TBRI & TRAUMA-INFORMED CLASSROOM TRAINING EVALUATION

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TBRI & TRAUMA-INFORMED CLASSROOM

TRAINING EVALUATION

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Abstract

Complex developmental trauma can lead to many psychological and behavioral issues in children. Trust-Based Relational Intervention® (TBRI) is a trauma-informed, evidence-based therapeutic model to care for children who have experienced complex developmental trauma. One thing that almost all children experiencing trauma have in common is that they are required to attend school. Teachers are the caregivers spending the most time with children second to their families, and in some cases, primary to their families. The effects of trauma are known to impact school behavior and performance. Children who have experienced trauma are more frequently referred for special education and disciplinary action, test lower than their peers, and fail out of school at higher rates. Despite these unfortunate facts, research has shown that schools can help promote resilience to mitigate the effect trauma has on students by creating trauma-informed classrooms. The TBRI & Trauma-Informed Classroom training is an online training that is available to the general public. Participants who completed this training were surveyed in order to assess the quality and the outcomes of the training, as well as ways to improve comprehension and implementation. This study had three main findings. First, participants are successfully implementing TBRI. Second, the training could be improved by the addition of live training sessions and classroom specific content. Finally, a lack of organizational buy-in is a hinderance to TBRI implementation for some. Understanding how this training is translating to practice is essential for future trainings. Creating trauma-informed classrooms that serve as places of healing for children who have experienced trauma is vital to the well-being of students who are in them.

Literature Review

The National Child Traumatic Stress Network defines complex trauma as a child's "exposure to multiple traumatic events – often of an invasive, interpersonal nature – and the wide-ranging, long-term effects of this exposure" (2018). The effects of experiencing such trauma can be pervasive throughout many aspects of that child's life. Emotionally, these difficulties include inability to trust, regulate emotions, and feel safe. Physically, the extreme stress from experiencing trauma can lead to a compromised immune system, limited brain development, and increased risk for bodily harm from risky behaviors. Children who have experienced trauma often over or under respond to stimuli, which can lead to responses such as dissociation. Complex trauma is more prevalent than many expect, as approximately sixty-eight percent of Americans experience some form of childhood trauma (Copeland et al., 2007). Common causes of childhood trauma are physical, psychological, and/or sexual abuse, neglect, family or community violence, substance abuse, and long-term illness (National Child Traumatic Stress Network, 2018). Disruption of a typical home environment leading to placement in foster or alternative care is another known source of trauma that affects over 400,000 children in the United States (AFCARS Report, 2020).

In a study conducted to determine the relationship between trauma experienced during childhood and risk behaviors and disease in adulthood, researchers found that there is a strong, graded relationship between occurrence of adverse childhood experiences (ACEs) and increased risk factors for the leading causes of death in adults (Felitti, et al., 1998) The adverse childhood experiences identified in this study included: psychological, physical, or sexual abuse; witnessing violence towards mother, and living with substance abusers, mentally ill, suicidal, or imprisoned adults. Since this study's release, further research has been done that demonstrates

resilience can combat the negative outcomes associated with increased ACEs during childhood (Poole et al., 2017). Resilience is one's ability to overcome hardship and it can be improved through protective factors including positive relationships and community support.

As enrollment in secondary education is compulsory in the United States, most children experiencing trauma have in common their attendance at school (Diffey, 2021). After their families, teachers are often the caregivers spending the most time with children. The effects of trauma, particularly as they relate to perpetuated fear, are known to impact school behavior and performance (Purvis et al., 2015). Children who have experienced trauma are more frequently referred for special education and disciplinary action, test lower than their peers, and fail out of school at a higher rate (Purvis et al., 2015).

For schools serving at-risk populations, interventions designed to alleviate the effects of trauma have the greatest likelihood for bringing positive, lasting changes to behavior (Purvis et al., 2015). An intervention of this kind needs to have structure and support so that reasonable expectations are maintained, and relationships can be formed. Trust-Based Relational Intervention ® (TBRI) is one such intervention. TBRI is a therapeutic model that trains those who care for at-risk children to provide effective support and intervention (Purvis et al., 2013). TBRI strategies are divided into three principles: Empowering, Connecting, and Correcting. The Empowering Principles are designed to meet a child's physical and environmental needs. Some of these include hydration, nutrition, and adequate sensory inputs. The Empowering Strategies also include creating a predictable, safe environment with regular routines. The next principle, Connecting, is based on promoting healthy relationships and self-awareness. As mentioned earlier in relation to combatting the effects of ACEs, the development of relational skills is a strong protective factor against the impacts of trauma. Teaching and modeling healthy

relationships is based upon four skills: the ability to give care, receive care, feel comfortable with an autonomous self, and negotiate one's needs (Cassidy, 2001). The final set of principles are the Correcting Principles, which focus on behavioral change. There are proactive strategies which aid in the development of self-regulation through teaching children skills for difficult situations before they encounter them (Purvis et al., 2013). This occurs through the use of scripted life value terms, such as "gentle and kind" or "accepting no." There are also responsive strategies which are enacted while an undesirable or unsafe behavior is occurring. The IDEAL response is invoked during these situations. IDEAL is an acronym that stands for immediate, direct, efficient, action-based, and leveled at the behavior, not the child. This method of behavior correction allows for the caregiver to maintain a relational connection during the correction and ensure that their response matches the behavior. TBRI is a caregiving model, meaning it can be applied in a wide range of settings including homes, schools, camps, and residential treatment facilities (Purvis et al., 2014).

Previous research on TBRI has shown that its implementation in schools can help promote resilience to mitigate the effect trauma has on students. One study conducted at an Oklahoma elementary school where ninety-eight percent of the student body was living in poverty and seventy-five percent of students had a caregiver in prison (Purvis et al., 2015). The student body was struggling both academically and behaviorally. Two years after Trust-Based Relational Intervention was integrated into the daily practices of the school, teachers and educational staff reported dramatic changes in the students' behaviors and ability to develop healthy relationships. They described these changes in students as lasting and valuable. Teachers expressed a newfound understanding and lens through which they viewed disruptive behaviors. Teachers reported that by understanding why their students were doing something, they found

themselves more capable of meeting the need behind the behavior, instead of just correcting the behavior repeatedly.

Another study was conducted in a charter school at a residential treatment facility for at-risk youth. After two years of TBRI implementation throughout their organization, they reported a sixty-eight percent decrease in office referrals for physical aggression and an eighty-eight percent decrease of verbal aggression (Purvis et al., 2015). The positive results of both these implementation studies supported the idea that addressing the underlying causes of behavioral issues of students who had experienced complex trauma led to better behavioral outcomes. Both of these studies led to additional TBRI implementation and training for schools to create classrooms that serve as safe, healing spaces for children who have experienced complex trauma.

In the fall of 2019, TBRI & Trauma-Informed Classrooms Training was made available online to educators for a fee. When the COVID-19 pandemic began, the training was made available at no cost. The training was designed to equip educators to help disarm fear, optimize learning, and meet the needs of vulnerable children, such as those who are from backgrounds of abuse, neglect, and/or trauma. The training consists of four seminar videos for a total of four hours and forty-eight minutes of video content. There is also a PDF guide that can be downloaded to accompany the training. The guide is made up of four sections: Trauma & the Brain: The Impact of Trauma at School, Empowering Our Students: Meeting Physical Needs, Connecting in the Classroom: Creating Relationships that Matter, and Correcting Behavior: Rethinking Classroom Management. There are discussion questions, external resources, and presentation information in each of the sections. Over 21,000 people participated in this training.

The overall aim of the current study was to evaluate the implementation of TBRI and Trauma-Informed Classrooms training and identify areas of the training that could be improved.

The current study aimed to understand if TBRI was being successfully implemented as a result of the training and generate recommendations to improve future trainings. Based on previous successful studies of TBRI in school settings, there are three hypotheses:

1. As a result of this training, participants would feel they are successful in implementing TBRI.
2. Due to the asynchronous aspect of the training, participants would want additional live sessions to aid in a better understanding of the content.
3. Due to the individual viewing of this training, participants may face low organizational buy-in as a barrier to successful implementation.

Methods

Participants

The current study recruited twelve participants who had participated in TBRI & Trauma-Informed Classrooms training. Participants were recruited through a university institute Facebook page. Eleven participants were white and one was Latino. Ten participants were female, one was male, and one did not specify. Participants' professions included elementary school teacher, art teacher, parent educator, social worker, foster parent, and special education teacher. Most of the participants had been exposed to TBRI prior to participating in the training through printed materials, conferences, or other trainings (67%). All of the participants reported having a direct care role with the children they served.

Procedure

A link to the survey was made available through the university institute Facebook Page in March of 2021 for one week. The link connected participants directly to a survey. The survey included consent for participating in research, inclusion criteria screening, and multiple choice and short answer questions related to the training. Approval for this study was obtained through the Texas Christian University Institutional Review Board. Participants were not compensated for their time.

Measures

Training Effectiveness and Implementation Survey

A survey was created for this study based upon previously used TBRI training questions. The survey was published online via Qualtrics. The survey consisted of 36 items and took approximately 15 minutes to complete. The question breakdown was: one for consent, eight for demographics, two for TBRI exposure, five for professional demographics, one for TBRI confidence, fourteen for TBRI Use, three for TBRI buy-in, one for organizational TBRI implementation, and one for final input. The answer options varied by question and consisted of a mixture of answer choices and short answers. An example of a question with answer choices is "To what extent have you used the TBRI Principles and Strategies since completing the training?" The answer choices were: "I use TBRI on a daily basis", "I use TBRI a couple of times a week", "I use TBRI a couple times a month", or "I do not use TBRI". An example of a short answer question is "What are some of the barriers that have prevented you from using TBRI?" Questions could be skipped without penalty.

Data Analysis Plan

In order to examine the hypotheses, qualitative data coding using a phenomenological approach was planned. Due to the small number of participants recruited, data was read and described for each participant. Trends in data were described, noted, and discussed between primary author and advisor.

Results

TBRI Knowledge and Confidence

For the current sample, one hundred percent of participants reported using TBRI on a regular basis following this training. Seventy-five percent reported using TBRI on a daily basis and twenty-five percent reported using it on weekly to monthly basis. Seventy-five percent reported using TBRI in their professional lives. Eighty-three percent of participants reported having a deep understanding of TBRI. Ninety-two percent of participants reported confidence in their ability to use TBRI in their work with children. One hundred percent of participants reported feeling confident in their ability to address the needs of the children they work with.

Thirty-three percent of the current sample reported low levels (Disagree or Strongly Disagree) of confidence in their ability to use their knowledge to train others in TBRI. Eighty-three percent of the participants reported feeling equipped to implement and sustain trauma-informed practices within the classroom. Seventeen percent of participants agreed that trauma informed practices are effective and meet student needs within the classroom, however they are not completely confident in their abilities.

TBRI Principles

When asked which module of the training participants found most valuable, answers varied. In Table 1 below, the percentage of participants who selected each principle is listed.

Those who selected 'Other' were given the chance to expand upon that answer choice and they disclosed, "All of it was useful".

Table 1

Most Valuable TBRI Principles

Principle	Percent of Participants
Trauma and the Brain	25%
Empowering Principles	17%
Correcting Principles	25%
Attachment and the Connecting Principles	25%
Other	8%

Training Improvements

For the current sample, fifty percent of participants indicated that having the training available online and asynchronous was convenient, but the format limited connection with trainers and other trainees. Participants reported that being able to discuss and practice what they were learning with others would have improved the training.

Twenty-five percent of the current sample identified a second area for improvement as a need for more classroom-specific content such as videos. The current training uses video clips from a TBRI camp to demonstrate knowledge and skills. During this camp, the adult to child ratio was one to one which does not match the typical classroom environment. In addition, a participant indicated the training could be more sensitive to the multiple, diverse, and simultaneous needs a teacher is called to meet every moment of the day.

Seventeen percent of the sample indicated that there was nothing they would change about the training. Eight percent indicated that the training should be free of cost all the time.

Impact

In the current sample, one hundred percent of participants reported that the training made a significant or somewhat significant impact in their work with children and families. One hundred percent of participants reported that as a result of implementing TBRI, they had seen positive outcomes. One hundred percent of participants answered that they had not witnessed any negative outcomes as a result of implementing TBRI.

Forty-two percent of participants indicated that as a result of this training, they noticed new behaviors among trained adults. These behaviors included different classroom management techniques, different perspectives on behavior, increased empathy towards students, increased self-regulation and attunement to the child's needs. Twenty-five percent of participants reported new behaviors in the children they work with, including the use of TBRI language (scripts, redo's, and compromises), increased communication of needs, and increased relationship skills.

Participants reported using TBRI with varying numbers of students. Thirty-three percent reported using TBRI with 1-20 children. Fifty percent reported using TBRI with 20-50 children. Sixteen percent reported using TBRI with over 50 children.

Barriers

In the current sample, barriers of implementation fell into two main categories. The first category is organizational buy-in. In the context of TBRI implementation, organizational buy-in can be defined as an organization's commitment to training all their employees. Thirty-three percent of participants identified a lack of organizational buy-in as a hinderance to their

implementation of TBRI. Examples included inflexible codes of conduct, counterproductive administrative interference, and co-workers not believing in or being trained in TBRI.

The second area identified as a barrier to implementation was a lack of resources – specifically human, material, and temporal. One participant described his/her barrier to implementation as a lack of material resources to meet students' physiological needs, such as food, water, and sleep. The same participant also identified a need for more human resources in the classroom to feel they could successfully implement TBRI, a lower adult to child ratio.

In addition to the main two barriers identified, seventeen percent of participants reported that their implementation could be improved with further TBRI training. Separately, one participant reported that they planned to train parents in his/her community, but they were unable to conduct the trainings due to COVID-19.

Discussion

The overall aim of the current study was to evaluate the implementation of the TBRI and Trauma-Informed Classrooms training and identify areas of the training that could be improved. Specifically, the current study aimed to use the results from the survey to determine whether TBRI was being successfully implemented as a result of the training and generate recommendations to improve future trainings. Results indicated the following implications in each of the topics below.

Implications

TBRI Knowledge and Confidence

All participants reported using TBRI regularly and seeing positive impacts as a result of their TBRI use. This indicates a successful training, especially considering ninety-two percent of participants reported confidence in their ability to use TBRI. Only seventeen percent of

participants reported they would like further training. The training these participants requested is a more in-depth training that would go beyond what is covered in this training.

The high level of successful implementation from this training is noteworthy due to the fact that this training occurred online and asynchronously. Some uncertainty with regards to implementation was expected from participants when it came to implementing TBRI due to the lack of live interaction, but participants reported regular and confident use despite the training format.

TBRI Training Principles

Previous TBRI classroom studies demonstrated the Correcting Principles to be the most useful for educators. Seeing as this population of participants were also educators, similar results were expected. However, the TBRI principles participants found most useful varied greatly. This indicates that different participants may take-away different pieces of the training regardless of what may seem most applicable to their professional role, such as Correcting Strategies. This diverse mix of answers also indicates that the training is successful in that there was not one area that stood out as the best, but rather, all the sections were useful in some way.

Training Improvements

Due to the online and asynchronous delivery of this training, suggestions to incorporate live components into the training were expected. This hypothesis proved to be correct, as fifty percent of participants indicated that a way to improve the training would be to have some sort of live component. Multiple participants suggested live, online opportunities to interact with trainers and other trainees would improve the experience. Having the opportunity to engage with others during the training process could lead to more confidence in their TBRI practice as well.

The second identified area for improvement is the need for classroom-specific training materials. Seeing as most of the training content is filmed at TBRI camp, where the adult to child ratio is one to one, it is not always translatable to a classroom. One participant said the training needs to demonstrate a more comprehensive understanding of the diverse needs teachers must meet at any moment. This summarizes the idea that the training videos could be updated and expanded to be more classroom specific.

Impact

One hundred percent of participants reported seeing positive impacts as a result of TBRI implementation, indicating that the training was successful in educating individuals to implement TBRI. The opportunity for participants to give examples made it clearer how this success can be seen: changes in adult behavior and changes in child behavior. Examples of changes in adult behavior were described by forty-two percent of participants. These changes reflect that the participants who underwent training successfully learned and are modifying their behaviors as a result of their new TBRI knowledge. The behavioral changes in children reflect success for both TBRI and this training specifically as it indicates that the trained caregivers are consistent and successful enough in their implementation to create behavioral changes in the children they work with.

Barriers

As identified before, there were two main barriers of implementation: lack of organizational buy-in and lack of resources. The lack of organizational buy-in is a barrier that has come up in other TBRI settings, so it was hypothesized to be the main barrier in this study. When an entire organization is not on board with the practice of TBRI, the intervention is less effective because the interactions between children and adults are inconsistent. This was

demonstrated in this study by participants who reported a lack of administrative support, lack of staff involvement, and strictly enforced conduct codes with no leniency for certain behaviors. The implication here is that for successful implementations of TBRI, it is best when entire organizations undergo the transition to being trauma-informed. However, training individuals is also important, as they can make significant differences for the children in their care, regardless of whether their organization is willing to transition or not.

The second barrier to implementation is a lack of resources. This response was unexpected, seeing as TBRI can be implemented at little to no cost. The need for resources in order to implement TBRI can be divided into three categories: temporal, human, and material. The temporal need refers to the time necessary to undergo training. This can be tied into the organizational buy-in barrier. If an organization is requiring TBRI training for everyone, then a time to do so and way to complete it will be provided. However, if an educator is looking to be trained independently of their organization, the length of the training and finding the time to complete it could be a barrier. The human need refers to the fact that when a teacher is alone in the classroom, they have a high adult to student ratio. In order to successfully implement TBRI, one participant explained that they would need supporting staff throughout the day. Finally, a participant reported that lack of material resources creates a barrier using the physiological strategies, which ensure a child is well-fed, rested, and hydrated. This concept that meeting instrumental needs is not always feasible is not a new one and in many other organizations where TBRI is being used, community partnerships have been forged to ensure that these basic needs are met. As meeting these needs is a vital component for successful empowerment, this barrier is significant if not addressed.

Summary of Findings

Each area of the results has implications, but they can be summarized into four main points. First is that as a result of this specific training, participants are frequently and confidently using TBRI and reporting positive impacts in children as a result. These impacts are clear in the reported behavioral changes of children in the care of these participants. The next finding is that online, asynchronous trainings are limited in ways that in-person trainings are not. While online may sometimes be the only viable option, a live training addition would likely help boost confidence in implementation as well as provide clarity where needed. The next finding is that educators desire more classroom-specific training content. This was evident throughout multiple survey questions and reflects that the training is not tailored enough to the specific needs of educators. They were clearly able to learn from this training, but their learning would have been enhanced by seeing examples of TBRI being practiced in settings that more closely resembled their everyday experiences, Finally, as we have seen before but saw reiterated here, the implementation of TBRI is limited when organizational buy-in is lacking.

Recommendations

In light of these results, the author has prepared three recommendations to inform the development and modification of future trainings. The first is identifying and providing solutions to educators for ways that they can overcome the physiological strategy barrier through the development of community partnerships. Advice and examples of how to do this should be included in the future so that caregivers are able to meet the physiological needs and empower the populations they are working with.

The second recommendation is the development of resources to aid individuals in gaining organizational buy-in. This could exist in any number of ways – an extended training, materials to distribute within their organizations, organization-specific explanation of how TBRI could

help, etc. This would give willing individuals a basis upon which they could begin to work within their organizations to generate whole systems that are trauma informed as opposed to a few trauma informed individuals in a system, which in turn would improve the implementation of TBRI in these settings.

My final recommendation is the development of classroom-specific training materials for use in this training. The lack of these was highlighted numerous times in this research and it is a logical next step for training improvement. These scenarios should be sensitive to the complex dynamics that exist in a classroom to best aid the implementation of TBRI in these settings. This could also be tied into the remaking of several older institute materials that are being updated for other reasons.

Conclusion

The value of understanding how effective a training is and how to improve it cannot be overstated. Gathering this data is crucial for ensuring that future trainings are as effective as possible in order to reach as many children as possible. This survey highlighted several areas for change in future trainings, but also indicated success within classrooms as a result of the training. The population surveyed was particularly useful as they have all had time since being trained to field-test TBRI and report back what would have improved their training, what is useful, and how it is creating an impact. Understanding how to improve this training is essential for the future of TBRI.

Limitations

This study has a major limitation that warrants discussion. The sample for this study was small. As over 21,000 participants completed the online TBRI and Trauma-Informed Classroom training and only twelve participated in this study, the sample size may not be representative of

the entire sample of participants who completed the training. The small sample size was partially due to limited time to distribute the survey as well as the method of delivery. To increase participation in the future, sending the survey directly via email to potential participants could be more effective. Having this small of a sample size meant that the data could be interpreted for trends and a full qualitative analysis could not be completed. Because the survey is developed, it could be used again to collect additional data. Gathering more data from the target participant group would lead to deeper and more statistically meaningful information for the evaluation of this training. Despite being a small sample size, this data is useful for identifying trends among the group that participated in this training. The qualitative data gathered from these responses answers the research questions posed and provide feedback on the training.

Another limitation of this study is that participant use of TBRI prior to training was not assessed, and thus not accounted for in the results. Sixty-seven percent of participants had been exposed to TBRI in some way prior to this training. Evaluating participant use of TBRI prior to training could be useful for determining whether the results reported in this study can be attributed solely to the TBRI and Trauma-Informed Classroom Training, or if some of the results were influenced by prior TBRI exposure.

For future studies, directly investigating the changes that the TBRI and Trauma-Informed Classroom Training or other trauma-informed classroom interventions have on student behavior could give insight to the true efficacy of the training. This study gathered some of that information through the positive impact examples, but directly investigating the relationship between training and child behavior would lead to clearer conclusions on the subject. Depending on the results, that type of research could help further demonstrate the need for classrooms to be trauma informed.

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