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Student Self-Harm:

The Impact on an Elementary School Principal's Leadership

by

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DEDICATION

To the future leaders whose students and staff struggle with the reality of trauma and self-harm, may you lead with compassion, grace, kindness, empathy, and love. With those qualities as your guiding tenet, you will help more than hurt, save more than lose, and lead more than manage.

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Research on self-harm and children tends to focus on adolescent children (12 years of age and above). There is limited available information about self-harm in children ages 11 years and younger. This study utilized autoethnography as the methodology to provide a rich description of the professional experiences and practices of an elementary school principal who worked with self-harming primary-aged students. Based on an autoethnographical analysis, this study proposes future research and makes recommendations for school leaders implementing trauma-informed practices, educators working with self-harming students, and districts committed to proactive support.

CHAPTER 1

INTRODUCTION

> Experience is, for me, the highest authority. The touchstone of validity is my own experience. No other person's ideas, and none of my own ideas, are as authoritative as my experience. It is to experience that I must return again and again, to discover a closer approximation to truth as it is in the process of becoming me.—Carl Rogers, 1961, p.23

In 2021, I was the principal of a primary elementary school serving students in transitional kindergarten through third grade. I was nearing the end of my third year as principal when a handwritten note from one of my teachers appeared on my desk with the words, “Have you ever seen this?” scribbled on the paper. Attached to this note was a piece of paper with a student rendition of four popular children’s television characters hanging from a gallows with blood coming out of their mouths and blood-stained clothes.

What made the situation more disturbing than just the picture was that an 8-year-old boy produced this rendition. I immediately went to speak with the boy. During our conversation, he volunteered that he “practiced” cutting himself and he “wanted to die.” What this student did not know at the time was, at that moment, he changed my leadership style and purpose forever. This incident opened my eyes to the fact that self-harming thoughts and actions are possible at a young age. Over the next two years, six of my students, ages nine and below, attempted or verbalized the desire to self-harm, including an attempted suicide. As the leader of the school, these incidents were traumatizing. They opened my eyes to the fact that there were students on my campus desperately in need of trauma-informed teaching and that my school was in need of trauma-informed leadership. These incidents changed my leadership style from “manager” to “advocate.”

The reality of this form of trauma appearing in the elementary school setting, and more specifically, the primary grades, altered my leadership style and my perspectives on trauma-informed leadership. I witnessed the need for trauma-informed leadership in my school and the necessity to impart this perspective to my staff. Lucas (2007) said, "Children desperately need educators and caregivers who understand how to observe and come to know children for who they are, what they are struggling with, and what they need" (p. 88). As Souers (2018) stated, teachers have always known trauma and its related side effects impacts student learning, yet many teachers have found being sensitive to students affected by stress a major challenge. However, on a positive note, 85% of teachers believed they should play a specific role in supporting students' mental health in the school setting" (Reinke et al., 2011).

Problem Statement

There is very little knowledge, and even less acknowledgement, of the prevalence of self-harm among younger children. In recent years, there has been considerable research interest in determining the prevalence of self-harm (O'Connor et al., 2009), but most of the attention regarding this topic has focused on adolescents, ages 12 to 18 years. Little research has been conducted on primary-school aged students (Simm et al., 2008). While some believe primary school-aged children are too young to understand the concept of self-harm, scientific literature now suggests self-harming thoughts can appear as early as preschool age (Tishler et al., 2007). As an elementary school principal, I can attest firsthand that a young child can conceptualize self-harming thoughts but all educators must be aware children in the primary grades require trauma-informed leadership as much as their adolescent counterparts. As Bath (2008) stated:

> Children affected by developmental trauma need adults in their lives who can understand the pervasive impact of their experiences and who recognize that the pain from ruptured connections can lead to a range of challenging behaviors. They need adults who can develop trauma-informed approaches that promote healing and connection. (pp. 20-21)

While self-harming behaviors have the potential to impact the trajectory of a child's life, educators are also affected and often unaware of how to best help these students. In fact, during my entire professional career in education, I have never received specific training on self-harming behaviors. I have been trained on mandated reporting and trained that I have to report possible threats to student safety. However, I have never received a systematic process on a model guidance process for managing self-harm in schools.

Brunzell et al. (2018) indicated student trauma also impacts educators. Examples of this impact include burnout, stress, exhaustion, and sadness (Lucas, 2007). In addition, trying to intervene with a student under traumatic stress impacts the educators' life outside of school (Dowling & Doyle, 2017). Educators have reported symptoms such as weight gain, exhaustion, increase in smoking, desire to quit work, and depression in their personal lives (Brunzell et al., 2018). This impact on educators' personal and professional lives may lead to negative perceptions of students who self-harm and are in need. Best (2004) noted educators are likely to have a wide range of attitudes and understanding of a child who has self-harmed. In addition to the legal requirements of being a mandated reporter, your role in education determines your responsibilities when working with self-harming students. According to Venet (2019), teachers' responsibilities included establishing healthy boundaries, facilitating connections, showing compassion, knowing the available resources, and deferring to others when circumstances are

beyond your skill set. The same responsibilities apply to principals. In addition, school principals are responsible for creating, implementing, and training staff on the particulars of a school safety plan. In severe cases, the school principal is responsible for contacting the psychiatric emergency team. In addition to these legal and ethical obligations, school principals also have the responsibility of contacting parents, sharing difficult information with families, and debriefing staff. This all takes place alongside the awaiting backdrop of logistical paperwork. Thus, everyone is affected when a child engages in self-harm, including educators. Yet, they often do not have the tools to help these vulnerable students.

Positionality

I have been an educator for 25 years and, during the course of this research, I served as the principal of a preschool through third grade elementary school. My first job in education, as a middle school teacher, arose from interpersonal connections rather than training or schooling. The mother of two of my college roommates was a superintendent and she helped her sons and their friends get jobs. Years later, the opportunity to become a school principal came about in the same fashion—I was provided an opportunity for a principalship through my interpersonal relationships rather than years of training as an assistant principal.

My White, male privilege has definitely enhanced my professional career. Ironically, I had never consciously viewed myself as a privileged White male. I grew up in a diverse neighborhood and through my active participation in sports, I was consistently a teammate to Black and Brown students. Many times, my skin color was the minority on the team. In my experience with athletics, I learned I had to earn my spot on the team through performance. Participating in sports gave me the mindset that nothing would be given to me. I have now come

to realize my power and privilege as a White male and how my interpersonal connections afforded me a professional career.

Through sports, I learned to handle disappointment, work through adversity, and move on from pain, whether physical or emotional. Those lessons remain with me today. In fact, I describe my approach to school leadership as a "learn as I go" experience where it is okay to fail, as long as I learn from my mistakes and move forward. While I have been privileged professionally to "learn as I go," I also value the opportunity to formally grow as an educator, which is why I pursued a teaching credential in 1996 and an administrative credential in 2004. Yet, the administrative training I received was very procedural. I learned about logistics and managerial skills. I did not learn about how to build a school culture. I had never heard the term "trauma-informed approaches to education." I did not learn how to be a transformative school leader.

In 2021, I completed an Ed.D. degree in educational leadership for social justice. In the doctoral program, I learned the value of critical self-reflection and cultural humility. Coupled with my experiences as a school leader, my leadership praxis continued to change and improve. For example, in my graduate degree program, I have read about many theories, including feminist theory. I have always been surrounded by women with strong personalities. My grandmothers, aunts, and mother were the alphas in their relationships. They also taught me feminist perspectives and encouraged me to break away from the typical "male" stereotype. Having a background in sports, a traditionally masculine field, meant this feminist perspective challenged me. I learned to try to see any social dynamic through the eyes of the other person

and take ownership of my role. That challenge is ever-present and a guiding factor when working with my students and staff.

In fact, as of the end of the 2021 school year, my entire school staff was women. They have helped me grow as a leader. While I often still felt the need to figure it out on my own, learn as I go, and fight through adversity, they have also helped me learn to listen to the perspectives of others. Through the feminist perspective, I have learned my role as a school leader is more than just as an administrator or a manager. Rather, our work as educators starts with caretaking. This ethic of care became a crucial part of my praxis, especially when facing the phenomenon of young students who engage in self-harm. While I wish I could go back in time to handle things differently as a school leader, I was grateful for the opportunity to learn and grow as a school leader and recognize growth will continue. One thing remains constant: my commitment to my students.

Purpose of the Study

The purpose of this study was to examine the numerous incidents of self-harm that have occurred among students in the younger grades at my school site through the lens of my role as the school leader. While still interested in understanding more about why and how this phenomenon is possible among young children, my professional role has been as a school leader, placed in the position of leading a community through such traumatic events. Therefore, by engaging in this autoethnography, I wished to understand how the self-harming behaviors of my students have impacted my leadership. Autoethnography connects the personal to the cultural and social context through research, method, and writing that demonstrates concrete action, emotion, and introspection (Ellis, 2004). I reviewed these previous self-harming incidents, the

aftermath of these incidents, and the resulting decisions and policies implemented at the school through the lens of trauma-informed leadership. Moreover, I examined how the ethics of care and transformative leadership might inform decision making at a school suffering from traumatic events. These concepts provided a framework for me to learn from these experiences so that I was better prepared to lead my school community in the future. Furthermore, this study may help other school leaders learn from my lived experiences.

Conceptual Frameworks

To analyze and interpret the autoethnographic data, this study borrowed from three frameworks to apply concepts of trauma-informed, caring, and transformative leadership. Trauma-informed leadership requires school leaders to establish a community of safety. The ethics of care framework prioritizes caring for others above all other aspects of the job. Finally, a transformative leadership practice encourages leaders to constantly self-reflect and interrogate decisions to meet the needs of everyone in their community. Transformative leadership has the power to transform communities by engaging in authentic practices that allow healing to occur through trust and caring. Taken together, these three frameworks were applied to the autoethnographic data to better understand how to lead a school when the community experiences the phenomenon of children engaging in self-harm.

Trauma-Informed Pedagogy and Leadership

First, this study borrowed from trauma-informed pedagogy to inform the concept of trauma-informed leadership. While trauma-informed leadership may be less known, trauma-informed pedagogy is a well-established theoretical framework (Bath, 2015). Trauma-informed pedagogy usually relates to practices for a teacher in the classroom setting, but as a principal and

leader, I was responsible for developing those teachers. As such, the concept of pedagogy can apply to my development of the teachers as much as it applies to the teachers' development of the students. As a result, I view trauma-informed pedagogy and trauma-informed leadership as virtually synonymous. Throughout this study, the two terms are used interchangeably. The only difference between the two terms is trauma-informed leadership implies a wider perspective as it relates to the entire organization.

Generally, trauma-informed pedagogy is centered around three fundamental principles (Bath, 2015; Crosby, 2015). These principles suggest trauma-informed teaching occurs when an educational environment is created to ensure safety, when that environment builds connections, and finally when that environment supports the development of coping skills (Bath, 2015). Crosby et al. (2018) offered yet another way of describing trauma-informed teaching as:

> In essence, trauma-informed teaching seeks to acknowledge the ways in which a young adolescent's life course is subsequently affected by trauma, and to use trauma-sensitive strategies in place of the traditional, punitive, and trauma-blind school practice that has historically compounded the effects of students' trauma. (p. 17)

Taken together, trauma-informed teaching involves awareness that trauma may affect students in the educational setting and creating a supportive environment to support those students. Trauma-informed leadership is therefore similar to trauma-informed teaching but applies to the larger school community. As a school leader, trauma-informed leadership recognizes students' behaviors may be the result of their traumatic experiences (Thomas et al., 2019). Building and maintaining positive relationships between staff and administration, staff and students, and students themselves is a hallmark of trauma-informed leadership (Thomas et al., 2019). In

summary, trauma-informed leaders create and maintain an environment where everyone is treated with compassion and understanding.

Ethic of Care

The act of caring has always been important and valued when educating young children. Goldstein (1998a) argued, historically, caring has been viewed in the affective domain instead of the intellectual domain. She also suggested this simplistic view of caring limits teachers' understanding of what it means to be an educator and understates the complexity and challenge of working with young children.

Examining the dilemma of self-harm through the lens of care ethics allowed me to prioritize caring as central to the role of a school leader and demonstrate the need for educational leaders to expand their understanding of caring. Noddings (1992) advocated for an educational decision-making template that asks teachers to view their classrooms as families for whom we all are responsible. Martin (1995) further supported the idea of care ethics in school by suggesting "this type of education is becoming increasingly important as the real lives of American students move further and further from the traditional nuclear family" (p. 27). Thus, care ethics is a central component to understanding leaders' decision making when a community is experiencing trauma.

Leadership

Finally, the essence of transformative leadership is the change created in people and communities. This study examined the change created in me, as a school leader, and the change I have created in my staff, my school site, and my students as a result of my experiences. Ultimately, the ways in which leadership is carried out on a daily basis is a combination of the

knowledge obtained from research and from lived experiences. There are many different understandings of leadership. Some suggest it is a transactional and interactive event (Northouse, 2019). Authentic leadership requires the individual to be self-aware, moral, and transparent. Authentic leaders have a clear concept of their own values, place others before themselves, and work to create change for the common good (Northouse, 2019). Adaptive leadership looks at leadership as a transactional process where leaders are affected by their followers; therefore, the experiences leaders have with others molds their leadership. Transformative leadership is similar to adaptive leadership in that transformative leadership is a process between followers and leaders. However, transformative leadership requires leaders to identify a needed change in the individual or the institution. This critical reflection of all, self, and others leads to transformation of the leader and the follower (Hall et al., 2002). Transformative leaders have the ability to influence others to such a degree that they would be willing to take risks and travel paths not normally traveled (Finzel, 1994). In addition, Burns (1978) suggested transformational leadership moves both the leader and follower to a much higher level of moral responsibility and ethics.

Research Question and Methodology

My experience as a school leader in a community suffering from several incidences of children engaging in self-harm generated the following two research questions:

1. How has my experience of students who self-harm at a young age impacted my leadership as an elementary school principal?

2. In what ways have I implemented concepts of trauma-informed, caring, and transformative leadership at an elementary school suffering from the phenomenon of young children engaging in self-harm?

For the purposes of this study, the young child was defined as five to nine years of age. These ages align with the transitional kindergarten through third grade elementary school where I served as principal and experienced the phenomenon of six self-harming children over the past 2 years.

To address this research question, I engaged in the qualitative method of autoethnography to detail my experiences of working with students who self-harmed and how those experiences affected my leadership. As Chang (2008) noted, "Autoethnography is an excellent instructional tool to help not only social scientists but also practitioners . . . gain profound understanding of self and others." (p. 1). The process of an autoethnography includes analyzing personal experiences while considering how others may experience similar circumstances. This process requires the autoethnographer to illustrate characteristics of the experience in order to make those characteristics familiar to the reader. In addition, the method of autoethnography, while written from my perspective, provides an opportunity to understand those who have influenced my leadership.

Although self-narratives focus on the author, self-stories often contain more than self. The irony of self-narratives is they include the self but not only the self. Others often enter self-narratives as persons intimately and remotely connected to self. According to Nash (2002), as a relational being, the self is invariably connected to others in the family, the local and national community, and the world as "a series of overlapping, concentric circles with others" (p. 226).

Friends, acquaintances, and even strangers from the circles are interwoven in self-narratives. Therefore, studying the self and writing self-narratives are extremely valuable activities in understanding the self and others connected to the self (Chang, 2008). Furthermore, the process of interrogating the self and the impact of others is a critical component of transformative leadership (Darder, 2016; Weiner, 2003). As such, the process of an autoethnography aligned with the conceptual framework used in this study.

With limited research on self-harming among primary-aged students, the autoethnography allowed me to bridge the gap in literature. As Leavy (2017) stated, "This method is useful when the researcher has personal experience with the topic under investigation and is willing to delve into that experience as a starting point for inquiry" (p. 144). I also chose this design and methodology because, while I know my context is unique to me, I believe there are other leaders in similar contexts who could learn from my experience. An autoethnography should be an authentic narrative that allows the reader to grasp the experience and interpretation of one particular case (McIlveen, 2008).

In the end, autoethnography was the optimal methodology for this study which sought to examine the impact of students' self-harm on leadership. This methodology is an instrument that can explore and portray a culture where a phenomenon is taking place (Méndez, 2013). As Bochner and Ellis (2006) stated, it "show(s) people in the process of figuring out what to do, how to live and what their struggles mean" (p. 111). Not only did I build meaning in my life by examining my past experiences, but others may be able to reflect on similar experiences and do something beneficial for themselves or others through this narrative (Ellis, 2004). To help build

this meaning, this study used reflections, anecdotal notes, and information gathered from conversations with students and parents.

Limitations and Delimitations

As with any autoethnography, I addressed an issue from a single perspective. I shared my experiences as a school leader working in a school community with young students who self-harmed. I realize my experiences may be unique and not generalizable to all school leaders with similar experiences, yet if others are experiencing similar leadership challenges, they may benefit from reading my autoethnography. In addition, I acknowledge my experiences have been dependent on the information parents and primary-aged students shared with me. In that way, this study was reliant on information others provided that I interpreted. Autoethnographic studies have a history of criticism for self-indulgence, narcissism, introspection, and individualism (Atkinson, 1997; Coffey, 1999). However, Bochner and Ellis (1996) explained how autoethnographies are useful because they "allow another person's world of experience to inspire critical reflection on your own" (p. 22).

Because an autoethnography focuses on one perspective, I have considered only my experiences with students who self-harm. In addition, my experiences as a school leader have been contained within the context of a primary-grade elementary school. Therefore, my focus was on the primary-aged students I work with every day. While readers of this study may work with children of different age groups, they may gain understanding of my story to help them with their story.

Significance of the Study

This autoethnography fills a current gap in the literature regarding students and self-harm. Previous research on self-harm has centered on adolescents (Simm et al., 2008). Only a few studies have focused on primary-aged students who self-harm. Additionally, very little research has examined how schools and leaders address the topic of self-harm. This research, focusing on leadership and primary-aged students who self-harm, should draw attention to the need for trauma-informed leadership in our schools.

The possibilities for social justice from this research are immense. As Crosby et al. (2018) noted, "Trauma-informed teaching is, within itself, an act of social justice education" (p. 16). Marginalized individuals and communities are at higher risk for trauma-causing events (Farquhar & Dobson, 2004). The opportunity to enhance the lives of all involved are profound. Given that up to 40% of students are exposed to some form of trauma, whether it is abuse, family violence, or exposure to violence (National Child Traumatic Stress Network, 2014 as cited in Brunzell et al., 2018), more and more school educators are likely to encounter students who have experienced trauma. This exposure to the impact of trauma on students also impacts the educator (Brunzell et al., 2018), thus creating the need for more professional knowledge on how to best meet the needs of these students. More often than not, the challenge for the educator comes from a feeling of being "unsupported" for this type of work (Simm et al., 2008). These feelings of being unsupported, regardless of the position, lead to vicarious trauma, compassion fatigue, and an overall impact to the professional working with a student who has self-harmed. Working closely with a child who has experienced a trauma exposes teachers and caregivers to that same trauma (Lucas, 2007). Those experiences then begin to weigh on the educator and affect the

individual's mental health. Frequent exposure to traumatic incidences as an expected outcome of these professions render instructors more susceptible to psychological problems (Bozgeyikli, 2018). In turn, trauma can diminish the relationship between educator and student. An educator's emotional health supports his or her ability to nurture and facilitate the growth of children (Goleman, 1995). In other words, children are more likely to flourish when the emotional state of the educator is positive and healthy.

The possibilities of social justice also extend to the student. Trauma can affect children's imagination and subsequently their ability to envision a life without trauma and stress (Van der Kolk, 2014). Some recent community studies have shown one-third to one-half of adolescent students in the United States have committed some form of self-harm or nonsuicidal self-injury (NSSI), while older studies have argued the rate falls somewhere between 13% to 23% (Peterson et al., 2008). Children of lower socioeconomic backgrounds are at greater risk of experiencing traumatic stress (Goodman et al., 2012) and in turn experience the greatest impact on their academic achievement (Goodman et al., 2012). African American students are twice as likely to grow up in an impoverished community and often encounter more crime, neighborhood violence, and overall trauma (Brandt, 2006). This can lead young children to feeling hopeless and despondent. For young people, a diminished capacity for hope is one of the most significant threats to civic engagement (Ginwright, 2011). Recognizing, understanding, and responding to the trauma in our students' lives is vital to keeping our students healthy, safe, engaged, supported, and challenged to educate the whole child (Souers, 2018). In the end, the key to a positive trajectory for an affected student is early identification (Davis, 2016). Therefore, the goal of this study was to encourage and empower other educational leaders so they may acquire

an understanding of the necessity of trauma-informed, caring, transformational leadership practices in order to serve as social justice advocates for students in their particular context.

Definitions of Key Terms

Authentic Leadership: Authentic leadership is leadership that is genuine and "real" (Northouse, 2019, p. 197).

Compassion Fatigue: Compassion fatigue is the reduction in an individual's ability to exhibit compassion as a result of prolonged exposure to circumstances that require constant or long-standing commitment to help (Zartner, 2019).

Leadership: Leadership is a process whereby an individual influences a group of individuals to achieve a common goal (Northouse, 2019, p. 5).

Nonsuicidal Self-Injury (NSSI): NSSI results from harming oneself without suicidal intent by inducing pain, breaking bones, ingesting toxic substances, or interfering with the healing of wounds (Peterson et al., 2008).

Primary Grades: Primary grades are grades kindergarten through third in a traditional public school system.

Primary Aged: Primary aged refers to students in grades kindergarten through third grade—typically ages five through nine.

Self-Harm: Self-harm is an individual's conscious or unconscious intention to cause injury, completed in a limited period of time, resulting in "tissue-damage" (Best, 2006).

Trauma: Trauma is a physical and emotional response to a threatening event(s) as a result of individual, interpersonal, or social experiences (Loomis et al., 2019).

Trauma-Informed Leadership: Trauma-informed leadership involves awareness that students, staff, and the community need an educational environment that ensures safety, builds connections, and develops coping skills.

Trauma-Informed Teaching: Trauma-informed leadership is the awareness that students need an educational environment that ensures safety, builds connections, and develops coping skills (Bath, 2015).

Vicarious Trauma: Vicarious trauma is sometimes referred to as secondary trauma and is a process of change resulting from empathetic engagement with trauma survivors. It can have an impact on the helper's sense of self, worldview, spirituality, affect tolerance, interpersonal relationships, and imagery system of memory (Zartner, 2019).

Organization of Chapters

Trauma-informed leadership is often thought about when tragic events occur. However, leadership with an understanding of how trauma affects the lives and opportunities of our young students should be the central focus of any leadership style. Chapter 1 has briefly outlined the problem and purpose of the study. Chapter 2 provides a synthesis and analysis of relevant literature and theory. Chapter 3 outlines the methodology implemented for this study, which is autoethnography (Ellis & Bochner, 2000). Chapter 4 provides the autoethnographic data. These data are derived from life experiences and information collected through my workings with students and their families through the phenomenon of self-harming incidents reported at the elementary school. Finally, Chapter 5 contains an analysis of my experiences through the conceptual framework. The chapter concludes with implications and recommendations for educational leaders experiencing a similar problem of practice and for future research.

CHAPTER 2

LITERATURE REVIEW

This autoethnography demonstrated the power of critical reflection and self-examination when it came to constructing an elementary school principal, educational leader, and agent for social justice. In this chapter, I reviewed literature that provides the reader context for understanding the dynamics of my leadership journey. First, I reviewed the literature on the social and emotional development of children and how that development plays out for the student and the educational professional when the development is not "typical." Second, I examined the literature on self-harm, as my journey as an educational leader has included self-harming students. Within this examination, I reviewed operational definitions, the differences between adolescent groups, and the effects of self-harm on both the students and the professionals. Third, I explored the literature on trauma-informed approaches. This exploration investigated pedagogy and leadership. Next, I delved into the ethic of care as a theoretical framework to inform leadership practice during traumatic incidents. Finally, I reviewed the literature on leadership styles and concluded with transformative leadership as an approach for school leaders dealing with trauma.

Social and Emotional Development of Children

To understand self-harming behavior in children, researchers have posited there may be a connection to the inability to regulate emotions—a component of social and emotional development in children. In addition to learning academic content, children also develop their ability to engage with others and recognize emotions. Social and emotional development refers to a child building capacity to understand themselves and others. More specifically, social and

emotional development is a child's ability to understand the feelings of others, control his or her own feelings and behaviors, get along with other children, and build relationships with adults (Early Childhood Mental Health, n.d.).

It is important for educators to understand and nurture the social and emotional development of children because of its influence on their health. For instance, children's social and emotional experiences influence their brain development and those experiences play a large role in determining behavior, learning, and health outcomes (Nelson et al., 2014). In addition, relationships with adults and other children play a determining role in the development of social and emotional regulation (Nelson et al., 2014), such that nurturing relationships generally support appropriate regulation, which in turn leads to positive outcomes. Unhealthy or abusive relationships, on the other hand, can lead to social and emotional dysregulation and produce negative outcomes related to learning and health (Nelson et al., 2014). Thus, the type of social and emotional relationships a child experiences, whether positive or negative, can influence their ability to regulate their emotions and social interactions with others.

The ability to regulate emotions and socially interact with others are development skills by nature; in other words, humans learn to do this over time. When children enter school, they often vary in their ability to appropriately regulate their emotions and social interactions. While most children manage to adhere to classroom routines and the overall school environment very easily, many do not, and this has led schools to focus on the social and emotional development of their students (Denham & Brown, 2010; Gillies, 2011; Greenberg et al., 2003; Maguire et al., 2016). Zins et al. (2007) noted "schools are social places and learning is a social process" (p. 191). Due to the importance of social interactions in the learning process, it is clear that

emotions, which interact with social interactions, play a central role in the development of behavior and learning (Maguire et al., 2016). Behaviors are often the expression of emotions. During school-based social experiences, educators often focus on reducing behaviors seen as problematic, such as withdrawal or depression, or behaviors that manifest externally, such as aggression or disruption. There is some evidence suggesting exhibiting problematic behaviors is directly related to the absence of emotional recognition skills (Dodge et al., 2002). For example, children tend to attribute anger to others when they inaccurately recognize emotions. These behaviors are a concern due to the potential long-term impact on the child. Researchers have agreed children who exhibit problematic behaviors at a young age are at greater risk for developing antisocial behaviors and other behavioral disorders in the future (Campbell, 2006; Lynam 1996). In fact, social-emotional competence throughout childhood is an important predictor of later functioning (Rucinski et al., 2018).

For school-aged children, forming and maintaining positive peer relationships are critical skills needed to develop social and emotional competence (Gallagher, 1993). These peer relationships have been found to pervasively affect children's functioning from early childhood through adulthood (Odom et al., 1992). Understanding the necessity of positive peer relationships for childhood development heightens the need for educators to create positive social experiences. To foster positive social experiences in a school setting and build this competence, it is important to understand the developmental stages of young children.

While the ability to recognize another "emotionally" begins to develop in the first year of life (Flom & Bahrick, 2007), Selman and colleagues (1983) (as cited in Gallagher, 1993) highlighted four themes that show how social and emotional competence develop over time.

Selman and colleagues identify four themes in the social and emotional development of young children. These themes are understanding friendships, social perspective coordination, strategies for interpersonal negotiation, and processes characterizing friendship relationships. First, from approximately 3 to 7 years of age, children's understanding of friendships is "egocentric." In other words, young children rarely consider the feelings or needs of others. They also identify friends in terms of overt and observable physical attributes (Harter, 1988; Selman & Schultz, 1990). Next, in terms of their social perspective coordination, children at this age have a similar physical orientation (Gallagher, 1993). While students are aware of feelings, they find it difficult to distinguish between intentional and unintentional acts. As a result, children evaluate differences based on physical behaviors or traits. When it comes to strategies for interpersonal negotiation, children in this age group tend to be impulsive. For example, during conflict, they may withdraw from interaction to reduce conflict or use physical force to overpower the other child (Gallagher, 1993). Children at this age try to change the other children or transform themselves to cope with conflict. Gallagher (1993) provided examples of how children navigate interpersonal negotiations; namely, children will use forceful blocking, impulsive grabbing, denial, and rejection when trying to alter others. However, when modifying their own behavior, children will blindly obey, automatically withdraw, impulsively escape, or deny their own feelings and reactions. Whether directed inwardly or outwardly, both strategies are equally immature. In the last theme regarding friendship development, children at this level try to gain the most joy from interpersonal exchanges. In other words, children attempt to maximize their level of excitement, entertainment, and affect (Parker & Gottman, 1989). This is done through coordinated play. Parallel play—or play done side by side—is the most basic form of

coordinated play and requires low levels of coordination between children, has the lowest levels of satisfaction, but is also the least likely to incite conflict (Gallagher, 1993). On the other hand, fantasy play—or play that requires roles—is verbally demanding and requires clear communication, behavioral control, and that each child consider the other (Gallagher, 1993). As a result, fantasy play is more likely to involve conflict or disagreement. However, exposure to this type of play can assist children in the development of their skills of recognizing others' emotions and managing conflict. Taken together, these four themes suggest children are at the beginning stages of developing emotionally and socially and their social and emotional competence is immature and prone to misunderstanding.

Typically, children begin to mature emotionally and socially around 8 years of age. Selman and Schultz (1990) described this understanding of friendship as "unilateral"—that is, children begin to understand feelings and intentions are as important as actions in friendships. However, children's understanding is limited to their own experiences (Gallagher, 1993). Children begin to evolve in terms of their social perspectives during this stage. They become better at differentiating between physical and psychological characteristics, allowing them to distinguish between intentional and unintentional acts (Gallagher, 1993). While they are aware each person has feelings, the child is still concerned the relationship is physically equal. "Reciprocity is seen more in reciprocal actions than in terms of reciprocal perspectives" (Gallagher, 1993, p. 202). In regard to interpersonal negotiation, children at this age begin to exert power and control. Students may begin to use threats, bribes, orders, and criticism to solve interpersonal conflicts (Selman & Schultz, 1990). During this stage of development, children who do not get their way may view the situation as unfair. In the end, control of the interpersonal

negotiation is obtained through the peer's submission (Gallagher, 1993). Inclusion and the avoidance of rejection now characterizes friendship development. As Gallagher (1993) mentioned, this phase is now about self-presentation. During this phase, students begin to form groups and gossip. This negative gossip and teasing may be used because children view these as low-risk strategies (Parker & Gottman, 1989). The process of forming groups and gossiping allows children to determine which groups and behaviors they want to identify. During the developmental stages of childhood, the four themes highlighted above blend together to help form the emotional understanding of a child. Emotional understanding is a necessary and essential social task (Halberstadt, 2003).

Consistent with the reviewed literature on social and emotional development, children should become increasingly able to identify emotions as they develop through primary school (Selman, 1981). In addition, children should be able to interpret emotions in specific social contexts. This social and emotional ability allows children to express their own emotions competently in their social environment. Children's developing skills in emotional understanding, along with the development of competent emotional expression, permit them to successfully navigate the complex social and academic school environment and develop positive social behaviors. Unfortunately, the classroom can become a confusing and disturbing place for children who are unable to accurately identify emotions or interpret others' emotions in specific contexts (Raver et al., 2007). This may result in children displaying problematic behaviors. Sadly, educators often treat such behaviors in school as problematic and focus on reducing disruption. Children exhibiting problematic behaviors may actually present symptoms of larger conditions resulting from toxic stress that could eventually lead to self-harm (Goodman et al.,

2012). Therefore, with the looming threat of self-harm, it is important to understand the impact of emotional understanding on behavior.

Self-Harm

Social and emotional development in children is largely dependent on the amount(s) and type(s) of traumatic stress experienced during childhood. Traumatic stress is so prevalent during childhood that nearly 35 million children in the United States have experienced one or more forms of childhood trauma (McGruder, 2019). Babies are born with an intact stress response system (Perry & Szalavitz, 2006). When an infant's brain receives signals that something is not right, those signals register as distress. If the stress is relieved quickly and consistently in early childhood, children develop the typical social and emotional abilities to cope with stress and trauma in the future (Perry & Szalavitz, 2006). Atypical social and emotional development occurs when the stress or trauma is repetitive, negative, and persistent. In these situations, the areas of the brain responsible for social and emotional development will be underdeveloped (Perry & Szalavitz, 2006). Those who struggle with social and emotional regulation usually come to the attention of their teacher. Social and emotional dysregulation is also associated with symptoms many children present to the school nurse (Shannon et al., 2010). When children are socially and emotionally underdeveloped and exposed to events that remind them of their traumatic experiences, they can respond with atypical behaviors such as self-harm.

Unfortunately, there is no universal definition or understanding of self-harm. In basic terms, self-harm is the act of hurting oneself without suicidal intent. However, in the research, there are many synonymous phrases or names with self-harm. Self-harm is known as nonsuicidal self-injury (NSSI), cutting, self-mutilation (SM), self-injury, deliberate self-harm (DSH), self-

injurious behaviors (SIBs), self-destructive behavior, self-cutting, self-poisoning, overdosing, self-wounding, delicate cutting, attempted suicide, and parasuicide (Best, 2006; Peterson et al., 2008; Roberts et al., 2019). Some researchers have created classifications to define self-harm which include "major self-mutilation," "stereotypic self-injury," and "moderate/superficial self-mutilation" (Best, 2006, p. 162). Best (2006) also explained how further categorizations have been used to describe the most common forms of self-harm as episodic, repetitive, and compulsive.

The exact meaning of self-harm is somewhat dependent on the researcher and the researcher's motive. For example, if the researcher is interested in referrals to hospital psychiatric services, he or she may equate self-harm with drug overdoses since this is the most common problem in that context (Goddard et al., 1996; Hawton et al., 2000; McLaughlin et al., 1996). If the researcher focused on suicide, self-harm may be identified as suicidal-related behavior (Brent, 1997). From a counseling perspective, the focus may be on cutting, burning, and other forms of self-mutilation since those behaviors are linked to childhood trauma (Gardner, 2001). Other behaviors such as anorexia and bulimia could be included in the definition since they involve self-harm but may be excluded because they are already classified as "eating disorders" (Best, 2006). These are all examples of how difficult it can be to create an operational definition of self-harm.

There have also been various attempts to operationally define self-harm. In 2004, a definition for self-harm was proposed as "A full and conscious intention by the individual to cause injury, completed in a limited period of time, resulting in 'tissue-damage' that leads to scarring" (Camelot Foundation & Mental Health Foundation, 2004). This definition was not

universally accepted because it excluded forms of self-harm that did not permanently damage body tissue and assumed a level of conscious intent (Best, 2006). This definition has since been revised to include cutting, burning, banging, hair pulling, bruising, self-strangulation, and self-poisoning (Best, 2006).

Given the variations in terminology, I operationalized self-harm as any intent to cause self-injury, including attempted suicide, completed in a limited period of time for the purposes of this study. By using this working definition, this study incorporates previous definitions and examples. This working definition also allows for interchangeable terms of self-harm (i.e., NSSI, DSH, SM, and SIBs). Overall, no matter how the term self-harm is defined, self-harm is a phenomenon present in schools and classrooms.

Self-Harm in Adolescence

Research on self-harm and children tends to focus on adolescent children (12 years of age and above). There is limited available information about self-harm in children ages 11 years and younger (Simm et al., 2010). The literature reviewed for this study includes data on both children and adolescents and self-harm to provide a perspective for understanding the magnitude of this phenomenon.

This literature review identified four quantitative reports around the topic of self-harm and children under 12 years of age (Ayton et al., 2003; Dow, 2004; Meltzer et al., 2001; Nadkarni et al., 2000). Two of these studies (Ayton et al., 2003; Nadkarni et al., 2000) were hospital-based and examined the frequency of young children presenting with self-harm. The findings of these studies suggested young children rarely present to emergency departments with DSH (Simm et al., 2010). These two studies provided limited information regarding the age

group involved in this study. According to Simm et al. (2008), "It is reasonable to assume that primary-school aged children who present to A&E [emergency rooms] will not be perceived, or recorded, as self-harming if the adults concerned do not consider the possibility of self-harm in children" (p. 255). The other two reports (Dow, 2004; Meltzer et al., 2001) focused on community-based studies. The Meltzer et al. (2001) study focused on the rates of DSH outside a hospital setting in children between the ages of 5 and 15 years old. The researcher in the study interviewed the parents of children under 11 years of age. According to parents, 1.3% of children between the ages of 5 and 10 years old had attempted self-harm (Meltzer et al., 2001). The researcher also interviewed older children (4,249 participants between the ages of 11 and 15 years old) and their parents. The study found children's and parents' reports of self-harm did not align. Only 1% of parents said their children self-harmed while 5% of the children reported they committed self-harm (Meltzer et al., 2001). This disconnect between parents' perceptions of self-harm and children's actual attempts suggest the percentage of children under 11 years old may be higher than suggested in the report. Dow (2004) conducted a study using data from phone call records of a self-harm hotline for children. Of those phone calls, 2% were from children between the ages of 5 and 11 years old (Dow, 2004).

Some qualitative studies of adolescents have suggested self-harm can start as early as primary-school age (Len & Kortum, 2004; Spandler, 1996; Sutton, 1999). Of particular note is Spandler's (1996) study. In this report, she conducted interviews with individuals between the ages of 15 and 25 years old who experienced repeated self-harm. A participant from Spandler's 1996 study (as cited in Simm et al., 2008) stated, "The first time I harmed myself–I was about

four–stabbed myself in the arm with a fork, seeing blood–and thinking afterwards, god this feels good . . . when I was about eight I started using razor blades" (p. 255). Spandler (1996) added:

> Many of the young people expressed some confusion and uncertainty, sometimes realizing that their self-harm had begun earlier than they had previously envisaged. Thus, some of the young people recalled banging their head as a young child or eating harmful substances such as glass, and queried, "does that count?" (pp. 43–44)

The importance of this study was that it suggested young children who self-harm do not realize they are self-harming. This study also suggested self-harm may change over the years of a child's life and take a new form, making the previous form unrecognizable as self-harm. Regardless of the form, self-harm affects the child in ways the child may not understand.

Effects of Self-Harm

The effects of self-harm can be both short- and long-term. In addition, the effects of self-harm are physical and psychological. While the physical effects of self-harm may be more visible and harmful, the psychological effects are just as devastating (Tracy, 2012). In fact, individuals who self-harm are often consumed with self-harming behaviors and self-harming thoughts (Tracy, 2012). Regardless of the nature of the self-harm or the duration of the effects, self-harming behaviors have the potential to be debilitating.

While self-harm is traditionally viewed as negative, there are perspectives that view self-harm as having positive effects. These possible positive effects include expression of difficult feelings, communicating a need for help, release of pain and tension, sense of control, distraction from painful emotions or circumstances, feeling alive, or feeling something other than feeling numb (Tracy, 2012). Individuals who self-harm may believe doing so releases feelings of anger,

pain, and sadness. However, over time, those raw emotions that led to the act of self-harm, including guilt and shame, continue to exist and may worsen over time (Self-Harm, 2019). The physical and psychological damage self-harm causes dramatically outweighs the temporary positive effects of self-harm.

The physical effect of self-harm lies on a continuum, ranging from minor effects such as scratches or bruises all the way to death. Some of the physical effects of self-harm include wounds, scars, permanent scarring, infections, nerve damage, broken bones, hair loss, bald spots, damaged tendons, blood vessels, and muscles, permanent weakness or numbness in certain areas of the body, loss of limb or appendage, multiorgan damage and/or failure, septicemia, and death (Self-Harm & Self-Injury Causes & Effects, 2019; Signs, Symptoms, & Effects of Self-Injury, 2019; Tracy, 2012). Whether or not some of these effects become long-term depends on the way in which a person harms himself or herself, the presence of alcohol or drugs, and any coinciding mental health disorders (Self-Harm & Self-Injury Causes & Effects, 2019).

Effects of self-harm are not only limited to the physical domain. Psychological effects also take place when an individual engages in self-harm. It only makes sense that since powerful emotions lead individuals to self-harm, those self-harming actions would cause strong emotional reactions (Tracy, 2012). Some of the psychological effects of self-harm include irritability, desire to be alone or loneliness, shame, guilt, stress about having to create a story to cover the self-injury, reduction in coping skill capacity, low self-esteem, self-hatred, depression, feelings of helplessness and worthlessness, social withdrawal and avoidance, and poor interpersonal relationships (Self-Harm & Self-Injury Causes & Effects, 2019; Signs, Symptoms, & Effects of Self-Injury, 2019; Tracy, 2012).

The effects of self-harm are not only limited to the individual. Self-harm also impacts family members and loved ones (Prior, 2016). The effects on family and friends are far more psychological than physical. Some possible vicarious effects for loved ones include guilt, shame, confusion, fear for the self-harmer, fear for self, conflict in marriage and parenting approaches, feeling paralyzed in action, withdrawal in family relationships, paranoia, and inadequacy (Prior, 2016). Often, the self-harmer believes he or she is only harming himself or herself and does not realize the impact on others.

Family members and friends are not the only ones affected by students who self-harm. A review of the literature illustrated the vicarious trauma school counselors and teachers experience while working with students who self-harm (Best, 2006; Lucas, 2007; Roberts et al., 2019; Simm et al., 2008, 2010). Teachers, who are the closest to students of all school personnel, have reported feelings of fear, anger, emotional and physical strain, burnout, stress, exhaustion, and sadness (Lucas, 2007). Additional literature described feelings of alarm, panic, anxiety, shock, fear, distress, upset, taken aback, fazed, freaked out, repulsed, bewildered, being mystified, and frustration on behalf of schoolteachers (Best, 2006). Further literature has demonstrated school professionals feel incompetent, fearful, insufficient, and out of their depth when working with students who self-harm (Simm et al., 2010). The research has not been limited to teachers. School personnel such as counselors and support staff have reported feelings of concern, lack of awareness, uncertainty, uncomfortableness, and confusion (Roberts et al., 2019; Simm et al., 2008). Whether discussing the self-harmer, a relative, teacher, or school employee, the effects of self-harm reach far and wide. As a result, schools and school leaders should pursue alternate methods and structures to support students and staff who deal with self-harm. This may take

form in the way a classroom is led, the manner in which a school is systemized, or the way a leader chooses to lead.

Trauma-Informed Approaches

As previously stated, the social and emotional development of children and likelihood of self-harm is largely dependent on the amount and types of traumatic stress experienced. Complex trauma greatly affects behavior and academic performance in schools (Wolpow et al., 2009). Providing trauma-informed care in schools will give children with trauma a higher level of support to access educational opportunities (Plumb et al., 2016). Therefore, it is only logical to use trauma-informed approaches in the classroom and the entire school.

First, it is important to understand the concept of trauma-informed care (TIC). Harris and Fallot (2001) created this framework to improve clinical practice and social service delivery (Carello & Butler, 2015). While the framework was developed for the clinical setting, it also applies to educational contexts. To be trauma-informed is to understand the individuals involved may have experienced violence, victimization, and other traumatic experiences and apply that understanding to systems development and delivery of services to meet the needs and vulnerabilities of trauma survivors (Butler et al., 2011; Carello & Butler, 2015; Harris & Fallot, 2001). Regardless of the setting, simply stated, to be trauma-informed is to be open-minded to and compassionate of the histories of individuals and how those histories currently affect their lives.

As TIC has grown in popularity, the term "trauma-informed" has been used in multiple ways. A review of the literature has shown trauma-informed used interchangeably with "trauma-informed culture" (Holmes et al., 2015), "trauma-informed practice" (Klain & White, 2013),

"trauma-informed systems" (Ko et al., 2008), "trauma-informed policy" (Bowen & Murshid, 2016), "trauma-informed principles" (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014), and "trauma-informed services" (Butler et al., 2011). The only distinction made between the terms involves TIC and "trauma-informed services" (Butler et al., 2011). Trauma-specific services refer to clinical interventions or treatments (Small & Huser, 2019). To show the difference between services and care, Hopper et al. (2010) noted:

> TIC is the more general service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment. (p. 82)

TIC recognizes the intersection of trauma across all aspects of an individual's life and strives to promote healing and reduce the risk of retraumatization.

Trauma-Informed Pedagogy

Pedagogy refers to the art, or profession, of teaching. Therefore, trauma-informed pedagogy relates to the use of TIC in the classroom. "Well-developed trauma-informed practices are universal and benefit all students" (Venet, 2019, p. 3). Using a trauma-informed approach within the classroom helps teachers create a safe, caring, and predictable environment for students to learn (Venet, 2019). Creating this type of environment is essential to ensure a sense of safety for students.

Trauma-informed pedagogy does not mean teachers need to know the complete histories of all their students. A common misconception is teachers need to know which students have experienced trauma and the details of those traumas (Venet, 2019). Teachers simply need to

know children who have experienced trauma may have significant resistance to learning or struggle in the classroom because of the trauma's effects on the child's self-regulation and relational abilities (Brunzell et al., 2018). It is more important for the teacher to show unconditional positive regard for each student, use restorative practices when disciplining, and consider student motivation, skill, and capacity when designing learning experiences (Venet, 2019). Using this approach, teachers can create a safe and caring environment for their students. Simply stated, the teacher does not need to be a "trauma detective." In fact, teachers should avoid questioning students directly about the details of their traumatic experiences or ask the students to discuss them during class activities (Venet, 2019). For example, this can happen when teachers ask students to write about previous experiences during writing prompts. Although unintentional, students may experience distress reflecting on trauma (Venet, 2019). Perry and Szalavitz (2017) argued even in the counseling setting, children who discuss traumatic experiences are more likely to develop symptoms of posttraumatic stress disorder. It is important to remember individuals' needs vary and no one should be forced to discuss trauma (Perry & Szalavitz, 2017). This is definitely true in an educational setting and providing a predictable school environment for trauma-affected children allows them to guide their own disclosure.

The connection between self-harming and trauma, including toxic stress, requires early intervention from a supportive adult. Prolonged adversity and the absence of a supportive network of adults who can teach coping strategies cause negative effects of trauma in children (Garner et al., 2012). Implementing a trauma-informed approach in the classroom is crucial to meeting the needs of students who face exposure to trauma (Jensen, 2009). Fortunately, teachers are in an optimal position to teach coping skills, model appropriate problem solving, demonstrate

emotional processing, and ensure psychological safety by instituting consistent expectations and routines (Baum et al., 2009). Teachers are also able to immediately implement classroom-based interventions that address a student's mental health (Wolmer et al., 2011). Teacher-provided interventions can improve students' self-esteem and coping skills, while reducing anxiety and depression (Stopa et al., 2010). The literature highlighted above supports the use of trauma-informed pedagogy in the classroom to promote the emotional well-being of students and, in turn, reduce the risk of self-harm.

Trauma-Informed Leadership

Similar to trauma-informed pedagogy, the same concepts of creating a safe, caring, and predictable environment are found in trauma-informed leadership, which applies TIC to the context of an entire school or district. Trauma-informed schools recognize the signs and impact of trauma, create policies and interventions to prevent retraumatization, and aid in the overall recovery (Wiest-Stevenson & Lee, 2016). In essence, trauma-informed leadership takes the same practices teachers use in the classroom and applies those practices to the entire school. A trauma-informed leader creates a school environment that supports students and staff in coping with experienced trauma.

To comprehend why an entire school or district should be trauma-informed requires an understanding of the dilemma. Childhood trauma affects approximately two thirds of Americans (Centers for Disease Control and Prevention, 2016). In turn, that trauma affects multiple domains of a person's life (Felitti et al., 1998). According to the National Center for Education Statistics (2015), 90% of students attend public school. Therefore, public schools provide an optimum setting to implement interventions. In fact, the majority of American children receive mental

health services in the public school system (Farmer et al., 2003; Ko et al., 2008). Additionally, most children remain in the school system for 13 years (Plumb et al., 2016). In other words, school leaders have a lengthy amount of time to mitigate the effects of trauma on students during these developmental years, thus demonstrating the need for trauma-informed leadership.

In addition to the social justice aspect of trauma-informed leadership, evidence supports that creating trauma-responsive schools benefit students and staff. Schools that provide professional development on trauma and stress demonstrated an increased understanding of trauma and increased the use of trauma-informed practices in the classrooms (Hoover, 2019). In addition, trauma-responsive schools have noted positive effects on students' daily functioning, self and social awareness, decision-making capacity, relationship skills, and isolation (Hoover, 2019). Students who improved their social-emotional skills were more successful in self-regulating, making friends, and reflecting on behaviors and feelings (Báez et al., 2019). In contrast, students whose social-emotional development was disrupted struggled in these areas (Cohen et al., 2005). A trauma-informed school provides support for students whether or not they are identified as needing support. The school is designed to assume someone under their care is in need of social and emotional support.

An increased recognition within the education profession of the benefits of trauma-informed leadership on student success could lead to reforms and initiatives across the educational landscape. As the impact of trauma and traumatic stress has become more understood, the call for schools to provide trauma-informed interventions has increased (SAMHSA, 2014). This call is a result of evidence demonstrating reductions in traumatic stress reactions in schools occurred where schoolwide trauma interventions were implemented

(Rolfsnes & Idsoe, 2011). In fact, referrals for school-based mental health interventions have been found to be more successful than referrals to agencies outside of the school context (Evans & Weist, 2004). This same trend applies to trauma-specific interventions (Jaycox et al., 2010). The acknowledgment that trauma-informed practices are needed has also led to schoolwide social, emotional, and behavioral supports. There has been an increase in interest toward other schoolwide approaches such as positive behavioral interventions and supports (PBIS), social emotional learning, restorative practices, mindfulness, and overall schoolwide culture and climate (Thomas et al., 2019). Similar to trauma-informed practices, these approaches have provided healing, connection, support, and learning for trauma-exposed students (Thomas et al., 2019). Due to the increasing levels of adversity our children face, the need to provide care and a safe environment continues to be a top priority.

Ethic of Care

Ethics of care, also called care ethics, is a philosophical perspective rooted in feminism that uses an approach focused on morality and decision making by examining relationships in conjunction with the context. Psychologist Carol Gilligan originally coined the phrase "care ethics" (Gilligan, 1982). This ethical theory was created to offset Kohlberg's (1958) theory of stages of moral development. Gilligan (1982) believed Kohlberg's theory was an ethic of justice, because Kohlberg's (1958) theory was based on the premise that there is one moral point of view or one just rule. She suggested an ethic of justice was interested in moral rules that could be applied universally all the time. In contrast, Gilligan's (1982) ethic of care focused on relationships in real-life scenarios. The ethic of care recognized the context over universal rules. It conceded the specifics of the situation was important in determining how to respond. In the

end, the theory focused on the response to others over the consequences of actions or duties (Gilligan 1982).

Gilligan's (1982) theory continued to expand through the work of Nel Noddings. Noddings (1984) expanded on the ethic of care by focusing on intimate relationships. In her examination of the ethic of care, Noddings believed it was important to differentiate between natural caring, or wanting to care, and ethical caring, or needing to care (Noddings, 1984). Noddings understood caring relationships are basic to human existence and consciousness. She identified two parties in caring relationships as the "one-caring" and the "cared-for" (Noddings, 1984). Additionally, she affirmed both parties have some form of obligation to care reciprocally and meet the other morally, although not in the same manner. She described caring as an act of "engrossment" where the "one-caring" accepts the "cared-for" without judgement. Simultaneously, the "one-caring" needs to resist projecting self onto the cared-for. Noddings believed any ethical action originated from the innate human response of natural caring and the memory of being "cared-for" that promotes striving toward the ideal self. Similar to Gilligan (1982), Noddings rejected universal principles for prescribed action and judgment, arguing care must always be contextually applied.

Noddings identified two stages of caring: "caring-for" and "caring-about" (Noddings, 1984). The first stage refers to the actual hands-on application of caring and the latter to a state of being where one nurtures caring ideas or intentions. In her stance on the ethic of caring, Noddings further argued the extent to which one could care was limited. She argued this scope of caring is strongest toward others who are capable of reciprocating the care. She also theorized the ability to care lessens as you move farther from the self as a result of knowing less about the

individual and the context. This view prompted Noddings to speculate it is impossible to care for everyone. Noddings (2013) stated "I shall reject the notion of universal caring – that is, caring for everyone – on the grounds it is impossible to actualize and leads us to substitute abstract problem solving and mere talking for genuine caring" (p. 18). She maintained while the one caring has an obligation to care for those close in proximity, there is less of an obligation to care for distant others if there is no hope care will be completed. These claims have proven highly controversial and Noddings later revised them. Although eventually revised, these new claims differed from those shared in an earlier book (Noddings, 2002), in which she endorsed a stronger obligation to care about distant humans and affirmed caring about as an important motivational stage for inspiring local and global justice, but continued to hold it is impossible to care for all, especially distant others.

While Gilligan (1982) and Noddings (1984) are the philosophers most commonly associated with care ethics, other notable authors have contributed to the theory. Annette Baier (1987) suggested morality could coexist with universal rules. Baier believed it was important to promote sentimental traits like gentleness, compassion, and sympathy (Baier, 1987). She identified trust as the fundamental trait of morality, advocated moral emotions should be developed, and believed the ethics of care and the ethics of justice could unite (Baier, 1994). Virginia Held (1993) suggested an ethic of justice was not flawed but limited. Held (1993) argued each individual had an innate need for care, and care was the fundamental moral value. Similar to the other authors, she described feminist ethics as focused on the experience, emphasized reason and emotion, dialogue, and the context. In later writings, Held (2006) combined care ethics with global concerns. She posited that care ethics were capable of dealing

with the violence and power that exists in all relations, including global relations. Held (2006) stated:

> The small societies of family and friendship embedded in larger societies are formed by caring relations. . . . A globalization of caring relations would help enable people of different states and cultures to live in peace, to respect each other's rights, to care together for their environments, and to improve the lives of their children. (p. 168)

She suggested care ethics, when central to the thinking process, has the potential to create communities that promote healthy social relations instead of pursuing self-interest.

Eva Feder Kittay (1999) continued the work of previous care ethicists by specifically expanding care ethics to caring for the seriously disabled. Similar to previous authors, Kittay suggested ethics of justice are dependent on the principles and practices of care. She focused on the needs of those caring for "dependents" as much as the "dependents" themselves. She believed reform needed to take place that allowed resources and opportunities to be provided to those providing care.

Joan Tronto (1994) explored the intersectionality of care ethics, feminist theory, and political science. She advocated for shared power through the use of care ethics. She also argued care ethics have been used to serve the social elite. She suggested the phases of care should include "caring about," "taking care of," care-giving," and "care-receiving." She also endorsed the idea that socially powerful individuals in society purchase caring services, eschew care-giving work, and avoid responsibility for the quality of hands-on care.

The notion of care ethics has grown dramatically since its birth in the early 1980s (Gilligan, 1982; Noddings 1984). While the idea of care ethics primarily originated from the

experiences of women, men are just as capable of perceiving the world through a lens of care. Whether a man or a woman, the first step is to realize care ethics is a relationship ethic. As a relational ethic, care ethics is not concerned about the individual, but rather the relation. How one chooses to go about caring for those relationships depends on his or her view of what motivates others—their understanding of leadership.

Leadership

As an elementary principal, every day is consumed with curating those relations with staff and students. To that end, a school administrator must possess the communication and interpersonal skills to build those relationships and then maintain them as time goes on. In other words, a school administrator needs to be a good "leader." The difficulty emerges when defining the term "leadership." Although we believe we know what the term "leadership" means, the truth is the word has different meanings for each of us (Northouse, 2019). Throughout the past century, scholars and practitioners have been unable to reach consensus on a universal definition for leadership (Northouse, 2019). The purpose of this research was not to discuss the various definitions of leadership to arrive at a universal definition. Rather, this research examined the purpose of one's leadership. This research defined leadership purpose as what you are driven to achieve and deliver, which means it defines who you are and what makes you distinctive (Beaton, 2018).

Ethics

In defining one's leadership style and leadership purpose, the concept of ethics comes into the fold. It is necessary to reflect and recognize important values to hold as a leader. Once

that realization of internal principles has occurred, ethical leadership can be achieved. Hoffman (2000) suggested the following as it relates to ethics-based leadership:

> When one has internalized and committed himself to caring or justice principles, realizes one has choice and control, and takes responsibility for one's actions, one has reached a new level. One may now consider and act fairly toward others, not only because of empathy but also as an expression of one's internalized principles, an affirmation of oneself. One feels it is one's duty or responsibility to consider and be fair to others. This connection between self, principle, and duty may in some cases result from an emotionally powerful 'triggering event' that causes one to reexamine one's life choices and leads to a new moral perspective and sense of social responsibility. (p. 19)

In the case of this research, that "triggering event" mentioned above is a student performing an act of self-harm.

Adaptive Leadership

Conceptually, adaptive leadership incorporates four varying perspectives: systems, biological, service orientation perspective, and psychotherapy (Heifetz, 1994). According to the systems perspective, adaptive leadership assumes the problems people face are complex and dynamic, ever-changing, and connected to other relationships (Uhl-Bien et al., 2007). The biological perspective of adaptive leadership understands people evolve and learn from adapting to internal signals and external environments (Northouse, 2019). The service orientation perspective refers to the concept of a leader using his or her expertise to find solutions to problems (Northouse, 2019). Finally, the psychotherapy perspective acknowledges people adapt more successfully when they face challenges directly, resolve internal conflicts, and learn new

attitudes and behaviors (Northouse, 2019). Heifetz and Linsky (2004) denoted the importance of adaptive leadership by stating:

> Problems that we can solve through the knowledge of experts or senior authorities are technical challenges. . . . In contrast, the problems that require leadership are those that the experts cannot solve. We call these adaptive challenges. The solutions lie not in technical answers, but rather in people themselves. . . . Most problems do not come cleanly bundled as technical or adaptive. They include elements of each. (p. 3)

The challenge of adaptive leadership is recognizing those moments that require a personal understanding—both of self and others.

Adaptive leadership also refers to the adaptations required of people in response to changing environments (Northouse, 2019). While this type of leadership usually refers to how leaders promote change in others, adaptive leadership can relate to the leaders themselves. Simply stated, adaptive leadership is the preparation to deal with change and the ability to adjust to new circumstances. Specifically, the intent of adaptive leadership is to encourage change and learn new ways of coping to meet new challenges and grow in the process (Northouse, 2019). Adaptive leadership is required when the problem and solution require learning rather than a "quick fix" (Heifetz, 1994). In other words, adaptive leadership addresses the gap between the values people hold and the reality they face (Heifetz & Linsky, 2002). Heifetz and Linsky (2002) added those values may have been effective at one time but may now interfere with the current educational challenges at hand. In the case of this research, my realization that self-harm was occurring in primary-aged students directly contrasted with my existing beliefs about when self-harm occurred. This realization forced me to adapt my leadership.

Authentic Leadership

In addition to being ethical and adaptive, this research considered the need for authentic leadership. The journey to authentic leadership begins with understanding the story of your life. Your life story provides the context for your experiences and through it, you can find the inspiration to make an impact on the world. Your personal narrative is what matters. “Your life narrative is like a permanent recording playing in your head. You replay the events and personal interactions that are important to your life, attempting to make sense of them to find your place in the world” (George et al., 2007, p 2). While life stories of authentic leaders cover the full spectrum of experiences, many leaders have reported their motivation came from a difficult experience in their lives (George et al., 2007). Authentic leaders have used these formative experiences to give meaning to their lives. They reframed these events to rise above their challenges and discover their passion to lead.

On a technical level, there is no single accepted definition of authentic leadership (Northouse, 2019). Rather, there are multiple definitions proposed from varying viewpoints, each with a different emphasis (Chan, 2005). Given the variations in terminology, I used an operational definition of authentic leadership that comes from the intrapersonal perspective for the purposes of this study. Specifically, authentic leadership is when leaders lead with conviction based on their life experiences and the meaning they have attached to those experiences (Shamir & Eilam, 2005). By using this working definition of authentic leadership, the emphasis is placed on the leader and what goes on within that leader.

Transformative Leadership

The final aspect of leadership needing investigation that student self-harm affects deals with transformative leadership. Initially, authentic leadership was viewed as a component of transformational leadership (Karadag & Öztekin-Bayir, 2018). However, as the name implies, transformational leadership is a style of leadership that changes and transforms people, including the leader. Transformational leadership is viewed as more psychological in nature and less embedded in traditional theories of power (Allix, 2000). For many years, the terms transformational and transformative leadership were used synonymously (Van Oord, 2013). More recently, scholars such as Shields (2010, 2014) have separated transformative leadership from the transformational approach. Shields (2010) described transformative leadership as the need to:

> Begin with critical reflection and analysis and to move through enlightened understanding to action—action to redress wrongs and to ensure that all members of the organization are provided with as level a playing field as possible—not only with respect to access but also with regard to academic, social and civic outcomes. (p. 572)

Thus, transformative leadership requires critical reflection. Weiner (2003) suggested a reflective and active state of intense discovery. For others, the act of leadership must go beyond simple personal reflection. Darder and Mirón (2006) stated critical practices must be central to the educators' efforts to face the reality of uncertainty in schools today. Transformative leadership has also been described as an approach that "both inspires and transforms individual followers so that they too develop a new level of concern about their human condition and, sometimes, the condition of humanity at large" (Foster, 1989, p. 41). Although followers are

primarily the recipients of transformative leadership, the approach also affects the leader. The process is one where a person connects with another and the levels of morality and motivation rise in both the leader and follower (Northouse, 2019). In short, transformative leadership is the ability to understand a new reality and effectively communicate that understanding with others.

Conclusion

Experiences with leading an elementary school through numerous incidences of self-harm among young children has prompted the need for research to consider examining how to best support school communities. The literature on self-harm began with a review of social and emotional development and the important role schools and educators play in contributing to positive social interactions and the development of emotional regulation skills. Defining self-harm is tricky, leading to inconsistent research on the prevalence of such acts, especially among younger children. However, knowing this occurs and recognizing the amount of time young children spend in school requires a review of school leadership practices that can support students and school communities. Trauma-informed approaches in schools have been found to contribute to a safe, caring environment where students can focus on learning. Prioritizing the ethics of care further creates an environment of trust. Finally, transformative leadership practices require leaders to self-reflect for authentic relationships to thrive in a school environment. Taken together, this body of literature informed the current autoethnographic study, which will review how I implemented the concepts of trauma-informed, caring, and transformative leadership at an elementary school suffering from the phenomenon of young children engaging in self-harm.

CHAPTER 3

METHODOLOGY: AUTOETHNOGRAPHY

This chapter is designed to highlight autoethnography as a qualitative research method. In addition, this chapter provides support for using autoethnography as the methodology for this particular study and illustrating its significant alignment with leadership. To establish autoethnography as a viable research method, autoethnography and qualitative research must be defined. Autoethnography is a genre of writing and research that expresses lived experiences, acknowledges the complications of being positioned within the events of a study, and extends and explores the use of the first-person voice (Bochner & Ellis, 2016).

Qualitative Research

The research methodology for this study was autoethnography, which is categorized as a qualitative research approach. A qualitative research approach allows the researcher to make knowledge claims based primarily on constructivism, post-positivism, pragmatism, participatory perspectives, or a combination thereof (Creswell, 2003). A qualitative research approach involves an interpretive, naturalistic approach to the world that indicates qualitative researchers study phenomena in their natural settings (Denzin & Lincoln, 2011). The purpose of investigating the natural setting is to interpret the phenomena in terms of the meanings people in the natural setting make of their experiences. Some characteristics of a qualitative approach are: (a) the data collected includes words, (b) the outcome is a process rather than a product, (c) the focus is on how participants make sense of their lives and experiences, and (d) the language is expressive (Creswell, 2007). The qualitative researcher's goal is to better understand human

behavior and experience (Bogdan & Biklen, 2007). This qualitative study was conducted using autoethnography, a burgeoning form of research and writing about the self (Ellis, 2004).

Autoethnography

Autoethnography is a form of ethnography that makes the researcher's life and experiences the focus of the research (Reed-Danahay, 1997). Ethnography is a research approach that focuses on learning about the social and cultural life of communities, institutions, and other settings. Ethnography takes the position that human behavior and the ways in which people construct meaning of their worlds and lives are highly variable and depend on the specific characteristics of the individual context. The product of ethnography is an interpretive story or narrative about a group of people (LeCompte & Schensul, 1999). Ellis (2004) stated ethnography is a research approach that describes people and culture. In autoethnography, the researcher is the subject and the researcher's interpretation of the experience is the data (Ellis & Bochner, 2000). This inquiry method gives the researcher easy access to the primary source of information, which is the researcher. This ease of access makes the researcher's perspective a privileged one over other researchers in data collection and analysis (Chang, 2008). Since its inception nearly 2 decades ago, the meaning of autoethnography and its place in qualitative research has evolved. Autoethnography has also been described as personal narratives, narratives of the self, personal experience narratives, self-stories, first person accounts, and personal essays (Ellis & Bochner, 2000). Autoethnography is self-reflexive research delving into the self and the social (Reed-Danahay, 1997). Unlike other forms of qualitative research where the researcher is expected to remove personal bias from writing, autoethnography is written in first person voice. The first-person accounts provide rich descriptions of significant events, people, and cultural norms. The

first-person voice is essential to depict the unique role the self plays in an autoethnographic study (Ellis, 2004). Readers of autoethnographical literature enter the inner workings of the studied social context and are able to compare their experiences with the author's experiences. Patten (2004) described this experience as somewhat of a collaborative journey between the reader and the author. Vergara (2017) stated, "In other words, the autoethnographic narrative aims to provide a flexible, though accurate, account of the personal experiences of the ethnographer as they are intimately entangled in the historical context and the social structure of society" (pp. 67–68). This study examined and described my experiences and changes to my leadership practices as an elementary school principal. I contend that by telling my story, I set a scene which weaved intricate connections between life and art, experience and theory, and evocation and explanation.

Autoethnography is research, writing, and method that connect the autobiographical and personal to the cultural and social (Ellis, 2004). Autoethnography is an intersection of native anthropology, ethnic autobiography, and autobiographical ethnography (Reed-Danahay, 1997). Autoethnography may be seen as a blurred genre because it overlaps with writing practices in anthropology, sociology, psychology, journalism, and communication. Furthermore, Denzin and Lincoln (2011) described autoethnography as a genre of writing and research that connects the personal through multiple layers of consciousness. Using their description, as an autoethnographer, I first gazed through an ethnographic lens that allowed me to focus outwardly on the social and cultural aspects of my personal experiences. I then made interpretations, expressing my vulnerability throughout the process. As I gave details, reflected, and took an introspective perspective, this expression of vulnerability involved confronting my characteristics and practices that are less than flattering. As I convey my story, autoethnography

exposes that vulnerability to a larger audience. Ellis (2004) further expounded that autoethnography is writing about the personal and its relationship to culture. Because culture is comprised of self and others, autoethnography is not simply a study of self. Autoethnography is a study with self as the main character and others as supporting actors in the lived experience (Chang 2008). In this dissertation, I described the story of my evolution as a school leader as a result of working with students who have self-harmed. I cannot effectively describe that evolution without the supporting actors for this study, my students.

Autoethnography has become a powerful source of research for practitioners in the fields of humanistic disciplines such as education, counseling, social work, and religion (Chang, 2008). The nature of writing autoethnography lends itself to appeal to readers more than conventional scholarly writing because the author's voice resonates from the page. The sharing done in autoethnographic writing permits readers to understand themselves better and also gives the writer more insight about self and others. Therefore, the writing can transform the lives of the writer and reader in the process of the exchange of experiences. As I share my experiences, the lives of those reading my story can possibly connect their lives to my experiences and undergo a transformative moment in their own context.

Autoethnography is closely related to phenomenology and hermeneutics. Phenomenology discounts the notion of scientific realism and the view that empirical sciences have a privileged position over other studies (Schwandt, 2001). Phenomenology questions and describes the personal experience. The goal of phenomenology is to identify and describe the researcher's experiences on a daily level. Phenomenology does not construct a theory of explanation but offers the possibility of insight that brings the experience into view (Van Manen, 1990). This

examination of all aspects of the personalized experience allows the researcher greater opportunity to arrive at the core meaning of the experience.

Hermeneutics is a branch of knowledge that deals with interpretation. It is the study of interpreting meaning within a context. Hermeneutic research would ask the question, "What does this experience really mean?" Autoethnography is situated in this branch of knowledge. In autoethnography, the researcher is studying himself or herself within a subculture and attempting to make meaning of all experiences in this setting. A hermeneutic approach helps us connect our thinking with our experience of reality (Raudenbush, 1994).

The Current Study

For this dissertation, I chose autoethnography as the methodology because I tell a story of change, combine experience and theory, and use narratives with explanations with the goal of having readers apply the lessons I have learned in my personal experiences to the context of their own lives (Lewis, 2007). In choosing autoethnography, I asked readers to understand my story and become coparticipants, engaging in the storyline morally, emotionally, aesthetically, and intellectually (Ellis & Bochner, 1996).

Through reflection, I employed the narrative approach to tell my story for this study (Lincoln & Denzin, 2000). Ellis (2004) noted "narrative" refers to stories people tell and the way they organize their experiences into meaningful episodes. Using the narrative approach, the researcher becomes the object of research and the text allows the reader to be a participant in dialogue, thereby rejecting the view that the reader is a passive receiver of knowledge (Ellis & Bochner, 2000). Narratives offer perspectives on events and permit past memories to be fully present in the moment toward shaping the future (Lewis, 2007). Narratives provide the catalyst

to answer the question, “What is happening here?,” provide the author and reader with a deeper understanding of the social setting, and aid in the construction of meaning. Richardson (2000) contended the narrative provides a way to learn about one’s self and the topic under investigation—a way of knowing and discovering new aspects of the topic and one’s relationship to it. As I wrote my story, I gained insight about who I was as an educational leader, and who I continue to be. I want readers to situate themselves in the story to evoke them to look within themselves for connections to their lived experiences and discern how my story may help shape their future context.

Sources of Data

In this autoethnographic study, I was the primary source of data. This study of my leadership journey examined internal and external sources of data. Internal sources of data included past memories, self-observation, and self-reflection. External sources included student-created artifacts, interview data, meeting notes, written summaries, and incident reports. The memory, self-observation, and self-reflection data capture past and present perspectives of my lived experiences. The external data provided additional information and context as I shared the narratives.

This autoethnography was structured in a chronological manner. It examined my perspectives and understandings of self-harm, leadership, trauma, child development, and care through my lens as a secondary teacher, as a new and inexperienced elementary school principal, and as an elementary principal who has first-hand knowledge of the reality of self-harming students. Precisely because of the researcher’s use of self, the voice of the insider is truer than that of the outsider; thus, autoethnography is more authentic than traditional research approaches

(Reed-Danahay, 1997). The data shared through each lens mentioned above showed how my perspectives evolved and adapted across one consistent storyline.

Analytical Plan

In writing this study, I recognized data collection is not always sequential to data analysis in qualitative research (Chang, 2008). In other words, data collection does not necessarily need to precede nor be separated from data analysis. Rather, they may occur simultaneously. This study blended the chronological autobiographical data with the analysis of the resulting implications toward my understanding of trauma, self-harm, and leadership. The purpose of autoethnographic data analysis and interpretation is to gain understanding of the connection between self and others. Consistent with Ellis' (2004) proposal, I analyzed themes that appeared in the data. "Personal narratives such as autobiographies, biographies, and life stories are likely to present fuller pictures, ones in which the meanings of events and relationships are more likely to be told than inferred" (Laslett, 1999, p. 391). These personal narratives allowed for a much broader audience to internalize and comprehend the personal and structural changes that took place during this journey.

To properly analyze and interpret data critically, I used Hatch's (2002) proposed strategy. First, I reviewed the data to identify themes. Second, I wrote analytic memos with identifying characteristics for each theme. Next, I studied the memos for interpretation and analysis of those themes. Finally, to summarize my findings, I reviewed the data deductively through the lens of trauma-informed approaches, care ethics, and transformative leadership and inductively allowed themes to emerge. The analysis and interpretations of those themes were linked to the personal

narratives and the literature reviewed in Chapter 2. From that analysis, implications and recommendations were shared in Chapter 5.

Validity and Limitations

In traditional forms of research, the terms generalizability, or transferability, and validity are used to show the potential of reproducing study findings and accuracy of findings to address the intended research questions. In qualitative research, the term validity refers to the credibility and trustworthiness of the project and its findings (Leavy, 2011, as cited in Leavy, 2017). Some researchers prefer the term credibility, while others use trustworthiness (Leavy, 2017). Regardless of the term used, trustworthiness or validity refers to the quality of the research and whether the reader believes you have established trustworthiness (Aguinaldo, 2004). Therefore, the onus is placed on the researcher to accurately and truthfully share the narrative in a way that allows the reader to transfer findings to their particular context.

Writing is an integral feature of the research process. There can never be a neutral report or study since used language conventions are actively involved in the construction of the presented reality (Sparkes, 2000). Given nontraditional foundations of autoethnographic research, judgement by criteria derived from traditional social research does not apply. Various alternatives for autoethnographic judgement have been proposed. For example, Lincoln and Guba (1990) suggested the conventional methods of judgement be replaced with criteria such as credibility, transferability, dependability, and confirmability. In addition, open-ended, flexible criteria such as verisimilitude, authenticity, fidelity, believability, congruence, resonance, and aesthetic appeal have been suggested (Smith, 1993). Smith (1993) argued the selected evaluation criteria needs to be context-dependent since contexts are historically, culturally, and socially

situated and therefore, subject to review, interpretation, and reinterpretation over time. Although analytical, autoethnography aims to convey our lived experience as accurately and evocatively as possible to share feelings and emotions and hopefully make an empathic connection with readers.

Many critics claim autoethnography does not produce or rely on scientific knowledge. Scientific or "expert" knowledge is socially accepted in a way that common sense or personal knowledge is not. In addition, the manner in which knowledge is produced and who produces it dictates how status is attributed to knowledge (Muncey, 2005). Despite a variety of characteristics, autoethnographic writings all begin with the researcher's use of the self as the subject. This focus on biography rather than formality is a concern for some because of the belief that personal experiences are given too much value. However, some believe a researcher wanting to discover answers would make the best subject (Ellis, 1991). In addition to Ellis (1991), Bochner (2001) objected to the notion that a focus on self is decontextualized. Those who believe personal narratives emphasize a single perspective have failed to recognize that no individual voice speaks apart from a societal framework of co-constructed meaning. There is a direct link between the personal and the cultural. This culturally relevant personal experience and the intense desire to discover relevant meaning distinguish and strengthen autoethnography.

Rigor is also noted as a barrier to the acceptance of autoethnography. The requirements of a grounded theoretical framework, explicit methodological and data analysis procedures, and replicability are often noted as important aspects of traditional research, despite the obvious difficulties in applying these to autoethnography. Even those open to qualitative research recognize traditional criteria such as credibility, dependability, and trustworthiness are not

always easily applied to autoethnography (Holt, 2003). Despite the uniqueness of autoethnography, autoethnographers have to take precautions in interpreting, generalizing, and eliminating bias the same way any researcher using any other methodology would (Ellis, 1991). Autoethnography is attractive, not for its poetic license, but for its usefulness in illustrating implicit knowledge and improving practice (Duncan, 2004). Others have argued traditional criteria for judging validity cannot be, and need not be, applied to autoethnographic writing.

> The word criteria is a term that separates modernists from postmodernists . . . empiricists from interpretivists. . . . Both [sides] agree that inevitably they make choices about what is good, what is useful, and what is not. The difference is that one side believes that "objective" methods and procedures can be applied to determine the choices we make, whereas the other side believes these choices are ultimately and inextricably tied to our values and our subjectivities. (Bochner, 2000, p. 266)

Because different theoretical assumptions drive autoethnographic inquiry, it makes no sense to impose traditional criteria for judging the value of a personal study (Sparkes, 2000). It is suggested rigorous methodology and generalizability are not necessarily something we should attain. We should examine the narrative, not solely as data to be analyzed, but rather as a story to be respected and engaged (Bochner, 2001). To criticize the rigor of personal narrative is to miss the point. One does not need to engage systematically but personally (Frank, 2000). In other words, when examining autoethnography, the reader should evaluate for believability and applicability to their own lives.

CHAPTER 4

JASON'S STORY: AN AUTOETHNOGRAPHY OF ENLIGHTENMENT

Nothing ever becomes real 'til it is experienced—John Keats (Rollins, 2012, p. 81)

A critical autoethnographic study is centered around the researcher's personal story. From that story, implications, recommendations, and conclusions are made in conjunction with the literature. These insights aim to provide understanding of a particular social phenomenon. The onus is placed on the researcher to critically determine which facts should be included in the story and which should be excluded. This process is difficult because of the deep personal analysis that occurs during the process. An autoethnography forces the researcher to delve into an unexamined personal history, creating vulnerability. This critical reflection is necessary to accurately portray the evolving story of a particular social phenomenon.

This chapter includes my lived experiences as an elementary school principal working with children who have self-harmed and how those experiences altered my leadership. Specifically, I sought to answer two research questions guiding my study:

1. How have students who self-harm at a young age impacted my leadership as an elementary school principal?
2. In what ways did I implement the concepts of trauma-informed, caring, transformative leadership at an elementary school suffering from the phenomenon of young children engaging in self-harm?

These experiences represent the autoethnographic data that support my analysis and conclusion for this study. This chapter is split into three chronological sections: (a) a recount of my years as a secondary teacher, (b) a summary of my first few years as a new and inexperienced elementary

school principal along with the specific encounters with students self-harming, and (c) a depiction of an elementary school principal with first-hand knowledge of the reality that elementary students self-harm. These sections present my analysis and understanding of self-harm, leadership, trauma, child development, and the ethic of care throughout various stages of my professional career culminating in my present style of leadership. As is true with any autoethnographic study, the majority of the narrative presented in this chapter comes from a personal recollection of pertinent events and experiences, along with an analysis of external data such as notes, summaries, and reports.

To provide a conceptual backdrop of my experiences in education, it is necessary to revisit the concept of an ethic of care. Caring is commonly understood as being kind and showing concern, often characterized by smiles and hugs. This general understanding can minimize the complexity and intellectual challenge that come with working with children. There is no doubt we want our schools and classrooms to be nurturing, inclusive, and supportive of our students. In fact, caring is a long-standing expectation of the school setting and care-giving is seen as a primary responsibility of the classroom teacher (Goldstein, 1998a). However, associating these traits to the term "caring" creates barriers for the field of early childhood education. This limited definition of caring suggests caring is a feeling, personality trait, or temperament that makes one suitable to work with children (Katz, 1971). This view does not acknowledge caring as an intellectual act. Thus, the perception of early childhood educators is they are not as professional or intelligent as teachers of older children (Goldstein, 1998a). Since the concept of caring is such a dominant narrative in the school setting, it is important to see caring as intellectual pursuit—an ethic.

When discussing an ethic of care, it is important to make a distinction between "caring for" and "caring about." "Caring for" involves a specific and concrete action meant to benefit the development of the relationship and parties involved in the relationship (Hawk, 2017). Hawk (2017) also explained "caring about" does not necessarily involve a concrete action but rather the full range of all our senses and capabilities. Caring is something you choose to do, not something you are. Noddings (1984) added caring is not an attribute or personality trait but rather a relation. Caring takes place when a person provides care and a person receives that care in such a manner that the one-caring experiences a motivational shift. This shift compels the one-caring to put the goals and needs of the cared-for ahead of themselves (Noddings, 1984). Rooted in this shift is the assumption that all situations have an ethical component and no two situations are identical (Hawk, 2017). There are no universal principles—there is no black and white. This motivational shift is often seen in the parent-child relationship. This shift often takes place in the school setting, as well. Teachers are the ones-caring and the students are the cared-for. Whether they are consciously aware of this or not, many educators enter the profession of teaching to engage in caring interactions and teach their students more than just academic knowledge. To my own detriment, as an elementary school principal, I have often given myself to the benefit of the students (and teachers). Not only do students have the opportunity to gain academic knowledge, they also have the opportunity to learn how to care. This is a moral perspective of the teacher-student relationship that has the potential to transform teachers, administrators, and the entire educational setting. With each of my experiences shared in this chapter, I was often unable to "care for" or provide a concrete action. Rather, I was often relegated to "care-about" and step out of my personal frame of reference and try to place myself in the frame of my students.

The Teaching Years

My teaching career began in the late 1990s during a teacher shortage and the introduction of standards in the profession. I had just graduated from college and was in need of a "real" job. Fortunately, for me, the school district in my hometown was in need of teachers. Up to this point in my life, I had given no thought to becoming a teacher. The profession was not on my radar. However, the idea of not having to work nights or weekends, and the ability to have the summer months off made the job of teaching much more desirable. I figured I would teach for a couple years until I decided to start my "real" job. I started my teaching career under an "emergency" credential. This allowed me to teach under the premise I would go back to school and obtain my teaching credential. I had 5 years to complete the schooling for my credential (it would be 3 years before I started taking any credential classes). I was the stereotypical emergency credential teacher. Most emergency credentialed teachers were novices with no formal training who had never taught in a public school (Goe, 2002). As a 22-year-old, I was handed a teacher's edition text, a roll sheet, and a "good luck." Needless to say, I had no concept of school leadership, child development, the ethic of care, or trauma-informed practices when I began working with students.

I began my teaching career as a middle school algebra teacher. Since I had no training on how to manage and instruct a classroom, I taught my class the way I was instructed during my time as a student. I focused on getting through the material and ensuring students had a lot of homework. I thought a good teacher was one that could get all students to pass the class. While educational research had long since established the need to focus on classroom climate (Dwyer et al., 2004), without training as a teacher, I gave no thought to the "culture" of the classroom or

providing emotional support for students in need. While research had emerged about the importance of remaining mindful of students' development (National Education Goals Panel Working Group, 1995; Thompson & Lagattuta, 2006), I had never considered the emotional or social developmental stages of my students. There was no consideration given toward "life" that could be happening to these students and completing 50 math problems was the least of their concerns. I just assumed all students were there to focus on my subject and, if they did not do the work, it was because they were "lazy" students or they "didn't care."

Heartbreak

It was the fall of 1996 when I stepped into the classroom as a teacher for the first time. Ironically, I joined the staff at the middle school where I was once a student. Many of my colleagues were my former teachers. It was such a juxtaposition to sit in the staff lounge listening to them moan and groan over the implementation of "standards" while I still felt awkward calling them by their first name. Not only was I in a state of transition coming out of college and entering the workforce, but the profession was transitioning, as well. Between 1995 and 1998, content standards were introduced into California schools specifying what students should be taught in every grade (Rose et al., 2006). My school was on the "bad" side of town in a desert community near Los Angeles. This community attracted individuals and families that needed affordable housing. Oftentimes, the residents moved here to move away from the issues (i.e., gangs and drugs) in their previous residence. However, many times, the issues followed.

My concept of a student quickly changed during my first year in the classroom. While I was aware of trauma and had experienced traumatic experiences of my own as an adolescent, I always compartmentalized those events and assumed they only happened to me. Although I was

unaware at the time, I was able to heal from my own personal traumatic experiences because of the support system present in my life. A supportive network of adults can alleviate the negative effects of trauma and toxic stress (Garner et al., 2012). I assumed everyone was able to work through similar events, and if they were unable to socially or emotionally cope with similar experiences, it was because they were "mentally weak." My student, Brad, changed that mindset and introduced me to the concept of trauma and its effect on student achievement, morale, engagement, and overall well-being.

Brad was a 14-year-old boy in the eighth grade. He rarely participated in class, did not appear to have any close peers in the class, never did homework, and never completed a test. He literally had a 0% as an overall grade in the class. I tried reaching out to a parent multiple times to discuss his performance. I was always prepared to give the speech about the importance of homework, their role as a parent, and his future prospects if he continued this pattern through the remainder of his academic career. As a 22-year-old kid, I was ready to tell this family what they were supposed to do and how they were supposed to do it. However, I never made contact with his parents. I was in the process of writing this kid off. I figured, if they do not care, why should I? Luckily, I learned the reason I should care.

By chance, I was able to engage Brad in a conversation one day. This conversation took place during my conference period, so no other students were around. I told him about my frustration because I was unable to get any work from him to measure what he knew. I posed a couple math problems to him just to see where his ability level was and hoped he would answer. He answered each question correctly. I then proceeded to ask him additional questions that were a bit more advanced. He answered those correctly, as well. I was baffled. Here was a student that

knew exactly what he was supposed to know, yet never demonstrated his knowledge by choice. I remember asking, “Why don’t you do your work? You could be getting an ‘A’ in the class.” His response was, “Who cares about getting an ‘A’? I don’t want to get an ‘A’.” That comment led our discussion in a different direction. Through our conversation, I learned Brad had an older brother who died 2 years prior. Specifically, he was murdered. Brad proceeded to share the specifics of his brother’s death, the investigation that followed, and the toll his brother’s death took on his family. This sharing of traumatic events without prompting is not uncommon. In fact, trauma can disrupt attachment to caregivers and cause youth to easily bond with anyone who shows an interest in them (Craig, 2017). He shared how his brother was tied to the back of an off-road vehicle and drug through the desert to his death. He shared that his parents did not seem to care about anything anymore. He felt like they had given up. The pop psychologist in me diagnosed Brad’s behaviors as a child begging for attention and support. I never tried again to reach his parents. I did not think to reach out to the principal or counselor. I figured I had the answer and there was nothing to gain from a conversation with the parents. I was too cocky in my perception of my skills and too naïve in actual skills to know any better. While I was able to get a little bit of participation from Brad after our conversation, for the most part, his behavior stayed the same. We would have an occasional quick conversation, but I was never able to “fix” what I perceived was the problem. My final memory of Brad was on the final day of school when I passed out final grades and the smile and look he gave me. I gave Brad a “D” as his final grade despite his lack of work and participation. It was one of my first reflective, individual thoughts as a teacher to give him that grade. I did not believe a failing mark was representative

of Brad's knowledge on the subject. I also thought this boy deserved a break and if giving him a passing grade put a smile on his face, I was happy to do so.

I realize this interaction with Brad enlightened me to the effects of trauma on a student. His trauma was the origin of my perspectives on trauma-informed practices and leadership that I hold today. The literature describes this phenomenon as vicarious posttraumatic growth (Brunzell et al., 2018). Vicarious posttraumatic growth is defined as positive, professional changes resulting from vicarious trauma exposure (Arnold et al., 2005; Brunzell et al., 2018; Meyerson et al., 2011; Tedeschi et al., 2015). Had I known not necessarily the specifics of his history, but that there was a history in advance, I would like to think I would have handled his lack of effort in my class differently. As I examine this reflection, I realize I failed Brad. I could have been more proactive in supporting him throughout the years. It is also important that I allowed myself grace during this reflection. As Rodriguez (2012) stated, it is important to view yourself as a continually emerging learner trying to improve at helping students. While I failed to make an immediate change in my thought process, this new knowledge obtained from working with Brad started the ball rolling toward my belief in proactive leadership. His willingness to disclose this personal experience to me demonstrated how effective and powerful an ethic of care is to an individual in need of support. Brad was my introduction to a child truly "hurting." Although this particular example does not directly portray a student committing the act of self-harm, it does illustrate the argument that self-harm may take the shape of self-neglect. Self-harm and self-neglect can function similarly in that they both can cause physical and psychological damage (Berkley, 2020).

Unaware

A few years later and a new school setting brought me face-to-face with another case of student trauma. I was now in my mid-20s and had recently married. I was in my third year as a middle school math teacher. I left my first school and the area I knew so well and was now working in an urban school district with a reputation for having "difficult" students. That reputation came from all of the White families who sent their children to private schools because they were afraid to send their kids to school with kids of color. The city had, and still has, a highly segregated school population. I loved working at this school because it reminded me of my neighborhood as a teenager. While it was true the student body was affiliated with gangs, and fights and weapons were common, this school was full of amazing students who wanted to learn and grow. What those kids did not understand at the time, and I did not fully realize until later, was that all those experiences helped equip me to handle students and their personal struggles. One such struggle formed my views on trauma and care more rapidly than others.

Nick was a 14-year-old student in my eighth-grade math class. At best, Nick's attendance was sporadic. By this time in my career, I was not as quick to throw in the towel for a student, but it was frustrating that Nick missed so many days. When he did come to class, he worked hard on his assignments and all the additional tasks given to him. He never had the necessary materials. In fact, he would ask me for a pencil every time he was there. His skills were dramatically low, and to this day, he may have been the lowest skilled student I had ever worked with at the middle school level. Each class period he was there, I would usually sit next to him to help him get through a little bit of the work.

Nick's appearance led me to assume he was not a product of a home life where a parent made sure there was a meal on the table every night or a designated space in the house for studying. Nor did it seem like there was much parental support or involvement at all. He would rotate through a few different t-shirts he would always wear with a pair of blue jeans. Nick would keep his hair tied in the back with strands of hair popping out on the sides. He looked like many of our students who came from households without a lot of extra money to spend on clothes and appearances. Every once in a while, when standing or sitting next to him in class, I would catch a smell of his body odor. It was not every time, so I figured he was like most teenage boys and would sometimes shower and choose to skip his daily grooming on other days.

His reality came to light one afternoon when he stopped by my room after school. Nick had missed class that day and he came to explain why. His explanation made all my other interactions with him make sense. It explained his absences and lack of materials. It explained why some days he was too tired to work or hungry on other days. He shared with me that his mother was an addict. Nick shared how when she would go on one of her binges, she would go through their room (he shared a room with a younger sister) and take their clothes from the dresser. She would then leave the house and go throw the clothes in a trash dumpster. She would then come home and take the little bit of food from the refrigerator and throw the food away in the dumpster. When she was done throwing things in the house away, Nick would leave the house and spend the midnight hours trying to find the dumpster where she threw everything away. He would then climb into the dumpster and fish out his clothes, his sister's clothes, and anything else he could retrieve (including food). Sometimes this would take all night and last until the early morning hours. There were times he would fall asleep when he got home and

would not make it to school the next day. On other days, he tried to clean the clothes he retrieved the night before. While Nick's story is startling and heartbreaking to read, he is not alone. More than 8 million children live in a home where at least one parent is addicted to drugs or alcohol (Lipari & Van Horn, 2017). This accounts for close to 12% of children under the age of 17. In other words, roughly 1 out of every 8 students in our schools is trying to cope with this form of stress.

I was in awe. I could not believe what I was hearing. As with Brad, I felt so helpless. I also felt so naïve. Up until this point in my career, I would have never imagined one of my students was living in these types of conditions. I have since learned the most traumatizing events youth experience tend to involve interpersonal traumas in which a child experiences victimization in the home (Charuvastra & Cloitre, 2008). Since I had never knowingly taught a student who was experiencing this type of home life, I was slow to recognize the symptoms of a student experiencing that form of trauma. The literature has suggested it is difficult for educators to develop the knowledge and skills to identify and respond to students in real schools and in real time who may be experiencing or reacting to a traumatic experience (Alvarez, 2017). Once again, I had that thought of "what if?" What if I would have known some of this information when I first started working with Nick rather than toward the end of the school year? I could have lined up supports for him sooner than I did. I could have been more helpful. How was I going to be able to help the student in need if the telling behaviors were not visible? As I did years earlier, I felt like I failed my student. Contrary to my first experience with Brad, I reached out for support this time. I knew only to reach out to my school counselor, but I never saw Nick again. I can only assume Nick and his sister were taken into custody and placed into a different

home. Perhaps something worse happened. I never asked what happened to Nick and at the time, I thought it was none of my business. I will never know if that was the right decision.

While there are lingering feelings of doubt about my role in Nick's life, there are other realizations that came from this experience. I realize I must have been projecting an ethic of care onto my students. Noddings (1984) supported this realization in his assertion that the primary aim of every educational effort should be the enhancement of caring. For Nick to share his personal struggles with me after school when he did not need to see me showed I was someone he viewed as a caregiver and ally. I also realize extreme trauma does not show up in similar behaviors. While Brad seemed to shut down after experiencing his trauma, Nick did not seem to give up. Rather, he spent all his time surviving. I see that reaction to trauma does not necessarily manifest itself in introverted behaviors. Students like Nick are why one of the principles of a trauma-informed approach is to understand many students have histories of trauma that may make them vulnerable and to incorporate that understanding into the educational practice (Carello & Butler, 2015). In fact, only a minority of youth experiencing stress or adversity will demonstrate traumatic symptoms (Alisic et al., 2014). As such, our students may not display any behaviors on the outside but struggle internally.

Here?

After 6 years of teaching, including a stint as a high school math teacher, I eventually moved on to my fourth school district. This new district had high performing schools and high achieving students. We were a year removed from the attacks of 9/11 and the implementation of *No Child Left Behind* (No Child Left Behind [NCLB], 2001). The discipline issues present in this district paled in comparison to the districts and schools I had previously worked. This district

was one where teachers longed for a job offer, and once they secured the job, they never left. For the most part, the kids managed themselves and the teachers were able to focus on the art of teaching. I felt so fortunate to be there but also felt a bit awkward and out of place. The energy level of the students was not as frantic, and they were much more subdued than my previous schools. I was not required to supervise common areas in case discipline issues arose. The student population consisted of a high percentage of Asian students. I had no experience working with this population. My experience as a student and in the first years of teaching centered on the experiences of Black, Latino, and White students. I realized during my first staff meeting I was in a completely different environment when the topic of gum chewing came up as a schoolwide "problem." I remember thinking if that was our biggest problem, we have no problems. I thought my past experiences as a teacher were exactly that—in the past.

Katie was an eighth-grade student in my honors algebra class. By all accounts, she was a typical adolescent teen. She had a great sense of humor, was very concerned with her academic performance, and had a strong network of friends. In class, Katie would ask intelligent and poignant questions. When she missed a question on a quiz or test, she would ask to come after class to review and figure out where she made her mistake. There was nothing in her mannerisms or behaviors to suggest Katie was experiencing any sort of trauma in her life. I discovered I was, once again, incorrect in assuming all was good in Katie's world.

Late in the school year, Katie stopped coming to class. At first, I thought she was ill. As the days mounted, I began to question her whereabouts. I remember asking the counselor if she had any information regarding Katie's absences. I was shocked to hear Katie was hospitalized for self-inflicted injuries. It turned out Katie was struggling with her home environment. She felt

an enormous amount of pressure from her parents to excel academically. When she did not meet the expectations of her father, he would become upset and belittle her. I learned Katie spent the entire year with me and, I assume in prior years, being emotionally abused by her father. It had reached a breaking point in her mind and she decided to take action. Katie cut herself multiple times along both of her arms. Fortunately, the cuts were not lethal and her life was spared.

I never saw Katie again. She never returned to my school and the following year she moved on to the local high school. I heard through district channels she was doing fine academically and was involved in private and school counseling. I tried to put myself in Katie's position in an attempt to figure out what I could have done to help. Knowing that 2.3% of children (U.S. Department of Health and Human Services, 2017), or roughly one student from every class period in a typical middle school or high school, experience psychological or emotional abuse would have helped me create a more supportive environment for Katie and the rest of my students. When exercising an ethic of care, it is common to engross yourself in another's concerns enough to "feel for them" and want to act on their behalf (Noddings, 1984). Noddings (1984) explained:

> Apprehending the other's reality, feeling what he feels as nearly as possible, is the essential part of caring from the view of the one-caring. For if I take the other's reality as possibility and begin to feel its reality, I feel, also, that I must act accordingly. (p. 16)

While I do not think there was anything I could have done to prevent Katie's self-harming actions, this experience once again provided evidence that my classroom needed to be built upon a trauma-informed approach. Incorporating a trauma-informed approach in the classroom is crucial to meet the needs of students who face exposure (Jensen, 2009). As a teacher, I needed to

create a climate and support system for my students on the premise that one or more of my students experienced trauma.

The Years as Principal

After almost 2 decades in the classroom, I decided to try my hand at school administration. I taught seventh through twelfth grade during my time in the classroom and it naturally made sense for me to take an administrative position at a middle school or high school. This was the age group I was accustomed to and I knew what to expect in regard to student behavior, social and emotional development, and academics. I took a job in a nearby district as an assistant principal in a middle school. As any new hire in a position, I was ready to put the skills and knowledge I acquired over the years to good use. I wanted to "show-off" my expertise of the age group and make a difference for the school and community. As fate would have it, that job lasted a grand total of 8 weeks. Soon into my stint as a middle school assistant principal, I had a chance encounter with my former superintendent. Soon after that meeting, I received a call from my former superintendent asking if I was interested in becoming the principal for an elementary school. Not only was I being asked to lead an elementary school, I was being asked to lead a school that serviced preschool through third grade students only. I could not pick a student base further away from my knowledge of student development and further away from my knowledge as a classroom teacher. My only first-hand knowledge of this age group was my own parental experience with my two children. I accepted the position and left the comfort of the familiar middle school student age group.

I have to be honest—one appeal of the job offer was my thought: "How difficult could it be?" Along with my wife, we had raised two children through this developmental phase, and as

far as I was concerned, we did a great job. Our children were "typical" by all accounts. We never faced any major roadblocks to their education, social development, or behavior. I assumed I could have that same presence or control over an entire student body. I learned the naiveté of my arrogance very early on.

As I did at the beginning of my teaching career with no formal knowledge of how to interact with my new clientele, I administered the same way I was accustomed to seeing administrators work. I was very disciplinarian with the students in the beginning because I was used to seeing that type of behavior from a secondary administrator. As I think back, the teachers loved it. I replaced a principal who was viewed as "soft" when it came to student discipline. The teachers believed students could do whatever they wanted and get away with it (ironically, the teachers did not turn that analysis inward because they also believed they could do whatever they wanted and get away with it). I mistakenly believed if I was a tough disciplinarian, I could "scare" the kids into behaving properly. As far as the students were concerned, I believed the biggest issues I would encounter with this age group would be issues with sharing, friendships, homework, and "not playing fair." I truly believed I had left behind the traumatic concerns my students had experienced during my teaching days (and the short stint as an assistant principal). I compartmentalized my experiences as a teacher as only applicable to a classroom setting. I mistakenly did not take what I had learned in the classroom and immediately transfer that mindset to an entire school culture.

Wake-up Call

In 2017, I was in my third year as the principal of the preschool through third grade elementary school in the same district where I learned over a decade earlier that gum chewing

was the scourge of the campus. I was now in my early 40s and still actively parenting my two children who were students in my school district. President Trump had recently taken office and there was a sense of tension and fear among the staff and the Asian and Latino communities that my campus served. Parents shared their fears of being deported and their children being singled out.

During my third year as principal of this school, I started to feel confident as a site administrator. The responsibilities of the position were somewhat routine at this point. In addition, I was transitioning from the perception of myself as "an elementary principal who came from the middle school" to just "an elementary principal." This change in perception was taking place because of how I communicated with the students, parents, and staff. As the principal, I made sure to be visible each morning and afternoon for the parents. During the school day, I made sure to be visible when the students were outside for the staff and students to witness. I made it a point to have an "open door policy" and when I spoke with parents and staff, I made sure to be open and honest in order to build trust. While others were shifting their perceptions of me, my own mindset and perspective of the job were also transitioning. I now understood the role of the elementary setting as developmental, nurturing, and foundational for the upcoming academic years. For the most part, student behaviors fell within the spectrum of what I expected. I considered myself fortunate during administrative meetings when my colleagues from secondary schools would share stories of their students involved with narcotics, fights, sex, and self-harm. I remember thinking to myself, "I'm glad I don't have to deal with those things." For the most part, that thought was true.

Towards the end of the school year, I was given a note from a third-grade teacher attached to a student drawing. The note simply asked, “Have you ever seen this?” I then opened the folded paper of the student’s drawing to reveal a student’s hand-drawn version of characters from a popular children’s show hanging from a gallows. An image depicting children’s characters hanging from the gallows with blood coming out of their mouths obviously disturbed me. I immediately held a conference with the student (Courtney). I was ready to discipline Courtney and have a talk about how inappropriate the picture was for school or any setting for that matter. During the discussion, Courtney shared he could hear voices in his head and that he “wanted to die.” I had heard that phrase in jest many times from my middle school students when they were embarrassed or being dramatic about a mistake they made. I had never heard a calm 8-year-old boy make this declaration in a very serious tone. His calm, blunt declaration aligned with the research that students can gain an overwhelming desire to self-injure to the point where they feel like they can no longer control the behavior (Tracy, 2012). The conversation became more disturbing as he shared with me that he “practiced” cutting himself with plastic knives. Once our conversation ended, I contacted the Psychiatric Emergency Team (PET) and Courtney’s parents. After a brief evaluation, Courtney went home under the care and supervision of his parents. Courtney missed the next day of school but returned a day later without further incident. The year ended and he moved on to the next school (my school ends at third grade).

I sat back and reflected on what happened. Looking back, I admit I was somewhat dumbfounded and amazed I had a preschool through third grade primary elementary school student vocalizing suicidal and self-harming thoughts. I was completely caught off guard. I had no idea students at this age could comprehend, let alone act on, notions like suicide and self-

harm. This original viewpoint of mine conflicted with past studies that have shown self-harm does occur in this age range (Meltzer et al., 2001). At the time, I remember thinking, "Was Courtney an aberration? Were his feelings a result of something we were doing or not doing at school? Did I have other 'Courtneys' on my hands and not know it?" Those were the questions flying through my mind as I reflected on my first encounter of a young child and self-harm. During the 3 years I knew Courtney, he was a student staff described as "off" or "weird." Up to the discovery of the picture and the ensuing parent conference, I had only ever interacted with his mother with no knowledge of a father until the day of the event. Studies have shown the role of the father is important to the formation of a child's healthy state of mind (Jin & Lan, 2014, as cited in Zhang et al., 2019). In fact, father involvement reduces impulsivity and violent tendencies in children because fathers' interactions tend to require movement and strength. In turn, these interactions allow children to experience a wider range of emotions and gain new intrapersonal skills that help them cope with internal feelings (Zhang et al., 2019). I fell into the trap of explaining this incident and Courtney's behavior away as a parental issue. To me, this incident was so far out of my expectation of normalcy for this age group that the only logical reason was lack of parental involvement. Assessing that train of thought now, I realize that logic was only a self-defense mechanism to explain away my uncomfortable reality. Purvis et al. (2012) shared well-intentioned caregivers may not at first realize the significance of trauma-informed practices and principles for their work with young children. I now realize I was terrified to admit I may have a problem at my school. Simm et al. (2010) argued educational professionals tend to label the topic of self-harm as 'taboo' and feel it belongs 'over there.' I soon learned Courtney's experience was not an isolated event.

Wait, There Is More

Aaron comes from a family with five brothers and sisters. His oldest brother suffered from cerebral palsy, his mother was perpetually pregnant, and his dad was rarely home because he was the sole income source for the family and would work long hours to make ends meet for the family. I share these facts not out of judgement, but rather to show Aaron's family had a lot on their plate. It is important to note this family dynamic is not only unique to Aaron. As of the year 2019, an estimated 2.6 million families had at least one child with a disability living in the home (Young, 2021). Aaron was quiet, reserved, and often kept to himself during unstructured playtime. Aware of his family situation, he was a student I would keep an eye on during the school day. I was worried he was alone because the other students ostracized him. In reality, other students often asked Aaron to play, but he would either quietly decline or just walk in the opposite direction. He always looked like he had a lot on his mind.

The year was still 2017 and we were in the early months of the new school year. I was 5 months removed from the incident involving Courtney. My focus was all over the place as I was actively involved in my oldest daughter's senior year of athletics, helping her prepare for college, and personally looking into returning to school to advance my education. Needless to say, my lens was pointed a bit inward.

Aaron's mother was someone I spoke with frequently because she had a difficult time getting Aaron to school on time. She would share her difficulties getting all her kids to their respective schools in the morning, including her son with special needs. Giallo et al. (2012) argued for possible stressors children like Aaron may experience:

> It is widely acknowledged that siblings may experience stressful life events that predispose them to poor psychosocial outcomes. Many disruptions and changes to family time and routines are often experienced, including time spent attending appointments and engaging in medical or therapeutic interventions. Their brother or sister may have extensive caregiving needs that demand the attention of their parents, or siblings themselves may have caretaking responsibilities. Often, the home environments of these children are stressful, and their parents may experience health and well-being difficulties. (pp. 36–37)

As a result of these conversations, Aaron's mother was comfortable sharing the honest details of their home life with me. Some of those details were shared when she scheduled a morning meeting with me. In examining the notes of this meeting, Aaron's mother shared that Aaron was hurting himself at home and repeatedly screaming, "I don't want to live" on multiple occasions. In those same meeting notes, his mother also shared that Aaron, her 7-year-old son, was taking a fork and stabbing himself in the forearms hard enough to break the skin and cause himself to bleed. Aaron's mother was not looking for an explanation or to cast blame. Rather, she was asking for support for her son, both professionally from an outside source and internally at school. By this point, I had made a few connections with individuals in the mental health industry through boards and panels in which I participated. I was able to connect his mother with an outside counseling agency. Aaron began counseling sessions soon after introducing the two parties. In addition, I immediately began having my school counselor meet with Aaron each week to discuss his emotions and behaviors.

Aaron's incident(s) struck a different nerve than Courtney. While Courtney's imagery and talk were disturbing, his actions were only talk. Aaron, on the other hand, physically stabbed himself and caused damage to his own body. As Best (2006) explained, even an abstract level of knowing that individuals self-harm is not the same as being actively aware. Once again, I tried to explain the incident away as a "cry for attention." For my emotional safety, I minimized this experience. I accepted the myth that self-harmers are attention seeking and that the severity of the injury is the true measure of how serious the problem is (Simm et al., 2008). At the time, I still had not reached that point of self-reflection where I could examine my role and the school's role in this newly appearing trend. I see now that I was not demonstrating an ethic of care by explaining away Aaron's experience. In alignment with Hawk (2017), I had failed to take that ethic of care I displayed in the classroom as a teacher and successfully transfer it to an out-of-classroom context. The cultural change I would eventually want for my campus was not yet clear to me. The change process, whether individual or organizational, requires readiness on behalf of the participant(s) (Purvis et al., 2012). As I would eventually realize, transformative leadership may be developmental, requiring multiple experiences to achieve.

Not Just for the Boys

The calendar had just turned to 2018 and I was still in the throes of parenting two high school daughters. In addition to all the chaos in my personal world, our school district was reeling from internal strife that resulted in the departure of all district leadership, including the superintendent. I was literally on my own in terms of leading the school. I had no mentor to guide me nor anyone supervising me to make sure I was doing everything correctly. I was flying solo and I liked it.

When you work with students at such a young age, you tend to see all body shapes and sizes. It is not abnormal for a girl to be the tallest in the class or a boy to be smaller and thinner than his classmates. As a result, I do not put too much stock in body size. That said, as an adult working with children and mindful of obesity rates in the United States, I worry when I have a young student who is extremely overweight. Similarly, I worry when I have a young student who is extremely undersized. Research has shown eating disorders have steadily increased since the 1950s and obesity in children has increased dramatically in the past decade, leading to an emphasis on dieting and weight loss among children (Rosen, 2010). In my role as an educator, I often educate students and their families on proper nutrition and eating habits. However, children of this age do not usually have defined muscle tone and therefore look "thin". Riley was a second grade girl who physically looked like all the other girls in her grade. There was nothing in her appearance that alarmed me or the other staff members.

Riley came to my attention when she wrote "I look ugly" on one of her classroom papers. Her teacher thought it would be a good idea for me to talk with Riley. As a father of two girls, I was comfortable talking with Riley about self-image and felt capable of handling any topic that would come up during a conversation. However, I was unprepared for the tidal wave of emotions and thoughts Riley shared. I remember asking the question, "Why do you think you look ugly?" Little did I know the comment she wrote on her paper was not a knee-jerk reaction to something that happened that day but rather a consistent and daily recurring thought. In vivid detail, she described for me how she viewed herself in regard to her weight and body shape. During our conference, Riley shared that she believed she was overweight and wrote down on my note pad that she was "round and fat." Her self-disgust went beyond her body and included her clothes

and her hair. As a principal, I always look to solve problems. I remember feeling concerned but also figured there was not yet a "problem" I could solve. That conclusion changed after a few more discussions with her mother and teacher.

I called Riley's mother in for a conference and shared some of the issues Riley was dealing with on a daily basis. In the notes from this conference, her mother shared her concern that Riley was coming home lethargic every day and not eating much at dinnertime. I asked the usual questions about sleep patterns and morning eating habits. Her mother assured me everything was normal and that she sent Riley to school every day with a packed lunch. Later that day, after the conclusion of the conference, I shared with Riley's teacher the concerns Riley's mother brought up. Upon further discussion with the classroom teacher, the teacher mentioned Riley never had lunch. It was not until my follow-up conversation with Riley that I learned she was throwing her lunch away in the trash after she arrived to school and was not eating throughout the day. I immediately went into problem solving mode but also wanted to be sensitive to the topic. Having two daughters, I was completely aware of how food and eating patterns could be a sensitive topic. The teacher and I agreed the teacher would now ensure Riley had something to eat each day. If not, she would notify me and I would make sure the cafeteria provided her lunch. In addition, I made the cafeteria staff aware to be on the lookout to make sure Riley had something to eat each day in case the teacher missed it. This approach of involving multiple stakeholders is consistent with the research that has shown you should work from a team perspective when responding with care to students facing trauma (Souers, 2018). Lastly, after explaining our plan to Riley's mother, I asked for approval so that Riley could see our school counselor each week. This time, I included Riley in the plan. Nothing was hidden

from her. Riley was completely aware that the teacher, cafeteria staff, counselor, and I would be looking out for her to make sure she was safe and healthy. It is important for children to have the opportunity to learn how to care (Goldstein, 1998a). My hope was that this would provide a sense of safety and understanding that she would not get away with not eating.

Once again, I was amazed to work with a student exhibiting behaviors I thought were only possible among adolescents and adults. Whether it was increasing in fact or in awareness, self-harm in students requires examination (Best, 2006). I did not expect to have an 8-year-old student on campus starving herself because of her distorted self-image. Although I may have been unaware that eating disorders were prevalent in younger children, the Agency for Healthcare Research and Quality (2009) reported hospitalizations for eating disorders have increased by 119% for children under the age of 12. It is estimated roughly 5% of adolescent girls have an eating disorder (Rosen, 2010). In my immediate reflection of Riley's predicament, I connected her behaviors to those of my other students exhibiting extreme behaviors. However, once again, I viewed Riley's behaviors as more of an outlier and not symptomatic of a larger problem. The way the self-harming behavior was viewed influenced the way the issue was managed in the school (Simm et al., 2008). Reflecting upon it now, I realize Riley depriving herself of food was a form of self-harm. Girls are most likely to self-harm as an act of self-hatred or self-punishment (Simm et al., 2010). Strong emotional reactions, such as low self-esteem and self-hatred, are common psychological effects of self-harming acts (Tracy, 2012). Even more so, I now realize Riley's behavior may have been a symptom of a deeper concern.

Katie 2.0

Within weeks of becoming aware of Riley, another second-grade girl demanded my full attention. I first met Taylor before she was a student at the school; her older sister also attended my school. Taylor was the youngest of two daughters and a pleasure to be around each day. For the first 2.5 years as a student, she always appeared happy. She was kind, often volunteering to play with a child with special needs or talk to a classmate who was sad or lonely on a particular day. When not at school, Taylor and her mother conducted a clothing drive to help others. She was an extremely selfless young lady—one every teacher would love to have in class. What I was unaware of was that her parents were going through a divorce and Taylor was struggling to cope with the effects of their separation.

I became aware of Taylor's struggles through my daily communication with her mother when I would see the family in the morning. Taylor's mother informed me of the divorce and that Taylor was having a hard time not having her father at home. It is common knowledge that many marriages end in divorce. In fact, Wolchik et al. (2000) estimated approximately 40% of U.S. children will live in a divorced household by the time they are 16 years old. It is also estimated that roughly 1 out of every 4 children involved in a divorce will experience long-term mental health and behavioral problems (Hetherington & Kelly, 2002). I told her mother I would keep an eye out for Taylor to see if she was showing any distress at school. In addition, I asked if I could share this information with Taylor's teacher. My hope was that by triangulating (parent, teacher, principal) the attention on Taylor, we could support and catch her at the onset of an emotional or behavioral breakdown or even prevent those behaviors altogether. Once again, I was wrong. Although I was strategic in implementing a loose supportive structure for Taylor, I

could not prevent and protect her at all times. Shortly thereafter, Taylor's mother informed me she was trying to find professional counseling for her daughter. I applauded her decision and offered my support for Taylor and her sister. I remember asking what brought about this decision. That is when I learned Taylor started cutting herself at home. Her mother discovered Taylor with cuts along her upper arms and torso. It turns out Taylor would grab any object with a sharp edge and dig that object into her skin. Through her mother, I learned this behavior was relatively new and discovered early on. Thankfully, Taylor immediately began seeing a professional counselor. While Taylor's physical acts were startling for her mom and me, her emotional reaction was not uncommon to children struggling with parental divorce. As Garg et al. (2007) stated, depending on the mental state and resources of the parent, children of single parents may feel their emotional needs are going unmet, increasing the risk of adjustment problems. Furthermore, the disruption in routine and possible parenting inconsistency can contribute to the child's emotional instability and insecurity.

Perhaps it was my familiarity with the family or Taylor's openness and willingness to talk, but I talked with Taylor about her therapy. I would not get into the specifics of their discussions or the events that led to her finding counseling but rather an overall discussion of her therapy. I would ask if it was going well and if she liked it. I wanted to acknowledge that this was now part of her life, just like every other aspect of her life. As I examine that decision to engage in that type of conversation with a student, I realize I was modeling an ethic of care. When caring for students, educators need to know their students well enough to know their unique experiences, motivations, and needs (Rabin & Smith, 2013). Taylor seemed willing and happy to share and I think it gave her a sense of normalcy. While Taylor's actions took place at

home and I had no way of preventing her from hurting herself, I somehow felt a sense of responsibility. When not in control, caregivers can feel an intense degree of failure (Lucas, 2007). What was I doing wrong? How could a school site administrator prevent behaviors at home? Was it even within my "jurisdiction?" What in the hell is going on this year? These were the questions flying through my mind. As I look back, I am still unsure whether I could answer some of those questions. Educators are often caught up in the minutia and challenges of the situation (Souers, 2018). I think that may have been the case with me. I should have taken a step back and examined a wider perspective.

Can it Get Any Worse?

During my tenure as elementary school principal, I have had the opportunity to learn and grow professionally. Becoming the principal of a preschool through third grade environment has provided the challenge of working with an entirely new age group. Working with a staff made up entirely of women also presented new challenges I had not experienced at my previous schools. Just the day-to-day paperwork and logistics of running a school were learning curves. However, the biggest hill for me to climb as an administrator was my knowledge, implementation, and management of special education and the laws therein. Upon my arrival in 2014, my school was the home to all of the school district's special day classes (SDC) from preschool through third grade. I had students on campus whose disabilities ranged from minor speech impairments to nonspeaking, nonambulatory children with feeding tubes. I soon grew to love this aspect of my job and the children in the program. Each and every day was truly unique when working with this population of students.

Daryl was one such child in this program. In 2014, I met Daryl as a 4-year-old preschool student. On paper, Daryl did not present as a student with a "major disability." He had a bit of a lisp and trouble producing some sounds. He was born with a cleft palate, which contributed greatly to his speech difficulties. Daryl's home life was anything but traditional. His father was in and out of jail. His mother left his great grandmother who was in failing health to raise him and his siblings. Meanwhile, the mother had a new baby and chose to raise and keep the new child. Daryl would rarely see his biological parents because the great grandmother had custody and often refused to let Daryl see his mother and father. Needless to say, this was a great amount of trauma for one child to handle. Daryl is 1 of 15 million children in the United States who experience at least two adverse childhood experiences (Robert Wood Johnson Foundation, 2017). Exposure to consistent trauma and stress over a period of time can greatly impact the social-emotional, cognitive, and academic growth of a child (Ganzel & Morris, 2011). Daryl would verbally and physically assault others to take out his frustration at school against his peers and the adult staff members.

Daryl and I would spend the next 5 years attached at the hip as I was often called in for support to calm Daryl down during one of his tantrums. Although his tantrums were often severe and violent, they were always directed externally. He would try to hit, spit, choke, or throw things at the adult or classmate. He would cuss and say things like "you're ugly," "I hate you," or "you're stupid." This began to change during his final year at our school. His tirades began to turn inward. Daryl's phrasing went from "I'm going to kill you," to "I want to kill you," to "I want to die," to finally, "I'm going to kill myself." His physical behaviors also morphed into self-harming behaviors. Daryl would hit himself in the face or run into the classroom wall and

start slamming his head against the wall. These outbursts would be so severe that staff would have to intervene for Daryl's safety. Staff quickly learned to remove objects, especially sharp objects, from sight during his tantrums, as Daryl would grab the objects and begin stabbing himself with them. Here was a student unraveling in front of my eyes and I felt helpless. Every effort of mine to get Daryl help was met with push back from his caregiver. When I would share the events of a day with his guardian, I was called a "liar," and told, "You made him do that!" Just like the others, I was at a loss with this case, but for a completely different reason. Unfortunately, there was no happy ending to this story from my perspective. Daryl continued with his behaviors and the caregiver continued with her responses up until his final day on campus.

Looking back, I realize I was caught up in the sheer number of times I was called in for support and the intensity of Daryl's harming behaviors. The continuous barrage of outbursts in conjunction with the disregard of the guardian created anger and animosity within me. I was so mad at the guardian for accusing me of fabricating 5 years' worth of lies that I took my focus away from the real issue—Daryl's trauma and how he presented that trauma. If educators do not create caring relationships, they will fall back on quick-fix measures to gain student compliance instead of creating a care-focused student environment (Bondy et al., 2007; Rabin & Smith, 2013; Rosiek, 1994). That is exactly how I failed Daryl. I know now that I cannot get caught up in the severity of the symptoms but must rather focus on the severity of the cause(s). Because of that misstep, I did not originally connect the dots between Daryl and the other students at my school exhibiting self-harming behaviors. Upon reflection, I can now see Daryl was one more student at my school suffering from trauma and should not have been considered an outlier.

Gasp!

The month was April of 2018 and I felt like a boxer standing in the middle of the ring after taking countless uppercuts from all directions. I felt confused and dysregulated. A short-term impact can be felt when deep, empathic engagement (ethic of care) with a suffering individual(s) brings on an immediate case of compassion fatigue (Bober et al., 2006). The events of the past months and stories of my students suffering from their respective traumas seemed to be perpetually present in my mind. Courtney, Aaron, Riley, Taylor, and the ever-present dealings with Daryl left me stunned and somewhat numb. At the time, I did not have the vocabulary to explain what I was feeling. I now believe I was experiencing a sense of compassion fatigue. Compassion fatigue can occur when the exposure to events that require such endurance are constant (Zartner, 2019). Despite the mental and emotional exhaustion of learning these truths about my students, I continued to question: Had trauma and self-harm always been this prevalent at the schools I worked in as a teacher? Did this occur every year at my elementary school? Was this the first time I noticed? Was there something in the water? I continuously tried to figure out the answers, as if answers were possible. The knockout blow was about to land and put me down for the count.

Jordan was a third-grade boy just like any other third-grade boy. He liked to run around at recess with his friends. He was starting to pay attention to how he was dressed and if he looked "cool." You could tell he was beginning to mature just a bit earlier than most of his peers. He was always smiling whenever I would see him on campus. In the classroom, he was neither the strongest nor weakest of students. He was just an average kid. My relationship with his mother was not the best. Although I never said anything to her, I thought Jordan's mother was

teaching her son to play the victim and always blame everyone else for any perceived shortcomings. Throughout the first few years of his academic life, Jordan would miss too many days of school. When I would speak to Jordan's mother, she would get defensive and always have an excuse ready. It was always the fault of the teacher or another student. Jordan's mother was raising Jordan by herself and doing the best she could. Jordan's mother would fall in and out of jobs and I think finances were an issue. Based on what I know, Jordan's father was not a fixture in his life. All of this to say, on the surface, Jordan seemed to do quite well despite the troubles of his home environment.

That all came crashing down one morning when Jordan's mother requested a meeting with me. I remember thinking, "Here we go again. What is she going to complain about this time?" His mother came into my office, sat down, and just looked at me. It was a different look than I had seen from any of my parents before. His mother started to talk about Jordan and how he was being bullied at school. I was about to share with Jordan's mother that I had never witnessed any acts of bullying nor did Jordan ever show any signs of being upset at school. Before I spoke, I noticed Jordan's mother began to tear up. Something inside me recognized there was something going on behind the scenes besides accusations of bullying. When I asked, "Is everything okay?" his mother started to cry. She informed me Jordan was in the hospital and under medical supervision. Jordan had taken a rope and attempted to hang himself by the ceiling fan in his bedroom. Research has suggested children under 12 tend to use less complex strategies such as hanging when attempting suicide (Tishler et al., 2007). Fortunately, according to the statements his mother made during the meeting, Jordan made so much noise in the process that Jordan's uncle, who was at the house supervising Jordan, went back to Jordan's room to see what

all the noise was about and found Jordan. His mother never shared a hypothesis of why Jordan attempted suicide. She never placed blame on the school or any one individual. I never saw Jordan again. After his hospitalization, Jordan went on independent study and eventually moved from the area.

I do remember sitting alone at my conference table after my meeting with Jordan's mother. I remember silently staring down at the table in shock. Educators whose role is to provide support, services, and resources are susceptible to vicarious trauma (Bassett & Taberski, 2020). Although I was connected to a failed attempt in the past with my student Katie, I never experienced emotions as I did that day. The sheer age and developmental level of a third-grade student attempting to hang himself was a shock to the system. Over the course of 2 school years, just as Brad had done 2 decades earlier, my students forced a realization upon me—young students experiencing trauma are capable of self-harm. These experiences not only changed my perspective, but hopefully the lives and perspectives of my staff and students, as well.

The Initial Change

While I know my leadership will continue to change and adapt as time moves on, those experiences with my students have enlightened me to a phenomenon I did not realize existed. I use the word "enlightened" because I believe it best describes the change in my leadership. In my opinion, enlightenment is the process in which one develops socially, psychologically, and possibly spiritually. It comes from thinking for yourself, accepting new knowledge, and recognizing a reality that one was not previously aware. In my reflection, then and now, I accepted the new knowledge that primary-aged students both think and act on self-harm. Self-harm was not the property of teenagers and adults. I was now aware this reality existed, and it

existed in my backyard. I was enlightened. The next question I had to ask myself was, "Now what?" Information is only useful if you choose to do something with it. I knew I needed to change something. I was unsure what needed changing—myself, the school environment, teachers, parents, academic workload, or society's expectations. I just knew something had to change.

As with everything else in my professional career, I was going off gut instincts. In my teaching credential program, neither trauma-informed classrooms nor care were discussed. Occasionally, the term "whole-child" would be mentioned with no tangible explanation of what that really meant. The focus was on lesson planning and classroom management. During my administrative credential and master's program, we would talk about analyzing data, organizational leadership, and the law. There was no discussion of trauma-informed leadership or an ethic of care. In no way am I blaming my training programs, as there are too many aspects in any profession to cover in entirety during training. My point is only that I now had this serious dilemma on my hands with no formal training to fall back on.

The first problem-solving step I chose to take was a serious self-examination. Was there something I was doing or not doing as a school leader to contribute to these experiences of my students? I believe I had been so consumed with the logistical aspects of the job and so worried about showing everyone I was a capable principal that I did not focus on prevention. I remember my first few years as a teacher was spent teaching the way I was taught. I learned how to control a classroom of kids, organize my thoughts, and pace information while adhering to the bureaucracy and mandates of the profession. After a few years, the daily activities of a school day became second nature and I was able to examine my practice, reflect on my pedagogy, and

begin to change my teaching style. The same held true for my first few years as an elementary principal. I modeled my style after administrators I admired and focused on smaller tasks that could be accomplished quickly and noticeably. I worried about the physical appearance of the school and the logistics of traffic patterns. Similar to how I was as a teacher, I was trying to survive while learning all of the administrative minutiae that came with the position. In some ways, I am very fortunate the incidents described within took place after I had a handful of years under my belt. Not that I was the wise-old sage with all the answers, but I was at a point where I was no longer focused on the trivial aspects of the job, but rather I was starting to examine the deeper aspects of the job and ask "Why?".

Having had experience trying to implement a few different programs at my school, I learned my teachers often did not see value or importance in the same way I saw value and importance. The same held true in this instance, as well. I knew if I asked each and every staff member if they were concerned about our students self-harming and whether we should do something to prevent self-harming acts from taking place, each person would give a sincere affirmation. However, I also believed if I universally implemented a "solution," it would be viewed as a "knee-jerk" reaction to a few isolated incidents and staff may view it as "another thing" teachers and staff would have to fit into the school day. In previous years, I may have succumbed to this train of thought. However, these interactions with my students changed my perception of what was important. I had a new image of reality and new focus on what was important to our students and staff. That focus—the social and emotional well-being of our students and staff—was unwavering. The transformation in my leadership had begun to take a more authentic leadership style. I now had a clear focus and passion to change our school

environment. Those instances with students who were engaging in self-harm or reacting to trauma who had revealed their inner struggles transformed me from an elementary principal focused on keeping the ship afloat to one focused on giving the ship a destination.

Now that I had my purpose, I needed to convey my thoughts, hopes, and wishes to the staff in a way that garnered their support. I needed to massage the message into the fold. It was not that I thought the staff would disagree with the importance of caring and prevention. Rather, I was worried staff would view my newfound objective as another program to implement. As I reflect on how I began implementing a trauma-informed approach at my school, I think it was a mistake and I feel guilty I was not direct in calling it a trauma-informed approach. I never shared these stories about the students with my staff. I never shared with them how these students changed my view of the purpose of leadership. I should have given it a name and us a common language. Perhaps I did not give my teachers enough credit to understand the concept, see the value, and implement trauma-informed practices throughout the school. Looking back, that may have been a mistake an inexperienced principal made. In essence, I tried to hide the vegetables in the food so my teachers would not know they were eating them.

I began introducing trauma-informed practices at my school through a fortunate instance of serendipity. Debra, a second-grade teacher, mentioned to me that she would like to start holding morning meetings with her class each day. She asked if I would be okay with the practice, and if so, would I be okay with her reaching out and sharing the idea to other teachers. I had my opening. Morning meetings are educational practices that foster community and empathy, along with social and emotional skills (Responsive Classroom, 2016). Traditionally during these meetings, students would share information about important events in their lives.

This time also provided students with the opportunity to improve their listening skills and provide support and empathy to their peers. They created a welcoming and nurturing classroom environment where all students could share and be heard. In essence, this was a trauma-informed practice a teacher suggested. No longer was I the mean administrator implementing a top-down approach of a new program. Rather, I was the supportive administrator fostering the creative ideas of one of my teachers and helping that idea spread over the campus. The spark had been lit. It was now my job to fan the flames.

One of the lessons I have learned as an administrator is there is no universally loved and accepted idea. I have also learned if you earn enough support on one side of an issue, that support will go far to quell naysayers. I had confidence that my strong, creative, and energetic teachers would follow Debra's lead. I also knew I had some teachers who would need a bit more prodding to try something new. Within that small cohort of resistant teachers were a couple of strong personalities that loved to share their opinions. To offset their resistance, I decided to garner the support of my biggest group—the parents. I held a meeting one evening to share data about the school and answer questions. There were about 200 parents in attendance. During this meeting, I decided to speak candidly with the parents about my perspectives as their principal. I shared how state, district, school, and individual families' expectations weighed heavily on our teachers and students and created a large level of stress. While not citing specific examples, I shared with the parents that I have seen the negative effects of that stress on our students. I also acknowledged our school had a responsibility to educate their children. I also shared that I believed an important part of that education is social and emotional education. As I was speaking to my students' parents, I suddenly realized the way I wanted to verbalize my wishes for the

school and my students—in a nonthreatening way understandable to all. I said, “When your student leaves this school, I want them to be able to read, enjoy going to school, and be good kids.” For me, this saying encompassed all my wishes for our students. Reading is that fundamental skill that must be achieved to succeed in any aspect of life. “Being a good kid” referred to social skills like sharing, being kind, helping others, and standing up for each other. I shared that “enjoy going to school” meant I wanted kids to feel welcome, safe, relaxed, and with a sense of ownership at school. I continued by sharing that in order to achieve these three wishes, social and emotional learning (SEL) needed to take place during the day at school. I shared my vision for the school was everyone cared for each other, including the principal, teachers, parents, and students. This was the first meeting I ever held as a principal where I received an immediate and resounding positive response. The parents were overwhelmingly in favor of this vision.

I shared my new slogan with my staff in the ensuing staff meetings and have repeated it many times since. I explained to all staff members what I meant in each of those three parts of my slogan. I shared what I wanted for the school with anyone willing to listen. Each time I share that slogan, I think about how I arrived at this vision for my school. I no longer think of those students as much in terms of their individual story, but rather a collective force that moved me to adapt, transform, and become a more authentic leader. I have realized if we are going to prevent history from repeating itself at our school, a sense of caring for the individual needs to be at the root of all we do in and out of the classroom. The majority of my teachers began trying some form of SEL during the school week, if not daily. As a school, we were well on our way to a cohesive, consistent implementation of a trauma-informed practice. The campus culture was

beginning to change and teachers were beginning to see the value of a trauma-informed approach.

CHAPTER 5

NOW WHAT: A CRITICAL ANALYSIS

You have so much pain inside yourself, you try and hurt yourself on the outside because you need help—Princess Diana (Bashir, 1995, para. 62)

The purpose of this autoethnography was to examine the change in my leadership as an elementary school principal due to experiences with primary school children who engaged in acts of self-harm. To be exact, this autoethnography aimed to answer the following research questions:

1. How have my experiences of students who self-harm at a young age impacted my leadership as an elementary school principal?
2. In what ways did I implement the concepts of trauma-informed, caring, transformative leadership at an elementary school suffering from the phenomenon of young children engaging in self-harm?

During this process, I chose to immerse myself in a reflective recollection of past events. This self-examination was enlightening and, at times, disconcerting. The purpose of this final chapter is to analyze the autobiographical data describing the self-harming incidents of my students, how those incidents changed my leadership perspective, and the new implementation of trauma-informed practices at my school. I discovered my journey of understanding, acceptance, and awareness paralleled the experiences of other educational professionals who have experiences with self-harming students. The more experiences you have with self-harming students, the greater your ability to recognize these behaviors in other students, which in turn leads to an increased understanding and awareness of actions that must be taken (Simm et al., 2008).

It is important to note during this reflective journey of my leadership and implementation of trauma-informed practices at the school, the COVID-19 global pandemic took place (Centers for Disease Control and Prevention, 2021). On March 13, 2020, my school district closed and in-person learning halted for my teachers and students. While the pandemic and subsequent school closure did not alter my leadership from the authentic style discussed in this narrative, the pandemic did halt the implementation of the in-class, trauma-informed and schoolwide practices. Yet, my experiences and resulting transformations still hold true. Using an autoethnographic process, I am responsible for narrating my past experiences in order to interpret my consciousness in the present (Belbase et al., 2008). The sudden and drastic change to my school environment does not lessen those experiences that led me to this point. Moreover, as this critical reflection of my leadership includes a review of trauma-informed approaches, the lessons learned are likely informative as the world recovers from COVID-19. The pandemic has impacted over 33 million U.S. citizens and has been a source of trauma for many families who have lost loved ones, lost jobs, had to relocate, or experienced isolation. Recent research is only starting to indicate the impact COVID-19 has had on young children, from "learning loss," to lack of access to meals, to increases in neglect and domestic violence (Kidman et al., 2021). Thus, the timing of this study, while challenging, will hopefully provide transformative practices that my school community will need after COVID-19.

Insights

I chose to use an evocative autoethnography as the tool to analyze the social phenomena of self-harming students in my school because it allows for an examination of my singular topic. Evocative autoethnography allows readers to connect with the researcher's feelings and

experiences (Méndez, 2013). Foley (2002) advocated for more reflexive and narrative practices to bridge a gap between research and ordinary people. The goal of this study is to share my experiences and analysis of those experiences with the aim of affecting change elsewhere. As Bochner and Ellis (1996) stated, "On the whole, autoethnographers don't want you to sit back as spectators; they want readers to feel and care and desire" (p. 24). Perhaps Vergara (2017) said it best when she claimed an evocative autoethnography is the ideal research tool because it has the potential to change societal values. Moreover, this method of study forced me to examine my role as elementary school principal (if any) in the instances of my students self-harming and determine: What could I have done to prevent those occurrences? What should I do in the future to reduce the likelihood of additional occurrences? How have those events changed me as a leader? With these questions in mind, a group of themes emerged that guided the analysis in this chapter. It is my hope that with this research, educators will begin or continue discussions about students self-harming, especially within the context of elementary schools, and provide recommendations to educators who wish to provide social and emotional support to their students.

Awareness

One of the first themes that appeared to me through the analysis of my narratives was awareness, or my lack thereof. With the exception of Daryl, I was unaware those individual students were experiencing traumatic events that would lead them to the notion of self-harm. I think it is even more accurate to say I was aware of traumatic events that occurred in the lives of some of those students (i.e., divorce) but projected my coping skills onto those students. I assumed since they were not exhibiting demonstrative behaviors at school, they must be coping

with life adequately. I also think my lack of a clear understanding of what self-harm looked like at the onset of these experiences affected my responses. There is a general lack of consensus when it comes to defining self-harm (Simm et al., 2008). I now realize self-harm may come in the form of stabbing or cutting but may also take the form of self-starvation. Including self-starvation as an act of self-harm goes against the literature that has shown eating disorders are a separate category (Best, 2006). I understand eating disorders are placed in a separate category, but listening to Riley and hearing how she was depriving herself of food solidified that behavior as an act of self-harm. She was deliberately committing an act that was harming her body.

Toxic Stress

The narratives of these children contained one common element—toxic stress. Stress is a word people commonly use every day. Stress is a response to the demands we encounter on a daily basis throughout our lives (Franke, 2014). Toxic stress takes place when the response is strong, frequent, or prolonged (Harris, 2018). Harris (2018) stated:

> Toxic stress response can occur when a child experiences adversity – such as physical or emotional abuse, neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship – without adequate adult support. This kind of prolonged activation of the stress-response system can disrupt the development of brain architecture and other organ systems and increase the risk for stress-related disease and cognitive impairment, well into the adult years. (pp. 54–55)

Each narrative shared in this study included some element of toxic stress. It is now evident that Nick repeatedly digging his clothes out of a dumpster was a clear case of toxic stress. The same

could be said for Brad coping with the murder of his brother or the emotional abuse Katie experienced. When I examine the young students in my elementary school, I see toxic stress in all of them. Aaron is coping with a brother with special needs and the attention lost because the mother is tending to the brother's needs. In addition, Aaron's father is rarely home because of the financial burden. Taylor and Jordan were both reeling from a divorce and the financial hardships placed on the mother because of the separation. Daryl's parents abandoned him, his father was in and out of jail, and he was living with a caregiver with failing health. While the causes may not be as overt as other students, I also believe Riley and Courtney experienced toxic stress. Their thought processes and statements like "I want to die" and withholding food showed an internal struggle that had been taking place for some time. Studies on trauma among children have found five common symptoms of traumatic or toxic stress: 1) reexperiencing (i.e., Taylor and Jordan), 2) avoidance (i.e., Aaron and Riley), 3) arousal (i.e., Courtney and Daryl), 4) internalizing behaviors (i.e., Courtney, Aaron, Riley, Taylor, and Jordan), and 5) externalizing behaviors (i.e., Daryl; Goodman et al., 2012). Reexperiencing is characterized by flashbacks, nightmares, or psychological reactivity (American Psychiatric Association [APA], 2000). I argue Taylor and Jordan were constantly reliving their parents' divorces. Avoidance can be shown through emotional detachment, diminished affect and interests, and evading possible traumatic reminders (APA, 2000). Aaron and Riley displayed these symptoms through their social withdrawal at school. Arousal is defined as difficulty concentrating, hyperactivity, restlessness, and irritability (APA, 2000). Courtney struggled with concentration and Daryl could never remain still or focused. Internalizing behaviors include anxiety or depression, withdrawal, and somatization (Graham-Bermann & Levendosky, 1998). I think all students discussed in this study experienced

some form of anxiety, depression, or withdrawal. Externalizing behaviors include aggression, delinquency, or acting out (Graham-Bermann & Levendosky, 1998). This was Daryl's primary symptom shown in the school setting.

Vicarious/Secondary Trauma

When analyzing my experiences, it also became very evident the students were not the only ones traumatized. I have come to realize I was exposed to vicarious, or secondary trauma, through their actions. School personnel are often aware of the adversity facing their students but may not have the adequate skills to respond, thus increasing their vulnerability to vicarious or secondary trauma (Anderson & Bronstein, 2012). Vicarious trauma is a term used in the social service and counseling fields that can be described as "harmful changes that occur in professionals' view of themselves, others, and the world as a result of exposure to the graphic and/or traumatic material of their clients" (Baird & Kraken, 2006, p. 181). Baird and Kracen (2006) added vicarious trauma can impact a caregiver's underlying beliefs in five areas: trust, safety, control, esteem, and intimacy. Secondary trauma (Figley, 1983) is also known as compassion fatigue (Figley, 1995). Both terms are similar to vicarious trauma and all three terms are often used interchangeably. However, the major difference is that secondary trauma occurs when you develop symptoms similar to those of posttraumatic stress disorder (PTSD) through the process of working with trauma survivors. "Professionals who listen to reports of trauma, horror, human cruelty, and extreme loss can become overwhelmed and may begin to experience feelings of fear, pain and suffering similar to that of their clients" (Gentry, 2002, p. 41). These symptoms are usually displayed in one of three ways: (1) re-experiencing the survivor's trauma, (2) avoidance of and/or numbness to the trauma, and (3) persistent arousal. The difference

between PTSD and secondary trauma is that a trauma survivor experiences PTSD and a person who works with a trauma survivor experiences secondary trauma (Jenkins & Baird, 2002). In this study, I realized I became numb to my students' traumas in the end. It was not that I did not care for my students or feel compassion for their experiences. Rather, their experiences morphed into one sense of grief. As I mentioned earlier, they lost their individuality in my mind and thus, their individual stories lost some of my compassion. While I was able to recall each of their stories, the associated feelings combined into one feeling. I no longer feel compassion for one student more than the other. Each harrowing narrative evokes the same amount of sadness. Logically, I think I should feel more for Jordan than for Courtney. However, there is no emotional divide. The literature on vicarious trauma has supported this sense of numbness. Short-term effects can occur when empathetic engagement with a suffering individual leads to an immediate onset of compassion fatigue (Bober et al., 2006).

Screening

One of the common themes mentioned in this study was wishing I had known the students' backgrounds prior to their self-harming event so that I may have been able to prevent the act from taking place in some way. If I could not have prevented the act, I could have created a more supportive environment for the student. In analyzing my journey, I realize it would have been helpful to know if my students were experiencing intense or toxic stress. In essence, I wish I could have given them the Adverse Childhood Experiences study (ACEs; Felitti et al., 1998). When data from the first ACE study were released, two-thirds of the population surveyed endorsed at least one category of ACE. In fact, 12.6% endorsed four or more categories of ACEs (Felitti et al., 1998). Findings were clear that adverse childhood experiences are rampant in our

society. Findings were so shocking and alarming that some questioned their authenticity. Further studies about ACEs have validated the original findings (Harris, 2018). Despite the ACE survey being medical in nature, the information gained would be useful in the educational setting. As an elementary school principal, I would want to know which of my students was experiencing toxic stress or had experienced an adverse experience so I could better support that student. When I reflect on Jordan, perhaps we could have implemented something at school to prevent his suicide attempt if we would have known his backstory. Individuals with a higher ACE score are more likely to attempt suicide (McGruder, 2019).

The concept of screening for toxic stress or childhood adversity can prevent physical and emotional problems later in life. A child risks inadequate stress responses when exposed to childhood adversity and toxic stress. The first several years of life are important years for increasing neuroplasticity development, after which it begins to fade (Gerwin, 2013). If preventive measures are implemented during the early stages of development, appropriate stress responses to adversity can be achieved. Screening is a way to identify those children who would benefit from preventive measures and therapeutic interventions, if needed.

The notion of screening still falls on the shoulders of the medical field. The American Academy of Pediatrics (AAP) recommends screening for factors such as social isolation, poverty, unemployment, low educational achievement, single-parent home, non-biologically related male living in the home, family or intimate partner violence, young parental age, and parental factors such as low self-esteem, substance abuse, and depression (Flaherty & Stirling, 2010). The AAP has not identified a specific screening tool used for toxic stress, nor have they chosen one to use with usual screening protocols such as the developmental milestones (Franke,

2014). Social-emotional screening has been shown to predict behavioral problems and would fit with the need to identify children at risk of toxic stress (Briggs-Gowan & Carter, 2008). Despite the gaining momentum of understanding the importance of identifying children at risk for toxic stress and adverse experiences, the school setting remains out of the loop. For all I know, my students' pediatricians may have screened them, but that information would never have become available to me. I needed an educational screening.

Prevention

In the process of analyzing this autoethnography, I realize I referenced the desire to prevent my students from committing these acts of self-harm. I also realize this urge to protect my students comes from my innate parental emotion to protect and not from a logical or realistic frame of mind. I am incapable of being in all places at all times for each of my students. I cannot prevent traumatic events from taking place and children hurting as a result of those events. However, it is possible to implement preventive measures that provide positive influences and create healthy interactions with supportive adults. Students who receive routine anticipatory guidance to help build resiliency and positive parenting develop the buffers required to handle stress and avoid toxic stress (Franke, 2014). We, as a school system, have the ability to create positive adult interactions and provide that anticipatory guidance due to our daily access to our students. While prevention requires a team effort, educators play an integral role when it comes to our youngest students. Factors that reduce the risk of toxic stress include the presence of a caring and supportive adult, positive family changes, structured school environment, access to health care and social services, and involvement with religious community or extracurricular organized activity (Flaherty et al., 2010). The school environment has the capability to provide

caring adults with screening to reduce the risks of toxic stress and thus the likelihood a student will self-harm. The screening is such a necessity of the preventative process because preventive interventions should be focused on children with the greatest risk of experiencing trauma. Research has shown children with no risk of toxic stress may actually experience an adverse stress response when exposed to interventions (Miller-Lewis et al., 2013). Within a school setting, it is possible to establish a culture of awareness, understanding, and compassion in conjunction with screening and interventions to reduce the prevalence of toxic stress. This integrative approach involving an ethic of care could prevent young children from self-harming in the future.

Caring

The one overarching theme throughout this study involves care. Caring is present throughout the narratives of my students. It is a part of the authentic leadership style achieved as a result of those caring relationships with my students. Caring is also the basis for my suggestions on how to work with self-harming students and students suffering from toxic stress moving forward. An ethic of care is the reason behind the origin of this study. "Care ethics is a relational ethic that recognizes the social and moral implications of all educative experiences" (Rabin & Smith, 2013, p. 164). I have learned from this autoethnographic analysis that adopting an ethic of care means, as an educator, you must be willing to create a relationship in which moral education can take place. I realize it is also important for the educator to temper his or her own aspirations for the student. In fact, Goldstein (1998b) argued in a caring relationship, educators as carers must balance their goals for the student to account for the student's aspirations, even when educators may believe their goals are in the student's best interest.

This study has also shown care ethics require a strong capacity to understand personal aspects of self, relational boundaries, and needs of both individuals. To 'care for' requires competency in skills such as listening, articulation, framing, observation, questioning, empathy, imagination, creativity, responsiveness, responsibility, self-reflection, mindfulness, and humility (Hawk, 2017). Needless to say, educators everywhere vary in their competency with these skills. Developing caring relationships is a challenge. Even more so, the increasing diversity of our schools adds to the complexity of developing these relationships and increases the importance of a multicultural understanding of care (Wilder, 1999). Cultural diversity was a challenge for me working with my self-harming students. At times, I struggled with the cultural differences involved in the parenting that took place. For example, it was hard for me to fathom how a father could be absent from his child's academic life. As Nieto (2015) suggested, educators need to question their implicit beliefs and assumptions to challenge the cultural stereotypes of care. It is necessary to resist looking for culturally White practices that we assume define 'caring' (Thompson, 1998). This reflective analysis has started that process for me.

I have learned through my experiences that an ethic of care cannot be optional. Rather, it should be a central tenet of your school or classroom. In other words, the presence of caring needs to be visible to all. If educators do not learn to create caring relationships, they will rely on procedures that gain quick behavioral compliance rather than care-focused procedures that create safe and caring educational environments (Charney, 2002). Despite that a school consists of educators at various stages of their careers, they should all have a concern for the well-being of their students. With that assumption, it is possible to create a culture where an ethic of care is central. There are many ways this can happen. As Hawk (2017) stated, only our creativity limits

our ability to find ways to connect and build relationships with students. In the end, an ethic of care requires a complete engrossment in the relationship as it unfolds in the moment and a commitment to the well-being of the individual and the relationship (Noddings, 2013). This act of caring requires the ownership of not only the classroom teacher, but every staff member to transform the culture of a school.

Recommendations

This autoethnographic study has analyzed many experiences of my journey as an elementary school principal working with primary-aged students who self-harm. As part of that analysis, the evolution of my leadership from an inexperienced principal who mimicked former role-models toward an authentic leadership style was discussed. This study fills a gap in the literature concerning self-harming primary-aged students and a male elementary school teacher's implementation of an ethic of care. From this analysis, recommendations surfaced for school leaders wanting to implement a trauma-informed or healing-centered approach within their school setting, educators working with primary-aged students engaging in the act of self-harm, and school districts committed to providing proactive support for students who have experienced trauma.

Implementing Trauma-Informed and Healing-Centered Approaches

My experiences as an elementary school principal have taught me that any new approach can be successful when you implement from a position of caring. Caring, along with illustrating the potential benefit for students, is the key to implementation. Along my journey, I have made some mistakes in the way I introduced a trauma-informed approach to my school site. For example, I should have created a common language among my staff by using the term "trauma-

informed" from the onset. I have also been fortunate along the way. I was lucky that Debra wanted to start holding morning meetings in her classroom. Her eagerness allowed me an avenue to promote the idea and the majority of the staff was in support because the idea came from a fellow teacher. While there are programs that help support a trauma-informed approach, such as the Responsive Classroom and Positive Behavior Interventions and Supports (PBIS), there is no canned program used to check the trauma-informed implementation box. Rather, trauma-informed is a mindset and belief system all educators, staff, students, families and community members alike share. It is a shared recognition that stress has a powerful impact on the behavioral, emotional, relational, and academic well-being of students (Peeples, 2019). Bath (2008) identified three core tenets of trauma-informed care: providing safety, establishing connections, and teaching how to manage emotions. It is important to create connections that allow students to not only understand their realities but also see the possibilities (Zartner, 2019). As a school leader, I recommend strategic planning, establishing a common language and understanding of terms, providing professional development, and direct intervention for traumatized students. Specifically, based on my experiences, I would recommend the following progression when implementing a trauma-centered approach as a school leader: a) ensure there is a climate of respect and support toward students and staff on your campus, b) communicate the reason for implementation, c) establish a common language and understanding of terms, d) provide tangible examples of appropriate support to staff, e) provide training on care ethics to staff, f) identify students in need of direct intervention, and finally, g) continue to assess if additional resources are needed.

For school leaders interested in implementing a trauma-sensitive approach, there is a slight alternative to the trauma-informed approach—a healing-centered approach. Trauma-informed approaches originated to offset the overuse of harsh discipline to address disruptive behaviors (Bottiani et al., 2017). Bottiani et al. (2017) shared harsh discipline (e.g., school suspensions) may further harm students who have experienced traumatic events. Trauma-informed care provides a mechanism to support young children who have experienced trauma. However, a trauma-informed approach presumes the trauma is an individual rather than collective experience (Ginwright, 2018). As an example, Sinha and Rosenberg (2013) argued children in high violence neighborhoods displayed elements of trauma. A healing-centered approach not only examines the trauma but the possibility of well-being. In this approach, the traumatic experience(s) and healing process are experienced collectively. This approach is strength based and includes culture as a central feature.

> A healing centered approach to addressing trauma requires a different question that moves beyond 'what happened to you' to 'what is right with you' and views those exposed to trauma as agents in the creation of their own well-being rather than victims of traumatic events. (Ginwright, 2018, p. 5)

As with a trauma-informed approach, there is no tangible healing-centered approach to implement in schools. Rather, similar to trauma-informed, healing-centered approaches are about the mindset of the school or educator. Elliott (2018) stated, "Our work is not so much about trying to fix or control children . . . it is about creating spaces where healing, transformation, and growth can occur" (p. 29). As of 2021, this mindset is more important now than ever. As the global population continues to recover from the COVID-19 pandemic, our children now enter

our school systems with a new source of trauma. Miller (2021) suggested as many as 43,000 U.S. children have lost a parent to the COVID-19 virus. Previous studies have also demonstrated how children who lose a parent are at higher risk of experiencing traumatic grief, poor educational outcomes, and self-harm or suicide (Kidman et al., 2021). The "new normal" should no longer consider trauma an individualized experience but rather a collective experience requiring a healing-centered approach. Our entire society has experienced this traumatic event; therefore, a healing-centered focus is critical to the emotional and mental well-being of staff and students. Ginwright (2018) shared his recommendations to consider when establishing a healing-centered culture: a) build empathy, b) encourage young people to dream and imagine, c) build critical reflection, and d) take loving action. Consistent with the overarching theme of this chapter, healing-centered approaches include and depend on an ethic of care.

Educators Working With Self-Harming Primary-Aged Students

Through my experiences in education and through the analysis of this autoethnographic study, I have learned an ethic of care must be the basis for all interactions with self-harming students. There is a tendency in education to value the intellect over the affect (Rabin & Smith, 2013). To place an ethic of care at the forefront goes against what many educators are trained to do—deliver content. Learning to "care for" requires more than learning new strategies. It requires a fundamental shift in mindset. In my own experiences, I was often conflicted with the desire to be in the moment and care for my student and the educational responsibility of returning the student to class to avoid a learning loss. To educate with care is to take on the "emotional labour" of teaching (Isenbarger & Zembylas, 2006). To educate with care is to equally value the emotional and intellectual intelligence of a child.

While prevention is the ultimate goal when it comes to self-harm, I now understand the reality is that students, even primary-aged students, will engage in self-harming acts. As shown in this study, it is easy to become overwhelmed by the personal and societal expectations of helping students in dire situations. It is important for each educator to know it is okay to not have all the answers and know every support resource available for a hurting student. More importantly, educators should work collectively to address the challenges of their students. Creating an environment where the student feels valued, safe, and free of traumatic stress is key to working with a self-harming student. The joy or stress associated with the learning environment enhances or diminishes a child's ability to learn (Blair & Diamond, 2008). While there are legal and safety protocols to follow when learning information about a risk to student safety, there is no step-by-step procedure when it comes to caring for a student who has self-harmed or may be experiencing toxic stress. Understanding each situation is unique and that each student has unique needs is key to providing a safe environment for the student—a core tenet of care ethics. Providing general approaches when working with students is more applicable in this context. For example, Souers (2018) provided six ways to respond to students experiencing trauma: a) identify what need a behavior is expressing, b) see the worth in each student and build from his or her strength, c) remember that kids cannot learn if they do not feel safe, d) work from a team perspective, e) consider whether a basic need is not being met, and f) give students grace. I have also learned it is important to give yourself grace. Nothing prepares you for the feelings that come when working with a self-harming student.

School Districts Committed to Providing Proactive Support

My failure to recognize the trauma symptoms in my students as a classroom teacher and elementary school principal have shown how important it is to know as much vital information as possible regarding the traumatic events our students experience. This knowledge could and should be used to provide proactive support for our students who have experienced trauma. While making use of this information may be innovative to the field of education, it is not unheard of to collect background information on traumatic experiences. With the emergence of the ACEs study (Felitti et al., 1998), medical practitioners have begun implementing those questions into their intake questionnaires when examining new patients. The information gleaned from those intake surveys have allowed physicians to properly diagnose the symptoms and therefore treat the cause(s) more accurately.

The same concept could be applied to the context of education. School districts have the opportunity to provide an extra layer of proactive support for their students by providing an intake survey to parents when they register their children in a school system that asks about traumatic experiences of the family. Knowing whether a child has experienced trauma provides a more accurate picture of the child and possible reasons for behaviors and/or learning difficulties (e.g., lack of focus). Though ACEs would not solve racism within the school system or, more specifically, within school discipline, applying them to the school setting could help reduce the disproportionality of discipline policies used on Black and Brown students. Joseph et al. (2020) noted racial bias, in conjunction with a lack of training on ACEs, may lead educators to view behaviors of Black and Brown students as deviant rather than a cry for help. Students who experience traumatic events are also more likely to be placed in the special education pipeline of

a school system. This is especially true if the child's symptoms include disruptive behaviors, as students with disruptive behaviors are often identified as having a learning disability. Knowing a student has experienced an adverse childhood event may support the notion that the behavior or learning difficulty is a result of trauma. In this case, the traumatic event needs to be addressed through therapy such as counseling instead of assigning blame to cognitive ability. The social justice aspect of this recommendation is immense. Students of color are disproportionately disciplined within the school setting and diagnosed with learning disabilities. While, in theory, the special education setting is meant to provide an equal education to the general education setting through the use of supports, students participating in special education traditionally obtain a reduced education in comparison to their general education peers. Accurately identifying the cause of behaviors and learning difficulties could prevent students who are cognitively similar to their general education peers from being misplaced in a special education environment. Thus, fewer students in the special education system would allow that system to appropriately provide for students in need of special education support.

I propose each school district implement the practice of providing a trauma-based intake survey to parents during their initial enrollment in the district. From there, that information would be disseminated to the principal of each school regarding their particular students. Based on my experience, the principal should identify those students most likely in need of school counseling support. In addition, this background information should be considered when discipline issues arise or special education assessments are requested. The administrator or any other school personnel does not need to know the specifics of the intake survey. The key to knowing the results is knowing which students to provide additional, proactive support to instead

of waiting for students to begin demonstrating behaviors or academic difficulties. The hope is that the school already has a trauma-informed or healing-centered approach and the classrooms have behavioral and academic supports built within.

Future Research

The lack of research surrounding the topic of self-harm in primary-aged students calls for further studies, both quantitative and qualitative. As Simm et al. (2008) stated, little research has focused on primary-school aged children and self-harm. In addition, as trauma-informed approaches become more mainstream, future investigations should study the impact those approaches have at the classroom and school level. In my opinion, it would be interesting to see the difference in efficacy when trauma-informed approaches are implemented schoolwide versus individually in classrooms. Finally, and most importantly, I believe future studies should examine the use of screening tools in the education setting. I believe the data would show screening for toxic stress at the school level decreases external behaviors and suspensions and increases attendance, academic achievement, and overall educational satisfaction for the student.

Conclusion

As an educator, first in the classroom as a secondary teacher and sequentially as the principal of a preschool through third grade elementary school, I have experienced the reality of self-harming students at all levels. I have also noticed an increase in self-harming behaviors on the part of my students. This perceived increase may be a result of heightened awareness or an actual increase in students' self-harming attempts. As Best (2006) suggested, whether the increase is fact or due to awareness, self-harm is a social issue worthy of public examination. This examination falls short when it comes to self-harm and primary-aged school children. The

literature shown in this study with children under 11 was primarily restricted to studies from the United Kingdom and Australia (Ayton et al., 2003; Dow, 2004; Meltzer et al., 2001; Nadkarni et al., 2000; Simm et al., 2008, 2010). The lack of research on this topic in the United States may be due to arrogance, but most likely stems from a fear of examining and admitting we may have this problem with children of such a young age. Findings from this study will hopefully expand the conversation around the topic of self-harm and the reality that it takes place across every level of schooling.

This study used the qualitative method of autoethnography to examine my experiences as a school leader with self-harming students to determine how my leadership has changed as a result of those experiences. This study has shown my leadership transformed from a cynical, results-based principal to one that embraces, values, and implements an ethic of care along with trauma-informed and healing-informed practices. This study has demonstrated how my experiences with my students gave me a clear and concise vision of what I wanted for my students, staff, and school community. In other words, those experiences formed a more authentic leader.

Finally, this study has shown there are ways to improve proactive support for our hurting students. Taking a trauma-informed or healing-centered approach to your classroom or school can diminish the effects of toxic stress and secondary trauma, resulting in a safer and healthier environment for students and staff. Approaching interactions from an ethic of care allows the educator to experience the student as a human being and in doing so, has the potential to become a caregiver who can help the child heal from adverse traumatic experiences. This study has also demonstrated the value of screening for those traumatic experiences. My experiences as an

elementary school principal has taught me there is no ‘magic bullet’ that can fix any problem. However, I have also discovered, with a committed effort on the part of school leaders, educational settings have the ability and power to reduce the daily stress our students experience to ultimately reduce the likelihood of toxic stress and self-harming behaviors.

REFERENCES

Agency for Healthcare Research and Quality (2009, April 1). *Eating disorders sending more Americans to the hospital.* AHRQ News and Numbers. https://www.ahrq.gov/news/nn/nn040109.html

Aguinaldo, J. P. (2004). Rethinking validity in qualitative research from a social constructionist perspective: from "is this valid research?" to "what is this research valid for?" *The Qualitative Report*, *9*(1), 127+.

Alisic, E., Zalta, A. K., Van Wesel, F., Larsen, S. E., Hafstad, G. S., Hassanpour, K., & Smid, G. E. (2014). Rates of post-traumatic stress disorder in trauma-exposed children and adolescents: meta-analysis. *The British Journal of Psychiatry*, *204*(5), 335–340. https://doi.org/10.1192/bjp.bp.113.131227

Allix, N. M. (2000). Transformational leadership: democratic or despotic? *Educational Management & Administration*, *28*(1), 7–20. https://doi.org/10.1177/0263211X000281002

Alvarez, A. (2017). "Seeing their eyes in the rearview mirror": Identifying and responding to students' challenging experiences. *Equity & Excellence in Education*, *50*(1), 53–67. https://doi.org/10.1080/10665684.2016.1250686

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Author.

Anderson, E. M., & Bronstein, L. R. (2012). Examining interdisciplinary collaboration within an expanded school mental health framework: a community–university initiative. *Advances in School Mental Health Promotion*, *5*(1), 23–37. https://doi.org/10.1080/1754730X.2012.664860

Arnold, D., Calhoun, L. G., Tedeschi, R., & Cann, A. (2005). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology*, *45*(2), 239–263. https://doi.org/10.1177/0022167805274729

Atkinson, P. (1997). Narrative turn or blind alley? *Qualitative Health Research, 7*, 325–344. https://doi.org/10.1177/104973239700700302

Ayton, A., Rasool, H. & Cottrell, D. (2003). Deliberate self-harm in children and adolescents: Association with social deprivation. *European Child and Adolescent Psychiatry, 12*, 303–307. https://doi.org/10.1007/s00787-003-0344-0

Báez, J. C., Renshaw, K. J., Bachman, L. E. M., Kim, D., Smith, V. D., & Stafford, R. E. (2019). Understanding the necessity of trauma-informed care in community schools: A mixed-methods program evaluation. *Children & Schools*, *41*(2), 101–110. https://doi.org/10.1093/cs/cdz007

Baier, A. (1987). Hume: The woman's moral theorist? In Kittay, E. F. & Meyers, D. (Eds), *Women and Moral Theory*. Rowman & Littlefield. https://doi.org/10.1111/j.1527 2001.1989.tb00582.x

Baier, A. (1994). *Moral prejudices: Essays on ethics*. Harvard University Press.

Baird, K., & Kracen, A. C. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychology Quarterly*, *19*(2), 181–188. https://doi.org/10.1080/09515070600811899

Bashir, M. (Host). (1995, November). The princess and the press. *Panorama*. BBC. https://www.pbs.org/wgbh/pages/frontline/shows/royals/interviews/bbc.html

Bassett, J., & Taberski, M. (2020). From active shooter to COVID-19, understanding your vicarious trauma. *About Campus*, *25*(4), 10–14. https://doi.org/10.1177/1086482220953127

Bath, H. (2008). The three pillars of trauma-informed care. *Reclaiming Children and Youth*, *17*(3), 17–21. https://elevhalsan.uppsala.se/globalassets/elevhalsan/dokument/psykologhandlinar/trauma-informed-care.pdf

Bath, H. (2015). The three pillars of traumawise care: Healing in the other 23 hours. *Reclaiming Children and Youth 23* (4), 5–11. https://www.traumebevisst.no/kompetanseutvikling/filer/23_4_Bath3pillars.pdf

Baum, N., Rotter, B., Reidler, E., & Brom, D. (2009). Building resilience in schools in the wake of hurricane Katrina. *Journal of Child & Adolescent Trauma, 2*(62), 62–70. https://doi.org/10.1080/19361520802694323

Beaton, M. (2018, January 30). Your leadership purpose [Web log Beaton Executive Coaching]. https://www.beatonexecutivecoaching.com/your-leadership-purpose/

Belbase, S., Luitel, B., & Taylor, P. (2008). Autoethnography: A method of research and teaching for transformative education. *Journal of Education and Research*, *1*(1), 86–95. http://dx.doi.org/10.3126/jer.v1i0.7955

Berkley, K. (2020, July 23). *How can you break the cycle of self-harm and self-neglect?* HealthyPlace. https://www.healthyplace.com/blogs/speakingoutaboutselfinjury/2020/7/how-can- you-break-the-cycle-of-self-harm-and-self-neglect

Best, R. (2004, Sept.) *Deliberate self-harm in adolescence: An educational response*. Paper presented at the British Educational Research Association Annual Conference, University of Manchester. https://www.leeds.ac.uk/educol/documents/00003754.htm

Best, R. (2006). Deliberate self-harm in adolescence: A challenge for schools. *British Journal of Guidance & Counselling*, *34*(2), 161–175. https://doi.org/10.1080/03069880600583196

Blair, C., & Diamond, A. (2008). Biological processes in prevention and intervention: The promotion of self-regulation as a means of preventing school failure. *Development and Psychopathology*, *20*(3), 899. https://doi.org/10.1017/S0954579408000436

Bober, T., Regehr, C., & Zhou, Y. R. (2006). Development of the coping strategies inventory for trauma counselors. *Journal of Loss and Trauma*, *11*(1), 71–83. https://doi.org/10.1080/15325020500358225

Bochner, A. P. (2000). Criteria against ourselves. *Qualitative Inquiry, 6*(2), 266–272. https://doi.org/10.1177/107780040000600209

Bochner, A. P. (2001). Narrative's virtues. *Qualitative Inquiry, 7*(2), 131–157. https://doi.org/10.1177/107780040100700201

Bochner, A. P., & Ellis, C. (1996). Talking over ethnography. In C. Ellis & A. P. Bochner (Eds.), *Composing ethnography: Alternative forms of qualitative writing* (pp. 13–45). Alta Mira Press.

Bochner, A. P., & Ellis, C. (2006). Communication as autoethnography. In G. J. Shepherd , J. S. John & T. Striphas (Eds.), *Communication as . . . : Perspectives on theory* (pp. 13–21). Sage. https://doi.org/10.4135/9781483329055.n13

Bochner, A., & Ellis, C. (2016). *Evocative autoethnography: Writing lives and telling stories*. Routledge.

Bogdan, R., & Biklen, S. (2007). *Qualitative research for education: An introduction to theories and methods*. Pearson.

Bondy, E., Ross, D. D., Gallingane, C., & Hambacher, E. (2007). Creating environments of success and resilience: Culturally responsive classroom management and more. *Urban Education*, *42*(4), 326–348. https://doi.org/10.1177/0042085907303406

Bottiani, J. H., Bradshaw, C. P., & Mendelson, T. (2017). A multilevel examination of racial disparities in high school discipline: Black and white adolescents' perceived equity, school belonging, and adjustment problems. *Journal of Educational Psychology*, *109*(4), 532. https://psycnet.apa.org/doi/10.1037/edu0000155

Bowen, E., & Murshid, N. (2016). Trauma-informed social policy: A conceptual framework for policy analysis and advocacy. *American Journal of Public Health*, 106, 223–229. https://doi.org/10.2105/AJPH.2015.302970

Bozgeyikli, H. (2018). Psychological needs as the working-life quality predictor of special education teachers. *Universal Journal of Educational Research*, *6*(2), 289–295. https://doi.org/10.13189/ujer.2018.060211

Brandt, D. (2006). *Delinquency, development, and social policy*. Yale University Press.

Brent, D. (1997). Practitioner review: The aftercare of adolescents with deliberate self-harm. *Journal of Child Psychology and Psychiatry, 38*, 277–286. https://doi.org/10.1111/j.1469-7610.1997.tb01512.x

Briggs-Gowan, M. J., & Carter, A. S. (2008). Social-emotional screening status in early childhood predicts elementary school outcomes. *Pediatrics*, *121*(5), 957–962. https://doi.org/10.1542/peds.2007-1948

Brunzell, T., Stokes, H., & Waters, L. (2018). Why do you work with struggling students? Teacher perceptions of meaningful work in trauma-impacted classrooms. *Australian Journal of Teacher Education, 43*(2), 116–142. https://doi.org/10.14221/ajte.2018v43n2.7

Butler, L. D., Critelli, F. M., & Rinfrette, E. S. (2011). Trauma-informed care and mental health. *Directions in Psychiatry*, *31*, 197–210. https://www.researchgate.net/profile/Lisa-Butler5/publication/234155324_Trauma-Informed_Care_and_Mental_Health/links/02bfe50f9b4cbb8051000000/Trauma-Informed-Care-and-Mental-Health.pdf

Burns, J. M., (1978). *Leadership*. Harper & Row.

Campbell, S. B. (2006). *Behavior problems in preschool children: Clinical and developmental issues*. Guilford Press.

Camelot Foundation & Mental Health Foundation. (2004). *Launch of inquiry into self-harm among 11–25 year olds*. House of Commons, Westminster.

Carello, J. & Butler, L. D. (2015). Practicing what we teach: Trauma-informed educational practice. *Journal of Teaching in Social Work, 35*(3), 262–278. https://doi.org/10.1080/08841233.2015.1030059

Centers for Disease Control and Prevention. (2016). Adverse childhood experiences (ACEs). https://www.cdc.gov/violenceprevention/aces/index.html

Centers for Disease Control and Prevention. (2021). *COVID data tracker*. https://covid.cdc.gov/covid-data-tracker/#datatracker-home

Chan, A. (2005). Authentic leadership measurement and development: Challenges and suggestions. In W. L. Gardner, B. J. Avolio, & F. O. Walumbwa (Eds.) *Authentic leadership theory and practice: Origins, effects, and development* (pp. 227–251). Elsevier Science.

Chang, H. (2008). *Autoethnography as method.* Left Coast Press.

Charney, R. (2002). *Teaching children to care: Classroom management for ethical and academic growth, K-8*. Center for Responsive Schools.

Charuvastra, A., & Cloitre, M. (2008). Social bonds and posttraumatic stress disorder. *Annual Review of Psychology*, *59*, 301–328. https://doi.org/10.1146/annurev.psych.58.110405.085650

Coffey, A. (1999). *The ethnographic self*. Sage.

Cohen, J., Onunaku, N., Clothier, S., & Poppe, J. (2005). *Helping young children succeed: Strategies to promote early childhood social and emotional development*. National Conference of State Legislatures and Zero to Three.

Craig, S. E. (2017). *Trauma-sensitive schools for the adolescent years: Promoting resiliency and healing, grades 6–12*. Teachers College Press.

Creswell, J. (2003). *Research design: Qualitative, quantitative and mixed methods approaches*. Sage Publications.

Creswell, J. (2007). *Qualitative inquiry & research design. Choosing among five approaches*. Sage.

Crosby, S. D. (2015). An ecological perspective on emerging trauma-informed teaching practices. *Children & Schools*, *37*(4), 223–230. https://doi.org/10.1093/cs/cdv027

Crosby, S. D., Howell, P., & Thomas, S. (2018). Social justice education through trauma informed teaching. *Middle School Journal*, *49*(4), 15–23. https://doi.org/10.1080/00940771.2018.1488470

Darder, A. (2016). Critical leadership for social justice: Unveiling the dirty little secret of power and privilege. *Radical Imagine-Nation, 1*(1), 1–21.

Darder, A., & Mirón, L. F. (2006). Critical pedagogy in a time of uncertainty: A call to action. *Cultural Studies? Critical Methodologies*, *6*(1), 5–20. https://doi.org/10.1177/1532708605282814

Davis, M. D. (2016). *Trauma-focused training program for teachers* (Doctoral dissertation, The Chicago School of Professional Psychology). (Order No. 10111683)

Denham, S. A., & Brown, C. (2010). "Plays nice with others": Social-emotional learning and academic success. *Early Education and Development*, *21*(5), 652–680. https://doi.org/10.1080/10409289.2010.497450

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2011). *The Sage handbook of qualitative research*. Sage.

Dodge, K. A., Laird, R., Lochman, J. E., & Zelli, A. (2002). Multidimensional latent construct analysis of children's social information processing patterns: Correlations with aggressive behavior problems. *Psychological Assessment*, *14*(1), 60.

Dow, P. (2004). I feel like I'm invisible. *Children talking to ChildLine about self-harm. Submission to the National Inquiry into self-harm among young people.* NSPCC. https://image.guardian.co.uk/sys-files/Society/documents/2004/09/06/ ChildLineselfharm.pdf

Dowling, S., & Doyle, L. (2017). Responding to self-harm in the school setting: The experience of guidance counsellors and teachers in Ireland. *British Journal of Guidance & Counselling*, *45*(5), 583–592. https://doi.org/10.1080/03069885.2016.1164297

Duncan, M. (2004). Autoethnography: Critical appreciation of an emerging art. *International Journal of Qualitative Methods,* 28–39. https://doi.org/10.1177/160940690400300403

Dwyer, K. K., Bingham, S. G., Carlson, R. E., Prisbell, M., Cruz, A. M., & Fus, D. A. (2004). Communication and connectedness in the classroom: Development of the connected classroom climate inventory. *Communication Research Reports*, *21*(3), 264–272. https://doi.org/10.1080/08824090409359988

Early Childhood Mental Health (n.d.). *What is social & emotional development?* https://dmh.mo.gov/healthykids/parents/socialemotionaldevelopment

Elliott, N. (2018). Helping teachers practice mindfulness in special education classrooms. *Energy Magazine*, 26-29. https://www.mindful-leaders.org/wp-content/uploads/2020/05/HelpingTeachers_Practice_Mindfulness_In_Special_Education-Niki-Elliott_septoct2018.pdf

Ellis, C. (1991). Sociological introspection and emotional experience. *Symbolic Interaction*, *14*(1), 23–50. https://doi.org/10.1525/si.1991.14.1.23

Ellis, C. (2004). *The ethnographic I: A methodological novel about autoethnography*. Rowman and Littlefield Publishers.

Ellis, C. & Bochner, A. P. (1996). *Composing ethnography*. Sage Publications.

Ellis, C. & Bochner, A. P. (2000). Autoethnography, personal narrative, reflexivity. In Y. S. Lincoln & N. K. Denzin (Eds.), *Handbook of qualitative research* (pp. 733–768). Sage Publications.

Evans, S. W., & Weist, M. D. (2004). Implementing empirically supported treatments in the schools: What are we asking? *Clinical Child and Family Psychology Review, 7*, 263–267. https://doi.org/10.1007/s10567-004-6090-0

Farmer, E. M., Burns, B. J., Phillips, S. D., Angold, A., & Costello, E. J. (2003). Pathways into and through mental health services for children and adolescents. *Psychiatric Services*, 54, 60–66. https://doi.org/10.1176/appi.ps.54.1.60

Farquhar, S., & Dobson, N. (2004). Community and university participation in disaster-relief recovery: An example from eastern North Carolina. *Journal of Community Practice, 12*, 203–217. https://doi.org/10.1300/J125v12n03_12

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experience (ACE) study. *American Journal of Preventive Medicine*, 14, 245–258. https://doi.org/10.1016/S07493797(98)00017-8

Figley, C. R. (1983). *Traumatic stress and the role of the family and social support system*. Serco Marketing.

Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 3–28). The Sidran Press.

Finzel, H. (1994). *The top ten mistakes leaders make.* Victor Books/SP Publications.

Flaherty, E. G., Stirling, J., & Committee on Child Abuse and Neglect. (2010). The pediatrician's role in child maltreatment prevention. *Pediatrics*, *126*(4), 833–841. https://doi.org/10.1542/peds.2010-2087

Flom, R., & Bahrick, L. E. (2007). The development of infant discrimination of affect in multimodal and unimodal stimulation: The role of intersensory redundancy. *Developmental Psychology*, *43*(1), 238. https://psycnet.apa.org/doi/10.1037/00121649.43.1.238

Foley, D. E. (2002). Critical ethnography: The reflexive turn. *International Journal of Qualitative Studies in Education*, *15*(4), 469–490. https://doi.org/10.1080/09518390210145534

Foster, W. (1989). Toward a critical practice of leadership. *Critical perspectives on educational leadership*, *3*, 39–62. https://docuri.com/download/critical- perspectives-on-educationalleadership1989_59c1ca85f581710b28605ab2_pdf#page=35

Frank, A. W. (2000). The standpoint of storyteller. *Qualitative Health Research, 10*(3), 354–365. https://doi.org/10.1177/104973200129118499

Franke, H. A. (2014). Toxic stress: effects, prevention and treatment. *Children*, *1*(3), 390–402. https://doi.org/10.3390/children1030390

Gallagher, T. M. (1993). Language skill and the development of social competence in school-age children. *Language, Speech, and Hearing Services in Schools*, *24*(4), 199–205. https://doi.org/10.1044/0161-1461.2404.199

Ganzel, B. L., & Morris, P. A. (2011). Allostasis and the developing human brain: Explicit consideration of implicit models. *Development and Psychopathology*, *23*(4), 955–974. https://doi.org/10.1017/S0954579411000447

Gardner, F. (2001). Self-*harm: A psychotherapeutic approach.* Brunner–Routledge.

Garg, R., Melanson, S., & Levin, E. (2007). Educational aspirations of male and female adolescents from single-parent and two biological parent families: A comparison of influential factors. *Journal of Youth and Adolescence, 36*, 1010–1023. https://doi:10.1007/sl0964-006- 9137-3

Garner, A., Shonkoff, J. P., Siegel, B. S., Dobbins, M. I., Earls, M. F., McGuinn, L., Pascoe, J., & Wood, D. L. (2012). Early childhood adversity, toxic stress, and the role of the pediatrician: Translating developmental science into lifelong health. *Journal of the American Academy of Pediatrics, 129*, 223–233. https://doi.org/10.1542/peds.2011-2662

Gentry, J. E. (2002). Compassion fatigue: A crucible of transformation. *Journal of Trauma Practice*, *1*(3-4), 37–61. https://doi.org/10.1300/J189v01n03_03

George, B., Sims, P., McLean, A. N., & Mayer, D. (2007). Discovering your authentic leadership. *Harvard Business Review*, *85*(2), 129. https://www.simplylifeindia.com/uploads/8/1/1/5/8115412/discovering_your_authentic_leadership.pdf

Gerwin, C. (2013). *Innovating in early head start: Can reducing toxic stress improve outcomes for young children.* Center on the Developing Child, Harvard University. https://developingchild.harvard.edu/science/key-concepts/toxic-stress/tackling-toxicstress/innovating-in-early-head-start-can-reducing-toxic-stress-improve- outcomes-foryoung-children/

Giallo, R., Gavidia-payne, S., Minett, B., & Kapoor, A. (2012). Sibling voices: The self- reported mental health of siblings of children with a disability. *Clinical Psychologist*, *16*(1), 36–43. http://doi.org/10.1111/j.1742-9552.2011.00035.x

Gillies, V. (2011). Social and emotional pedagogies: Critiquing the new orthodoxy of emotion in classroom behaviour management. *British Journal of Sociology of Education*, *32*(2), 185–202. https://doi.org/10.1080/01425692.2011.547305

Gilligan, C. (1982). *In a different voice*. Harvard University Press.

Ginwright, S. (2011). Hope, healing, and care: Pushing the boundaries of civic engagement for African American youth. *Liberal Education*, *97*(2), 34–39. http://www.sbh4all.org/wp-content/uploads/2016/08/hope-healing-care-article.pdf

Ginwright, S. (2018). The future of healing: Shifting from trauma informed care to healing centered engagement. *Occasional Paper*, *25*. http://kinshipcarersvictoria.org/wpcontent/uploads/2018/08/OP-Ginwright-S- 2018-Future-of-healing-care.pdf

Goddard, N., Subotsky, F., & Fombonne, E. (1996). Ethnicity and adolescent deliberate self-harm. *Journal of Adolescence, 19,* 513–521. https://doi.org/10.1006/jado.1996.0050

Goe, L. (2002). Legislating equity: The distribution of emergency permit teachers in California. *Education Policy Analysis Archives, 10(*42). https://epaa.asu.edu/epaa/v10n42/

Goldstein, L. (1998a). More than gentle smiles and warm hugs: Applying the ethic of care to early childhood education. *Journal of Research in Childhood Education, 12*(2), 244–261. https://doi.org/10.1080/02568549809594888

Goldstein, L. (1998b, April). *Taking caring seriously: The ethic of care in classroom life*. [Paper presentation]. Annual Meeting of the American Educational Research Association, San Diego, CA. (ERIC Document Reproduction Service No. ED419801). https://files.eric.ed.gov/fulltext/ED419801.pdf

Goleman, D. (1995). *Emotional intelligence*. Bantam Books.

Goodman, R. D., Miller, M. D., & West-Olatunji, C. A. (2012). Traumatic stress, socioeconomic status, and academic achievement among primary school students. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*(3), 252. https://doi.org/10.1037/a0024912

Graham-Bermann, S. A., & Levendosky, A. A. (1998). Traumatic stress symptoms in children of battered women. *Journal of Interpersonal Violence*, *13*(1), 111–128. https://doi.org/10.1177/088626098013001007

Greenberg, M. T., Weissberg, R. P., O'Brien, M. U., Zins, J. E., Fredericks, L., Resnik, H., & Elias, M. J. (2003). Enhancing school-based prevention and youth development through coordinated social, emotional, and academic learning. *American Psychologist*, *58*(6–7), 466. https://psycnet.apa.org/doi/10.1037/0003-066X.58.6-7.466

Halberstadt, J. (2003). The paradox of emotion attribution: Explanation biases perceptual memory for emotional expressions. *Current Directions in Psychological Science*, *12*(6), 197–201. https://doi.org/10.1046%2Fj.0963-7214.2003.01261.x

Hall, J., Johnson, S., Wysocki, A., & Kepner, K. (2002). Transformational leadership: The transformation of managers and associates. *EDIS*. https://journals.flvc.org/edis/article/view/108144

Harris, M., & Fallot, R. D. (2001). *Using trauma theory to design service systems*. Jossey- Bass.

Harris, N. B. (2018). *The deepest well: Healing the long-term effects of childhood adversity*. Houghton Mifflin Harcourt.

Harter, S. (1988). Developmental and dynamic changes in the nature of the self-concept: Implications for child psychotherapy. In S. Shirk (Ed.), *Cognitive development and child psychotherapy* (pp. 119–160). Springer.

Hatch, J. A. (2002). *Doing qualitative research in education settings*. State University of New York Press.

Hawk, T. F. (2017). Getting to know your students and an educational ethic of care. *Journal of Management Education*, *41*(5), 669–686. https://doi.org/10.1177/1052562917716488

Hawton, K., Fagg, J., Simkin, S., Bale, E. & Bond, A. (2000). Deliberate self-harm in adolescence in Oxford 1985–1995. *Journal of Adolescence, 23*, 47–55. https://doi.org/10.1006/jado.1999.0290

Heifetz, R. A. (1994). *Leadership without easy answers*. (Vol. 465). Harvard University Press.

Heifetz, R. A., & Linsky, M. (2002). *Leadership on the line: Staying alive through the dangers of leading*. Harvard Business School Press.

Heifetz, R. A., & Linsky, M. (2004). When leadership spells danger. *Educational Leadership*, *61*(7), 33–37. https://www.wisconsinrticenter.org/wp-content/ uploads/2019/04/6.3-When-Leadership-Spells-Danger.pdf

Held, V. (1993). *Feminist morality: Transforming culture, society, and politics*. University of Chicago Press.

Held, V. (2006). *The ethics of care*. Oxford University Press.

Hetherington, E. M., & Kelly, J. (2002). *For better or for worse: Divorce reconsidered.* W.W. Norton & Company.

Hoffman, M. L. (2000). *Empathy and moral development: Implications for caring and justice*. Cambridge University Press.

Holmes, C., Levy, M., Smith, A., Pinne, S., & Neese, P. (2015). A model for creating a supportive trauma-informed culture for children in preschool settings. *Journal of Child and Family Studies,* 24, 165–169. https://link.springer.com/content/pdf/10.1007/s10826014-9968-6.pdf

Holt, N. L. (2003). Representation, legitimation, and autoethnography: An autoethnographic writing story. *International Journal of Qualitative Methods*, 18–28. https://doi.org/10.1177/160940690300200102

Hoover, S. A. (2019). Policy and practice for trauma-informed schools. *State Education Standard*, *19*(1), 25–29. https://nasbe.nyc3.digitaloceanspaces.com/2019/01/Hoover_January-2019-Standard.pdf

Hopper, E. K., Bassuk, E., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal,* 3, 80–100. https://benthamopen.com/ABSTRACT/TOHSPJ-3-80

Isenbarger, L., & Zembylas, M. (2006). The emotional labour of caring in teaching. *Teaching and Teacher Education*, *22*(1), 120–134. https://doi.org/10.1016/j.tate.2005.07.002

Jaycox, L. H., Cohen, J. A., Mannarino, A. P., Walker, D. W., Langley, A. K., Gegenheimer, K., et al. (2010). Children's mental health care following Hurricane Katrina: A field trial of trauma-focused psychotherapies. *Journal of Traumatic Stress, 23*, 223–231. https://doi.org/10.1002/jts.20518

Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validational study. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies*, *15*(5), 423–432. https://doi.org/10.1023/A:1020193526843

Jensen, E. (2009). *Teaching with poverty in mind: What being poor does to kids' brains and what schools can do about it*. Association for Supervision and Curriculum Development.

Jin, C. & Lan, L. (2014). A meta-analysis of the difference between juvenile delinquents and ordinary juveniles in parenting styles. *Chinese Journal of Special Education*, *21*(02), 90–96.

Joseph, A. A., Wilcox, S. M., Hnilica, R. J., & Hansen, M. C. (2020). Keeping race at the center of school discipline practices and trauma-informed care: An interprofessional framework. *Children & Schools*, *42*(3), 161-170. https://doi.org/10.1093/cs/cdaa013

Karadag, E., & Öztekin, O. (2018). The effect of authentic leadership on school culture: A structural equation model. *International Journal of Educational Leadership and Management*, *6*(1), 40–75. (ERIC Document Reproduction Service No. EJ1166860). https://files.eric.ed.gov/fulltext/EJ1166860.pdf

Katz, L. G. (1971). Sentimentality in preschool teachers: Some possible interpretations. *Peabody Journal of Education*, *48*(2), 96–105. https://doi.org/10.1080/01619567109537774

Kidman, R., Margolis, R., Smith-Greenaway, E., & Verdery, A. M. (2021). Estimates and projections of COVID-19 and parental death in the US. *JAMA Pediatrics*. doi:10.1001/jamapediatrics.2021.0161

Kittay, E. F. (1999). *Love's labor: Essays on women, equality, and dependency*. Routledge.

Klain, E., & White, A. (2013). *Implementing trauma-informed practices in child welfare*. Baltimore, MD: State Policy Advocacy & Reform Center. http://childwelfaresparc.org/brief-implementing-traumainformed-practices-in-child-welfare/

Ko, S., Ford, J., Kassam-Adams, N., Berkowitz, S., Wilson, S., & Wong, M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice*, 39, 396–404. http://dx.doi.org/10.1037/0735-7028.39.4.396

Kohlberg, L. (1958). *The development of modes of thinking and choices in years 10 to 16.* (Ph.D. Dissertation)*,* University of Chicago.

Laslett, B. (1999). Personal narratives as sociology. *Contemporary Sociology, 28*(4), 391–401. https://www.jstor.org/stable/2655287

Leavy, P. (2017). *Research design: Quantitative, qualitative, mixed methods, arts-based, and community-based participatory research approaches.* The Guilford Press.

LeCompte, M. D., & Schensul, J. J. (1999). *Designing and conducting ethnographic research*. AltaMira Press.

Len, A. and Kortum, J. (2004). Self-injury: The secret language of pain for teenagers. *Education, 124*(3), 517–527.

Lewis, C. B. (2007). *Identity: Lost, found, and (re)constructed through healing narratives---an autoethnography of tragedy, travail, and triumph*. Ohio University.

Lincoln, Y. S. & Denzin, N. K. (Eds.). (2000). *Handbook of qualitative research* (pp. 163–188). Sage Publications.

Lincoln, Y. S. & Guba, E. G., (1990). Judging the quality of case study reports. *International Journal of Qualitative Studies in Education*, *3*(1), 53–59. https://doi.org/10.1080/0951839900030105

Lipari, R. N., & Van Horn, S. L. (2017). Children living with parents who have a substance use disorder. *The CBHSQ report*. https://www.ncbi.nlm.nih.gov/books/NBK464590/

Loomis, B., Epstein, K., Dauria, E. F., & Dolce, L. (2019). Implementing a trauma-informed public health system in San Francisco, California. *Health Education & Behavior*, *46*(2), 251–259. https://doi.org/10.1177/1090198118806942

Lucas, L. (2007). The pain of attachment–"You have to put a little wedge in there"– How vicarious trauma affects child/teacher attachment. *Childhood Education, 84*(2), 85–91. https://doi.org/101080/00094056.2008.10522979

Lynam, D. R. (1996). Early identification of chronic offenders: Who is the fledgling psychopath?. *Psychological Bulletin*, *120*(2), 209. https://psycnet.apa.org/buy/199601404-003

Maguire, L. K., Niens, U., McCann, M., & Connolly, P. (2016). Emotional development among early school-age children: Gender differences in the role of problem behaviours. *Educational Psychology*, *36*(8), 1408-1428. https://doi.org/10.1080/01443410.2015.1034090

Martin, J. R. (1995). *The schoolhome*. Harvard University Press.

McGruder, K. (2019). Children learn what they live: Addressing early childhood trauma resulting in toxic stress in schools. *Mid-Western Educational Researcher, 31*(1), 117–137. https://www.mwera.org/MWER/volumes/v31/issue1/V31n1-McGruder-COMMENTARY.pdf

McIlveen, P. (2008). Autoethnography as a method for reflexive research and practice in vocational psychology. *Australian Journal of Career Development 17*(2), 13–20. https://doi.org/10.1177/103841620801700204

McLaughlin, J., Miller, P. & Wawrick, H. (1996). Deliberate self-harm in adolescents: Hopelessness, depression, problems and problem-solving. *Journal of Adolescence, 19*, 523–532. https://doi.org/10.1006/jado.1996.0051

Meltzer, H., Harrington, R., Goodman, R., & Jenkins, R. (2001). *Children and adolescents who try to harm, hurt or kill themselves*. Office for National Statistics. https://www.researchgate.net/profile/Rachel-Jenkins-4/public ation/237427010_Children_and_Adolescents_Who_Try_to_Harm_Hurt_or_Kill_ Themselves/links/00b4952fe0b816d6000000/Children-and-Adolescents-Who- Try-to-Harm-Hurt-or-Kill-Themselves.pdf

Méndez, M. (2013). Autoethnography as a research method: Advantages, limitations and criticisms. *Colombian Applied Linguistics Journal*, *15*(2), 279–287. http://www.scielo.org.co/scielo.php?script=sci_arttext&pid=S0123-46412013000200010

Meyerson, D. A., Grant, K. E., Carter, J. S., & Kilmer, R. P. (2011). Posttraumatic growth among children and adolescents: A systematic review. *Clinical Psychology Review*, *31*(6), 949–964. https://doi.org/10.1016/j.cpr.2011.06.003

Miller, J. (2021, April 8). *As many as 43,000 U.S. children have lost a parent to COVID-19.* USC News. https://news.usc.edu/184646/thousands-of-children-lost-a-parent-to-covid-19-usc- research/

Miller-Lewis, L. R., Searle, A. K., Sawyer, M. G., Baghurst, P. A., & Hedley, D. (2013). Resource factors for mental health resilience in early childhood: An analysis with multiple methodologies. *Child and Adolescent Psychiatry and Mental Health*, *7*(1), 1–23. https://doi.org/10.1186/1753-2000-7-6

Muncey, T. (2005). Doing autoethnography. *International Journal of Qualitative Methods, 4*(3), Article 5. http://www.ualberta.ca/~iiqm/backissues/4_1/pdf/muncey.pdf

Nadkarni, A., Parkin, A., Dogra, N., Stretch, D. & Evans, P. (2000). Characteristics of children and adolescents presenting to accident and emergency departments with deliberate self-harm. *Journal of Accident and Emergency Medicine, 17*, 98–102. http://dx.doi.org/10.1136/emj.17.2.98

Nash, C. (2002). Cultural geography: postcolonial cultural geographies. *Progress in Human Geography*, *26*(2), 219–230. https://doi.org/10.1191/0309132502ph365pr

National Center for Education Statistics. (2015). *The condition of education*. https://nces.ed.gov/programs/coe.

National Education Goals Panel Working Group. (1995). *Technical Planning Group report: Reconsidering children's early development and learning: Toward common views and vocabulary 95*(3). National Education Goals Panel.

Nelson, H. J., Kendall, G. E., & Shields, L. (2014). Neurological and biological foundations of children's social and emotional development: An integrated literature review. *The Journal of School Nursing, 30*(4), 240–250. https://doi.org/10.1177/1059840513513157

Nieto, S. (2015). *The light in their eyes: Creating multicultural learning communities*. Teachers College Press.

No Child Left Behind Act of 2001, P.L. 107-110, 20 U.S.C. § 6319 (2002). https://www.congress.gov/bill/107th-congress/house-bill/1

Noddings, N. (1984). *Caring: A feminine approach to ethics and moral education*. University of CA Press.

Noddings, N. (1992). In defense of caring. *The journal of clinical Ethics*, *3*(1), 15-18.

Noddings, N. (2002). *Starting at home: Caring and social policy.* University of CA Press.

Noddings, N. (2013). *Caring: A relational approach to ethics & moral education* (2nd ed.). University of California Press.

Northouse, P. G. (2019). *Leadership: Theory and practice. Eighth edition*. Sage Publications Ltd.

O'Connor, R., Rasmussen, S., Miles, J., & Hawton, K. (2009). Self-harm in adolescents: Self-report survey in schools in Scotland. *British Journal of Psychiatry, 194*(1), 68–72. https://doi.org/10.1192/bjp.bp.107.047704

Odom, S. L., McConnell, S. R., & McEvoy, M. A. (1992). Peer-related social competence and its significance for young children with disabilities: Issues and strategies for intervention. In *Social competence of young children with disabilities: Issues and strategies for intervention* (pp. 3–35). Brookes.

Parker, J., & Gottman, J. (1989). Social and emotional development in a relational context. In Berndt, T., & Ladd, G. (Eds) *Peer relationships in child development*. Wiley and Sons.

Patten, J. T. (2004). *Navigating unfamiliar territory: Autoethnography of a first-year elementary school principal* (Publication No. 3126327) [Doctoral dissertation, The University of Utah]. ProQuest One Academic.

Peeples, J. (2019, October). A culture of compassion. *California Educator,* 20–25.

Perry, B., & Szalavitz, M. (2006). *The boy who was raised as a dog.* Basic Books.

Perry, B. D., & Szalavitz, M. (2017). *The boy who was raised as a dog: And other stories from a child psychiatrist's notebook--What traumatized children can teach us about loss, love, and healing*. Hachette.

Peterson, J., Freedenthal, S., Sheldon, C., & Andersen, R. (2008). Nonsuicidal self-injury in adolescents. *Psychiatry, 5*(11), 20–26. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2695720/.

Plumb, J. L., Bush, K. A., & Kersevich, S. E. (2016). Trauma-sensitive schools: An evidence based approach. *School Social Work Journal, 40*(2), 37–60.

Prior, D. (2016, February). The effects of self-harm on the family. *Sunrise*. https://www.sunrisertc.com/the-impact-of-self-harm-on-the-family/

Purvis, K., Cross, D., Jones, D., & Buff, G. (2012). Transforming cultures of care: A case study in organizational change. *Reclaiming Children and Youth*, *21*(2), 12. https://search.proquest.com/scholarly-journals/transforming-cultures-care-case study/docview/1326253666/se-2?accountid=133566

Rabin, C., & Smith, G. (2013). Teaching care ethics: Conceptual understandings and stories for learning. *Journal of Moral Education*, *42*(2), 164–176. https://doi.org/10.1080/03057240.2013.785942

Raudenbush, C. A. (1994). *Improvisation: An autoethnography of my first year as an administrator* (Publication No. 9544855) [Doctoral dissertation, The University of Kansas, Curriculum and Instruction]. https://search.proquest.com/docview/304189968?accountid=133566

Raver, C. C., Garner, P., & Smith-Donald, R. (2007). The roles of emotion regulation and emotion knowledge for children's academic readiness: Are the links causal? In B. Pianta, K. Snow, & M. Cox (Eds.), *Kindergarten transition and early school success* (pp. 121–148). Brookes Publishing.

Reed-Danahay, D. (1997). *Auto/Ethnography: Rewriting the self and the social*. Berg.

Reinke, W. M., Stormont, M., Herman, K. C., Puri, R., & Goel, N. (2011). Supporting children's mental health in schools: Teacher perceptions of needs, roles, and barriers. *School Psychology Quarterly, 26*, (1), 1–13. https://psycnet.apa.org/doi/10.1037/a0022714

Responsive Classroom. (n.d.). *Principles and practices.* https://www.responsiveclassroom.org

Richardson, L. (2000). Evaluating ethnography. *Qualitative Inquiry*, *6*(2), 253–255. https://doi.org/10.1177/107780040000600207

Robert Wood Johnson Foundation (2017, Oct. 19). *Traumatic experiences widespread among U.S. youth, new data show.* https://www.rwjf.org/en/library/articles-and-news/2017/10/traumatic-experiences-widespread-among-u-s--youth--new-data-show.html

Roberts, E. A., Comeau, J. K., Van Asselt, K. W., & Trepal, H. C. (2019). School counselors' experiences and practices of working with adolescents who self-harm. *Journal of School Counseling*, *17*(17). (ERIC Document Reproduction Service No. EJ1218587). https://files.eric.ed.gov/fulltext/EJ1218587.pdf

Rodriguez, V. (2012). The teaching brain and the end of the empty vessel. *Mind, Brain, and Education*, *6*(4), 177–185. https://doi.org/10.1111/j.1751-228X.2012.01155.x

Rogers, C. (1961). *On becoming a person; A therapist's view of psychotherapy.* Houghton Mifflin.

Rolfsnes, E. S., & Idsoe, T. (2011). School-based intervention programs for PTSD symptoms: A review and meta-analysis. *Journal of Traumatic Stress, 24*, 155–165. https://doi.org/10.1002/jts.20622

Rollins, H. E. (Ed.). (2012). *The letters of John Keats: Volume 2, 1819-1821: 1814-1821* (Vol. 2). Cambridge University Press.

Rose, H., Sonstelie, J., & Reinhard, R. M. (2006). *School resources and academic standards in California: Lessons from the schoolhouse*. Public Policy Institute of CA.

Rosen, D. S. (2010). Clinical report—identification and management of eating disorders in children and adolescents. *Pediatrics*. https://pediatrics.aappublications.org/content/pediatrics/early/2010/11/29/peds.2010-2821.full.pdf

Rosiek, J. (1994). Caring, classroom management, and teacher education: The need for case study and narrative methods. *Teaching Education*, *6*(1), 21–30. https://doi.org/10.1080/1047621940060104

Rucinski, C. L., Brown, J. L., & Downer, J. T. (2018). Teacher–child relationships, classroom climate, and children's social-emotional and academic development. *Journal of Educational Psychology*, *110*(7), 992. https://psycnet.apa.org/doi/10.1037/edu0000240

Schwandt, T. A. (2001). *Dictionary of qualitative inquiry*. Sage Publications.

Self-Harm (2019). *Psychology Today*. https://www.psychologytoday.com/us/basics/self-harm

Self-Harm & Self-Injury Causes & Effects (2019). *PRTC*. https://www.pineyridge.net/disorders/self-harm/causes-effects-symptoms/

Selman, R. (1981). The development of interpersonal competence: The role of understanding in conduct. *Developmental Review*, *1*(4), 401–422. https://doi.org/10.1016/02732297(81)90034-4

Selman, R. L., Schorin, M. Z., Stone, C. R., & Phelps, E. (1983). A naturalistic study of children's social understanding. *Developmental Psychology*, *19*(1), 82. https://psycnet.apa.org/doi/10.1037/0012-1649.19.1.82

Selman, R., & Schultz, L. (1990). *Making a friend in youth: Developmental theory and pair therapy.* University of Chicago Press.

Shamir, B., & Eilam-Shamir, G. (2005). "What's your story?" A life-stories approach to authentic leadership development. In *Leadership Now: Reflections on the Legacy of Boas Shamir* (pp. 51–76). Emerald Publishing Limited.

Shannon, R. A., Bergren, M. D., & Matthews, A. (2010). Frequent visitors: Somatization in school age children and implications for school nurses. *The Journal of School Nursing*, *26*(3), 169–182. https://doi.org/10.1177/2F1059840509356777

Shields, C. M. (2010). Transformative leadership: Working for equity in diverse contexts. *Educational Administration Quarterly*, *46*(4), 558–589. https://doi.org/10.1177/0013161X10375609

Shields, C. M. (2014). Leadership for social justice education: A critical transformative approach. In *International handbook of educational leadership and social (in) justice* (pp. 323–339). Springer. https://doi.org/10.1007/978-94-007-6555-9_19

Signs, Symptoms, & Effects of Self-Injury (2019). *Options Behavioral Health System*. https://www.optionsbehavioralhealthsystem.com/self-injury/effects-signssymptoms/

Simm, R., Roen, K., & Daiches, A. (2008). Educational professionals' experiences of self-harm in primary school children: "You don't really believe, unless you see it*". Oxford Review of Education, 34*(2), 253–269. https://doi.org/10.1080/03054980701663967

Simm, R., Roen, K., & Daiches, A. (2010). Primary school children and self-harm: The emotional impact upon education professionals, and their understandings of why children self harm and how this is managed. *Oxford Review of Education, 36*(6), 677-692. https://doi.org/10.1080/03054985.2010.501139

Sinha, J. W., & Rosenberg, L. B. (2013). A critical review of trauma interventions and religion among youth exposed to community violence. *Journal of Social Service Research*, *39*(4), 436–454. https://doi.org/10.1080/01488376.2012.730907

Small, S. A., & Huser, M. (2019). An extension educator perspective on trauma-informed care. *The Journal of Extension*, *57*(1). https://fyi.extension.wisc.edu/whatworkswisconsin/files/2014/ 04/Trauma-informed-Care-13.pdf

Smith, J. K. (1993). *After the demise of empiricism: The problem of judging social and educational inquiry*. Ablex.

Souers, K. (2018). Responding with care to students facing trauma. *Educational Leadership*, *75*(4), 32–36. https://www.ascd.org/el/articles/responding-with-care to-students-facing-trauma

Spandler, H. (1996). *Who's hurting who? Young people, self-harm and suicide.* Handsell Publishing.

Sparkes, A. (2000). Autoethnography and narratives of the self: Reflections on criteria in action. *Sociology of Sport Journal, 17*(1), 21–43. https://doi.org/10.1123/ssj.17.1.21

Stopa, J. E., Barrett, P. M., & Golingi, F. (2010). The prevention of childhood anxiety in socioeconomically disadvantaged communities: A universal school-based trial. *Advances in School Mental Health Promotion, 3*(4), 5–24. https://doi.org/10.1080/1754730X.2010.9715688

Substance Abuse and Mental Health Services Administration. (2014). Guiding principles of trauma-informed care. *SAMHSA News, 22*(2). https://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_2/trauma_tip/guiding_principles.html

Sutton, J. (1999). *Healing the hurt within: Understand and relieve the suffering behind self-destructive behavior*. How to Books.

Tedeschi, R. G., Calhoun, L. G., & Groleau, J. M. (2015). Clinical applications of posttraumatic growth. *Positive Psychology in Practice: Promoting Human Flourishing in Work, Health, Education, and Everyday Life*, *2*, 503–518. https://doi.org/10.1002/9781118996874

Thomas, M. S., Crosby, S., & Vanderhaar, J. (2019). Trauma-informed practices in schools across two decades: An interdisciplinary review of research. *Review of Research in Education*, *43*(1), 422–452. https://doi.org/10.3102/0091732X18821123

Thompson, A. (1998). Not the color purple: Black feminist lessons for educational caring. *Harvard Educational Review*, *68*(4), 522–555. https://doi.org/10.17763/haer.68.4.nm436v83214n5016

Thompson, R. A., & Lagattuta, K. H. (2006). Feeling and understanding: Early emotional development. In K. McCartney & D. Phillips (Eds.), *Blackwell handbook of early childhood development* (pp. 317–337). Blackwell Publishing. https://doi.org/10.1002/9780470757703.ch16

Tishler, C. L., Reiss, N. S., & Rhodes, A. R. (2007). Suicidal behavior in children younger than twelve: A diagnostic challenge for emergency department personnel. *Academic Emergency Medicine, 14*(9), 810–818. https://doi.org/10.1197/j.aem.2007.05.014

Tracy, N. (2012, August 24). Effects of self-harm, self-injury. *HealthyPlace*. https://www.healthyplace.com/abuse/self-injury/effects-of-self-harm-self-injury

Tronto, J. (1994). *Moral boundaries: A political argument for an ethic of care*. Routledge.

Uhl-Bien, M., Marion, R., & McKelvey, B. (2007). Complexity leadership theory: Shifting leadership from the industrial age to the knowledge era. *The Leadership Quarterly*, *18*(4), 298–318. https://www.sciencedirect.com/science/article/pii/S1048984307000689

U.S. Department of Health and Human Services (2017). *Child maltreatment 2017.* https://www.acf.hhs.gov/sites/default/files/cb/cm2017.pdf

Van der Kolk, B. A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma.* Penguin.

Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. State University of New York Press.

Van Oord, L. (2013). Towards transformative leadership in education. *International Journal of Leadership in Education*, *16*(4), 419–434. https://doi.org/10.1080/13603124.2013.776116

Venet, A. S. (2019). Role-clarity and boundaries for trauma-informed teachers. *Educational Considerations*, *44*(2). https://newprairiepress.org/cgi/viewcontent.cgi?article=2175&context=edconsiderations

Vergara, S. (2017). *Lived history of a transformative leader with a disability: An evocative autoethnography for social justice.* (Publication No. 10271156) [Doctoral dissertation, Loyola Marymount University]. ProQuest

Weiner, E. J. (2003). Secretary Paulo Freire and the democratization of power: Toward a theory of transformative leadership. *Educational Philosophy and Theory, 35*(1), 89–106. http://dx.doi.org/10.1111/1469-5812.00007

Wiest-Stevenson, C., & Lee, C. (2016). Trauma-informed schools. *Journal of Evidence Informed Social Work, 13*(5), 498–503. https://doi.org/10.1080/23761407.2016.1166855

Wilder, M. (1999, December). Culture, race, and schooling: Toward a non-color-blind ethic of care. In *The Educational Forum* (Vol. 63, No. 4, pp. 356–362). Taylor & Francis Group. https://doi.org/10.1080/00131729908984444

Wolchik, S. A., West, S. G., Sandler, I. N., Tein, J. Y., Coatsworth, D., Lengua, L., Weiss, L., Anderson, E. R., Greene, S. M., & Griffin,W. A. (2000). An experimental evaluation of theory-based mother and mother-child programs for children of divorce. *Journal of Consulting and Clinical Psychology, 68*, 843–856. https://doi: 10.1037/0022006X.68.5.843

Wolmer, L., Hamiel, D., Barchas, J. D., Slone, M., & Laor, N. (2011). Teacher delivered resilience-focused intervention in schools with traumatized children following the second Lebanon war. *Journal of Traumatic Stress, 24*(3), 309–316. https://doi.org/10.1002/jts.20638

Wolpow, R., Johnson, M. M., Hertel, R., & Kincaid, S. (2009). *The heart of learning and teaching: Compassion, resiliency, and academic success*. Office of Superintendent of Public Instruction (OSPI) Compassionate Schools.

Young, N. (2021, March 25). *Childhood disability in the United States: 2019.* United States Census Bureau. https://www.census.gov/content/dam/Census/library/publications/2021/acs/acsbr-006.pdf

Zartner, D. (2019). Focus on the positive: How do we keep our classes from becoming too depressing?. *Journal of Political Science Education*, *15*(3), 346–364. https://doi.org/10.1080/15512169.2018.1472000

Zhang, J., Wang, S., & Lu, Y. (2019). Father involvement in education predicates the mental health status of Chinese primary school students. *World Journal of Education*, *9*(4), 65–72. https://doi.org/10.5430/wje.v9n4p65

Zins, J., Bloodworth, M., Weissberg, R. & Walberg, H. (2007). The scientific base linking social and emotional learning to school adjustment. *Journal of Educational & Psychological Consultation*, *17*(2/3), 191–210. https://doi.org/10.1080/10474410701413145