care model on employees.

In this review I explored the prevalence of trauma and the impact of trauma on youth, teachers/staff members, and leaders/organizations. I developed a unique conceptual framework using a social constructivist perspective to understand the impact of secondary trauma on
As such, examining the impact of a trauma-informed care model on residential facility school teachers’ perspectives may yield socially significant findings. The literature review has provided strong support of pursuing a research project to answer the following research question:

- What are the experiences of teachers in a residential treatment center with regard to trauma-informed care?

Further subquestions include the following:

- What are the experiences of facility school teachers regarding secondary trauma?
- What practices may lessen this impact?
Chapter 3: Methodology

Introduction

In this section I describe the methodology of action research and why it was chosen for this study. The research question, purpose, and design will be explained. I also discuss the instruments and data collection methods. I then explain the data analysis procedures and discuss the limitations of the design, validation issues, and expected findings. Finally, ethical issues are addressed.

Through the framework of constructivism, this action research study was designed to better understand the experiences of teachers in residential facility schools. Herr and Anderson (2015) described action research as “inquiry that is done by or with insiders to an organization or community, but never to or on them” (p. 3). The action research approach aligns with the constructivist stance suggesting knowledge is generated through active involvement (Kim, 2014). The participants’ understanding and interpretation of the world around them is inherent in the constructivist theory of learning (Shank, 2002). As the researcher in this study, I was an insider to the setting, and my goal was to promote professional growth as well as to provide insight and knowledge to the body of existing literature on the subject. Participants were actively involved in the study, and collaboration amongst the participants was a key component.

Herr and Anderson (2015) noted that action research is “oriented to some action . . . that organizational . . . members have taken, are taking, or wish to take to address a particular problematic situation” (p. 4). Action research was chosen for this study because I work as the education director in the facility school that was studied. I gained insight about the teaching practices used in the school so that they could be improved. An essential premise of action research (Herr & Anderson, 2015; Minkler & Wallerstein, 2008; Schmuck, 2006) is that it “seeks
to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions” (Reason & Bradbury, 2001, p. 1).

Teachers in the chosen residential facility school had not been able to grasp onto a way of working with the youth and each other that resulted in a nurturing and therapeutic workplace environment. The action research process is collaborative and can lead to changes as the process is occurring (Herr & Anderson, 2015; Stringer, 2014). It enables reflection to impact practice and ongoing development to continue. The process is guided by research participants via repeated cycles of initiation, detection, and judgement (Kid & Kral, 2005; Schmuck, 2006; Stringer, 2014). Action research is a critical approach to structured inquiry that aims to give voice and consideration to participants by including them in the process (Groundwater-Smith, 2007). If understanding of facility school practices can be improved and translated into action, other facility schools may be helped to do the same. For these reasons, action research was determined to be the best approach for this study.

**Research Question**

The overarching question was:

- What are the experiences of teachers in a residential treatment center with regard to trauma-informed care?

Further subquestions included:

- What are the experiences of facility school teachers regarding secondary trauma?
- What practices may reduce this impact?

**Purpose Statement and Design**

The purpose of this action research study was to describe and understand the experiences of teachers working in a residential facility school and how those experiences were affected by
the implementation of a trauma-informed care model. The trauma-informed care model is generally defined as a framework for addressing trauma and creating a trauma-informed culture (Esaki et al., 2013).

Strongly embedded in the action research methodology is the involvement of participants in guiding the direction of the research study (Herr & Anderson, 2015; Kidd & Kral, 2005). Studies exploring the concept of trauma-informed care models lean toward this method because of the personal nature of traumatic impact and the need for insight into the nature of the participants’ experiences (Esaki, 2014). Action research was chosen because of the combined needs to promote change in current practices within the organization and to add to the existing body of literature addressing trauma-informed care in schools. This “double burden” (Herr & Anderson, 2015, p. 5) on the part of researchers makes action research, with its focus on intervention and change, the best model for this study.

Action research involves systematic steps oriented toward action (Herr & Anderson, 2015; Stringer, 2014). Overarching steps of the process which guided the overall study include developing a plan of action, acting to implement the plan, observing the effects of the action taken, and reflecting with subsequent action in mind (Herr & Anderson, 2015). This is reflected in Figure 2, Action Research Cycles: Concurrent Research and Focus Group Spirals. The Develop phase is used to create a plan of action. The Act phase is utilized to implement the plan. In the Observe phase, the implementation process is viewed in context. In the Reflect phase, results are analyzed. These phases repeat throughout the duration of an action research study to deepen understanding and guide the next steps.

A participant Focus Group was an integral part of this study. The Focus Group followed a separate action research spiral, as is depicted in the central section of Figure 2, Action Research
Cycles: Concurrent Research and Focus Group Spirals. This study used a responsive stance (Schmuck, 2006), which began with collecting diagnostic data. Schmuck’s (2006) Steps of Action Research (p. 34) involve initial baseline data collection, analysis of data for themes and ideas for action, distribution of data and actions to be taken, listing of hopes and concerns for new practices, trying new practices, and then collecting data again (Schmuck, 2006). These steps create a spiral for continued growth and deepening of understanding with regard to the initial research question. Figure 2 provides a visual display of the spiral, which includes Herr and Anderson’s (2015) and Schmuck’s (2006) steps. In the Data Collection phase, information is gathered to diagnose the situation. In the Analyze phase, data is reviewed for themes and ideas for action. In the Distribute phase, data is given to others and changes that will be tried are announced. In the Hopes/Concerns phase, desires and worries are brought out for group discussion. In the Try-Practice phase, a new practice is attempted. Each time the spiral is repeated, new practices and insights are gleaned. In this manner, participants are involved in ongoing growth and learning, and the knowledge about the research question is increased (Herr & Anderson, 2015).
Figure 2. Action Research Cycles: Concurrent Research and Focus Group Spirals

Based on the Develop, Act, Observe, Reflect Model of Herr and Anderson (2015, p. 5) and Schmuck’s Steps of Responsive Action Research (2006, p. 34).
Research Population and Sampling Method

Site Description

The residential facility school in this study was situated on the campus of an unlocked treatment facility, which housed approximately 100 male and female youth between the ages of 10 and 21 years. Males and females were educated in separate classes, and students were separated into nine multigrade classrooms based on age and treatment needs. When fully staffed, the school employed 12 teachers, 10 teachers’ aides, three supervisors, a counselor, an assistant principal, and an education/special education director. Teachers varied in length of employment and experience in education. All held current teaching licenses approved by the state education department. All employed teachers were participants in the study.

Youth residents were admitted into programs targeted toward conduct problems, sexually deviant behavior, human trafficking, substance abuse, gender nonconformity, and issues specific to Native Americans. Youth clients were provided with a therapist and a case manager upon being admitted to the program. The facility’s organization-wide behavior support program embedded the trauma-informed model framework into clinical, operational, and educational areas. The program was designed to take approximately six months to complete, though lengths of stay varied greatly among residents.

The residential facility introduced a trauma-informed care model approximately two years ago. The facility director and supporting administrative team were committed to changing the culture to one that is trauma-informed in all areas. The school staff members had basic instruction in trauma-informed care and the model, but implementation had remained superficial. Initial data collection served to determine the baseline understanding staff members had of the model and how they were using it.
Population

The facility had 12 teachers employed (B. Miller, personal communication, January 13, 2017), seven of whom were male and four who were female. Teacher ages ranged from 28 to 72 years. Nine of the teachers had special education certification (A. Ruble, personal communication, February 17, 2017). Two teachers were highly qualified to teach math, two in social studies, and three in language arts. Two teachers had physical education licensure. One teacher was licensed in science, and one was highly qualified in vocational training. Seven of the teachers lived in the immediate area, and five lived outside the city limits. Teachers worked from 6:45 am until 3:15 pm each day. Their morning duties involved waking the students up on resident units and running morning routines to get the students ready for school (T. Hightower, personal communication, February 24, 2017). Teachers transitioned to different classes each hour of the day, as residents did not move classes. Teachers were scheduled to work 176 school days each year and 30 days during the summer (Yearly Calendar, 2016–2017, Appendix A). Vacation time was set at 1 week during November for Thanksgiving, 2 weeks during the Christmas/New Year’s break, and 1 week during March for spring break. Teachers received 6 weeks paid vacation during the summer as well. The facility allowed an additional 15 sick/personal days per year for teachers (A. Ruble, personal communication, February 17, 2017).

The five administrative staff members also took part in the study. The education/special education director oversaw special education compliance and all aspects of the school. A senior treatment supervisor was employed to manage frontline staff to maintain safety and security for residents and facilitate communications between departments. An education supervisor focused on curriculum, assessment, project management, and direct supervision of teachers. Two treatment supervisors assisted in day-to-day management of residents and supervision of
frontline staff members. The administrative team comprised two females and three males. Three members of the administrative team had been with the company just over one year, one had been employed there for 8 years, and one for 3 years (A. Ruble, personal communication, February, 17, 2017).

**Sampling Method**

Purposeful sampling was used to determine participants in the study. Purposeful sampling involves selecting individuals for participation “based on a specific purpose rather than randomly” (Tashakkori & Teddlie, 2003, p. 713). Individuals who were teachers currently employed at the facility and agreed to participate were included in this study. These individuals had direct insight into the problem being studied and could carry out the practices developed by the focus group. Saunders, Lewis, and Thornhill (2015) referred to this as a homogenous grouping because all participants were similar in occupation and role within the organization.

Regarding sample size, Mason (2010) stated that the sample should be large enough to ensure pertinent views are discovered without becoming repetitive. Researchers typically use a measure of saturation to determine sample size (Mason, 2010). Saturation is dependent on many factors. In this study, the number of available teachers, the types of instruments that were used to collect data, and the nature of the study made reaching saturation possible with a fairly low number of participants (Ritchie, Lewis, & Elam, 2003). The sample size in this study was 12 teachers.

**Instrumentation**

The implementation phases are depicted in Figure 3, which shows the instruments used to gather data, as discussed below.
Figure 3. Schmuck’s (2006) Spiral of Responsive Action Research and Herr and Anderson’s (2015) Action Cycle including implementation instruments and focus group questions.
Program Records Review

Facility records were reviewed. These records included physical restraint frequency, regularity of students running away from the facility, frequency of staff calling off from work, and meeting notes. Records were reviewed at the beginning and at the culmination of the study.

ProQOL Survey

Staff also completed the Professional Quality of Life (ProQOL) survey at the beginning and ending of the study to reflect the level of compassion fatigue and compassion satisfaction felt by staff. The ProQOL has been validated in more than 200 published papers (Adams, Figley, & Boscarino, 2008; Newall & MacNeil, 2010; Stamm, 2010, 2012). First published in 1995 and revised several times, this tool is commonly used to measure the impact of working with trauma survivors (Stamm, 2010). Results are reported using standardized $t$ scores, which allows comparisons across various versions of the ProQOL. The ProQOL 5, formulated in 2012, was used for this study.

The ProQOL is a free, 30-item self-report measure of the positive and negative aspects of caring for individuals who have experienced trauma (Stamm, 2010, 2012). The ProQOL may be copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold (Stamm, 2010). It includes scales that measure Compassion Satisfaction and Compassion Fatigue using a Likert-type rating scale. Compassion Fatigue includes two subscales: Secondary Traumatic Stress and Burnout (Stamm, 2010, 2012). Cronbach’s alpha for the ProQOL Compassion Satisfaction scale is .88 ($n = 1,130$) (Figley & Stamm, 1996). The Burnout scale is 0.75 ($n = 976$), and the Compassion Fatigue scale is .81 ($n = 1,135$) (Figley & Stamm, 1996). Inter-scale
correlations showed 2% shared variance with Secondary Traumatic Stress (Figley & Stamm, 1996). See Figure 4 to view the ProQOL 5 measure.

**Observations**

Members of the administrative team (senior treatment supervisors, treatment supervisors and education supervisor, as described above) conducted observations of each teacher and completed an observation checklist to record evidence of a therapeutic community in classrooms. Observations were conducted during the data collection phase of the study, and data was used as a comparative measure throughout the implementation cycles. Observation items were adapted from the characteristics of a therapeutic community listed by Bloom (2000). (See the observation checklist in Figure 5.)

**Face-to-Face Interviews**

Semistructured participant interviews were conducted at the beginning of the study, once during the data collection phase, and at the culmination of the last phase of implementation. Creswell (2013) recommended creating an interview or protocol to guide interviews. This format of open-ended questions offers rich quotations that have been deemed helpful in enhancing feedback (Schmuck, 2006). Interviewees were asked to describe the challenges of working in a residential facility, how trauma impacted their experience at work, and factors that kept them in their jobs. Questions also revolved around the interviewees’ views of the workplace environment in the school and thoughts they had about improving it. Interviewees were asked to articulate what they had learned about trauma-informed care and any changes they had noted since the trauma-informed model was implemented (Bloom & Farragher, 2013). Table 3 provides a list of interview questions.
Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue
(ProQOL) Version 5 (2009)

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

<table>
<thead>
<tr>
<th>1=Never</th>
<th>2=Rarely</th>
<th>3=Sometimes</th>
<th>4=Often</th>
<th>5=Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am happy.</td>
<td>2. I am preoccupied with more than one person I [help].</td>
<td>3. I get satisfaction from being able to [help] people.</td>
<td>4. I feel connected to others.</td>
<td></td>
</tr>
<tr>
<td>5. I jump or am startled by unexpected sounds.</td>
<td>6. I feel invigorated after working with those I [help].</td>
<td>7. I find it difficult to separate my personal life from my life as a [helper].</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].</td>
<td>9. I think that I might have been affected by the traumatic stress of those I [help].</td>
<td>10. I feel trapped by my job as a [helper].</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Because of my [helping], I have felt &quot;on edge&quot; about various things.</td>
<td>12. I like my work as a [helper].</td>
<td>13. I feel depressed because of the traumatic experiences of the people I [help].</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. I feel as though I am experiencing the trauma of someone I have [helped].</td>
<td>15. I have beliefs that sustain me.</td>
<td>16. I am pleased with how I am able to keep up with [helping] techniques and protocols.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. I am the person I always wanted to be.</td>
<td>18. My work makes me feel satisfied.</td>
<td>19. I feel worn out because of my work as a [helper].</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. I have happy thoughts and feelings about those I [help] and how I could help them.</td>
<td>21. I feel overwhelmed because my case load seems endless.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. I believe I can make a difference through my work.</td>
<td>23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. I am proud of what I can do to [help].</td>
<td>25. As a result of my [helping], I have intrusive, frightening thoughts.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. I feel &quot;bogged down&quot; by the system.</td>
<td>27. I have thoughts that I am a &quot;success&quot; as a [helper].</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. I can't recall important parts of my work with trauma victims.</td>
<td>29. I am a very caring person.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. I am happy that I chose to do this work.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


www.isu.edu/~bhstamm or www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.

Figure 4. Professional Quality of Life (ProQOL) 5.
<table>
<thead>
<tr>
<th>Item</th>
<th>Observed</th>
<th>Not Observed</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of Sanctuary Community Meeting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reference to Sanctuary Seven Commitments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expectations frontloaded, reiterated, and/or reviewed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conscious problem solving facilitated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decisions made democratically and communally</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff facilitate resident control of impulses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff facilitate dignified and respectful treatment of each other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth allowed a “voice” (appropriately solicited)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth therapeutically held accountable for words and actions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal processing occurring via the Sanctuary S.E.L.F. model</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment appears physically safe for youth and staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment appears psychologically safe for youth and staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment feels supportive in nature</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffing protocols are met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level system and standard operating procedures are followed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active supervision evidenced</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventative measures taken</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Observer Notes:

*Figure 5.* Therapeutic Community Observation Checklist for Teachers. Based on characteristics of therapeutic environments from Bloom (2000).
### Table 3

**Structured Interview Questions**

<table>
<thead>
<tr>
<th>Questions Asked</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Describe the challenges of working in a residential facility school. What challenges do you face on a daily basis?</td>
</tr>
<tr>
<td>2. How does trauma affect your experience at work?</td>
</tr>
<tr>
<td>3. What keeps you in your current job?</td>
</tr>
<tr>
<td>4. How would you describe the environment at the school as a therapeutic community?</td>
</tr>
<tr>
<td>5. What do you think would improve the therapeutic quality of the environment at the school?</td>
</tr>
<tr>
<td>6. What have you learned about trauma-informed care in this phase of implementation?</td>
</tr>
<tr>
<td>7. What has changed with the implementation of Sanctuary? What has not changed?</td>
</tr>
</tbody>
</table>

### Focus Group

The focus group involved two prongs. Refer to Figure 3 for a visual representation of the focus group activities and their placement in the study. In the first prong, teachers read a book on trauma-informed care (Bloom & Farragher, 2013) and met weekly to discuss the concepts. The group members were asked to relate what they had read in the book study to the working environment and, in the focus group setting, create an ongoing list of promising practices and barriers to implementation that arise from the reading. The group selected from this list of practices to implement at each phase of the study and problem-solved as a group to find how to overcome the identified barriers. The second prong of the focus group was to meet during these data collection and planning phases of the study for reflection and discussion of promising practices they chose to implement (see Figure 3). The group was asked to list the positive
outcomes and areas of concern that arose during implementation. During the planning phase, the group determined if a practice should be continued, modified, or abandoned in the next phase of implementation. The decisions of the focus group guided subsequent practices that were implemented and vetted through the action research process. Figure 2 depicts the order of focus group activities and their relationship to the overall study.

**Participant Journals**

During the distribution, hopes and concerns, and implementation phases, each participant completed an online journal entry at least weekly to record their experiences. Schmuck (2006) recommended journal entry structures guide participants to reflect on the present, past, and future. Journals for this study was kept on an organizational computer-drive for ease of access. The journal template had a simple design that encouraged free expression, and it asked participants to reflect on their recent experience, identify future hopes, and articulate concerns they had regarding the trauma-informed care model and the environment of the school (Schmuck, 2006). Table 4 lists the specific journal entry prompts. The journals were reviewed prior to interview sessions so clarification could be sought by the interviewer if needed.
Table 4

*Questions for Online Participant Journal Entries*

<table>
<thead>
<tr>
<th>Questions Asked</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is your present experience with regard to trauma-informed care and its implementation in the daily aspects of your job?</td>
</tr>
<tr>
<td>2. How is this different or similar to your past experiences?</td>
</tr>
<tr>
<td>3. What hopes and concerns do you have regarding trauma-informed care and its implementation in the future?</td>
</tr>
</tbody>
</table>

**Data Collection**

Qualitative and quantitative methods were used to collect data. Multiple measures were chosen to improve validity of data and provide a multifaceted description of teachers’ experiences. All CU-IRB procedures were addressed prior to any data collection.

**Program Records Review**

Physical restraint data were recorded daily at the facility via Serious Incident reports, which were submitted through an organizational system. Designated organizational staff members were assigned the task of gathering data and assimilating it into categories of physical restraint, unauthorized absence from the facility, and physical assaults. Quantitative data were reviewed and reported for frequency during school hours regarding physical restraints, unauthorized absences, and physical assaults. The facility used a system to track employee absences and hours worked. Teacher data was retrieved from this system and reported in terms of number of days absent during each phase of implementation and aggregated into number of call-offs and scheduled vacation days.
ProQOL Survey

The survey was individually given and scored by hand at the onset of the study and again after the final data collection phase. Quantitative data from the ProQOL survey was measured via the Concise ProQOL Manual (Stamm, 2010). Three steps were followed to score the survey. ProQOL scores provided insight into teachers’ experiences with secondary trauma in the workplace and served as a pre- and post-measure.

Observations

Members of the administrative team (described earlier) were trained in observing for the specific items on the checklist prior to observing teachers. Participants were observed at least three times on different days and during different instructional times. At least two individuals observed each teacher to improve reliability of results. Observations lasted 15–30 minutes each. Qualitative observation data added to the depth of the evidence gathered by providing information in terms of trauma-informed practice in the classroom setting. These data assisted in determining the frequency of use of trauma-informed practices and provided context to inform the interview process.

Face-to-Face Interviews

Semistructured interviews were scheduled individually during teacher plan periods and were audio-recorded. Participant interviews were conducted at the beginning of the study, once during each data collection phase, and at the culmination of each phase of implementation. Each participant experienced at least four interviews over different days. Interviews averaged 15–30 minutes depending on participant input. Additional probes were used if respondent answers were unclear or needed further exploration. Interviews provided the opportunity for respondent validation as well. Questions from journal entries or focus group comments were further
discussed during interviews to ensure participants’ views were thoroughly understood (Schmuck, 2006). The interview process allowed deeper understanding of participant experiences by giving a forum for comments that may have been uncomfortable to voice in front of the group (Schmuck, 2006). Emerging themes were discussed in focus group meetings.

**Focus Group**

The focus group met weekly after school. Participants expanded trauma-informed care knowledge by reading a book by Bloom and Farragher (2013). Group members met approximately four times for about 30 minutes each. Participants were asked to read and reflect on chapters, and discussion was targeted toward creating an ongoing list of promising practices and barriers to implementation from the perspective of the participants (Schmuck, 2006). This list was then used to decide upon each trauma-informed practice to be implemented by the group. The group discussed the practice, described its attributes, and problem-solved barriers to implementation (Schmuck, 2006). Once a practice had been implemented and qualitative data had been collected (following the action research spiral outlined in Figure 2 and Figure 3), the focus group reflected on the process of implementation and on the pertinence of the practice to determine if it would continue to be implemented, if modifications needed to be made and further data taken, or if it should be abandoned and a new practice selected (Herr & Anderson, 2015).

**Participant Journals**

Through each phase of implementation, participants recorded reflections into their personal journals at least once per week. The journals were accessed through the organization’s private drive and were reviewed prior to participant interviews (Herr & Anderson, 2015). Journals added depth to the body of evidence by allowing individuals to expand upon their
personal experiences. These qualitative data allowed me to more clearly understand the input provided by teachers in interviews and focus group meetings (Koelsch, 2013).

Identification of Attributes

Attributes of this study included that it was an action research study, focusing on a residential facility school, and addressing the experiences of teachers. Another unique characteristic was the use of a particular trauma-informed care model, Sanctuary (Bloom, 1997), and its impact on teachers’ experiences. Qualitative and quantitative methods were used to collect data, relying heavily on participatory action from the research subjects. Collaboration was an essential component of the study (Herr & Anderson, 2015). Participants had to work together to reflect on current practices and had to be able to discuss possibilities of new practices, including the possible barriers to implementation. Participants needed to use collaborative skills to make decisions about next steps and to structure implementation to minimize barriers (Schmuck, 2006).

Data Analysis Procedures

A multitude of data resulted from the collection procedures described above. Reduction of data to useable information occurred as the process of collection happened (Ehrenberg, 1981). Each piece of data had to be reviewed with pertinent information being highlighted throughout the data collection process. As this study uses qualitative and quantitative methods to collect data, appropriate methods of analysis followed.

Program Records Review

Descriptive statistics were used to analyze all program records. Number of physical restraints, unauthorized absences, and physical assaults were recorded daily at the facility via Serious Incident reports, which were submitted through an organization system. Designated
organizational staff members were assigned the task of gathering data and assimilated into categories of physical restraints, unauthorized absences within the facility, and physical assaults (B. Miller, personal communication, January 13, 2017). Quantitative data were reported in a frequency distribution of occurrence in school and compared across months (Tashakkori & Teddlie, 2003).

The facility used a system to track employee absences and hours worked. Employee absences were reported in terms of absences per month and disaggregated into percentages of scheduled vacation days and sick days.

**ProQOL Survey**

Interval data from each area of the survey was converted to a t score with the raw score mean being 50, and the raw score standard deviation being 10. The manual provided a table for conversion with cut scores for each subscale. Group data from pre- and posttests were reviewed. A t test was run to determine the difference between pre- and posttest findings.

**Observations**

Observed frequency of the characteristics outlined in the Therapeutic Community Observation Checklist for Teachers (Figure 5) was analyzed to determine any change in frequency. Individual averages from observation scores were compared and described in terms of mean (average), median, and mode of observed commonalities.

**Face-to-Face Interviews**

Using constant comparative method (Harding, 2013), I analyzed the interviews by summarizing key points to better identify similarities and differences (Harding, 2013). Interviews were formulated in a combination of audio recordings and interviewer notes, so case study summary sheets were used to record the main points to reduce these data. To summarize
interviews, each interview was considered in terms of how it related to the research question, the pertinent information was recorded, and any repetition was eliminated (Harding, 2013). Transcripts were then coded using an open coding method of empirical codes, which are codes identified while data are examined rather than codes identified prior to receipt of data (Harding, 2013).

Lists of similarities and differences were also included (Harding, 2013). This method involved making a list of similarities and differences identified from interviews, amending the list as more information was added, and then discerning findings. As a method of reflective practice, commonalities were examined for subcategories and common perspectives shared by participants that existed within the given context. Harding (2013) suggested addressing an issue as a commonality when three quarters of respondents share this experience. Differences were also identified and examined for subcategories. Finally, any notable themes that could be identified, based on patterns in these data, were examined (Creswell, 2013).

Using constant comparative method (Harding, 2013), I took the following steps:

1. Recorded main points on case study summary sheets.
2. Eliminated repetition.
3. Coded as similarities/differences arose.
4. Made a list of similarities and differences.
5. Amended the list as more information was added.
6. Examined commonalities and differences for subcategories.
7. Noted any themes that materialized from the process.
**Participant Journals**

Using constant comparative method (Harding, 2013), I analyzed journal entries by summarizing key points to facilitate identification of similarities and differences (Harding, 2013). Journals were formulated using narratives, so case study summary sheets were used to record the main points to aid in reduction of data. To summarize journal entries, I considered each journal entry in terms of how it related to the research question, the pertinent information was recorded, and any repetition was eliminated (Harding, 2013). Summaries were then coded via open coding using empirical codes (Harding, 2013).

Lists of similarities and differences were also included (Harding, 2013). This method involved making a list of similarities and differences identified from journal entries, amending the list as more information was added, and then discerning findings. As a method of reflective practice, commonalities were examined for subcategories and common perspectives shared by participants that exist within the given context. Harding (2013) suggested addressing an issue as a commonality when three quarters of respondents share this experience. Differences were also identified and examined for subcategories. Finally, any notable themes that could be identified, based on patterns in these data, were examined (Creswell, 2013) using constant comparative method (Harding, 2013).

**Focus Group**

Focus group data was undertaken at the group (versus individual) level (Harding, 2013). Categories were identified through review of transcripts and coding. Transcripts were reviewed and coded from two of the focus groups. Commonalities and differences in comments were examined via constant comparative method (Harding, 2013). Coded information was then placed into categories, and thematic analysis was made where multiple respondents’ comments
were of a similar nature. Constant comparative method (Harding, 2013) was used to narrow the focus group transcript information and identify commonalities. Focus group data also included a list created by the focus group members of considered and attempted practices.

**Limitations and Delimitations of the Research Design**

**Limitations**

This action research design had several limitations, including the sample size and the subjective nature of qualitative research analysis. Results from action research studies are not statistically generalizable (Herr & Anderson, 2015). However, the collaborative process used in the study could be transferable to other similar settings (Herr & Anderson, 2015). In addition, the way trauma-informed care was used in the study could be helpful to others working in the residential care field. The instruments used in the study could also be used within similar contexts.

The following limitations have been noted:

1. Action research design. Action research is still in the process of being recognized as a viable contributing method to the research field (Herr & Anderson, 2015). The action research focuses on practitioner-based knowledge, and arguments still exist regarding its viability as a research method (Herr & Anderson, 2015). For instance, some skeptics raise concern with the transferability of data and the intermingling of the researcher in the action of the study (Herr & Anderson, 2015).

2. Sample size. The sample size of this study is restricted to the 12 teachers employed at the site during the time of data collection. This was a small sample size, which can limit the transferability of the findings. For example, results may not transfer to other
settings due to the specific context of the residential facility school and the exact trauma-informed care model being utilized.

3. Subjective analysis. The analysis procedures of the study include interpretation of participant perspectives via observations, journal entries, interviews, and focus group interactions. These are qualitative measures that can be subject to bias (Creswell, 2013).

Delimitations

Delimitations in the study include the setting, instrumentation, researcher positionality, and context. These issues limit the generalizability of the findings and may impact transferability of practices.

The following delimitations have been noted:

1. Setting. The setting was confined to one facility school within one youth residential treatment facility. The study was oriented to this particular facility and its individual context.

2. Instrumentation. The study involved the use of a trauma-informed care model. The model had already been decided upon by the facility administration at the time of the study, so this was the only model considered.

3. Researcher positionality. Researcher positionality was a concern because I was intricately involved in the management of the school, and the teachers were under my supervision. Within this study, I was an insider to the research. I was the researcher, but was also an administrator, supervisor, director, and educator. I had a specific interest in improving practices at the school and understanding how to better support teachers.
4. Context. The organizational context involved multiple factors, such as the difficulty level of the youth, the skill level of the staff members working alongside the teachers, and the systematic inner-workings of the school and facility. This issue was further complicated by the possibility of action research to “unreflectively reproduce current practices” (Herr & Anderson, 2015, p. 35).

Validation

Credibility

Several precautions were taken to approach credibility. The layering of participant journals, face-to-face interviews, and focus group interaction allowed for rich and thick description of participant perceptions and experiences (Geertz, 1983). Results further were supported by third-party observations of teachers in the process of teaching, the use of a quantitative survey as a pre- and post-measure, and monitoring of school serious incident data.

Credibility measures follow:

1. Triangulation. Triangulation (Bryman, 2008) consisted of cross-referencing participant journals, face-to-face interviews, and focus group interactions.

2. Third-party observations of teachers. Using the observation tool provided, members of the supervisory team conducted teacher observations to determine the extent to which the decisions of the focus group were being carried out in practice by the teachers during instruction.

3. Quantitative survey as a pre- and post-measure. The ProQOL survey provided quantitative support to the changes in teacher perceptions from the beginning to the end of the study.
4. Monitoring of school serious incident data. The number of physical restraints, unauthorized absences, and assaults occurring during school hours provided insight into the state of the school environment as a therapeutic community.

5. Reflexivity. Reflexivity, a self-analysis of how findings were deduced (Heaton, 2004), enhanced validity. This was accomplished through a research diary of impressions and thoughts that recorded how decisions were made (Harding, 2013).

**Dependability**

Measures to improve reliability of findings included addressing rival explanations, active reflection and discourse, member checking, and collaborative decision making.

Dependability measures follow:

1. Addressing rival explanations. Any findings that did not fit the patterns identified were addressed and rival explanations were considered (Harding, 2013).

2. Reflection and discourse during focus group meetings. Herr and Anderson (2015) discussed the tendency of social institutions to draw constituents back into norms and actions that have become “omnipresent” (p. 28). To offset the potential for recreating current practices, particular attention was paid to emancipation of participants from the status quo (Carr & Kemmis, 1986; Herr & Anderson, 2015). This was done through reflection and discourse during focus group meetings.

3. Member checking. When identifying areas of consensus and disagreement, numbers of supporting and disagreeing respondents were recorded and positions were clarified to assist with validity of the identification (Harding, 2013). Member checking was also utilized to validate interpretive findings (Harding, 2013;
Koelsch, 2013; Sagor, 2011). Members of the focus group were asked to determine if any misrepresentation had occurred in the analysis.

4. Collaborative decision making. The above-mentioned measures supported the collaborative nature of action research, as these processes served as “means of equalizing power relationships within the research relationship by enlisting participants as members of the research team” (Koelsch, 2013, p. 12). Further, as is partial to action research, participants guided the direction of the study through purposeful collaborative decision making.

**Expected Findings**

I undertook this study expecting that teachers in a residential treatment center would be able to clearly describe their experiences, particularly regarding trauma-informed care. Experiences involving secondary trauma were expected to evolve as well. The hope was that the collaborative model would inform others in similar settings in terms of practices that may reduce the impact of working in a highly stressful environment with youth who have experienced trauma in their lives.

**Ethical Issues**

The Belmont Report (The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979) established ethical guidelines regarding the treatment of research participants. The guidelines require all participants to voluntarily give informed consent prior to participating in a research study. Research projects must be presented to and approved by an Institutional Review Board (IRB) to ensure the priorities of respect for person, beneficence, and justice will be upheld when the study is carried out. Researchers must protect the well-being of participants and must explain the benefits and risks to participants prior
to exposing them to research conditions (LaMonte, 2016). Please see Appendix B for the Informed Consent document in this research study.

The Concordia University–Portland Institutional Review Board (CU IRB) process evaluates research projects involving human subjects to determine ethical integrity (Concordia University, n.d.). It involves a pre-application, an application, and post IRB requirements. The committee was made up of volunteers to avoid financial conflicts of interest. There were eight standing members, two alternate members, and a director on the committee. The director does not vote on IRB application decisions unless there is a tie. The CU IRB process took approximately twelve weeks.

**Conflict of Interest Assessment**

Action research methodology carries with it an inherent conflict of interest because of the ongoing involvement between researcher and participant (Herr & Anderson, 2015). In the current study, I was the supervisor of the teachers involved in the study and the director of the program serving as the setting. To mitigate the risk caused by this conflict, teachers were not forced to participate in the study (LaMonte, 2016). Input, level of participation, and application of practices associated with the study did not impact performance evaluations (Herr & Anderson, 2015).

**Researcher’s Position**

As the director of the program being studied and the supervisor of the participants, I was an insider to the research. This situation is sometimes referred to as *practitioner research* or *administrator research* (Herr & Anderson, 2015). Possible issues that could arise in this position include subjectively biasing results, allowing organizational norms to skew interpretations, and influencing practitioner input. Validity measures were put into place to offset these concerns.
(see the previous section). The insider position also has advantages (Herr & Anderson, 2015); in this case, I was dedicated to the school and teachers involved in the study. I wanted to improve the culture and working conditions of the school. I understood the complexities and context associated with the setting and the barriers faced by the participants. Given my position, I could focus on the practices that had the most promise and participants felt would most impact their success.

**Ethical Issues in the Study**

Herr and Anderson (2015) stated that all action researchers should “enter into the process expecting to face ethical challenges” (p. 145). Action research methodology brings with it the ethical conundrum of the involved researcher. As is integral to the method, I was intricately involved with the participants throughout the research process (Herr & Anderson, 2015). This interaction, along with the personal nature of the collaborative process and the fact that the study was fundamentally involved in the participants’ daily practice, created the possibility of researcher bias, contextual norms, and researcher positionality. Still, there was no deception in this study. An informed consent form was reviewed with each participant, and only those who agreed and signed the form were involved in the study. Consent forms will be retained for 3 years.

**Chapter 3 Summary**

In this section I described the methodology of action research and explained why it was chosen for this study. The study been designed to better understand the experiences of teachers in residential facility schools through the framework of constructivism. Collaborative decision making is integral to the process of action research. This study showed how a collaborative
model could assist participants in applying the trauma-informed care model to their setting, and I documented their perceptions regarding the process. The research question was identified as:

- “What are the experiences of teachers in a residential treatment center with regard to trauma-informed care?”

Subquestions included:

- “What are the experiences of facility school teachers regarding secondary trauma?”
- “What practices may lessen this impact?”

**Chapter 4: Data Analysis and Results**

**Introduction**

Through the framework of constructivism, this action research study was designed to better understand the experiences of teachers in residential facility schools. The purpose of this study was to investigate the experiences of teachers when implementing a trauma-informed care model in a youth residential facility school in southern Colorado. The primary research question and subquestions this study sought to answer follow:

- What are the experiences of teachers in a residential treatment center with regard to trauma-informed care?

Further subquestions included:

- What are the experiences of facility school teachers regarding secondary trauma?
- What practices may lessen this impact?

The purpose of this chapter is to show the data analysis, results of data analyses, and findings. I will describe the sample, discuss the research methodology and data analysis procedures, and provide raw data in appendixes (Appendixes C–H). A summary of the findings, including clusters of related patterns and themes, will be provided.
Description of the Sample

The facility employed 13 teachers, all of whom were invited to participate in the study and agreed to do so. One teacher left before beginning the focus group; thus, 12 teachers were involved for the duration of the study. The group taught differing subjects associated with their respective licensure, in accordance with state regulations. I used pseudonyms to protect the identity of each subject. Teachers’ experience ranged from first-year teachers to more than 20 years in the field. Table 5 describes the sample.

Teacher 1: Teresa had worked at the facility for 9 years at the time of the study. She began as a line staff and went through an alternative program to procure her teaching license. She was licensed in special education and language arts. She worked in the elementary and junior high classroom with the younger males at the facility.

Teacher 2: At the time of the study, Riley was a new teacher but had worked at the facility for 5 years after transferring from a facility out of state. He was previously a supervisor at the facility and is working on a temporary teaching license while he goes through a licensure program. Riley worked in the male alternative classroom with students who had the most significant behaviors at the facility.

Teacher 3: Jackson previously retired from teaching in public schools before coming to the facility 4 years ago. He taught science but was also licensed to teach math, and he was a special education teacher. Jackson did not move around the facility as other teachers did. He was set up in one classroom, and the youth transitioned to him.
Table 5

Participant Demographics

<table>
<thead>
<tr>
<th>Teacher (Pseudonym)</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Years of Experience</th>
<th>Subjects Taught</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher 1: Teresa</td>
<td>Female</td>
<td>White</td>
<td>9</td>
<td>Language Arts, Elementary Education, Special Education</td>
</tr>
<tr>
<td>Teacher 2: Riley</td>
<td>Male</td>
<td>White</td>
<td>5</td>
<td>Social Studies, Special Education</td>
</tr>
<tr>
<td>Teacher 3: Jackson</td>
<td>Male</td>
<td>White</td>
<td>4</td>
<td>Science, Math, Special Education</td>
</tr>
<tr>
<td>Teacher 4: Patricia</td>
<td>Female</td>
<td>White</td>
<td>4</td>
<td>Language Arts, Science, Math, Social Studies, Special Education</td>
</tr>
<tr>
<td>Teacher 5: Lucy</td>
<td>Female</td>
<td>White</td>
<td>1</td>
<td>Social Studies, Electives, Special Education</td>
</tr>
<tr>
<td>Teacher 6: Andre</td>
<td>Male</td>
<td>African American</td>
<td>2</td>
<td>Language Arts, Special Education</td>
</tr>
<tr>
<td>Teacher 7: Reese</td>
<td>Female</td>
<td>White</td>
<td>12</td>
<td>Special Education</td>
</tr>
<tr>
<td>Teacher 8: Valentine</td>
<td>Female</td>
<td>Two or More</td>
<td>9</td>
<td>Elementary Education, Special Education, Physical Education</td>
</tr>
<tr>
<td>Teacher 9: David</td>
<td>Male</td>
<td>White</td>
<td>3</td>
<td>Physical Education, Special Education</td>
</tr>
<tr>
<td>Teacher 10: Wallie</td>
<td>Male</td>
<td>African American</td>
<td>1</td>
<td>Career Technical Education, Special Education</td>
</tr>
<tr>
<td>Teacher 11: Rosco</td>
<td>Male</td>
<td>White</td>
<td>12</td>
<td>Math, Social Studies, Special Education</td>
</tr>
<tr>
<td>Teacher 12: Jason</td>
<td>Male</td>
<td>White</td>
<td>2</td>
<td>Math, Science</td>
</tr>
</tbody>
</table>

Teacher 4: Patricia had just recently returned to the facility at the time of the study. She worked at the facility for 4 years prior, beginning as a line staff and then going through a licensure program to earn her teaching license. She left the previous January to work in a public-
school setting and returned a few months later. Patricia was licensed as a special education teacher and also taught language arts, science, math, and social studies. Patricia taught a horticulture class as well as several electives and a language arts class.

Teacher 5: Lucy was beginning her second career as a teacher at the time of the study. She was going through a licensure program to earn a teaching license and was currently working off a temporary license. Lucy taught electives, including several personal growth and career exploration classes. She was new to the facility and worked there about one year.

Teacher 6: Andre was in his second career as a teacher at the facility. Andre was licensed in special education and language arts and had been with facility for 2 years. Andre liked to be creative and think “outside the box” to engage youth. In his language arts classes, he had created units that were therapeutic for the youth and tap into their talents, such as using song lyrics to tell stories and express emotions.

Teacher 7: Reese worked for the facility as a line staff several years ago. She entered into a licensure program and earned her license to teach special education. Reese then left the facility to teach in public schools. She returned about a year earlier to be a teacher at the facility. Reese handled all of the special education services at the facility. She spent a lot of time testing youth and conversing with them about their career interests. She also worked to make sure students receive the appropriate accommodations and modifications to help them access the educational environment. She had worked at the facility at total of 12 years.

Teacher 8: Valentine had been a teacher at the facility for 9 years at the time of the study. She was certified to teach elementary education, physical education, and special education. Valentine worked with the younger female youth in the elementary and junior high classroom. She enjoyed getting to know the youth and developing caring relationships with them. Valentine
liked to teach cooking when she could and thought it was important for the students to have exposure to many different cultures.

Teacher 9: David was the physical education teacher at the facility at the time of the study. He returned to the facility last year after leaving for about six months to work in another facility. He was a competent teacher who exhibited strong behavior management skills and had taught in the field for nearly 20 years. He had worked at the facility at total of 3 years.

Teacher 10: Wallie worked as the transition/vocation teacher for the facility at the time of the study. He had a temporary teaching license and was in a program to earn his teaching license in special education. Wallie worked with both males and females and directs the youth in passing the GED and gaining employment skills. He had a calming and reassuring presence with the youth. He enjoyed watching the students’ leadership skills grow as they improved in their ability to interact with others. Wallie had been at the facility for one year.

Teacher 11: Rosco had worked at the facility for 12 years at the time of the study. He retired from teaching in public schools and made the facility his second career. Rosco liked to use humor to engage the students. Rosco was licensed to teach math, social studies, and special education.

Teacher 12: Jason had been with the facility for 2 years at the time of the study. He retired from teaching in public schools and missed the interaction with students. Jason taught math at the facility. He was licensed to teach math and science. Jason enjoyed working with the youth and often volunteered to work in the living quarters to improve relations with the students.

**Research Methodology and Analysis**

This action research study was designed to explore the perceptions of teachers in a residential treatment facility. The conceptual framework involved social constructivism, a
theory of learning that views knowledge development as an ongoing evolution of experiences and reflection (Vygotsky, 1994). Social constructivist viewpoints are associated with knowledge generation of actively involved participants and align directly with the premise of action research for this reason (Kim, 2014). This framework supports addressing the assumptions through which employees experience the workplace so that communication can be clear and false perceptions can be redirected (Bolman & Deal, 2014).

To answer the research question and the two subquestions, qualitative and quantitative measures were used (see Figure 6). Qualitative data collection strategies included observations, interviews, journals, and a focus group. Quantitative data collection included frequency measures of youth physical restraints, runaways from the facility, and assaults, as well as staff call-offs and paid vacation time. Information from all forms of data collection was used to address each question.
This study was designed using action research, which is highly participative and involves including participants in the decision making that takes place in the study (Herr & Anderson, 2015). Action research addresses “in-the-moment” issues that are impacting current
organizational functioning. Using action research, data collection was guided by Herr and Anderson’s (2015) Action Cycle. The focus group was guided by Schmuck’s (2006) Spiral of Responsive Action Research.

Herr and Anderson’s Action Cycle (2015) consists of four phases, Develop, Act, Observe, and Reflect through which I, as the researcher, cycled three times. The Develop phase involves creating a plan to improve a current situation. In this situation, the situation being addressed was teachers’ perceptions of their work environment. Frequency data were reviewed and a decision was made on utilization of the focus group format. A book for study was chosen to assist participants in coming up with appropriate interventions to try. The Act phase entails implementation of the plan, which involved three focus group meetings during which the participants decided on practices to implement. The Observe phase involves paying close attention to what effects the action plan has in the current context. Observations of teachers in the instructional environment were conducted to gain data on implementation. I interviewed participants individually to determine understanding and perceptions of the situation. Participants also completed personal journals reflecting on their experiences.

The Reflect phase involves further planning on next steps derived from the information gleaned in the previous phases. I reviewed the observation data, interview data, and journal data at the culmination of each phase to determine further actions that needed to be taken. This is the spiral I went through as the researcher in determining actions and discerning themes throughout the study. During the focus group meetings, participants were also engaging in a spiral of action to determine interventions that would be utilized in the study.
Figure 7. Action research cycles: Concurrent research and focus group spirals. Based on the Develop, Act, Observe, Reflect Model of Herr and Anderson (2015, p. 5) and Schmuck’s (2006) Steps of Responsive Action Research (p. 34).
Participants followed Schmuck’s (2006) Spiral of Responsive Action Research, as evidenced by the blue diagram depicted in Figure 7. Figure 8 offers a closer view of this model.

In the *Data Collection* phase, information is gathered to diagnose the situation. The records review and staff survey initially provided participants with information to assist in assessing the current state of affairs.

![Schmuck’s Steps of Responsive Action Research](image)

**Figure 8.** Schmuck’s Steps of Responsive Action Research (2006, p. 34).

The group also gathered information by reading Bloom and Farragher (2013). In the *Analyze* phase, data are reviewed for themes and ideas for action. Participants in this study discussed the information from data and the book chapters. They engaged in discourse regarding
how this information might translate into options for interventions they could carry out in their daily practice. In the *Distribute* phase, data are given to others and changes that will be tried are announced. This task was completed at each focus group when the participants decided on the intervention that would be attempted. In the *Hopes/Concerns* phase, expectations and apprehensions are discussed to bring out desired outcomes and fears to the group. After each intervention was decided upon by the focus group, the participants conferred about their concerns and how the interventions would be helpful to the school. In the *Try/Practice* phase, a new practice is attempted with the hope of eliciting a different response. To carry out this phase, after each focus group meeting, the participants went into their daily instructional roles and attempted the practices as discussed in the focus group meeting.

**Data analysis procedures.** The data analysis protocols are discussed below: records review, staff survey, observation, interview, journal, and focus group. Data were reviewed after each phase of focus group meetings, observations, interviews, and journals.

**Records review protocol.** Data were gathered for the facility school for 2 months (June and July) prior to the study and for 3 months (August, September, and October) during the study. Data included physical restraints, walk-outs, runaways from the facility, and assaults. These data were analyzed using frequency counts (see Table 7). The records review also included employee absences and use of paid time off (PTO) for school staff during the months of July through October. I reviewed these data monthly to determine if changes were noted.

**Staff survey protocol.** The ProQOL survey was given as a pre- and posttest. The self-rated survey measures levels of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. Pre- and posttests were compared using paired t tests for each of the three categories
regarding the responses from the 12 teachers who participated in the study (see Table 6 and Appendix C).

**Observation protocol.** Observations were conducted of teachers in the instructional environment to determine the extent to which trauma-informed techniques were being used. A standard observation form, adapted from the characteristics of a therapeutic community listed by Bloom (2000) was used in all observations (see Figure 5). Observations took place over the months of September, October, and November 2017. Teachers were observed on multiple different days and at different times. To ease teachers’ anxieties and ensure the observations did not hold evaluative merit, I did not complete the observations. Operational supervisors and the assistant principal conducted the observations. I reviewed the observations after each set was completed and looked for trends in practice and evidence that the decided upon intervention was being used. See Appendixes D and E for observation raw data and a summary of these data.

**Interview analysis protocol.** Semistructured participant interviews were conducted at the beginning of the study, once during the data collection phase, and at the culmination of the last phase of implementation using formats suggested by Creswell (2013) and Schmuck (2006). I met with participants individually and used the predetermined questions (see Table 3) to guide the discussion. I recorded respondents’ answers using an iPhone and took notes as the interviews progressed. Using constant comparative method (Glaser & Strauss, 1967; Harding, 2013), I reviewed interview transcripts, recorded main points in case-study summary sheets, coded transcripts, and reviewed commonalities for subcategories and themes (Harding, 2013, p. 66). Harding (2013) indicated the threshold is one quarter of respondents for codes to be considered part of the findings. With 12 respondents, the threshold of three respondents was used to determine codes included in categories. Categories that arose from the interview analysis, which
met Harding’s (2013) criteria of two thirds of participants mentioning the item, included Challenges, Secondary Trauma Impact, Factors Needed to Help/Needs, Understanding of the Trauma-Informed Model, Reasons to Work in a Facility School, and Improvements. See Appendix F for a summary of the interview findings.

**Journal analysis protocol.** Participants were asked to complete four journal entries, one after each spiral was conducted. The journals used structured prompts (see Table 2), which remained the same for each entry. The format for the journals was a private Google Drive document. I created the documents and sent them to the participants individually. They each completed their document and sent it back to me. Constant comparative method (Harding, 2013) was used to analyze participant journal entries for commonalities and differences. Case study summary sheets were used to reduce data. Summaries were coded via open coding using empirical codes. Submissions were compared by organizing each respondent’s input for each journal question into a chart and comparing responses to the others as each was added. In this manner, commonalities and differences were gleaned, and categories were identified. Participant journal entries were highly variant, but common points were able to be identified from the various comments. Categories that were identified from journal entries included Improvements and Changes, Positives Regarding Trauma-Informed Care, and Concerns with Trauma-Informed Care in the Facility. See Appendix G for a summary of journal findings.

**Focus group protocol.** The focus group met in the school library after students were dismissed. I facilitated the discussions, and all teachers participated. The assistant principal was also present for the discussions. The meetings were recorded on a cellphone and later transcribed. Data from the focus group meetings were analyzed at the group level (Harding, 2013), and the analysis focused on how the discussion took place as well and the pertinent
comments made by individuals. Transcripts were coded and constant comparative method was utilized to identify common categories. The focus group data analysis followed Harding’s (2013) method of identifying discussed themes, placing codes into categories, noting where a code was attached to a sufficient number of respondents, and identifying commonalities and differences (p. 153). See Appendix H for a summary of the focus group findings.

The focus group met three times and followed Schmuck’s (2006) Spiral of Responsive Action Research (see Figure 7). Each week, the group arrived having read two chapters from Bloom and Farragher (2013). The group reviewed baseline or existing data regarding performance of trauma-informed care interventions from the staff observations, discussed previous perceptions of the identified skill or intervention that had been tried, decided to modify or change the intervention, and determined next steps. In alignment with the action research model, this process gave voice to participants as they participated in the discussion and decision-making process (Groundwart-Smith, 2007).

Three main categories were noted from the focus group discussions:

1. Reenactment triangle (a component of the trauma-informed care model).
2. The state of hyperarousal in staff.
3. Several intervention suggestions from staff.

The Action Research Spirals

As previously mentioned, this study utilized two spirals, the concurrent research and participant spirals, following the action research model. Herr and Anderson’s (2015) Action Cycle (p. 5) guided the study, while the focus group was guided by Schmuck’s (2006) Steps of Responsive Action Research (p. 34). I went through the spiral three times, and each progression through the spiral is referred to as a cycle. In each cycle of the spiral I used Harding’s (2013)
constant comparative method to determine commonalities and differences, determine actions that needed to be taken, and note any themes that were forming.

Participants went through Schmuck’s (2006, p. 34) Steps of Responsive Action Research three times, and this spiral guided the focus group. Each progression through the spiral is referred to as a cycle. Each cycle utilized information provided by data from the previous cycle to help the participants follow the process to make informed decisions about the interventions they had tried and the practices they might like to try in the future. Following are more detailed descriptions of each cycle of the participant and researcher spirals.

**The First Spiral**

![Participant Spiral 1 (Schmuck, 2006, p. 34).](image)

- **Data Collection**
  - Participants completed ProQOL survey, began reading the book, and learned about the process

- **Analysis for Ideas**
  - Participants met for first Focus Group, discussed current state of the model and brainstormed ideas for practices they might try

- **Distribute/Act**
  - Participants decided to try the first intervention: Community Meetings 1\(^{st}\) and 6\(^{th}\) periods

- **Hopes/Concerns**
  - Participants discussed issues around the intervention and ironed out what constitutes a Community Meeting, what times of day they would be done, and what to do about resistive youth

- **Try/Practice**
  - Participants tried the intervention in practice beginning the next day

*Figure 9. Participant Spiral 1 (Schmuck, 2006, p. 34).*
In the first participant spiral (Schmuck, 2006, p. 34), participants met for the first focus group meeting (see Figure 9). The *Data Collection* phase was comprised of participants completing the ProQOL survey of compassion fatigue (Figure 7, Participant Spiral 1) and a review of the restraint, runaways, and assault data from the records review. Bloom and Farragher (2013) was introduced, and the group process was explained to the participants. The *Analysis* phase was done when participants met for the first focus group and discussed the current state of the trauma-informed care model. They brainstormed ideas for practices they might try. In the *Distribute/Act* phase, participants decided to try the first intervention, community meetings. They decided to hold them during first and sixth periods. Much discussion in the *Hopes/Concerns* phase centered around what exactly was to be done during a community meeting, what it was and what it was not. Participants discussed concerns around uncooperative youth and how to handle these situations. In the *Try/Practice* phase, participants carried out the intervention beginning the following day.

*Figure 10.* Action cycle: Concurrent research spiral 1 (Herr & Anderson, 2015, p. 5).
In the first concurrent research spiral, depicted in Figure 10, the *Develop* phase involved the scheduling of the focus groups, identification of the journal and interview formats, and review of the starting points for the focus group discussion. The *Act* phase involved holding the first focus group meeting. During this meeting I met with all the participants as a group and introduced the process. The group reviewed the first chapters of the book *Restoring Sanctuary* (Bloom & Farragher, 2013), and, after much discussion, identified the first intervention that would be tried. During the first focus group, teachers also completed the ProQOL survey. After the focus group, I met with teachers individually for the initial interviews. The *Observe* phase involved collecting baseline data on all frequency items (restraints, runaways from the facility, assaults, staff call-offs, and scheduled paid time off). I also calculated the ProQOL scores via the manual (Appendix C). In the *Reflect* phase, I reviewed the content of the next chapters of the book, reviewed the ProQOL scores to see the compassion fatigue levels of the teachers, and reflected on the baseline data from the records review.

**The Second Spiral**

In the second Participant Spiral, based on Schmuck (2006, p. 34), the *Data Collection* phase involved observation data of teachers implementing Community Meetings, which was taken via the teacher observation checklist (see Figure 11). The assistant principal and treatment supervisors gathered these data and conducted the observations. In the *Analysis* phase, I reviewed data and presented it to the focus group during the second focus group meeting (see Appendixes D and E). The participants discussed these data and their experiences from implementation. They decided to continue the intervention. The next chapters of the book were reviewed, and the group brainstormed ideas for the next practice they would try. In the *Distribute/Act* phase, the group decided the second intervention would be to implement Trauma
Sensitive Systems. In the *Hopes/Concerns* phase, the group discussed exactly what systems they would implement and came up with staggered desk set-ups, a structure for classroom boards, and specific seating charts. During the *Try/Practice* phase, participants put the intervention into place.

<table>
<thead>
<tr>
<th>Observation data collected, teachers implemented Community Meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants met for second Focus Group, discussed data from observations and experiences from implementation, decided to continue intervention, reviewed chapters, and brainstormed ideas for the next practice</td>
</tr>
<tr>
<td>Participants decided to try the second intervention: Trauma Sensitive Systems</td>
</tr>
<tr>
<td>Participants discussed issues around the intervention and ironed out what practices would be involved (staggered desk set up, board structure, seating charts)</td>
</tr>
<tr>
<td>Participants tried the intervention in practice beginning the next day</td>
</tr>
</tbody>
</table>

*Figure 11.* Participant Spiral 2 (Schmuck’s Steps of Responsive Action Research, p. 34).

In the second Concurrent Research Spiral, based on Herr and Anderson (2015, p. 5), the *Develop* phase involved planning for how to address issues brought up in the interviews and journals, and looked at the next chapters in the book for pertinent points (Figure 12).
In the *Act* phase, the second focus group was held and follow-up interviews were conducted. I had conversations with teachers and actions taken to address particular issues that arose from the first set of interviews. The *Observation* phase involved my observation of the participant interactions during the focus group process. The treatment supervisors and assistant principal observed teachers using the identified practice during instruction. The *Reflect* phase constituted my reflection of participant interactions and facilitation of the group process. Transcripts of interviews were reviewed (Appendix F) and the impact of the process on teachers’ perceptions was considered.

*Figure 12. Action cycle: Concurrent Research Spiral 2 (Herr & Anderson, 2015, p. 5).*
The Third Spiral

In the third Participant Spiral (Schmuck, 2006, p. 34), the Data Collection phase consisted of ongoing observation data of teachers implementing the identified interventions during instructional time. Supervisors and the assistant principal examined seating charts and classroom organization to determine effectiveness of the systems. In the Analysis phase, participants met for the third focus group and discussed data from the observations. They also discussed their experiences with both interventions (community meetings and trauma sensitive systems) and made some modifications to how they were being implemented. The organization of desks proved problematic in some classes and helpful in others. The group determined that
the use of this intervention was highly dependent on the needs of the youth in the classroom.

Participants then brainstormed ideas for the next intervention.

In the third Concurrent Research Spiral (Herr & Anderson, 2015, p. 5), the Develop phase involved creating plans to assist with issues identified in the focus group, interview, and journal processes (Figure 14). One such issue was how to therapeutically interrupt a reenactment triangle once it was identified. Individual issues identified by teachers were also addressed in planning. In the Act phase, the final focus group meeting was held and individuals carried out identified plans for ending reenactment triangles. Discussion was held about the possibility of a team of individuals to assist with this issue in the future. The Observation phase included ongoing observation of participant interactions and the focus group process, along with continued observation of teachers in the instructional setting. The Reflect phase involved looking back at participant interactions in the focus group and considering participant interview responses and journal reflections.

As indicated in the spirals, participants learned new information, used data to make decisions, and explored their experiences with the interventions during the different phases of the study. As they learned more about the trauma-informed care model, they were able to discern interventions that would benefit them in the instructional setting. Through the process of discourse and reflection, participants made decisions that guided the study, which is the hallmark of action research (Herr & Anderson, 2015; Stringer, 2014). Participants were able translate the components of the trauma-informed care model to improve performance in their specific context (Schmuck, 2006) by engaging in the action research spirals.
Summary of Findings

Action research focuses on involving participants in decision making that addresses contextual issues (Herr & Anderson, 2015). This is accomplished through spirals of inquiry that involve repeated cycles of initiation, detection, and judgment (Herr & Anderson, 2015; Kid & Kral, 2005; Schmuck, 2006; Stringer, 2014). The overall study was guided by Herr and Anderson’s (2015) action research spiral including the steps of Develop, Act, Observe, and Reflect (p. 5). The Develop phase involves creating a plan to improve a current situation. The Act phase entails implementation of the plan. The Observe phase involves paying close attention to what effects the action plan has in the current context. The Reflect phase involves further planning on next steps derived from the information gleaned in the previous phases. Through the repetition of this process, data were gathered and analyzed to address the research question.

An integral part of the study was the participant focus group, which was guided by Schmuck’s (2006) Spiral of Responsive Action Research (p. 34). See Appendix H for a summary of focus group findings. The steps of the spiral include Data Collection, Analyze for
Ideas, Distribute/Act, Hopes/Concerns, and Try/Practice. The Data Collection phase involves gathering information to diagnose the situation. The Analyze for Ideas phase entails reviewing data to discern ideas for action. The Distribute/Act phase encompasses data being distributed and announcing the decided upon action that will be tried. The Hopes/Concerns phase includes listing participant expectations and worries to the group for discussion. The Try/Practice phase constitutes a period of attempting the new practice in context.

This study was grounded in the social constructivism conceptual framework, which holds that knowledge develops through an ongoing evolution of experiencing and reflecting (Kim, 2014; Vygotsky, 1994). The processes described in the above action research spirals led to the decisions made in the study and the actions taken. As is embedded in the action research model, repeated cycles of the spirals led to deeper understanding of the situation by those involved (Herr & Anderson, 2015).

Through participation in the study, participants experienced shifts in their perceptions, as evidenced through changes in their journal entries, interviews, and focus group comments. However, frequency data (youth restraints, runaways, and assaults; participant call-offs and vacation time) and survey data (ProQOL survey of Compassion Fatigue, Burnout, and Secondary Trauma) did not represent noticeable changes, which is representative of a participant perception shift rather than an environmental change (Table 6, 7, and 8; Appendix C). The action research models of Schmuck (2006) and Herr and Anderson (2015) were confirmed through the responses in this study.

Presentation of Data and Results

Data collected included a records review, a staff survey, participant observations, participant interviews, participant journal entries, and focus group input. I used frequency
measures to analyze the records review data. Data from the staff survey, which was provided as a pre- and posttest, was compared using paired $t$ tests (Appendix C). Participant observations were analyzed using frequency measures (Appendices D and E). The remaining data, that is, participant interviews, participant journal entries, and focus group input, were analyzed using the constant comparative method (Harding, 2013). See Appendixes F, G, and H for summaries of these data.

Comparative analysis involves comparing and contrasting data from multiple respondents until no new themes or issues arise (Glaser & Strauss, 1967; Harding, 2013). The premise of continually comparing and contrasting input from participants is a foundational concept in qualitative data analysis (Harding, 2013). Constant comparative method involves looking at similarities and differences in participant responses and creating categories in which to place data.

I also used coding to assist with the identification of categories. Harding (2013) noted that coding and the constant comparative method are frequently used together as part of the qualitative data analysis process. Transcripts of participant interviews, participant journal entries, and transcripts of focus group input were analyzed using an open-coding method of empirical codes, which are codes identified while data are examined rather than codes identified prior to receipt of data (Harding, 2013). This process allowed coding to occur in an ongoing manner while participants cycled through the action research spirals. See Appendixes F, G, and H for summaries of these data.

I organized data from the Records Review, the Staff Survey, the Participant Observations, the Participant Interviews, the Participant Journal Entries, and the Focus Group
Input to support the guiding research question and two subquestions. The primary research question and subquestions this study sought to answer follow:

- What are the experiences of teachers in a residential treatment center with regard to trauma-informed care?

Further sub-questions included:

- What are the experiences of facility school teachers regarding secondary trauma?
- What practices may lessen this impact?

Four themes emerged from the participant interviews, participant journal entries, and focus group input:

- Improved understanding of the importance of trauma-informed care and the components of the model.
- Development of shared interventions.
- Awareness of improvements and changes resulting from the process.
- Awareness of challenges and concerns of using trauma-informed care in a facility school.

The Research Question

The primary research question addressed in the study follows:

- What are the experiences of teachers in a residential treatment center with regard to trauma-informed care?

The themes that supported the research question were (a) improved understanding of the importance of trauma-informed care and the components of the model, (b) awareness of improvements and changes resulting from the process, (c) awareness of challenges, and (d) concerns of using trauma-informed care in a facility school.
Improved understanding of the importance of trauma-informed care and the components of the model. All participants noted that prior to working at the facility they lacked a thorough understanding of trauma-informed care. In journal entries, participants noted experience ranging from 2 years to only a few months, but all indicated improved awareness and understanding of trauma-informed care and the model through the action research process.

Jackson wrote, “I like the shift in perception, to prevention as an active approach rather than passive response to student behavior.” Teachers noted improved understanding in the components of the model, including the reenactment triangle, the concept of democracy, and the SELF model (Bloom, 2013). Valentine stated in an interview, “Staff awareness has definitely changed. People are more likely to question the reason behind the behavior than just respond to the behavior.” Multiple teachers stated in interviews the importance of trauma as a concept that must be addressed with youth. Reese stated, “Trauma affects all of our lives on a daily basis. The key is to recognize it and then let them [the youth] know we’re there to support.” Teresa also noted that if students are “focused on how [they] feel based on trauma, nothing else is really going to matter” and that if students are worried about their safety, they are “not going to absorb anything that’s being taught.” Teachers’ perceptions shifted to include an understanding of the necessity of dealing with the effects of trauma in their students.

Awareness of improvements and changes resulting from the process. Through triangulation of journal entries, interviews, and focus group transcripts, multiple improvements were noted resulting from the action research process. Teachers stated that staff became more proficient with the interventions associated with the model. Over time, as Teresa stated, the interventions became “less forced and more natural.” Rosco noted more “emotional mindfulness” in staff and described how teachers’ presence can impact the behavior and
emotional state of youth. Teachers perceived there to be less staff turnover, a reduction in restraints, and less aggressive behaviors, though the facility data did not necessarily support this perception. Jackson stated, “trauma-informed care is here to stay. I see tangible, lasting results.” Andre also noted that “past training experiences mostly focused on crisis management,” and he went on to state that the current model “helps students on a more dynamic level. All professionals, parents, and caregivers who help traumatized children should learn and master the practice of trauma-informed care.” Participants felt strategic use of the components of the trauma-informed care model, coupled with the training and discussion utilized in the study, allowed them to make use of the model more of a cultural norm.

**Awareness of challenges and concerns of using trauma-informed care in a facility school.** Nearly all participants noted the variant levels of youth ages, academic levels, and therapeutic capacity as challenges that impact their ability to do their job well. Teresa stated, “I have to attempt to teach multiple age, multiple level youth simultaneously while keeping them safe and staff safe.” Jackson also noted the “range of intellectual ability of the residents” as a challenge. Teachers noted the youth are highly unpredictable and engaging them is difficult. As Patricia said, “not knowing what to expect from any kid at any given time as far as attitude and mood and motivation” is a constant hurdle. In addition, teachers noted that the task is made more difficult when the staff they work with are different on any given day. David said, “working with different staff all day and inconsistent staff in classrooms that don’t have a permanent [staff]” are daily issues. Participants noted a shared concern with the trauma-informed care model in that staff members felt apprehensive of intervening with youth to hold them accountable. Staff members feared they would in some way worsening the trauma felt by the youth. Jackson iterated this point when he stated, “To me it seems that reenacting something
would just be more painful, and why would we want to do something more painful?” Teachers also were concerned that youth sometimes seem not to take the trauma-informed community seriously and may use sensitivity to triggers as a way to avoid consequences. Reese said that certain interventions were hard for younger youth who need modifications so they don’t just “laugh and joke and roll around on the floor.” Patricia noted that staff have differing levels of buy-in to the model, and “those with less buy-in cause disruptions in the process and culture.” Finally, Wallie noted a concern that training must be ongoing. He stated, “implementation of trauma-informed care implemented here at work will only be as good as the continuous training received from supervisors.” The participants were able to articulate challenges and concerns with implementation, but the concerns shifted from questioning the plausibility of the trauma-informed care model to the need to increase training and the need to address the contextual issues associated with a residential facility school.

**Subquestions**

The two subquestions follow:

- What are the experiences of facility school teachers regarding secondary trauma?
- What practices may lessen this impact?

The main theme that supported the subquestions was *development of shared interventions*.

**Development of shared interventions.** Through the focus group process, the participants came up with the following list of interventions that were plausible for the population and the environment:

- Reading the documented histories of the youth.
- Reenactment identification (a component of the trauma-informed care model).
• Having meaningful interactions with the youth.

• Utilizing community meetings (a component of the trauma-informed care model) at least twice a day.

• Developing and using trauma-oriented systems (such as seating arrangements, awareness of one’s personal presence as a trigger for youth, attending to how youth are grouped).

• Consideration of double-loop learning (a component of the model) to promote changes in the status quo.

They attempted three of these as a group: community meetings, trauma-oriented systems, and double-loop learning. Teachers were able to recognize the habit-forming thinking involved in having community meetings and appreciated the benefit of training students’ brains to think in terms of the questions modeled in the meetings. However, the spiral process of the action research model brought out other concerns with this particular intervention. When the group came back together for reflection, they said the group model of the community meetings was a struggle for younger youth. Reese, who was working with younger youth, stated, “With my group it’s a little difficult because they all have the attention span of a gnat, so even though there’s only seven of them, it’s like pulling teeth.” The participants were able to identify options, such as writing the answers to the questions. When Reese was concerned about the youth being able to write, Riley suggested, “Have them draw pictures,” and Teresa stated, “How about a rating scale, like 1, 2, and 3, where they just circle the number?” Reese then added, “Or a fill-in-the-blank version of the questions.” In this way, teachers used discourse to assist with lower functioning youth or those youth for whom the group model was not beneficiary.
The spiral process also brought out concerns with the intervention of developing trauma-oriented systems. The group decided to use a staggered desk set-up for the classrooms to provide a bolstered feeling of safety for the youth. This worked for a few classrooms, but upon group reflection, some youth reacted to the change of moving desks and preferred the traditional row set-up. Patricia stated,

I got a lot of resistance from the boys in B3 and B2 [classrooms]. There was a lot of resistance… ‘what’s going on? Why do we have to do this?’ Can’t we just do a traditional setting for the groups that don’t need it?

The group determined these systems must be responsive to the youth in the classroom and cannot be “blanket” measures for every class. Some classes benefitted, while others did not.

Teachers were excited to discuss the double-loop learning component of the model, which involves changing the status quo to enable growth and responsiveness to the group (Bloom, 2013). Patricia described a recent situation where this worked well for her:

[The youth] stood up, asked, “Can I say something?” And then he took over my class!

The kids were listening… and he had some really deep thoughts and the kids were engaged. He had them hooked! Allowing them to have that freedom to express themselves has really helped in that class.

Teachers determined this would be the next intervention they would try. They appreciated the opportunity to try and challenge the status quo. Teresa stated, “I don’t feel as trapped as I have in the past or in a rut with how we do things; I think there’s a little flexibility as to how I’m able to teach.” Teachers felt confident enough to make decisions about the need for trauma-informed systems with particular groups of youth and were ready to begin challenging the status quo to increase engagement of the youth.
Overview of Teachers’ Experiences

Additional information was discovered through the action research process. This information emerged from these data and was not initially addressed by the research question. Participants’ perception of trauma-informed care and the work environment of a facility school changed over the progression of the study, while the environment remained the same. Teachers had begun the project thinking trauma-informed care was a broadly taught and minimally understood theory, and an intervention in and of itself that worked only occasionally. Early discussions focused on trauma-informed care being a hinderance to youth accountability and the feeling that participants were unlikely to be able to involve youth in the concepts. Jackson noted in the first interview that “kids seem to use it [trauma] as an excuse for their behavior.” Most teachers thought they had little more than a superficial understanding of the trauma-informed care model utilized at the facility. For instance, Patricia stated in the first focus group meeting, “A lot of what we see is knee-jerk, human reactions, not necessarily trauma-based.” Teachers physically looked burned out and they spoke of feeling the effects of Secondary Trauma in a rather significant manner. For example, in the first focus group meeting, Riley stated,

We are all in a state of hyperarousal because of what we do. . . Every time I hear a sneaker squeaking I immediately get into a mode; anytime I hear anything that’s like that my mind automatically goes to that.

This demonstrates teachers’ perceptions at the beginning of the study were of high levels of burnout and significant impact of secondary trauma.

However, pretest scores from the ProQOL survey (measuring Compassion Fatigue, Burnout, and Secondary Trauma) were surprisingly positive. The scores showed most teachers to be in the average range for Compassion Satisfaction, Burnout, and Secondary Trauma. The
ProQOL survey was given as a pre- and posttest. The self-rated survey measures levels of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. Pre- and posttests were compared using paired $t$ tests for each of the three categories regarding the responses from the 12 teachers who participated in the study. See Table 6 for a summary of the ProQOL Survey results. See Appendix C for a comparison of the pre-test and post-test data.

Table 6

**ProQOL Survey Paired $t$-Test Results**

<table>
<thead>
<tr>
<th></th>
<th>Compassion Satisfaction</th>
<th>Burnout</th>
<th>Secondary Traumatic Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two-tailed P value</td>
<td>0.6727 (not statistically significant)</td>
<td>1.0000 (not statistically significant)</td>
<td>0.4363 (not statistically significant)</td>
</tr>
<tr>
<td>Mean of Pre- minus Post-test</td>
<td>0.54</td>
<td>0.00</td>
<td>1.08</td>
</tr>
<tr>
<td>95% confidence interval</td>
<td>From -2.17 to 3.25</td>
<td>From -2.87 to 2.87</td>
<td>From -1.84 to 3.99</td>
</tr>
<tr>
<td>$t$</td>
<td>0.4330</td>
<td>0.0000</td>
<td>0.8054</td>
</tr>
<tr>
<td>$df$</td>
<td>12</td>
<td>24</td>
<td>12</td>
</tr>
<tr>
<td>Standard error of difference</td>
<td>1.244</td>
<td>1.390</td>
<td>1.337</td>
</tr>
<tr>
<td>Mean (pre/post)</td>
<td>53.23/52.69</td>
<td>47.31/47.31</td>
<td>46.23/45.15</td>
</tr>
<tr>
<td>$SD$ (pre/post)</td>
<td>3.63/3.54</td>
<td>3.54/3.54</td>
<td>3.63/3.36</td>
</tr>
<tr>
<td>$SEM$ (pre/post)</td>
<td>1.01/0.98</td>
<td>0.98/0.98</td>
<td>1.01/0.93</td>
</tr>
<tr>
<td>$N$ (pre/post)</td>
<td>12/12</td>
<td>12/12</td>
<td>12</td>
</tr>
</tbody>
</table>

These data indicate teachers’ levels of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress were not significantly high to begin with, and they did not change substantially over the course of the study. The teachers’ perceptions of their environment and its impact on them differed, as demonstrated by their countenance and demeanor, from how they actually rated themselves, as demonstrated by the consistency in the survey scores.
Frequency data also remained consistent throughout the study with little to no change occurring. Data were gathered for the facility school for 2 months prior to the study beginning (June and July) and 3 months during the study (August, September, and October). Data included physical restraints, walk-outs, runaways from the facility, and assaults. These data were analyzed using frequency counts. See Table 7 for a summary of the frequency data. These data showed little variance across months.

Table 7

Facility School High Incidence Data

<table>
<thead>
<tr>
<th></th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Managements</td>
<td>20</td>
<td>46</td>
<td>33</td>
<td>25</td>
<td>55</td>
</tr>
<tr>
<td>Walk-outs</td>
<td>40</td>
<td>36</td>
<td>47</td>
<td>41</td>
<td>57</td>
</tr>
<tr>
<td>Runaways</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Assaults</td>
<td>31</td>
<td>46</td>
<td>36</td>
<td>42</td>
<td>48</td>
</tr>
</tbody>
</table>

The records review also included employee call-offs (absences) and vacation time for school staff during the months of July through October. See Table 8 for a summary of employee absenteeism across months. Again, these data recording the facility school’s high incidence data and employee absenteeism remained fairly consistent, indicating no environmental change occurred.

Table 8

Facility School Employee Absenteeism

<table>
<thead>
<tr>
<th></th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduled PTO</td>
<td>9</td>
<td>12</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Call-offs (Absences)</td>
<td>8</td>
<td>3</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>15</td>
<td>12</td>
<td>17</td>
</tr>
</tbody>
</table>
As the study progressed, teachers began to show surprise at the success they were having with the interventions they selected. Several teachers noted the process of decision making and teacher-led discussions was helpful for coming up with new ideas and for giving them an outlet to process their emotions and concerns. Valentine stated, “Talking about it with everyone really helps. People have good ideas and suggestions.” Teachers began utilizing the interventions they had decided upon and engaged in fruitful discussions about their utility.

Interestingly, observation data taken during the study showed that teachers did not substantially increase their overall use of the techniques categorized as part of a therapeutic community (Bloom, 2000). These techniques include the following:

- Use of Sanctuary (Bloom, 2000) community meeting.
- Reference to Sanctuary Seven Commitments.
- Expectations frontloaded, reiterated, and/or reviewed.
- Conscious problem solving facilitated.
- Decisions made democratically and communally.
- Staff facilitate resident control of impulses.
- Staff facilitate dignified and respectful treatment of each other.
- Youth allowed a “voice” (appropriately solicited).
- Youth therapeutically held accountable for words and actions.
- Verbal processing occurring via the sanctuary S.E.L.F. model.
- Environment appears physically safe for youth and staff.
- Environment appears psychologically safe for youth and staff.
- Environment feels supportive in nature.
- Staffing protocols are met.
• Level system and standard operating procedures are followed.

• Active supervision evidenced.

• Preventative measures taken.

Observations were conducted of teachers in the instructional environment to determine the extent to which trauma-informed techniques were being utilized. A standard observation form, adapted from the characteristics of a therapeutic community listed by Bloom (2000), was used in all observations. Observations took place over the months of September, October, and November 2017. Teachers were observed on multiple different days and at different times. Observers marked the presence or lack thereof for each of the above-mentioned techniques. See Table 9 for a summary of the frequency of observed therapeutic interventions used by teachers.

Table 9

<table>
<thead>
<tr>
<th></th>
<th>September</th>
<th>October</th>
<th>November</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>13.643</td>
<td>8.462</td>
<td>12.077</td>
</tr>
<tr>
<td>Median</td>
<td>11</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Mode</td>
<td>15</td>
<td>7, 8</td>
<td>13</td>
</tr>
<tr>
<td>Range</td>
<td>13</td>
<td>10</td>
<td>12</td>
</tr>
</tbody>
</table>

These data indicate teachers utilized the techniques about the same amount, yet their perceptions of the environment changed for the positive, indicating the action research model using the focus group as a springboard for discussion and decision making was the main catalyst for the change. See Appendixes D and E for a detailed representation of these observation data.

By the end of the study, teachers were focusing on high level skills from the trauma-informed care model, and rather than discussing if the model was useful, they were discussing how it was integral. Valentine noted, “In order to move forward . . . you’ve got to take care of
the trauma, before they can move forward in other areas.” Concerns switched from worrying about the theology and buy-in from students to other staff not having the depth of training the teachers do and continuing the process so that no ground is lost. Teresa stated,

In the beginning, I thought that Sanctuary was just for the kids and there was very little emphasis on staff; I’m starting to see that other end of it now and I think that we’re more focused on how staff feel, and I also see more buy-in from leadership.

Teachers’ perceptions shifted to encompass the needs of staff within the facility school environment, and they began to see the model as encompassing all of the organization rather than affecting only the students.

Chapter 4 Summary

The purpose of this action research study was to explore the experiences of teachers in a residential treatment center with regard to trauma-informed care. To analyze qualitative data collected in this study, I used the constant comparative method (Harding, 2013). To analyze quantitative data collected in the study, I used frequency measures. Through these processes, four themes were identified:

- Improved understanding of the importance of trauma-informed care and the components of the model.
- Development of shared interventions.
- Awareness of improvements and changes resulting from the process.
- Awareness of challenges and concerns of using trauma-informed care in a facility school.

Qualitative data collected through participant interviews, participant journal entries, and focus group input provided insight into the perceptions of participants throughout the study.
Quantitative data collected on the frequency of restraints, runaways from the facility, and assaults, as well as participant frequency of call-offs and paid time off, provided insight as to the state of the facility. A pre- and posttest gave insight into participants’ feelings regarding Compassion Fatigue, Burnout, and Secondary Trauma. Observation of participants in the instructional setting provided insight into actual teacher behavior.
Chapter 5: Discussion and Conclusion

This chapter is focused on discussing the results of this action research study. Findings will be summarized and results reviewed. Results will then be discussed in relation to existing literature, which was reviewed in Chapter 2, however, updated literature will now be included. Limitations of the study will be discussed followed by implications for practice, policy, and theory. I will then give recommendations for future research. In Chapter 4, factual data I collected during the study was presented. In this chapter, I present and evaluate the results of these data. Personal insights and interpretation will be included. Connections to the community of practice will be made and ways the study can inform existing literature will be discussed.

Summary of Results

Research Question

This study was guided by one research question with two subquestions. The primary research question and subquestions addressed in the study were:

- What are the experiences of teachers in a residential treatment center with regard to trauma-informed care?

The subquestions related to the primary research question were:

- What are the experiences of facility school teachers regarding secondary trauma?
- What practices may lessen this impact?

Theory and Significance

This action research study was guided by the social-constructivist conceptual framework. The framework of constructivism holds that knowledge is gained through experience and reflection (Vygotsky, 1994), which ties in the active involvement component of the action
research approach. Constructivist theory is built on the premise of participants’ understanding and interpretation of the world around them (Shank, 2002).

The constructivist theory guided this study. Vygotsky (1994) held that culture plays a significant role in learning. The study looked at the ways in which teachers viewed their work environment and how those changed through a collaborative process. The goals of learning from the constructivist viewpoint are cognitive development and deepening of understanding (Fosnot & Perry, 2005). Through participation in learning activities, a collaborative focus group, and action taken based on decisions made as a team, teachers in this study were able to increase knowledge and understanding of their students, their environment, and themselves.

The purpose of this study was to better understand teachers’ perceptions of their experiences in residential facility schools. My role in the study was as a researcher, insider, administrator, supervisor, director, and educator. I was an insider to the setting, and my goal, as the researcher, was to provide insight into teachers’ experiences, promote professional growth, and add to the body of existing literature on the subject of residential facility schools. The significance of this study was that it provided insight into the perceptions of teachers in residential facilities. This population is hard to hire and experiences significant turnover (Hughes, Matt, & O’Riley, 2015). Finding ways to retain teachers by attending to their perceptions of the work environment may be helpful to working toward greater consistency for students who are educated in these facility schools.

**Review of recent literature.** This study addressed a lack of understanding about the experiences of teachers in a facility school in southern United States regarding the utilization of a trauma-informed care model. According to recent research, trauma-informed care has become a viable and necessary means of addressing the needs of traumatized youth (Martin et al., 2017).
Lang et al. (2016) also found implementation of trauma-informed systems led to significantly improved knowledge, practice, and collaboration across all domains.

Working with and around traumatized youth can have a negative impact on care workers (Hughes, Matt, & O’Reilly, 2015). Koening, Rodger, and Specht (2017) found that the greater the discrepancy between teachers’ perceptions and expectations about their efforts in this environment and the responses they experience, the more stress and eventual burnout they experience. Blitz and Mulcahy (2017) noted that even with confidence in their abilities, teachers’ stress levels when dealing with this population substantially impact their emotional well-being. Middleton and Potter (2015) found a relationship between vicarious traumatization and turnover in child welfare professionals. The presence of personal past trauma in staff members’ history can also be a factor in the level of impact (Caringi, et al., 2015). Addressing vicarious, or secondary, trauma in care workers may prolong longevity in facility schools (Hughes, et al., 2015). Saunders and Hanson (2014) indicate that, to be effective, the scope of trauma training must include plans for ongoing training through implementation and buy in from the highest levels of leadership must be secured. Bryson et al. (2017) experienced similar findings and noted the importance of using data to motivate change.

Implementation of a trauma-informed care model positively impact school culture and employee countenance (Parris, et al., 2015). Teachers in a recently study by Anderson, Blitz, & Saastamoinen (2015) noted the simple fact of having a focus group model in which to discuss their experiences to be extremely beneficial. In addition, these researchers found use of coping mechanisms taught in conjunction with the trauma-informed care model were helpful to staff as well as students. Teachers can impact students in the facility school environment, but they need
resources and ongoing training related to trauma-informed care to be effective (Crosby, Day, Baroni, & Somers (2015).

**Methodology and Findings.** Action research “seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions” (Reason & Bradbury, 2001, p. 1). As an insider to the research, I was able to gain insight into teachers’ perceptions of their experiences and ways practices could be improved in facility schools. The study was guided by Herr and Anderson’s (2015) Action Cycle. Through the phases of Develop, Act, Observe, and Reflect, data were analyzed and action steps were defined. Participants engaged in a focus group that allowed for collaboration, reflection, and decision making. The focus group was guided by Schmuck’s (2006) Spiral of Action Research. During focus group meetings, participants reviewed data, discussed new learning, reflected on their experiences, and made choices about next steps. Findings indicated that participants’ perspectives were altered through participation in the study, though the environment remained the same. The collaborative nature of the focus group led to participant learning and insight. Participants also utilized the practices decided upon in the focus group in their daily instruction and completed reflective journals to further their personal reflection on the process and experiences. The constructivist theory explains that this new learning was achieved through collaboration and reflection of personal experiences (Shank, 2002).

**Discussion of the Results**

I will begin with a discussion of overall results that were gleaned from the study but did not directly answer the research question. These results demonstrate insights discovered through the study. I will then progress to a discussion of the results in relation to the research question and subquestions.
Big picture. The big picture result from this study was that participant’s perception of trauma-informed care and the work environment of a facility school changed over the progression of the study, while the environment remained the same. Frequency data from youth behaviors in school (restraints, assaults, and run-aways from the facility) indicated the students did not drastically change their behavior over the course of the study. Staff behaviors (call offs on scheduled work days and vacation days) also remained the same. The way staff rated themselves in terms of compassion fatigue also remained the same. However, teachers’ comments and feedback regarding the process demonstrated their perceptions shifted throughout the study. Teachers began making statements about how the trauma-informed care model impeded accountability for youth and how the model didn’t really relate to the environment in a wholistic manner. Riley stated, “I worry about the accountability needed and staff don’t feel like they can hold kids accountable because we’re doing Sanctuary.” Patricia also made the comment that, “I feel like most of what we do isn’t really trauma-related.” Rosco made a similar comment when he said, “They use it [their trauma] as an excuse a lot of the time.” Jackson felt similarly and noted, “I can’t tell when it’s real and when it’s just an excuse.”

By the end of the study, teachers had worked through their misconceptions about the model through the focus group process. They gained knowledge about trauma and its impact through their reading, and they gained implementation experience through attempting strategies and then coming back to discuss their experiences with the group. Teachers noted that the process itself was beneficial. Valentine stated, “I appreciate just being able to talk about it and problem solve. People have really good ideas.” Teachers’ opinions of the necessity of trauma-informed care shifted as well. Patricia noted, “Trauma impacts all of us, all of the time, whether it is with the kids, with staff, or with the organization.” Valentine stated, “They can’t move
forward until we address it [trauma].” Teresa stated, “We have to deal with trauma before they can learn.” Teachers began to understand deeper concepts of trauma-informed care, such as the Re-enactment Triangle (Bloom, 1997) and Double Loop Learning (Bloom, 2013). Their discussions centered around how the way they were interacting with the youth impacted the way the youth behaved and began discussing ways to circumvent this phenomenon. Teachers also began further discussing ways to engage the youth that took their trauma into consideration. These shifts in discussion and attitude demonstrated how their knowledge was expanded and their perceptions were shifted through the process of the study.

**Discussion of Research Question**

This study was guided by the following research question and subquestions.

- What are the experiences of teachers in a residential treatment center with regard to trauma-informed care?

The subquestions related to the primary research question were:

- What are the experiences of facility school teachers regarding secondary trauma?
- What practices may lessen this impact?

The research questions and results will be interpreted based on Herr and Anderson’s (2015) Action Cycle. The study was guided by the steps of this cycle, in a spiraling fashion, as is associated with the action research model. The participant focus group also cycled through a spiral. This group was guided by Schmuck’s (2006) Spiral of Action Response. The research spiral and participant spiral occurred concurrently three times in the study. Each cycle will be discussed in terms of both the participant spiral and the research spiral.
**The first spiral.** During the first cycle of the spiral, participants began reading a book targeted toward increasing their knowledge of the trauma-informed care model. Results of this spiral indicated participants were confused about the model and were not convinced of its necessity. Discussion involved what was meant by the terminology and ways to implement the model in practice. Participants decided to try Community Meetings as their first intervention. They decided to hold the meetings during 1st and 6th hours. Discussion revealed many teachers did not understand the purpose or the components of the Community Meetings. The focus group provided a platform for clearing up these misconceptions. Due to the general lack of knowledge and understanding of the participants, I felt this was an acceptable first step in the study.

During the first concurrent research spiral, the ProQOL survey was given to staff and frequency data were collected involving the environment at the school. Survey scores showed that teachers did not reflect inordinately high levels of compassion fatigue, burnout, or secondary trauma. Transcripts of initial interviews and the first focus group were reviewed. These results showed staff having low levels of understanding about the model and needing additional guidance as to the specific components of the model and the overall premise of trauma and trauma-informed care. Teachers struggled to come to conclusions and needed significant levels of facilitation to make decisions regarding next steps. Teachers viewed the trauma-informed model as an intervention rather than a way of operating. Patricia exhibited this stance when she stated, “Sometimes it works, but not always. It’s more of a tool for us.” This response indicates a view of the model as an applied intervention rather than a cultural foundation.

**The second spiral.** In the second cycle of the spiral, participants reviewed data from observations and discussed their experiences with the intervention they tried. They reviewed the next chapters of the book and made a decision about the next intervention they would attempt.
Results from this spiral indicated participants still needed practice on the first intervention, and some modifications needed to be made to the Community Meeting model. Participants were active in the discussion and were able to come up with ideas for how to address the issues they experienced in attempting the first intervention. Through the focus group process, the participants identified ways to modify the Community Meeting intervention without compromising the purpose of the intervention. The participants decided the second intervention would be to implement trauma-informed systems (staggered desk set-up, structure for classroom boards, and specific seating charts). Participants remained active in the focus group process but continued to need significant levels of facilitation to participate in a targeted manner.

In the second concurrent research spiral, transcripts of the focus group and participant interviews were reviewed. Participant journal entries were also reviewed. Results from this spiral indicated individual teacher issues that needed follow up conversations. The process gave teachers several outlets to voice their concerns and frustrations. It is unlikely this information would not have been provided to me had it not been for the process of the study. Observation data from the first two rounds of observations were reviewed, showing the incidents of teachers using Community Meetings increased after the first spiral, but use of other trauma-informed practices remained similar to the previous frequency.

**The third spiral.** In the third cycle of the spiral, participants reviewed data from observations and discussed their experiences in the interventions they tried, as they had done with the previous cycle. Ideas from the new chapters of the book were discussed. The intervention of trauma-sensitive systems met with mixed reviews from participants. Teachers had different responses to the staggered desk set up. The set up worked for some youth and classes, but did not prove successful in other groups, for various reasons. The group was able to
discuss modifications and determine some allowance for individual decision making when it came to the desk set up. Classroom boards and seating charts were successful, and the group determined to continue these practices. The group continued to need facilitation to come to a consensus, but teachers remained highly participative in the discussion process.

In the third cycle of the concurrent research spiral, focus group and interview transcripts as well as journal entries were reviewed. Issues that needed to be addressed were identified. Less personal issues from teachers were evident in this cycle, but more questions arose regarding specific, higher-level, trauma-informed practices. One such practice involved ways to interrupt a Re-enactment Triangle (Bloom, 1997) once it was identified. Teachers’ perceptions were shifting from questioning of the model to better ways to implement it. Most teacher responses reflected the imperative nature of trauma-informed care and the need for continued and broadened staff training. Teachers perceptions of the environment were also changing. Teresa noted the “issue of staffing is not as pressured as it used to be.” Reese also stated, “I see the benefit for staff as well as the youth.” Jackson noted that he, “understood much more why the youth act the way they do, and I notice things now that I didn’t before.” Andre began focusing on how his demeanor and vocalizations impact the youth. He said, “The way I talk and just my presence impacts [the youth]. I have to be aware of that happening. I think I remind a lot of them of someone from their past.”

Through the study, participants were led through a process of learning new information and using data to make informed decisions. Participants deepened their understanding of the model by taking small chunks of information, processing them, and putting them into practice. Participants furthered their learning by discussing their experiences with the group and problem-solving ways to improve their practices within the specific context of the facility school.
environment (Schmuck, 2006). These repeated cycles of action, reflection, and discourse demonstrate the effectiveness of the action research model (Herr & Anderson, 2015; Stringer, 2014).

**Discussion of the Results in Relation to the Literature**

This action research study was designed to address the problem of educating the increasing numbers of youth who reside in residential facilities and the impact this has on the teachers who work in this setting. Repeated cycles, or spirals, of data-informed decision making, implementation, and contemplation were utilized in concordance with the action research methodology (Herr & Anderson, 2015; Stringer, 2014). Through the three spirals in this study, teachers experienced notable shifts in their perceptions. Action research cycles have been shown to be an effective approach to addressing issues of direct practice while also contributing to the body of literature (Herr & Anderson, 2015; Schmuck, 2006).

This study is significant to teachers, administrators, and staff of residential facility schools and all those who work daily with traumatized youth. The results of this study provide evidence that a model of repeated participant involved discourse, data analysis, and decision making can positively impact the perceptions of staff members in this emotionally charged environment. Trauma-informed care is a viable option for addressing traumatized youth, but consideration must be made for how such a model is trained and how staff members are involved in its implementation. This is important for all domains in an organization, but it is most significant for frontline staff members (Lang, Campbell, Shanley, Crusto, & Connell, 2016). The impact of the environment on staff who work with traumatized youth must be recognized and addressed by organizational leaders as well (Hughes, Matt, & O’Reilly, 2015).
The cyclical process of involved participant action in this action research study (Herr & Anderson, 2015; Schmuck, 2006) significantly changed participants’ mindsets and perceptions regarding their workplace environment and the necessity of trauma-informed care for students and staff. Their experiences helped them realize they were part of a community and they did not have to deal in isolation with the issues they were experiencing. Participants realized their peers had pertinent suggestions for them, and that, as a team, they were able to resolve many of their concerns. The teachers were also empowered by the decision-making process and, as the process continued, this began to translate into empowerment of the youth through challenging the status quo regarding youth participation and engagement. The participatory nature and involvement between administrators and teachers in the process was noted by Hughes, Matt, and O’Reilly (2015). This finding also echoes that of Saunders and Hanson (2014), who noted the ongoing nature of training is essential to the success of implementing a trauma-informed care model.

**Limitations**

The outcomes of this study were expected. One unexpected limitation noted was that the level of teacher participation dropped for journal entries. Other limitations of the study included the action research design, sample size, and subjective nature of analysis.

**Participation in Journal Entries**

Teacher participation was notably less for journal entries, with only eight of the twelve participants completing all of the journal entries. If all of the teachers had participated in completing the journal entries, the study would have been strengthened and it is possible that the four teachers that did not complete the journal entries might have added different information from the teachers that did participate. Reminders to complete the entries and timely follow up
with participants who did not complete them may assist in rectifying this issue for future researchers.

**Action Research Design**

The action research model is a limitation that could have potentially negatively affected the study due to still being in the process of being recognized as a viable contributing method to the research field (Herr & Anderson 2015). As more studies that are completed using this method, the more recognition it will receive.

**Sample Size**

The sample size of this study was a limitation that could have potentially negatively affected the study due to being restricted to 12 teachers. These were the teachers employed at the site during the entirety of data collection in the study. This is a small sample size, which can limit the transferability of the study. For example, it is possible other facilities may not be using the same trauma-informed model or may have teachers unlike the teachers in this study.

**Subjective Analysis**

The analysis procedures of the study include interpretation of participant perspectives via observations, journal entries, interviews, and focus group transcript reviews. These are qualitative measures that can be subject to bias (Creswell, 2013). If this study were to be replicated, measures must be taken to triangulate data and increase objectivity in analyses of the data.

**Implication of the Results for Practice, Policy, and Theory**

The results of this action research study are presented to the scholarly and educational community. These results confirm findings in existing literature and support the constructivist theory of learning. The findings can be transferred to other similar populations.
Practice

This study was conducted at a residential facility school. The results of this study can be applied to other residential facility schools, particularly those interested in implementing trauma-informed care models. The results can also benefit other contexts where employees work in emotionally intense environments. Koening, Rodger, and Specht (2017) found that large discrepancies in teacher perceptions of expected and actual results contributed to increased rates of burnout and stress. The importance of perceptions and how they can be shifted in this type of atmosphere could be applicable to leaders of high needs classrooms, alternative education programs, residential facility frontline staff, and mental health workers.

Policy

Throughout this research study, participants engaged in repetitive cycles of highly participative decision making and discourse. The results indicated the benefits of ongoing and participative training processes. Administrators of facility schools could utilize this information when considering the effectiveness of classroom models of staff training and initiative implementation (Hughes, Matt, & O’Reilly, 2015). As a result of this study, the model of trauma-informed care training in the residential facility school in the study has changed from “sit and get” to “participate and reflect.” In the future this model will be applied to classroom support staff and supervisors in the school as well.

Theory

Little research exists in the area of residential facility schools, particularly with regard to teacher experiences. The results of this study support the constructivist learning theory (Vygotsky, 1994). The constructivist theory holds that culture and understanding of one’s environment plays a significant role in learning (Shank, 2002). This study showed that
participants started with a very superficial understanding of the trauma-informed care model that was being implemented at the residential facility school. Through the process of active involvement, data-informed decision making, and discourse, teachers’ knowledge and understanding of the model and the context of their environment were notably shifted. The study’s demonstration of increased knowledge developing from increased understanding supports the constructivist learning theory (Fosnot & Perry, 2005; Shank, 2002; Vygotsky, 1994)

**Recommendations for Further Research**

This study should be replicated. Recommendations to expand and extend the existing research base include expansion to other residential facility schools, longevity of shifts in teacher perceptions and practices, qualitative case studies of teachers’ experiences, and examining the model with frontline and supervisory staff members. These recommendations were derived from the methodology and identified limitations in the study.

**Expansion to Other Residential Facility Schools**

The residential facility school in this study was chosen for convenience, as I work in the school as the education director. The study included all of the employed teachers, but the sample size remained small because the school population is small. This study should be replicated in other residential facility schools that are also implementing trauma-informed care models to determine if the results would be similar.

**Longevity of Shifts in Teacher Perception and Practice**

This study was conducted over a six-week period. Participants cycled through the action research spirals three times. It is recommended future research consider examining the sustainability of teachers’ shifts in perception and how learning would continue beyond three cycles through the spirals and over time.
Examining the Model with Frontline and Supervisory Staff

One of the big picture findings in this study was the need to expand this type of training to other departments and staff populations throughout the facility. Teachers noted the culture developing could easily be disrupted by an unknowing staff person intervening in a manner that was counter-productive. A recommendation for further researcher is to utilize the action research model to involve frontline staff members and supervisors in the process and determine if results in this population would be similar to that of teachers’. This research could also examine the impact a model such as this would have on the facility as a whole, as compared to one department.

Case Studies of Teachers’ Experiences

This action research study focused on participants’ experiences with a trauma-informed care model in a residential facility school. Participation from teachers lessened for completion of reflective journal entries. A recommendation for further research would be to examine individual teachers’ experiences through qualitative case studies. More in-depth investigation of teachers’ perception shifts and experiences through the use of reflective journal entries and individual interviews could be beneficial to furthering understanding of how the trauma-informed care model and the action research cycles impact teachers and how the models are utilized in practice.

Chapter 5 Conclusion

Throughout this action research study, the following research question and subquestions were answered:

- What are the experiences of teachers in a residential treatment center with regard to trauma-informed care?
The subquestions related to the primary research question were:

- What are the experiences of facility school teachers regarding secondary trauma?
- What practices may lessen this impact?

The 12 participants in the study remained highly engaged throughout the study, with the exception of the journal entries at the end of the study. Based on these data that were collected from interviews, focus group transcripts, and journal entries, teachers’ perceptions about the trauma-informed care model were transformed. Teachers experienced increased knowledge and understanding with regard to the trauma-informed care model, their students, the context within which they work, and themselves. They began believing the trauma-informed care model was little more than an applied intervention with sporadic utility. By the end of the study, they were discussing how the model permeated every aspect of their work lives.

The study established notable benefits for teachers gaining deeper understanding of trauma and how it impacts youth and staff at the facility. Teachers began to understand the ongoing nature of complex trauma, rather than viewing trauma as an event that occurred in someone’s past. Their conversations switched over time from under what circumstances the trauma-informed care model might be applicable to how all aspects of their interaction with the youth centered around the youth’s trauma. Teachers began to see that educating the youth was not possible without first addressing the current impact of the youth’s trauma. They also began to notice that the trauma-informed care model was helpful to staff as well as students. Teachers also realized they were experiencing a form of trauma in their work environment and that they must take measures to address their own self-care.

The focus group model integral to the study (Schmuck, 2006) was so helpful to teacher learning that it has been determined to be continued, not only with teachers, but also introduced
to frontline staff as a training model. The notable changes in perception experienced by teachers answered the research question. Data showed teachers’ perceptions played a part in feelings of secondary trauma and when teachers learned more about the trauma-informed care model, they were able to utilize coping skills to more effectively deal with the secondary trauma they were experiencing. Teachers also identified practices that could assist in lessening the impact of trauma in the classroom setting. This study helped teachers to deepen their understanding of trauma-informed care and develop ways of interacting with youth to lessen the impact on everyone in the classroom. The action research process was integral in helping teachers to feel less isolated and have some control over their environment. As they took control and utilized their knowledge, their perceptions changed.
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Appendix A: Yearly Calendar

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**Legend:**
- **No School**
- **Quarter Begins**
- **First day of School**
- **State Assessments**
- **End of quarter**
- **Summer Session**
- **School holiday**
- **1/2 day**
- **No School-Teacher work day**
- **Modified Schedule**

**Notes:**
- Summer: 40 days
- Required ITE: At least 4 work days
- School Days: 171
Appendix B: Informed Consent Form

Informed Consent

CONSENT FORM

Research Study Title: Teacher Perceptions of a Trauma-informed Care Model in a Youth Residential School
Principal Investigator: Tammy Allen
Research Institution: Concordia University
Faculty Advisor: Heather Miller, Ph.D.

Purpose and what you will be doing:
The purpose of this survey is to examine educators’ perspectives regarding the implementation of a trauma-informed care model in a residential facility school. We expect approximately ten volunteers. No one will be paid to be in the study. We will begin enrollment on August 1, 2017 and end enrollment on November 1, 2017. To be in the study, you will complete a pre and post survey, be involved in a book study, participate in a collaborative focus group, engage in interviews, and be observed in the classroom setting. Completing these tasks should take less than two hours of your time each week.

Risks:
There are no risks to participating in this study other than providing your information. However, we will protect your information. Any personal information you provide will be coded so it cannot be linked to you. Any name or identifying information you give will be kept securely via electronic encryption or locked inside the Education Director’s office. When we or any of our investigators look at the data, none of the data will have your name or identifying information. We will only use a secret code to analyze the data. We will not identify you in any publication or report. Your information will be kept private at all times and then all study documents will be destroyed 3 years after we conclude this study.

Benefits:
Information you provide will help the organization’s school identify ways to best implement a trauma-informed model. Your input can help others who want to improve the educational quality at residential facility schools. Benefits from your involvement include your expertise being heard, your input being considered in the implementation process, and possible improvement in your skills and understanding of the trauma-informed model.

Confidentiality:
This information will not be distributed to any other agency and will be kept private and confidential. The only exception to this is if you tell us abuse or neglect that makes us seriously concerned for your immediate health and safety.

Right to Withdraw:
Your participation is greatly appreciated, but we acknowledge that the questions we are asking are personal in nature. You are free at any point to choose not to engage with or stop the study. You may skip any questions you do not wish to answer. This study is not required and there is no
penalty for not participating. If at any time you experience a negative emotion from answering the questions, we will stop asking you questions.

Contact Information:
You will receive a copy of this consent form. If you have questions you can talk to or write the principal investigator, Tammy Allen at taallen@abraxasyfs.com (email). If you want to talk with a participant advocate other than the investigator, you can write or call the director of our institutional review board, Dr. OraLee Branch (email obranch@cu-portland.edu or call 503-493-6390).

Your Statement of Consent:
I have read the above information. I asked questions if I had them, and my questions were answered. I volunteer my consent for this study.

Participant Name __________________________ Date ___________

Participant Signature ___________________________ Date ___________

Investigator Name ___________________________ Date ___________

Investigator Signature ___________________________ Date ___________

Investigator: Tammy Allen; email: ~~~
c/o: Professor: Dr. Heather Miller
Concordia University – Portland
2811 NE Holman Street
Portland, Oregon  97221
Appendix C: ProQOL Pre/Post Comparisons

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Appendix E: Observation Data Summary

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Appendix F: Summary of Interview Findings

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<th>Category</th>
<th>Codes</th>
<th>Participant by Number</th>
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</table>
| Challenges                        | Multiple levels of youth and highly variant needs;                   | Teacher 1, 4, 7, 8, 11, 10  
                                          | Unpredictability of youth;                                          | Teacher 4, 2, 9, 6, 10  
                                          | Inconsistent staff members                                             | Teacher 9, 10, 2, 8    |
| Secondary Trauma/Impact           | Need for self-care and self-checks                                    | Teacher 1, 6, 7        |
| Factors Needed to Help            | More access to technology                                             | Teacher 4, 8, 11, 12   
                                          | More staff members                                                   | Teacher 2, 4, 8         |
| Understanding of Trauma-informed Model | Awareness of trauma as primary, having to be addressed               | Teacher 1, 4, 6, 8     
                                          | Better understanding of trauma-informed care and model components     | Teacher 8, 2, 7, 12    |
| Reasons to Work in a Facility School | Help high needs youth                                                | Teacher 3, 2, 5        
                                          | Celebrate small successes, see progress                              | Teacher 4, 2, 6, 8     |
| Improvements                      | Less yelling by staff                                                 | Teacher 3, 12, 1, 10   
                                          | More support of staff                                                | Teacher 4, 6, 1        
                                          | Restraints going down                                                 | Teacher 6, 12, 10      
                                          | Teamwork, comradery, unity                                            | Teacher 7, 11, 12     |

**Interviews.** Semi-structured participant interviews were conducted at the beginning of the study, once during the data collection phase, and at the culmination of the last phase of implementation using formats suggested by Creswell (2013) and Schmuck (2006). Using constant comparative method (Harding, 2013; Glaser & Strauss, 1967), interview transcripts were reviewed, main points were recorded in case study summary sheets, transcripts were coded, and commonalities were reviewed for subcategories and themes (Harding, 2013, pg. 66). Harding (2013) indicated the threshold is one quarter of respondents for codes to be considered part of the findings. There were 12 respondents, therefore the threshold of three respondents was utilized to determine codes included in categories. Categories that arose from the interview analysis, which met Harding’s (2013) criteria of two-thirds of participants mentioning the item, included Challenges, Secondary Trauma Impact, Factors Needed to Help/Needs, Understanding of the Trauma-informed Model, Reasons to Work in a Facility School, and Improvements.

Challenges mentioned by two-thirds of participants included multiple levels of youth with highly variant needs, unpredictability of youth with shifting moods, engaging or reaching the youth, and dealing with inconsistent (often changing) staff members. Secondary Trauma Impact issues mentioned by two-thirds of participants included the need to do self-checks and maintain self-care. Factors Needed to Help/Needs mentioned by at least two-thirds of participants included more access to technology for staff and more staff members in general. Understanding of the Trauma-informed Model items mentioned by at least two-thirds of participants included a general awareness that trauma is a primary concern that must be addressed and a better understanding and awareness of the components of the model. At least two-thirds of participants listed a desire to help high needs youth and celebration of small
successes as Reasons to Work in a Facility School. Improvements noted by at least two-thirds of participants included less yelling by staff members, more support of staff, less restraints, and improved teamwork or comradery.
Appendix G. Summary of Journal Findings

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<td>Improvements/Changes</td>
<td>Increased proficiency, Increased awareness of trauma, Awareness of influence on youth</td>
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<td>Positives Regarding Trauma-informed Care</td>
<td>Long lasting intervention, Well-rounded focus</td>
<td>Teacher 3, 4, 6, 10, Teacher 3, 4, 6</td>
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<tr>
<td>Concerns with Trauma-informed Care at the Facility</td>
<td>Youth using trauma as excuse for misbehavior, Staff buy-in, need for continuous training</td>
<td>Teacher 1, 2, 4, Teacher 1, 10, 4</td>
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Journals. Constant comparative method (Harding, 2013) was used to analyze participant journal entries for commonalities and differences. Case study summary sheets were used to aid in reduction of data (Harding, 2013). Summaries were coded via open coding using empirical codes (Harding, 2013). Submissions were compared by organizing each respondent’s input for each journal question into a chart and comparing responses to the others as each was added (Harding, 2013). In this manner, commonalities and differences were gleaned, and categories were able to be identified. Participant journal entries were highly variant in nature, but common points were able to be identified from the various comments. Categories that were identified from journal entries included Improvements and Changes, Positives Regarding Trauma-informed Care, and Concerns with Trauma-informed Care in the Facility.

Improvements and Changes noted by at least two-thirds of participants included staff being more proficient, possessing more emotional mindfulness, feeling that a shift in perception had occurred, more buy-in by staff and students, deeper understanding of why youth behave in certain ways, and an improved awareness and consideration of trauma in decision making. Positives Regarding Trauma-informed Care included that the model is producing lasting results, there is less turnover in staff, it has provided a more well-rounded focus, and it helps reduce stresses of trauma. Concerns with Trauma-informed Care in the Facility included youth using trauma as an excuse for misbehavior, as well as staff with less buy-in causing disruption in the culture and the need for continuous training.

Teacher participation was notably less for journal entries. Only eight of the twelve participants completed the journal entries. The two-thirds threshold recommended by Harding (2013) to determine inclusion of input was dropped to three participants for these entries. Nuances of staff attitudes were also present in the journal entries. Of note were one teacher who focused heavily on wanting the work to be easier and staff members to have more support and time to themselves, one teacher contemplating his/her future with the organization, and a teacher being overly concerned with youth not being held accountable via the model. Several teachers were highly committed to helping youth and interested in delving deeper into therapeutic intervention methods.
Focus Group. Data from the focus group meetings was analyzed at the group level (Harding, 2013), and analysis focused on how the discussion took place as well and the pertinent comments made by individuals. Transcripts were coded and constant comparative method was utilized to identify common categories (Harding, 2013). The focus group data analysis followed Harding’s (2013) method of identifying themes that were discussed, placing codes into categories, noting where a code was attached to a sufficient number of respondents, and identifying commonalities and differences that were made (p. 153).

The focus group met three times and followed the version of Schmuck’s (2006) Spiral of Responsive Action Research and Herr and Anderson’s (2015) Action Cycle discussed earlier (see Figure 1, pg. 34). Each week, the group arrived having read two chapters from the book, Restoring Sanctuary: A New Operating System for Trauma-informed Systems of Care by Bloom and Farragher (2013). The group reviewed baseline or existing data regarding performance of trauma-informed care interventions from the staff observations, discussed previous perceptions of the identified skill or intervention that was tried, decided to modify or change the intervention, and determined next steps. In alignment with the action research model, this process gave voice to participants as they participated in the discussion and decision-making process (Groundwart-Smith, 2007).

Three main categories were noted from the focus group discussions. These included the Reenactment Triangle (a component of the trauma-informed care model), the state of Hyperarousal in staff, and several intervention suggestions. Intervention suggestions included
reading youths’ histories, engage in meaningful interaction, hold Community Meetings (a component of the trauma-informed care model), develop and utilize trauma-oriented systems in the classroom, and identify double-loop learning (a component of the trauma-informed care model).
Appendix I. Statement of Original Work

The Concordia University Doctorate of Education Program is a collaborative community of scholar-practitioners, who seek to transform society by pursuing ethically-informed, rigorously researched, inquiry-based projects that benefit professional, institutional, and local educational contexts. Each member of the community affirms throughout their program of study, adherence to the principles and standards outlined in the Concordia University Academic Integrity Policy. This policy states the following:

**Statement of academic integrity.**

As a member of the Concordia University community, I will neither engage in fraudulent or unauthorized behaviors in the presentation and completion of my work, nor will I provide unauthorized assistance to others.

**Explanations:**

*What does “fraudulent” mean?*

“Fraudulent” work is any material submitted for evaluation that is falsely or improperly presented as one’s own. This includes, but is not limited to texts, graphics and other multi-media files appropriated from any source, including another individual, that are intentionally presented as all or part of a candidate’s final work without full and complete documentation.

*What is “unauthorized” assistance?*

“Unauthorized assistance” refers to any support candidates solicit in the completion of their work, that has not been either explicitly specified as appropriate by the instructor, or any assistance that is understood in the class context as inappropriate. This can include, but is not limited to:

- Use of unauthorized notes or another’s work during an online test
- Use of unauthorized notes or personal assistance in an online exam setting
- Inappropriate collaboration in preparation and/or completion of a project
- Unauthorized solicitation of professional resources for the completion of the work.
I attest that:

1. I have read, understood, and complied with all aspects of the Concordia University Portland Academic Integrity Policy during the development and writing of this dissertation.
2. Where information and/or materials from outside sources has been used in the production of this dissertation, all information and/or materials from outside sources has been properly referenced and all permissions required for use of the information and/or materials have been obtained, in accordance with research standards outlined in the *Publication Manual of The American Psychological Association*.  

Digital Signature

Tammy L. Allen

Name (Typed)

2/23/2018

Date