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Evaluation of a Trauma-Informed Skills Training Curriculum for Educators

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ABSTRACT

Lack of accessible, skills-based training restricts educators' readiness to implement trauma-informed care (TIC), exacerbating educator stress and inequities in student outcomes. This study evaluates a 4-hour self-paced, online trauma-informed skills training delivered using schedules that varied by district to 493 educators across four school districts. Content delivery and instruction in skill application were guided by SAMHSA's Four Rs of a Trauma-Informed Approach framework. Implementation formats varied by district and were assessed using mixed methods to facilitate learning across settings. A pre-post design described changes in survey data reflecting assessed knowledge of TIC principles and self-reported confidence in applying them. Thematic analysis of participant reflections captured skills application. Findings indicated participant perceived effectiveness of training elements, comprehension, and reported skill use, supporting the training's perceived relevance and practicality. This training may support broader initiatives across system levels to foster trauma-informed school cultures and improve outcomes for both educators and students.

Keywords: trauma, trauma-informed skills, educator training, school culture

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Adverse Childhood Experiences (ACEs) (Felitti et al., 1998) include abuse, neglect, and disruptive family events that occur before age 18. Research suggests that 60.1% of adults and 57.3% of children report at least one ACE, while 16.1% and 14.8%, respectively, report four or more, which is the level at which risk for poor health outcomes increases substantially (Madigan et al., 2023; Madigan et al., 2024). The range of ACEs has recently expanded to include discrimination, racism, and bullying (Cronholm et al., 2015). ACEs and other stressors are potentially traumatic, which the American Psychological Association describes as experiences that result in "disruptive feelings intense enough to have a long-lasting negative effect on … behavior … and other aspects of functioning" (American Psychological Association, 2018).

The negative impacts of childhood trauma are proximal, long-lasting, and cumulative, contributing to poor behavioral, physical, and social outcomes through their effects on psychological and brain development. Disruptions in the hypothalamic-pituitary-adrenal (HPA) axis lead to dysregulation in response to stress (Gunnar, 2021). This increases risk for mental and physical health issues, including psychopathology, mental health disorders, social maladjustment (Struck et al., 2021), obesity, metabolic diseases, and early mortality (Bhutta et al., 2023).

Trauma undermines the psychological processes that drive social, emotional, and cognitive development, causing challenges in educational settings. Experiencing trauma negatively affects a child's academic functioning, academic performance (Bourne et al., 2022; Goodman et al., 2012), and cognition (Hawkins et al., 2021). Relative to those without these experiences, those exposed to trauma have higher rates of absenteeism (Crouch et al., 2019) and a greater likelihood of being disciplined (Perfect et al., 2016).

Effects of Trauma in the School Setting

The effects of trauma on student behavior and performance provide challenges for educators and school staff. Children who have experienced trauma have difficulty forming trusting relationships with peers and teachers (Courtois & Ford, 2009). Supporting these students can lead to compassion fatigue and secondary trauma in educators, which undermines effective teaching and contributes to teacher attrition (Ormiston et al., 2022). In the absence of familiarity with trauma-informed pedagogy, teachers may misinterpret trauma-related behavioral cues as defiance, resulting in counterproductive responses. Traditional behavior management strategies, such as public behavior charts and exclusionary consequences, can antecedently trigger or retraumatize children (Sanders et al., 2024; Stokes, 2022). Alternatively, a trauma-informed response realizes the widespread impact of trauma, recognizes its signs and symptoms in students, families, and colleagues, and responds to promote regulation and resist re-traumatization (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). SAMHSA translated this into a framework, the 4Rs of a Trauma-Informed Approach: Realize, Recognize, Respond, and Resist Retraumatization. This framework has been widely adopted to inform policy and practice at both the school and educator levels (NCTSN, 2017).

Teachers consistently report interest in better understanding the needs of students who have experienced trauma, especially seeking guidance on specific strategies applicable to the classroom (Berger et al., 2021). Lack of training in trauma and trauma-informed skills leaves teachers unprepared to recognize trauma and its effects and apply educational

principles that consider the needs of children with these experiences (Southall, 2024). In a recent review of state requirements for teacher training, Reddig and VanLone (2022) found that only five states explicitly incorporated training in trauma-informed care despite the growing recognition of its importance in school settings. There is a pressing need for standardized training programs that provide teachers and school staff with information about trauma and its effects and train them in trauma-informed educational practices.

Trauma Training for Educators

Several training programs for teachers that focus on trauma have been developed and evaluated. They vary considerably in content, format, delivery mode, length, targeted audience, evaluation design, and measurement. For example, Parker et al. (2020) examined the Compassionate Schools training approach with 133 teachers and other educational support staff. This model was provided via half-day or three-day trainings. It emphasized knowledge about trauma and ACEs, recognizing signs of abuse and neglect, and education on social and emotional learning skills. The training was didactic, included a simulation and a film on the impact of trauma on students, and provided training in mandatory reporting. Results indicated changes from pre-to-post attitudes related to trauma, and participants reported behavior changes 6 months following delivery of training. Dube et al. (2023) evaluated a trauma-informed care training implemented with 27 teachers and educational staff from kindergarten to 12th grade. Based on the SAMHSA 4Rs, the 8-hour training included trauma and its impacts, self-awareness, and use of trauma-informed strategies. Post-training surveys revealed high rates of satisfaction, and qualitative data indicated acquisition of knowledge and use of specific strategies. Other studies have confirmed positive reactions to similar training on trauma and trauma-informed care (Loomis & Rose, 2024). In this emerging literature, rigorous tests of training using randomized clinical trials or other comparative research designs are infrequently used. Further limitations in the literature include small sample sizes, inconsistent measurement, and insufficient attention to theoretical justification of training content, elements, and format.

Overview of Study

This study describes the implementations and evaluation of a trauma-informed training program for educators, developed to meet the field's demand for accessible skills-based instruction. A mixed-methods evaluation was employed, including pre-post measures of knowledge and confidence in using skills taught in the training, and qualitative feedback on participants' satisfaction and strategy use. We hypothesized that participants would show improvements in knowledge, greater intent to apply the skills learned, and positive reactions to the training delivery and material.

METHODS

The Trauma-Informed Educator Training Series (TIETS) was developed through a partnership between Cincinnati Children's Hospital Medical Center, Cincinnati Public Schools (CPS), and McKinsey Health Institute. This training was designed for educators, defined as professionally trained school staff working within and outside classrooms,

including teachers, paraprofessionals, administrators, school psychologists, and counselors. It served to equip educators with trauma-informed skills.

Course Design

An interdisciplinary team comprising child and school psychologists, school administrators, child abuse pediatricians, social workers, adult learning theory specialists, and community members with lived experience contributed to the design and development of the training. This team followed standard course development processes, including needs assessment, learning objective design, content development, and iterative review for accuracy and quality by a variety of stakeholders (e.g., educators, community members, and trauma experts).

TIETS was designed to address schools' time and cost constraints while moving beyond the primarily didactic, awareness-enhancing focus of extant, related trainings. As such, the training was delivered in an online, self-guided format accessible from any internet-enabled device with audio capability to enable learners to complete the four 1-hour sessions in 10–15-minute increments.

SAMHSA's 4Rs (SAMHSA, 2014) served as a pedagogical framework for facilitating skills development. Furthermore, the course relied on multiple forms of expertise, including lived experiences showcased through community member video stories. Grounded in adult learning theory (Knowles et al., 2015) to promote engagement and rapid skills development, it utilized brief didactic texts, expert commentary videos, school-based case scenarios, and interactive tools (i.e., participatory flashcards).

Curriculum Content

Curricula content was divided into four parts: The Trauma-Informed Educators We Want to Be, Foundations of Trauma and Resilience, Addressing Traumatic Events in the Community with Students, and Addressing Trauma with Students and Families. Participants were first introduced to the foundations of trauma, its impact on children's abilities to learn, the effects of cognitive biases and community trauma, and why people with certain identities (race, ethnicity, ability) are disproportionately affected. The training taught participants strategies for self-regulation, recognizing cognitive biases, reframing mindsets, and trauma-informed mandated reporting. Finally, participants learned to build student resilience by identifying strengths and protective factors and applying the Four Rs in the context of collective traumatic events (e.g., gun violence) and family engagement.

Implementations

TIETS was implemented twice (Implementations 1 and 2), with common elements and distinct features, expounded upon in the sections below. Four school districts participated in total, each involved in one implementation. Table 1 shows district-level demographic characteristics of students and teachers by implementation. The study was approved by the Institutional Review Board of Cincinnati Children's Hospital Medical Center.

Table 1: Demographics (2021-2022 School Year) of Districts Participating in Implementation 1 and 2

Implementation	1		2	
	Cincinnati Public Schools	Hamilton County ESC	Princeton City Schools	Northwest Local Schools
Staff Characteristics				
Teacher FTE	2311.8	61.8	392.5	565.7
Gender				
Female	76.2%	91.9%	76.8%	80.9%
Male	23.8%	8.1%	23.2%	19.1%
Race				
American Indian/Alaskan Native	0.0%	--	0.3%	--
Asian/ Pacific Islander	1.0%	--	1.0%	--
Black, non-Hispanic	23.6%	2.6%	11.9%	1.8%
Hispanic	1.7%	1.6%	0.8%	0.5%
Multiracial	0.5%		0.3%	
White, non-Hispanic	71.1%	95.8%	75.3%	97.7%
Not Specified	2.1%	--	10.4%	--
At Least Master's Degree	65.9%	76.4%	62.2%	58.2%
Average Years Experience	12.7	12.5	14.3	14.3
Student Characteristics				
Enrollment	35860		5509	8021
Gender				
Female	49.1		48.7	47.6
Male	50.9		51.3	52.4
Race				
American Indian/ Alaskan Native	0.2%		--	--

Implementation	1	2	
Asian	1.1%	3.2%	5.5%
Black, non-Hispanic	61.3%	38.2%	34.1%
Hispanic	9.7%	33.3%	6.8%
Multiracial	6.6%	5.9%	11.7%
Pacific Islander	0.1%	1.10%	0.3%
White, non-Hispanic	21.1%	18.2%	41.5%
Economic Disadvantaged	82.0%	68.1%	65.8%
Chronically Absent	52.0%	29.9%	41.7%

Sources:
https://reports.education.ohio.gov/report/report-card-data-district-teacher-report
https://reports.education.ohio.gov/report/report-card-data-district-enrollment-by-student-demographic
Note: This table comes from publicly available data. As per these sites, data that represents less than 10 students is masked to ensure student privacy. These are indicated by "—".

Implementation 1

Setting and Participants. For Implementation 1, training was offered to approximately 4,400 K-12 educational staff in 64 urban schools across the CPS district (361 enrolled). In this implementation, demographic data were not collected on individual participants. Training was provided between January 25 and March 31, 2021.

Format and Training Delivery. Educators were notified about the opportunity via email. Access information was provided and remained open throughout the training period. During the training period, participants were offered a forum for shared critical reflection through online discussion boards. Participation was voluntary. Participation was encouraged by offering contact hours that could be used for licensure and providing a custom badge for their signature/profile identifying them as "Trauma-Informed Educator."

Evaluation Design and Measures. Data were collected at pre-training and post-training. Participants completed surveys on knowledge (6 items) and confidence in using recommended strategies (10 items), and application of skills (2 items). In addition, at post-training, participants were asked about their recent use of the skills taught in the training ("Over the past week have you applied the knowledge and skills that have been taught in this course?" 5-point scale: 1=no, I am not sure that the knowledge and skills are a good match for me, 2=no, it was not necessary, 3=not sure, 4=yes, because circumstances made it necessary, 5=yes, I wanted to take the initiative). Creation of items was guided by a review of the existing literature evaluating similar trainings, although several questions were specific to the TIETS training. Participants were also asked to indicate the perceived

effectiveness with training elements (e.g., video stories, self-guided curriculum) using a 5-point scale (1=not at all effective, 5=very effective).

Implementation 2

Setting and Participants. Implementation 2 was conducted in three suburban school districts in Cincinnati (Hamilton County ESC, Princeton City Schools, and Northwest Local Schools), from October 15 to December 15, 2021.

Format and Training Delivery. Each district selected its preferred training format, including participant selection criteria (e.g., availability, scheduling, perceived need), delivery timeline (single day administration, 4-week, or 8-week), and discussion format (online board or in-person). They provided laptops, as well as registration assistance and instructional support, to staff members who requested additional resources to complete the training. Across the three districts, 132 teachers and other educational staff (e.g., administrators, discipline officers, and paraprofessionals) were mandated to participate.

Evaluation Design and Measures. The evaluation used a pre-post design and collected both quantitative and qualitative data. As with Implementation 1, participants completed surveys on knowledge (6 items), confidence in using recommended strategies (10 items), and they were asked about recent use of skills learned. Items were identical in both implementations except for two knowledge items in Implementation 2 that were modified to improve clarity, and one confidence item (#8) that differed between the two implementations. Participants were also asked to indicate the level of perceived effectiveness of training elements as in Implementation 1. Four weeks after training, those who completed the training were asked to provide a brief, written example of how they applied the skills learned in the training ("Please share an anecdote of when you have used the skills learned in this training with students, families, coworkers, and/or teachers.").

Analytic Plan

Surveys were administered using Google Forms. Items where the response category including numbers and text were coded to reflect only numeric values. Data from both implementations were combined into a single dataset and cleaned. Pre-post knowledge items were examined descriptively. Confidence items were analyzed using Wilcoxon signed-rank test. Analyses were conducted using R 4.2.2 (R Core Team, 2022).

In the qualitative data, participants were prompted to write anecdotes describing how they "used the skills learned in this training," which were thematically analyzed to identify patterns reflecting comprehension and application of skills taught in the course. Following Braun and Clarke's (2006) guidelines for thematic analysis, the team first established a theoretical position informing the analytic process. As the data consisted of brief, self-reported descriptions of skills use, the analytic team adopted a realist epistemology and semantic approach to coding. Specifically, anecdotes were treated as direct accounts of how participants understood and applied the training, and interpretation was limited to the explicit context of the anecdotes, rather than seeking latent meaning beyond what participants wrote.

Using this orientation, the team completed Braun and Clarke's (2006) six phases of thematic analysis. Coders independently familiarized themselves with data and inductively generated initial codes to capture the specific strategies participants described using. To indicate alignment with curricular content, this approach was triangulated with the deductive organization of codes into themes based on SAMHSA's 4Rs framework. Through discussion, team members refined a codebook, re-coded the data, and resolved discrepancies until reaching consensus on the categorization of codes (trauma-informed strategies) extracted from each data item (anecdote).

RESULTS

Table 2 summarizes the demographics of Implementation 2 participants (individual-level demographics were not collected in Implementation 1). Most were female (81.1%) and white (73.5%), with many serving multiple grade levels. More than half reported over 11 years of field experience (56.8%). Participant roles were split evenly between non-instructional (53.0%) and classroom-based (47.0%).

Table 2: Demographics of Participants in Implementation 2 (n = 132)

Demographic	District			Total n (%)
	Hamilton County ESC	Princeton City Schools	Northwest Local Schools	
	n	n	n	
Total	28	67	37	132 (100.0)
Gender				
Male	8	13	2	23 (17.4)
Female	18	54	35	107 (81.1)
Prefer not to answer	2	0	0	2 (1.5)
Race				
Asian	1	2	0	3 (2.3)
Black	6	14	4	24 (18.2)
Latino/a/e	0	2	0	2 (1.5)
Multiracial	0	3	0	3 (2.3)
White	19	45	33	97 (73.5)
Prefer not to answer	2	1	0	3 (2.3)
Grade Level(s) Served				
Pre-K through 5	6	34	37	77 (58.3)
6-8	15	20	0	35 (26.5)
9-12	24	28	0	52 (39.4)

Demographic	District			Total n (%)
	Hamilton County ESC	Princeton City Schools	Northwest Local Schools	
	n	n	n	
Time in Profession (years)				
<1	0	3	5	8 (6.1)
1-2	0	3	1	4 (3.0)
3-5	3	6	6	15 (11.4)
6-10	7	20	3	30 (22.7)
11+	18	35	22	75 (56.8)
Role Description				
Teacher	11	8	0	19 (14.4)
Other, classroom-based educator	9	3	31	43 (32.6)
Administrator	2	17	1	20 (15.2)
Counselor	1	15	2	18 (13.6)
Other, non-classroom-based educator	5	24	3	32 (24.2)

Training Retention

In Implementation 1, there were 361 participants who began training and completed the pre-survey; 103 (28.5%) completed training and the post-survey. In Implementation 2, 132 educators were mandated to participate and completed the pre-survey; 105 (79.5%) completed training and the post-survey.

Pre-Post Comparisons of Survey Items

Table 3 shows changes across six pre- to post-training items assessing knowledge. At baseline, results generally indicated high levels of knowledge in both implementations. There were differential levels of correct responding at pre-training between the implementation sites. In Implementation 1, 78.6% provided the correct answer to the question "What is trauma?" in contrast to 97.1% in Implementation 2. Item 2, with different wording in the two implementations, yielded 54.3% correct responses in Implementation 2 compared with 98.1% in Implementation 1. It is possible that this discrepancy reflects the different wording in the items. In terms of pre to post change, in Implementation 1, one of six items showed improvement and five had no change, although pre-training levels were high for most items. For Implementation 2, five of six items showed an improvement ranging from 1.9-21.0 percentage points. One item had a small drop from pre to post of 0.9 percentage points.

Table 3: Pre- to Post-Training Changes in Knowledge Across Six Assessment Items in Implementations 1 (n = 103) and 2 (n = 105)

Question		Implementation	Correct		Change
			n	%	Percentage points
1	What is trauma?	1 Pre	81	78.6	13.6
		1 Post	95	92.2	
		2 Pre	102	97.1	1.9
		2 Post	104	99.0	
2*	What steps should trauma-informed teachers take when they feel angry or frustrated toward a challenging classroom situation, such as when a student is acting defiantly or falling asleep in class?	1 Pre	101	98.1	0.0
		1 Post	101	98.1	
		2 Pre	--	--	--
		2 Post	--	--	
2*	What steps should trauma-informed teachers NOT take when they feel angry or frustrated toward a challenging classroom situation, such as when a student is acting defiantly or falling asleep in class?	1 Pre	--	--	--
		1 Post	--	--	
		2 Pre	57	54.3	21.0
		2 Post	79	75.2	
3	What are Adverse Childhood Experiences (ACEs)?	1 Pre	86	83.5	0.0
		1 Post	86	83.5	
		2 Pre	93	88.6	2.8
		2 Post	96	91.4	
4	What are protective factors?	1 Pre	99	96.1	0.0
		1 Post	99	96.1	
		2 Pre	100	95.2	-0.9
		2 Post	99	94.3	
5	What is an implicit bias?	1 Pre	95	92.2	0.0
		1 Post	95	92.2	

Question		Implementation	Correct		Change
			n	%	Percentage points
		2 Pre	85	81.0	11.4
		2 Post	97	92.4	
6*	Structural violence (sometimes referred to as institutional racism or systemic racism) is:	1 Pre	81	78.6	0.0
		1 Post	81	78.6	
		2 Pre	--	--	--
		2 Post	--	--	
6**	Which of the following terms refers to social, economic, and institutional structures and policies that prevent specific groups of people in a community from meeting their basic needs (e.g., concentrated poverty in areas of a city, lack of access to high quality childcare for inner city populations)?	1 Pre	--	--	--
		1 Post	--	--	
		2 Pre	86	81.9	6.7
		2 Post	93	88.6	

*These items differed in wording between the two implementations.

Note: "—" reflects cells that do not apply as those items were not administered.

Table 4 shows confidence in using trauma-informed skills as reflected by 10 items administered at pre- and post-training. All comparisons but one ("What is the level of stress you have about supporting students who have experienced trauma?" for Implementation 2) were statistically significant. At pre-training, the proportion of participants reporting high levels of confidence (rating 4 or 5) ranged across items from 11.4% - 55.3%. In Implementations 1 and 2, the largest proportion of participants reported the lowest confidence of 1 or 2 in the areas of tailoring teaching strategies to community context (29.1%, 10.5%), addressing traumatic community events (25.2%, 16.2%), and facilitating trauma-informed conversations with families (35.0%, 29.5%). Post-training, the range of very high confidence ratings levels was 9.5% - 37.9%. For the recent use of learned skills question administered at post-training, 62.1% of Implementation 1 participants and 72.4% of their Implementation 2 counterparts indicated that they had used trauma skills in the past week.

Table 4: Pre- to Post-Training Changes in Participant Confidence in Skill Use for Implementations 1 (n = 103) and 2 (n = 105)

1*** How confident do you feel about your ability to tailor specific classroom teaching strategies to the neighborhood and community context to avoid re-traumatization?

Implementation	1 n (%)	2 n (%)	3 n (%)	4 n (%)	5 n (%)	Missing n (%)	z
1 Pre	4 (3.9%)	26 (25.2%)	42 (40.8%)	28 (27.2%)	3 (2.9%)	--	-7.02*
1 Post	0 (0.0%)	1 (1.0%)	20 (19.4%)	61 (59.2%)	21 (20.4%)	--	
2 Pre	2 (1.9%)	9 (8.6%)	27 (25.7%)	8 (7.6%)	4 (3.8%)	55 (52.4%)	-3.79*
2 Post	1 (1.0%)	2 (1.9%)	18 (17.1%)	22 (21.0%)	10 (9.5%)	52 (49.5%)	

2 How confident do you feel in identifying the strengths and relevant protective factors of students to promote resilience?

Implementation	1 n (%)	2 n (%)	3 n (%)	4 n (%)	5 n (%)	Missing n (%)	z
1 Pre	6 (5.8%)	20 (19.4%)	44 (42.7%)	27 (26.2%)	6 (5.8%)	--	-7.39*
1 Post	0 (0.0%)	1 (1.0%)	15 (14.6%)	57 (55.3%)	30 (29.1%)	--	
2 Pre	3 (2.9%)	9 (8.6%)	53 (50.5%)	29 (27.6%)	11 (10.5%)	--	-6.08*
2 Post	0 (0.0%)	1 (1.0%)	20 (19.0%)	59 (56.2%)	25 (23.8%)	--	

3 How confident do you feel in supporting students to develop coping strategies to address potentially traumatic events, past or present?

Implementation	1 n (%)	2 n (%)	3 n (%)	4 n (%)	5 n (%)	Missing n (%)	z
1 Pre	7 (6.8%)	11 (10.7%)	45 (43.7%)	30 (29.1%)	10 (9.7%)	--	-6.61*
1 Post	1 (1.0%)	1 (1.0%)	12 (11.7%)	61 (59.2%)	28 (27.2%)	--	
2 Pre	2 (1.9%)	11 (10.5%)	45 (42.9%)	31 (29.5%)	16 (15.2%)	--	-5.40*
2 Post	0 (0.0%)	1 (1.0%)	18 (17.1%)	56 (53.3%)	30 (28.6%)	--	

4 How confident do you feel about your ability to address traumatic events in the community, both with an individual student and in the classroom setting?

Implementation	1 n (%)	2 n (%)	3 n (%)	4 n (%)	5 n (%)	Missing n (%)	z
1 Pre	7 (6.8%)	19 (18.4%)	49 (47.6%)	24 (23.3%)	4 (3.9%)	--	-6.97*
1 Post	0 (0.0%)	1 (1.0%)	24 (23.3%)	58 (56.3%)	20 (19.4%)	--	
2 Pre	2 (1.9%)	15 (14.3%)	49 (46.7%)	28 (26.7%)	11 (10.5%)	--	-6.07*
2 Post	0 (0.0%)	2 (1.9%)	22 (21.0%)	57 (54.3%)	24 (22.9%)	--	

5 How confident do you feel about your ability to support students who are experiencing trauma?

Implementation	1 n (%)	2 n (%)	3 n (%)	4 n (%)	5 n (%)	Missing n (%)	z
1 Pre	4 (3.9%)	8 (7.8%)	40 (38.8%)	43 (41.7%)	8 (7.8%)	--	-6.89*
1 Post	1 (1.0%)	0 (0.0%)	10 (9.7%)	55 (53.4%)	37 (35.9%)	--	
2 Pre	2 (1.9%)	11 (10.5%)	34 (32.4%)	41 (39.0%)	17 (16.2%)	--	-5.52*
2 Post	0 (0.0%)	2 (1.9%)	14 (13.3%)	54 (51.4%)	35 (33.3%)	--	

6 How confident do you feel about your ability to have trauma-informed conversations with families?

Implementation	1 n (%)	2 n (%)	3 n (%)	4 n (%)	5 n (%)	Missing n (%)	z
1 Pre	12 (11.7%)	24 (23.3%)	39 (37.9%)	24 (23.3%)	4 (3.9%)	--	-7.25*
1 Post	2 (1.9%)	3 (2.9%)	24 (23.3%)	50 (48.5%)	24 (23.3%)	--	
2 Pre	15 (14.3%)	16 (15.2%)	42 (40.0%)	19 (18.1%)	13 (12.4%)	--	-6.16*
2 Post	3 (2.9%)	5 (4.8%)	24 (22.9%)	54 (51.4%)	19 (18.1%)	--	

7 How confident do you feel about your ability to identify the circumstances in which a student or the student's family may need a referral for additional social emotional support and access to community-based resources?

Implementation	1 n (%)	2 n (%)	3 n (%)	4 n (%)	5 n (%)	Missing n (%)	z
1 Pre	6 (5.8%)	10 (9.7%)	35 (34.0%)	44 (42.7%)	8 (7.8%)	--	-6.84*
1 Post	1 (1.0%)	0 (0.0%)	18 (17.5%)	48 (46.6%)	36 (35.0%)	--	
2 Pre	5 (4.8%)	17 (16.2%)	40 (38.1%)	27 (25.7%)	16 (15.2%)	--	-6.43*
2 Post	1 (1.0%)	1 (1.0%)	20 (19.0%)	51 (48.6%)	32 (30.5%)	--	

8** How confident do you feel about your ability to build resiliency in students in the classroom?

Implementation	1 n (%)	2 n (%)	3 n (%)	4 n (%)	5 n (%)	Missing n (%)	z
1 Pre	6 (5.8%)		11 (10.7%)	45 (43.7%)	34 (33.0%)	7 (6.8%)	-6.87*
1 Post	1 (1.0%)		13 (12.6%)	61 (59.2%)	28 (27.2%)		
2 Pre	--	--	--	--	--	--	
2 Post	--	--	--	--	--	--	

8** What is the level of stress you have about supporting students who have experienced trauma?

Implementation	1 n (%)	2 n (%)	3 n (%)	4 n (%)	5 n (%)	Missing n (%)	z
1 Pre	--	--	--	--	--	--	
1 Post	--	--	--	--	--	--	
2 Pre	11 (10.5%)	33 (31.4%)	44 (41.9%)	11 (10.5%)	6 (5.7%)	--	.015
2 Post	13 (12.4%)	43 (41.0%)	21 (20.0%)	18 (17.1%)	10 (9.5%)	--	

9 How confident do you feel in addressing your own stress in the moment when interacting with a student or other educator?

Implementation	1 n (%)	2 n (%)	3 n (%)	4 n (%)	5 n (%)	Missing n (%)	z
1 Pre	2 (1.9%)	6 (5.8%)	38 (36.9%)	46 (44.7%)	11 (10.7%)	--	-6.08*
1 Post	0 (0.0%)	1 (1.0%)	8 (7.8%)	55 (53.4%)	39 (37.9%)	--	
2 Pre	3 (2.9%)	9 (8.6%)	40 (38.1%)	34 (32.4%)	19 (18.1%)	--	-4.90*
2 Post	0 (0.0%)	5 (4.8%)	20 (19.0%)	44 (41.9%)	36 (34.3%)	--	

10*** How confident do you feel in using skills or tools to support trauma-informed care in the classroom?

Implementation	1 n (%)	2 n (%)	3 n (%)	4 n (%)	5 n (%)	Missing n (%)	z
1 Pre	3 (2.9%)	20 (19.4%)	40 (38.8%)	34 (33.0%)	6 (5.8%)	--	-7.16*
1 Post	0 (0.0%)	1 (1.0%)	8 (7.8%)	71 (68.9%)	23 (22.3%)	--	
2 Pre	1 (1.0%)	3 (2.9%)	23 (21.9%)	17 (16.2%)	6 (5.7%)	55 (52.4%)	-3.50*
2 Post	0 (0.0%)	1 (1.0%)	14 (13.3%)	59 (56.2%)	31 (29.5%)	--	

Note. Scale anchors: 1 = Not at all; 3 = Somewhat; 5 = Very. *p<.001 **Items were changed from Implementation 1 to 2. ***Due to protocol deviations some data for these items is missing. Statistical comparisons were conducted on available matched data.

Note: "—" reflects cells that do not apply as those items were not administered.

Perceived Effectiveness of Training Elements

Participants evaluated the efficacy of training components using a 5-point Likert scale (5 = high efficacy). All elements received high ratings, with the mean score for each component ranging from 3.5 to 5. In Implementations 1 and 2, the elements most frequently rated as efficacious included case scenarios (90.3%, 83.8%), expert lecture videos (85.4%, 84.8%), post-session assessments (85.4%, 77.1%), and the self-guided format (80.6%, 79.0%). See Table 5.

Table 5: Participant Evaluations of Efficacy of Learning Elements for Implementations 1 (n = 103) and 2 (n = 105)

Element / Implementation	1 n (%)	2 n (%)	3 n (%)	4 n (%)	5 n (%)	Blank n (%)
Video Stories / 1	1 (1.0%)	4 (3.9%)	18 (17.5%)	40 (38.8%)	40 (38.8%)	0 (0.0%)
Video Stories / 2	1 (1.0%)	0 (0.0%)	19 (18.1%)	57 (54.3%)	28 (26.7%)	0 (0.0%)
Lecture Videos / 1	0 (0.0%)	3 (2.9%)	12 (11.7%)	44 (42.7%)	44 (42.7%)	0 (0.0%)
Lecture Videos / 2	0 (0.0%)	1 (1.0%)	15 (14.3%)	61 (58.1%)	28 (26.7%)	0 (0.0%)
Case Scenarios / 1	0 (0.0%)	1 (1.0%)	9 (8.7%)	40 (38.8%)	53 (51.5%)	0 (0.0%)
Case Scenarios / 2	0 (0.0%)	0 (0.0%)	17 (16.2%)	49 (46.7%)	39 (37.1%)	0 (0.0%)
Interactive Components / 1	2 (1.9%)	4 (3.9%)	17 (16.5%)	42 (40.8%)	38 (36.9%)	0 (0.0%)
Interactive Components / 2	1 (1.0%)	0 (0.0%)	33 (31.4%)	45 (42.9%)	25 (23.8%)	1 (1.0%)
Discussion Component / 1	5 (4.9%)	10 (9.7%)	27 (26.2%)	34 (33.0%)	27 (26.2%)	0 (0.0%)
Discussion Component / 2	4 (3.8%)	11 (10.5%)	32 (30.5%)	38 (36.2%)	19 (18.1%)	1 (1.0%)
Post-Training Assessment Questions / 1	2 (1.9%)	1 (1.0%)	12 (11.7%)	51 (49.5%)	37 (35.9%)	0 (0.0%)
Post-Training Assessment Questions / 2	0 (0.0%)	1 (1.0%)	23 (21.9%)	62 (59.0%)	19 (18.1%)	0 (0.0%)
Self-Guided Curriculum / 1	1 (1.0%)	4 (3.9%)	15 (14.6%)	43 (41.7%)	40 (38.8%)	0 (0.0%)
Self-Guided Curriculum / 2	0 (0.0%)	3 (2.9%)	16 (15.2%)	46 (43.8%)	37 (35.2%)	3 (2.9%)

Note. Response options: 1 - Not at all Effective to 5 - Very Effective.

Qualitative Findings

Of the 105 participants asked to share an anecdote describing how they used the skills in the training, 93 provided anecdotes that were suitable for analysis. Twelve responses contained only random characters, likely entered to bypass the required survey field, and were thus excluded as lacking interpretable content. Anecdotes varied in composition and character lengths (median 225). Some participants explicitly named specific strategies or concepts from the training (e.g., “I used the APR technique”), whereas others described actions reflective of strategies within the training. Participant anecdotes varied in focus. Most (76%) referenced using at least two of the four Rs. Nearly all anecdotes (95%, n=88) reflected at least one R. The remaining five reported not yet having applied skills from the training due to a lack of necessity or being on leave. Figure 1 presents the strategies

described in participant anecdotes and their relation to the Four Rs framework. This, alongside illustrative quotes labelled by participant number, are described below.

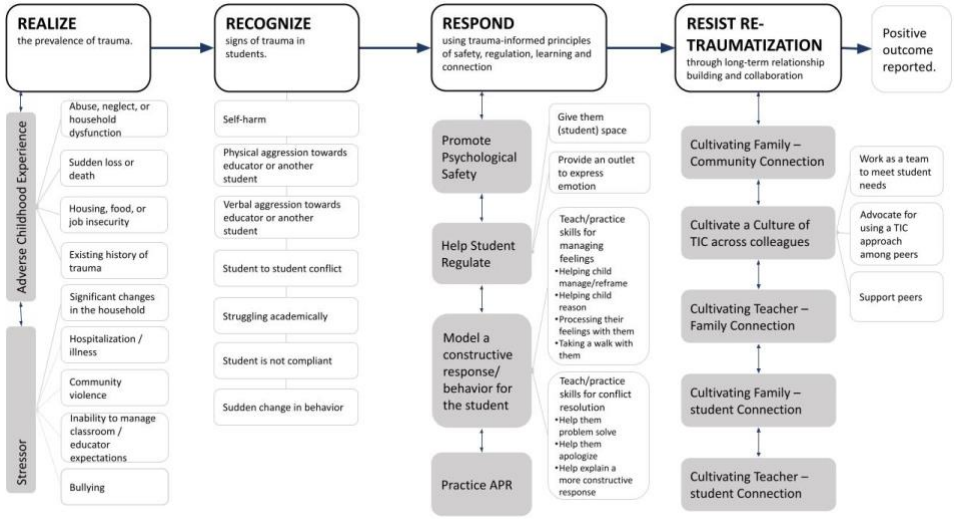


Figure 1: Themes and Subthemes Related to Participant Skill Application

Realize: Educators Understand the Prevalence of Trauma

Fifty-six percent of participants (n=52) described operationalizing Realize by indicating understanding the prevalence and widespread impact and sources of trauma. They described identifying the root causes of stressors or challenging student behaviors, naming both specific adverse childhood experiences (n=28), and broader community stressors as contributing factors. One educator (P2) described understanding that a friend and fellow educator was likely experiencing trauma after there was a school shooting at their school: "I try to support her by recognizing that she has indeed experienced significant trauma, responding by letting her know that I and others care for her and encouraging her to reach out to her previous therapist for support, and resisting re-traumatization by not forcing her to talk about what happened."

Recognize: Educators Identify Signs and Symptoms of Trauma in Students

Forty-five percent of participants (n=42) identified challenging student behaviors as potential indicators of underlying stress or trauma. Most commonly these behaviors reflected difficulties managing classroom or educator expectations (n=12), struggling academically (n = 6), or struggling to obey classroom rules (n=4). Participants described using behaviors as cues to demonstrate curiosity about a student's personal circumstances: "I have a student who has been acting out in class and been mean and rude to teachers intentionally. We met as a team to discuss what might be going on with him outside of

school that could be impacting his behavior" (P93). Some described challenging behaviors, such as verbal or physical aggression (n=7, 3, respectively) towards others and concerns for self-harm, which participants classified as potential symptoms of trauma.

Participants described trusting relationships with students as important to recognizing symptoms of trauma. Such relationships generated insight into students' personalities and personal backgrounds, enabling educators to identify changes in behavior patterns (n=7) and discern developmentally normal behaviors, personality traits, and potential indicators of trauma. For example, one participant (P64) wrote: "I was informed a month ago that one of the students was experiencing the loss of a parent," reflecting the recognition that a playground fight was likely related to the student's trauma history. The educator continued, "My approach was to intervene calmly, then make sure both students were okay. Once they saw I maintained a calm approach, they also relaxed and were able to explain what happened."

Respond: Educators Respond Using Trauma-Informed Principles of Safety, Regulation, Learning and Connection

Participants described utilizing trauma-informed principles to relieve stressful moments during the school day. They told stories about self-regulation, often using a technique taught in the training, Awareness-Pause-Reframe (APR), to mitigate cognitive bias and maintain composure in difficult circumstances. One participant (P102) illustrated using APR: "My student was making inappropriate comments in class… His attitude and comments made me angry. Then I remembered to calm down and look at the situation from a different perspective. Sure enough, he ended up saying that his mom didn't want him back (he was living with his uncle). I was able to understand why he was acting like that, and the principal and I decided on a different route of action: therapy."

Participants also recalled implementing similar, in-the-moment strategies to support students' perceptions of safety, regulation, and connection. Several reported re-establishing psychological safety by cultivating structure and consistency, which prevented escalated student behaviors or safety incidents. Others described providing students with emotional outlets and emphasized connection: "Teachers have asked me to talk or walk with a student to help them calm down... I listen and reassure them they are loved and cared for" (P49).

Finally, participants facilitated learning by modeling constructive strategies for emotional regulation and conflict resolution. A few participants reported success in triangulating multiple approaches, such as logical reasoning ("I have explained to a student how hitting does not feel good…"), problem-solving ("...and asked if they can give me an example of what they could do next time they get upset"), and skills-building through role play ("Then we acted it out so they could actually be in a situation where they are mad and show a correct way to express themselves and calm down" (P24)).

Resisting Retraumatization

Participants described resisting retraumatization by implementing longer-term strategies to promote trauma-informed principles of safety, regulation, learning, and connection. They referenced efforts to integrate trauma-informed care into their work

culture. One such strategy involved collaborative responses to student needs, such as building a student support plan and delegating roles based on educator expertise.

Another strategy was described as disrupting working cultural norms by encouraging colleagues to utilize a trauma-informed approach. One participant (P54) described such a situation with a student who was "struggling academically and behaviorally" and "combative when teachers redirected him." Initially, educators were "resistant to going out of their way to be patient and work with the student." This participant implemented the Four Rs, collecting context on the student's background; "I learned from the student's mother that his father was incarcerated off and on since the student was young. This explains some of his behaviors and resistance to authority figures" to encourage a trauma-informed approach.

They also emphasized the importance of peer support systems to increase educator capacities for implementing trauma-informed approaches, describing debriefing together, offering trauma-informed interpretations of student behaviors, and even stepping in during escalated moments to relieve colleagues.

Participants also facilitated long-term support to mitigate students' underlying stressors by building connections between educators and students, educators and families, and families and the community. They reported efforts to prevent retraumatization by working with caregivers to reduce a student's stressors, understand family needs, and connect them to community resources.

Above all, participants recognized that their presence as a trusted adult buffered against retraumatization of their students. One participant (P14) described: "I have a student who often… comes into the building angry. I have been watching for her in the hallway and going out of my way to say hello or just wave… I was excited because the other day, she went out of her way to say hello to me… Hopefully I've made a breakthrough with her so she knows that she can have a few minutes of time to process her feelings rather than me being upset that she is upset. This behavior change has been good for both of us."

DISCUSSION

This study builds upon and deepens a growing body of literature preparing educators to respond to students who have experienced trauma. There were two trauma-informed skills training implementations with overlapping and unique elements that permitted comparison between the two. Multiple school districts were included, reflecting diverse student bodies and educational personnel. Both teachers and other educational staff serving a wide range of grade levels (kindergarten – 12th grade) participated. A mixed-methods approach permitted synthesis of both quantitative and qualitative data. Qualitative discussion boards allowed for a learning community, and the follow up survey asked participants for examples of how they used trauma informed strategies. This work builds upon the next steps surfaced in previous work using only quantitative data, by adding a qualitative component (Bilbrey et al., 2022).

TIETS incorporated learning elements similar to other contemporary, evidence-based trauma-informed trainings. It included instruction on mandated reporting, which is also taught in the Compassionate Schools curriculum (Parker et al., 2020). Additionally, TIETS's content delivery was guided by adult learning theory (Bond Chan, 2022; Dube et al., 2023) and SAMHSA's Four Rs of a Trauma-Informed Approach framework. Notably,

TIETS was distinctive in its incorporation of equity principles, the use of vignettes and case scenarios to facilitate skills-building, and the incorporation of expertise from not only subject matter experts, but also community members with lived experience. Its online, self-paced format affords participants autonomy over their learning experience, a key component of adult learning theory (Knowles et al., 2015). Furthermore, this feature empowers learners to modulate engagement with potentially distressing training content, thereby contributing to a trauma-informed learning environment which facilitates learning (L'Estrange & Bentley, 2025).

Results from TIETS Training

Results from the surveys revealed that participants reported that they were knowledgeable about trauma and its effects on students prior to training. This reflects the extensive dissemination of basic information about trauma to educators that has occurred over the past decade. Other research has confirmed this foundational understanding of trauma in teachers and educational staff (Bilbrey et al., 2022). Given the recent recognition of the importance of trauma in educational settings, this consistent endorsement of prior exposure to information about trauma is a positive development. It suggests that more advanced and nuanced training about trauma will meet a prepared and receptive audience.

Results also showed that, in both implementations, changes in knowledge from pre to post demonstrated increased incremental learning in the context of relatively high scores prior to training. In general, participants reported acquisition of new knowledge from the training, although the high level of correct responses at pre-training precluded anything more than modest gains over time. Nevertheless, such knowledge of trauma and its effects on learning is correlated with teachers' sense of self-efficacy; as such, even limited knowledge increases may signal a meaningful impact (Tomlin et al., 2024). It is possible that the performance observed at pre-training reflected a particularly strong foundation of knowledge. Alternatively, the knowledge questions might have been insufficiently challenging. As prior research has also demonstrated high levels of knowledge prior to training, more careful construction of knowledge items may be needed to construct more challenging questions that reflect more advanced and nuanced elements of trauma training.

The field increasingly recognizes that stress from supporting students who have experienced trauma can contribute to secondary traumatic stress and, thereby, teacher attrition (Ormiston et al., 2022). This trend was reflected in our study population: 58.1% of participants in Implementation 2 reported experiencing this stress (as measured by combined endorsing of Somewhat to Very in response to confidence item #8) and 35.0% and 29.5% of participants in Implementations 1 and 2, respectively, indicated a lack of confidence in having trauma-informed conversations with families. Participants' baseline perceptions affirmed the need for practical, skills-based training, particularly in the areas of self-regulation and relationship-building with families, both of which are addressed in the TIETS curriculum. This finding was later echoed in Knox's (2025) evaluation of a separate, trauma-informed training for school staff, which similarly identified a need for practical, solutions-based training.

In both implementations, participants reported increased confidence in applying trauma-informed practices in the classroom, and at post-training a majority reported that they used the skills in the prior week. This finding is important, as educators often indicate a desire to learn practical strategies that are directly applicable to their settings (L'Estrange & Howard, 2022). Increased confidence in skills application suggests that educators not only acquired useful knowledge but also had a sense of how to apply it in the classroom. Qualitative findings from Implementation 2 provide examples of participants' reported use of trauma-informed practices, indicating participant comprehension and implementation of skills and strategies taught in the training.

Participants reported that they liked the materials and format of the training. The TIETS training was designed to be engaging and to go beyond more typical didactic training formats. The positive reactions of educators suggest that the use of vignettes, expert commentary, and self-reflection guidance are useful elements of training in trauma information and practices.

The uptake of training in Implementation 1 was low, with only 361 educational staff starting training. Participation was voluntary, and it is possible that busy schedules or less interest contributed to decreased sign-up. The training was new and outside of standard training delivery practices. More extensive promotion of the training and packaging in the context of standard training opportunities may result in greater participation. In contrast, Implementation 2 was mandatory, and assignments were made by district leadership. Although the uptake was high, the benefits of mandatory training need to be weighed against the relative merits of voluntary vs. compulsory participation and warrant future research. As school districts may differ in how they offer trainings, our examination of voluntary and mandatory approaches provides information about the relative merits of each. However, lower uptake raises concerns about scalability and access, each affecting the impact of training on schools and students. Given extensive and competing demands on time and resources, it is likely that training programs like TIETS will need to be prioritized and promoted within schools to achieve their full potential to transform education.

We also found different retention rates in completion of the TIETS training, with Implementation 2 having a substantially higher completion rate in comparison with Implementation 1. The difference may be attributed in part to the mandatory participation requirement in Implementation 2 in contrast to the voluntary nature of Implementation 1. There may also have been differences between participants or school environments that contributed to the discrepancy. Schools in Implementation 1 were primarily urban in contrast to the more suburban location of those in Implementation 2. Differences in student populations, school resources, neighborhood characteristics and resources, and educational staff may have contributed to completion rates. Other formats may have improved completion rates, such as in-person delivery, shorter duration, or more engaging content, all of which may be moderated by the contextual influences. These issues should be the focus of future research.

Study Limitations

The study had limitations that warrant caution in interpreting findings. The use of pre-post, single arm design precludes comparison with no training or alternative training.

Participation was voluntary in Implementation 1, raising the possibility of selection bias and limited generalizability to teachers and educational staff who did not choose to receive the training or who might have participated in mandatory training. Limited access to individual-level data of educators restricted our ability to examine participant characteristics and training impacts. Some participants did not complete the training, and some dropped out between pre- and post-assessment, resulting in missing data. Measures assessed knowledge, self-reported confidence, application of learned material, and intent to use learned principles and strategies. Direct observation would provide documentation of actual changes in behavior in the classroom. Psychometric properties of these measures were not examined but warrant future research. The high rate of correct responses at the pre-assessment administration of the knowledge questionnaires may reflect that the questions were too basic and did not assess for more nuanced and advanced aspects of the training. Participants were drawn from urban and suburban school districts in the Midwest, and results may not be generalizable to other school districts and regions or to grade levels not included in the study.

Future Directions in Research and Practice

There are opportunities to further expand this training to address limitations in the current literature. Offering training to pre-service educators (Crouch 2019) and long-term follow-up to determine retention and use of learned material (see Guerrero, 2022) would provide an opportunity to assess impacts on student behavior and learning. In addition, there is a need to determine if TIETS or similar trainings lead to actual changes in educational staff and student behavior. Research suggests that participant buy-in – defined as the endorsement of trauma-informed practices, rather than the intention to use such practices – is a predictor of successful implementation of trauma-informed practices by educators (L'Estrange & Bentley, 2025).

Organizational conditions, such as leadership support for trauma-informed care and workplace cultures that contribute to secondary traumatic stress among educators, are documented barriers to educator performance and implementation of trauma-informed practices (L'Estrange & Bentley, 2025). As such, training alone is insufficient and must be complemented with initiatives that sustainably address these organizational conditions (Sprang et al., 2025). Given school leaders' capacities to influence such organizational conditions, securing their endorsement prior to training (Sprang et al., 2025), as well as providing training and consultation on trauma-informed systems (Knox 2025), may enhance training effectiveness and educators' abilities to implement and sustain trauma-informed practices.

CONCLUSION

Across four school districts with diverse educator and student demographics, we observed modest increases in assessed trauma knowledge and increases in self-reported confidence in implementing trauma-informed practices. These findings were underscored by qualitative data from one of the implementations in which educators provided specific examples of using trauma-informed strategies with students. The training adds to the growing body of options available to schools to incorporate trauma-informed strategies in the academic setting.

REFERENCES

American Society for Addiction Medicine (2023). *The ASAM criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions* (4th ed.). Hazelden.

ATLAS.ti Scientific Software Development GmbH (2024). ATLAS.ti (Version 24) [Computer software]. http://atlasti.com

Barnett, B. (2020). Addressing sexual violence in psychiatric facilities. *Psychiatric Services*, *71*(9), 959–961. https://doi.org/10.1176/appi.ps.202000038

Borders, L. D., Lowman, M. M., Eicher, P. A., & Phifer, J. K. (2023). Trauma-informed supervision of trainees: Practices of supervisors trained in both trauma and clinical supervision. *Traumatology*, *29*(2), 125–136. https://doi.org/10.1037/trm0000382

Betan, E., Heim, A.K., Conklin, C.Z., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. *American Journal of Psychiatry*, *162*(5), 890–898. https://doi.org/10.1176/appi.ajp.162.5.890

Berger, R., & Quiros, L. (2014). Supervision for trauma-informed practice. *Traumatology*, *20*(4), 296–301. https://doi.org/10.1037/h0099835

Borders, L. D., Lowman, M. M., Eicher, P. A., & Phifer, J. K. (2023). Trauma-informed supervision of trainees: Practices of supervisors trained in both trauma and clinical supervision. *Traumatology*, *29*(2), 125–136. https://doi.org/10.1037/trm0000382

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. (2014). The use of triangulation in qualitative research, *Oncology Nursing Forum*, *41*(5), 545–547. https://doi.org/10.1188/14.ONF.545-547

Corbin, J., & Strauss, A. (2015). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (4th ed.). Sage.

deMayo, R. A. (1997). Patient sexual and sexual harassment: A national survey of female psychologists. *Professional Psychology: Research and Practice*, *28*(1), 58–62. https://doi.org/10.1037/0735-7028.28.1.58

Ellison, C. S. (2019). *Understanding the lived experiences of counselors who have been assaulted by clients* [Doctoral dissertation, Walden University]. ScholarWorks.

Engstrom, D., Hernandez, P., & Gangsei, D. (2008). Vicarious resilience: A qualitative investigation into its description. *Traumatology, 14*(3), 13–21. 10.1177/1534765608319323

Friedlander, M. L., Siegel, S. M., & Brenock, K. (1989). Parallel process in counseling and supervision: A case study. *Journal of Counseling Psychology*, *36*, 149–157. https://doi.org/10.1037/0022-0167.36.2.149

Glasser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Aldine.

Herbst, A. (2015). Ethical considerations when a client crosses sexual boundaries. *Society for the Advancement of Psychotherapy*. Retrieved from https://societyforpsychotherapy.org/ethical-considerations-when-a-client-crosses-sexual-boundaries-my-experience-as-a-student-therapist/#:~:text=Due%20to%20my%20client's%20existing,with%20great%20opportunities%20for%20growth.

Herlihy, B. L., & Corey, G. (2014). *Boundary issues in counseling: Multiple roles and responsibilities* (3rd ed.). American Counseling Association, Wiley.

Jerolmack, C., & Murphy, A. (2019). The ethical dilemmas and social scientific trade-offs of masking in ethnography. *Sociological Methods & Research*, *48*(4), 801–827. 10.1177/0049124117701483

Jordan, K. (2018). Trauma-informed counseling supervision: something every counselor should know about. *Asia Pacific Journal of Counselling and Psychotherapy*, *9*(2), 127–142. 10.1080/21507686.2018.1450274

Kale, S. (7 October, 2021). The indecent exposure epidemic: 'How are they not taking this seriously after Sarah Everard? '*The Guardian*. Retrieved from https://www.theguardian.com/world/2021/oct/07/indecent-exposure-flashing-sarah-everard-police-response

Kavanagh, A., & Watters, L. (2010). Consultant psychiatrists' experience of workplace violence—A national survey. *Irish Journal of Psychological Medicine*, *27*(2), 77–81. https://doi.org/10.1017/S0790966700001099

Kennedy, M. M. (1979). Generalizing from single case studies, *Evaluation Quarterly*, *3*(4), 661–678. https://doi.org/10.1177/0193841X7900300409

Kim, I., Moh, Y. S., Adams, C. R., & Kim, J. (2024). Introduction to trauma-informed counselor education and supervision (TICES) framework. *International Journal for the Advancement of Counselling*, *46*, 923–939. https://doi.org/10.1007/s10447-024-09573-0

Knight, C. (2018) Trauma-informed supervision: Historical antecedents, current practice, and future directions, *The Clinical Supervisor*, *37*(1), 7–37, https://doi.org/10.1080/07325223.2017.1413607

Lanthier, S., Du Mont, J., & Mason, R. (2018). Responding to delayed disclosure of sexual assault in health settings: A systematic review. *Trauma, Violence & Abuse*, *19*(3), 251–265. https://doi.org/10.1177/1524838016659484

McNally, M. R., & Fremouw, W. J. (2014). Examining risk of escalation: A critical review of the exhibitionistic behavior literature. *Aggression and Violent Behavior*, *19*(5), 474–485. https://doi.org/10.1016/j.avb.2014.07.001

Neukrug, E., & Hays, D. G. (2022). *Counseling theory and practice* (3rd ed.). Cognella Academic Publishing.

Occupational Safety and Health Administration (1970). Occupational safety and health standards: Occupational health and environmental control (Standard No. 1910.95). Retrieved from https://osha.gov/pls/oshaweb/?p_table/STANDARDS_1

Patton, M. C. (2022, November 14). Patient at San Antonio hospital who exposed himself to nurse has 6 prior arrests for indecent exposure, records show. Retrieved from https://www.ksat.com/news/local/2022/11/14/patient-at-san-antonio-hospital-who-exposed-himself-to-nurse-has-6-prior-arrests-for-indecent-exposure-records-show/

Preez, J. D. (2008) Locating the researcher in the research: Personal narrative and reflective practice. *Reflective Practice*, *9*(4), 509–519. https://doi.org/10.1080/14623940802431499

Robasco, A., Mariaskin, A., & McKay, D. (2023). Well, that was awkward: When clients develop romantic feelings for therapists. *Cognitive and Behavioral Practice*, *30*, 238–247. https://doi.org/10.1016/j.cbpra.2021.09.004

Rønnestad, M. H., & Skovholt, T. M. (1993). Supervision of beginning and advanced graduate students of counseling and psychotherapy. *Journal of Counseling & Development*, *71*, 396–405. https://doi.org/10.1002/j.1556-6676.1993.tb02655.x

Shatto, E. H., Stefurak, J., Rinner, A. E., & Kantra, L. M. (2023). Trauma-informed supervision: The supervisory needs of mental health therapists engaged in trauma-related work. *Journal of Counselor Preparation and Supervision*, *17*(5), 1–49. Retrieved from https://research.library.kutztown.edu/jcps/vol17/ iss5/2

Slochower, J. (2011). Analytic idealizations and the disavowed: Winnicott, his patients, and us. *Psychoanalytic Dialogues*, *21*, 3–21. https://doi.org/10.1080/10481885.2011.545317

Slochower, J. (2014). *Psychoanalytic collisions* (2nd ed.). Routledge.

Spera, C. (2015). *Idealization: Clinicians and the idealizing transference* [Master's Thesis, Smith College]. Smith Scholarworks.

Stark, C., Tapia-Fuselier, J. L., Jr., & Bunch, K. (2022). The Trauma-Informed Ethical Decision-Making Model: An integrative framework. *Journal of Trauma Studies in Education*, 1(1), 86–103. https://doi.org/10.32674/jtse.v1i1.3678

Stark, C., & Scroggins, C. (2023). *Artificial intelligence (AI)-assisted coding: Grounded theory analysis of leader development at the United States Air Force Academy (USAFA).* SAGE Research Methods Cases.

Stensvehagen, M. T., Bronken, B. A., Lien, L., & Larsson, G. (2022). Interrelationship of posttraumatic stress, hassles, uplifts, and coping in women with a history of severe sexual abuse: A cross-sectional study. *Journal of Interpersonal Violence*, *37*(5-6), 2289–2309. https://doi.org/10.1177/0886260520935479

Stiles, E., Dewane, C. J., Mullen, M. C., Perrotto, A. M., & Azzaro, R. (2020). Trauma-informed supervision guide. *Pennsylvania Coalition Against Rape*. Retrieved from https://pcar.org/sites/default/files/resource-pdfs/trauma_informed_supervision_guide_508.pdf

Stutey, D. M., Givens, J., Cureton, J. L., & Henderson, A. J. (2020). The practice of bridling: Maintaining openness in phenomenological research. *The Journal of Humanistic Counseling*, *59*(2), 144–156. https://doi.org/10.1002/johc.12135

Substance Abuse and Mental Health Services Administration (2014). Trauma-informed care in behavioral health services. Retrieved from https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

Tenbrunsel, A. E., & Messick, D. M. (2004). Ethical fading: The role of self-deception in unethical behavior. *Social Justice Research*, *17*(2), 223–236. https://doi.org/10.1023/B:SORE.0000027411.35832.53

United States Department of Justice (2011). Special report: Workplace violence, 1993-2009. *Office of Justice Programs, Bureau of Statistics*. Retrieved from https://bjs.ojp.gov/content/pub/pdf/wv09.pdf

Varghese, R., Quiros, L., & Berger, R. (2018). Reflective practices for engaging in trauma-informed culturally competent supervision. *Smith College Studies in Social Work*, *88*(2), 135–151. 10.1080/00377317.2018.1439826

Vaupel, C., Adler, M., Vincent-Höper, S., Gregersen, S., Schablon, A., & Nienhaus, A. (2024). Sexual harassment by patients or clients: Investigating its prevalence and associations with impaired mental-health among social and healthcare workers in

Germany. *Occupational Medicine, 74*, i310-i311. https://doi.org/10.1093/occmed/kqae023.0794

Vincent-Höper, S., Adler, M., Stein, M., Vaupel, C., & Nienhaus, A. (2020). Sexually harassing behaviors from patients or clients and care workers 'mental health: Development and validation of a measure. *International Journal of Environmental Research and Public Health*, *17*, 1–17. 10.3390/ijerph17072570

Waddell-Henowitch, C., McPhail, D., Kelly, C., & Ferris, S. (2024). Reiterating the need for trauma-informed and anti-oppressive spaces for disclosure of sexual violence: Learning from those who have lived through it, *Issues in Mental Health Nursing*, *45*(11), 1165–1175. 10.1080/01612840.2024.2396993

Watson, P., Norman, S. B., Maguen, S., & Hamblen, J. (2022). Moral injury among healthcare workers. National Center for PTSD. Retrieved from https://www.ptsd.va.gov/professional/treat/cooccurring/moral_injury_hcw.asp?utm_

Willness, C. R., Steel, P., & Lee, K. (2007). A meta-analysis of the antecedents and consequences of workplace sexual harassment. *Personnel Psychology*, *60*, 127–162. 10.1111/j.1744-6570.2007.00067.x

Wohlberg, J. W. (2006, April 4). *Sexual and other ethical boundary violations in psychotherapy: The victims 'perspective* [Paper presentation]. Columbia Analytic Society, New York City, NY. https://www.therapyabuse.org/p2-boundary-violations.htm

Yin, R. K. (2014). *Case study research design and methods* (5th ed.). Sage.

ROBERT T. AMMERMAN, PhD is a Professor of Pediatrics in the Department of Pediatrics at the University of Cincinnati College of Medicine and a pediatric psychologist at Cincinnati Children's Hospital Medical Center. His career has focused on developing ways to support children and their families involved with child abuse and neglect. He approaches this work with humility and recognition of the privileges that come from being a white, male scientist. He brings the family and collective experiences that come from the social challenges of substance abuse and mental health disorders.

SACHIKA S. SINGH, MA, is a Clinical Research Coordinator at the Mayerson Center for Safe and Healthy Children at Cincinnati Children's Hospital Medical Center. She uses a sociological lens to study trauma-informed care and organizational systems change to advance community resilience and health. Ms. Singh's upbringing as a South Asian, second-generation immigrant raised in an under-resourced Appalachian community shape her commitment to community-centered, anti-oppressive research. Their sociological training (BA/MA) further informs an approach that deconstructs structural forces and engages communities through reciprocal, equity-oriented research practices that challenge deficit narratives and researcher–participant hierarchies.

ROBERT S. KAHN, MD, MPH, is a Professor of Pediatrics in the Department of Pediatrics at University of Cincinnati College of Medicine. He is the Senior Strategic Advisor for Population Health at Cincinnati Children's Hospital Medical Center. Dr. Kahn's research interests lie at the intersection of poverty and child health, examining what

leads to worse health and where we might intervene most effectively in partnership with families and community agencies. Dr. Kahn has the privileges afforded a white, male physician leader. He also brought to the effort 25 years working exclusively on the health and well-being of marginalized children and families and a deep appreciation of his own family's historical journey overcoming disadvantages and injustice.

LAUREN M. PORTER, PhD, is a Senior Data Science Analyst at Cincinnati Children's Hospital Medical Center. She works with the Fisher Child Health Equity Center, focusing on educational equity and improving child health through community-based solutions. Dr. Porter has the privileges afforded a white female. Her approach is shaped by early lived experiences with addiction and chronic health conditions, cementing interest in how trauma influences educational experiences.

CARRIE E. BUNGER, PhD is the Vice President of Effective School Solutions at Beech Acres Parenting Center, where her service is driven by the belief that the strongest educational outcomes are achieved when schools, families, and community partners operate in a seamless ecosystem of support. As a scholar-practitioner with over two decades of experience in the field of education, Dr. Bunger's perspective is shaped by a multi-dimensional career that spans the classroom, school psychology, building-level administration, and district leadership. Dr. Bunger is committed to systemic equity and the necessity of fostering environments where every student feels seen and supported. Their professional identity is rooted in a whole-child philosophy, which informs the analysis of district-level implementation and advocacy for trauma-informed, culturally responsive practices.

HEATHER CALHOUN, MEd, EdS, NCSP, is the Trauma-Behavior School Psychologist for the Department of Early Childhood Education at the Cincinnati Public Schools. Her areas of interest and support include trauma-informed care in the education setting, social-emotional learning, restorative practices, and delivering evidence-based professional development training to educators on applying these theories and techniques in the school and classroom settings. Growing up in a small rural town and later practicing in a large urban public school shaped Ms. Calhoun's understanding of how implicit bias operates across interpersonal, institutional, and structural contexts. Drawing on her personal and professional experience, Ms. Calhoun brings a practitioner-informed lens to her role as a researcher on this project, contributing expertise in early childhood development, the impacts of trauma and toxic stress, and equity-oriented approaches to addressing behavioral challenges without reinforcing the school-to-prison pipeline.

JODIE A. SHORT, MHSA, is a Business Manager for the Mayerson Center for Safe and Healthy Children at Cincinnati Children's Hospital. Through more than twenty years of experience in human services, home visitation, child advocacy, and healthcare research and administration, she has supported the development of collaborative, trauma-informed, cross-sector systems that support children and families across educational, healthcare, and community settings. Raised in a poor, rural Appalachian community within a working-class family, Jodie's family and community have been deeply affected by the opioid crisis, shaping her understanding of trauma as a structural and intergenerational

experience. As a middle-aged, White woman in a leadership role within an academic medical center, she critically examines her institutional privilege and access to systems of power, bringing intentional reflexivity to her scholarship and practice in trauma, education, and child and family well-being.

DAWN DENNO, EdD, was most recently a Community Engagement Consultant in Community and Population Health at Cincinnati Children's Hospital where she worked to combat many of the social determinants that created barriers to well-being and thriving for children and families. Previously, Dr. Denno spent many years as a teacher and administrator for Head Start programs in many of Cincinnati's lower-resource neighborhoods, developing a deep understanding of the complex needs of children and families. Her areas of interest include school readiness, literacy, assessment, language development, and supporting children with challenging behavior.

SARAH ZAWALY, MSW, LISW, is a Clinical Program Manager at The Mayerson Center for Safe and Healthy Children at Cincinnati Children's Hospital. Sarah specializes in trauma informed practices and organizational change to reduce the impact of Adverse Childhood Experiences and support an optimal healing environment for staff, families, and patients. As a social worker, she is trained to critically attend to how her that her identities, experiences, and positional power influence her relationships, interpretations, and analytical approach. This reflexive stance informs her trauma-informed approach, which centers safety, choice, and the lived expertise of the individuals and communities she works alongside.

TAMARA E. BAER, MD, MPH, is a Senior Expert at McKinsey & Company, where she advises healthcare organizations on advancing patient-centered models that integrate clinical care with social and behavioral health supports for children and families. Her work spans provider and payer strategy, value-based care transformation, health-related social needs, and trauma-informed systems of care, with a particular focus on improving outcomes for vulnerable populations. A board-certified pediatrician, Dr. Baer brings more than 15 years of frontline clinical experience serving children and families. She has dedicated her career to driving healthcare system transformation that expands access, advances equity, and delivers measurable improvements in quality and value.

THOMAS J. LOTTMAN, MA, is the recently retired Senior Director of the Innovation Lab at Learning Grove. Tom has had a long history of work in social and emotional learning, especially emerging character strengths in early childhood. Over the past twenty-five years he has focused on optimizing learning opportunities for young children by preventing and mediating adverse childhood experiences and maximizing positive experiences with the adults in their lives. His work is focused on the fact that it is in the early years that children are grounded in loving to learn and learning to love.

ROBERT A. SHAPIRO, MD, is Professor of Pediatrics at the University of Cincinnati and Director of the Mayerson Center for Safe and Healthy Children at Cincinnati Children's Hospital. With over 30 years of work in child abuse and neglect, his research focuses on child maltreatment, toxic stress, and Adverse Childhood Experiences. From his

clinical experience in diagnosing children who have been victims of maltreatment, and from studying the child developmental consequences of childhood trauma, he believes that educating and increasing awareness of these outcomes is critical to improving the outcomes of youth. From his experience and training in treating injured and ill children, he recognizes the value of providing clear and easy to implement interventions for parents and supportive adults.