School as Sanctuary: Trauma-Informed Care to Nurture Child Well-Being in High- Poverty Schools

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Nomisha Kurian

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Abstract

Can schools become sanctuaries of well-being and care, rather than perpetuating or overlooking trauma? There is a growing call to investigate how schools might nurture trauma-informed relationships of care, trust, and rapport with at-risk students, particularly in high-poverty communities that experience high rates of interpersonal and collective adversity. This chapter provides an up-to-date overview of foundations and innovations in trauma-informed care in education. It pays special attention to high-poverty schools in India, while also presenting implications for schools around the world. The chapter begins with the foundations of trauma-informed education, explaining its historical origins, pioneering frameworks, and key concepts and terminologies used in this field. It then goes on to outline key debates and innovations in trauma-informed education regarding rejecting deficit-driven approaches, adopting assets-centered views of students'

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capabilities and strengths, developing locally contextualized school policies and pedagogies, and recognizing the systemic inequalities affecting child well-being. The chapter encourages educators and educationists to proactively respond to childhood adversity with trauma-informed cultures of care.

Keywords

Trauma-informed education · Child wellbeing · Adverse childhood experiences · Low-income students

Introduction

Trauma-informed care to protect and promote young people's well-being is urgent and necessary in schools due to the very nature of education as a daily collision of hearts, minds, and spirits. As two leading thinkers within trauma-informed education put it, "as an educator, you don't have a choice about being in the trauma business. You do have a choice in what you do about it" (Souers & Hall, 2018, p. 11).

Here are a few examples of acute, chronic, complex, and/or intergenerational trauma affecting how students engage with their schooling. The reader is cautioned that the list below contains references to child abuse and violence.

- A teacher witnesses her students trying to make sense of loss in the wake of California's "deadliest and most destructive" wildfire (Galguera & Bellone, 2020, p. 6). One student whose family raised pigs repeatedly writes "pig" on scraps of stationery each day and spends each playtime acting as a pig; another student states, "My mom was screaming in the middle of the fire" during a classroom activity (Galguera & Bellone, 2020, p. 6).
- 12-year-old Dev has been in out-of-home care since the age of 5, has witnessed domestic violence, and has been physically harmed by foster carers. Although his teacher tries to make conversation with him about music, games, and sports, Dev rarely opens up. Three years behind his classmates in terms of learning, Dev often seems disengaged – "staring off into space" and expressing a hatred of school and the belief that investing effort into education is "pointless" (Brunzell & Norrish, 2021, p. 86).
- 6-year-old James has been unusually quiet and tearful after witnessing an older peer being shot. Although his preschool teacher describes him as typically motivated and cooperative, he now screams, "Leave me alone!" when other preschoolers try to talk to him. James does not feel able to venture outside without an adult holding his hand during recess and lunch (Nicholson et al., 2018, p. 195).

Honing in on the Indian context:

- Sharda, a Dalit (lower-caste) girl in Bihar, is married off against her will at the age of 14. Her parents refuse to send her to school any longer. When she tries to enter

the classroom before her wedding, she finds that her name has been struck off the school register. No members of the gram panchayat (village council) intervene to stop this forced child marriage. She tells Human Rights Watch, "There was no one I could turn to who would help me" (Bajoria, 2014, p. 5).

- A 7-year-old girl in Andhra Pradesh becomes too frightened to attend school after being repeatedly beaten. Her mother reports, "she says she will not go and she hides behind that wall ... and says that "Sir will beat me, they will beat me"" (Morrow & Singh, 2014, p. 12).
- 10-year-old Sonia experiences parental bereavement after her father beats her mother to death. After being taken to a Delhi care home, Sonia refuses to cooperate with her peers and carers, making two attempts to run away and cutting herself (Modi & Hai, 2019).
- An 11-year-old child in Bangalore, who has become accustomed to violence as a form of classroom discipline, is asked if he wants kind teachers. He replies, "Kindness isn't important, we need to be scared because that's how we'll learn." (Kurian, 2020a, p. 199). His classmate adds, "If there isn't any hitting, I'm not sure if there's another good way to keep discipline because then the students will not be scared that the teacher is going to hit them" (Kurian, 2020a, p. 199). The region has been marked by colonial-era histories of punitive discipline in schools and intergenerational transmission of the idea that violence is acceptable (Kurian, 2020a).

These incidents yield a glimpse into the effects of adverse life experiences and histories upon young people's well-being and ability to learn. Indeed, "once one becomes aware of it, trauma seems to be hiding in plain sight in our schools" (NCSEA, 2019, p. 2). The next question is: What can we do about it? Can schools become spaces of well-being, healing, and peace, rather than reproducing or ignoring trauma? The COVID-19 pandemic has made dilemmas of care more relevant than ever (Moulin-Stożek et al., 2021) although the question of how to proactively promote child well-being extends beyond the pandemic.

This chapter explores some of the most significant theoretical and empirical work on trauma-informed care from an educational perspective. The chapter begins by charting the origin of trauma-informed education, its pioneering frameworks, and key terms and concepts used in the field of trauma-informed care. It then explores key debates and innovations in trauma-informed education around rejecting deficit-driven approaches, adopting assets-centered or strengths-based views of students' capabilities, and responding to the systemic inequalities affecting child well-being. It concludes with a list of points for reflection to assist educators, school-based professionals, researchers, and others interested in building trauma-informed school cultures of well-being.

With regard to geographical scope, while trauma-informed care is still nascent in India, it has been advocated by a rising number of India-based scholars and practitioners across healthcare, social work, and psychology (Choudhury, 2020; Golchha, 2020; Hughes, 2021; Malhi & Bharti, 2021; Modi & Hai, 2019; Suman, 2015). Insights from this growing body of work are thus woven throughout the chapter.

However, given the broad scope of trauma-informed education, the chapter draws on a variety of international scholars and diverse school contexts. The conceptual and empirical literature reviewed may thus be relevant to schools in a range of geographical and socioeconomic settings.

Trauma-Informed Education: The Birth of a Movement

Trauma-informed education would not have sprung into being without raising awareness at the turn of the millennium about the effects of childhood adversity. The first Adverse Childhood Experiences study – Felitti et al.'s (1998) survey of over 17,000 adults – revealed the enduring physical and psychological impacts of trauma-inducing events experienced in childhood. Adverse Childhood Experiences (ACEs for short) denote the term used to describe "all types of abuse, neglect, and other potentially traumatic experiences that occur to people under the age of 18" (NCSEA, 2019, p. 2). Felitti et al. (1998) found that individuals who had experienced four or more ACEs, compared to those with none, were 4–12 times more likely to suffer alcoholism, drug abuse, depression, and suicide attempts; 2–4 times more likely to smoke and self-report poor health; and 1.4- to 1.6 times more likely to undergo physical inactivity and severe obesity. Moreover, more ACEs a participant had, the more at risk they were for adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. ACEs thus correlated to multiple risk factors for poor health and the leading causes of death (Felitti et al., 1998). This study marked a turning point in scholarly awareness that children exposed to trauma tend to struggle with somatic, psychological, and behavioral difficulties later in the life course, even becoming more likely to suffer diseases, disabilities, and shorter life spans (Felitti et al., 1998). A compelling example comes from Nadine Burke Harris, an eminent physician in the field of trauma-informed care and the author of *The Deepest Well: Healing the Long-Term Effects of Childhood Adversity.* Harris writes about a seven-year-old preschooler who came into her clinic appearing perfectly healthy, but who had not grown by even a centimeter since suffering trauma at the age of four (Harris, 2018).

The prevalence of ACEs is high globally. For example, England's Children's Commissioner (2019) found that in the average classroom four children had poor mental health, four children are witnessing domestic violence, substance abuse, or severe mental health problems at home, and six are at-risk due to their family circumstances (Children's Commissioner, 2019). In India, Damodaran and Paul (2018) explain that "reliable statistics on ACEs in the Indian context remain unavailable as there is lack of surveillance data base and systematic investigations using the umbrella term "ACEs"" (p. 4). However, these researchers found in their sample of 600 youth that "ACEs were highly prevalent (91%) among youth and more than half of them had experienced three or more ACEs" (p. 2). Singh et al. (2014) found that India has the world's greatest number of child sexual abuse cases, an additionally jarring statistic given that the official rate recorded by the National Crime Records bureau is "considered artificially low" (Damodaran & Paul, 2018,

p. 77). Coupled with extensive evidence on the severe shocks and stressors experienced by disadvantaged Indian children (see Boyden et al., 2019), it is likely a substantial proportion of students in high-poverty Indian classrooms, as well as classrooms globally, will have experienced at least one form of childhood adversity. Indeed, "most educators encounter trauma-affected students throughout their careers, whether they know it or not" (NCSEA, 2019, p. 4).

For the sake of precision in terminology, it is important to note that "trauma" and "adversity" do not have the same meaning, although they closely overlap and are often used in conjunction in the field of trauma-informed care. Childhood adversity is a broad term that refers to multiple, possibly intersecting, life events and circumstances that undermine children's psychological and somatic health and well-being (Bartlett & Sacks, 2019). Trauma, on the other hand, is most widely defined as the *result* of "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individuals' functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA, 2014). Both affective and embodied elements produce trauma in the wake of adversity; the American Psychological Association (n.d.) defines trauma as "an emotional response to a terrible event like an accident, rape or natural disaster" including "shock and denial...unpredictable emotions, flashbacks, strained relationships" and "physical symptoms like headaches or nausea" (p. 1). It can also be seen as a psycho-spiritual wound in need of care and recovery: "trauma is a sudden harmful disruption impacting on all of the spirit, body, mind and heart that requires healing" (Moran & Fitzpatrick, 2008, p. 153, cited in Pihama et al., 2017). Adversity and trauma are thus distinctive terms.

Nevertheless, childhood adversity and trauma are inextricably interlinked, as the number of ACEs (Adverse Childhood Experiences) that an individual experiences correlates to their likelihood of suffering trauma (Bartlett & Sacks, 2019). Treisman (2016) lists relevant factors that determine whether or not an experience becomes traumatic and its effects: temperament, genes, age, life-stage, prior life experiences, the nature, intensity, duration, and frequency of the experience, the role of trauma-perpetrators in the child's life, others' willingness to believe and validate the child, levels of support given, the child's own meaning-making and causal attributions around the event, and risk and protective factors, and the cultural context (p. 4). These factors play a significant role in shaping the origin, development, and consequences of trauma, although each child's journey will be unique.

A key difference between trauma and typical hardship lies in the nature of the stress experienced. As Walkley and Cox (2013) explain, childhood stress lies along a continuum. On one end, developmentally appropriate stress is triggered when children experience healthy challenges that stimulate their growth (having to wait for a treat or make choices in play). However, on the other end of the continuum lies toxic stress, a term introduced by the Harvard Centre on the Developing Child in 2005 (National Scientific Council on the Developing Child, 2005/2014). Toxic stress overactivates a child's stress response system and feels painful and overwhelming enough to bear potentially lifelong consequences for children's emotional and

Table 1 Categories of trauma (Adapted from Hermans (1992), Perry and Szalavitz (2017), and van der Kolk (2014))

Category of trauma	Characteristics of traumatic experience
Acute	Single, one-off, isolated incident (e.g., an accident, terrorism, a natural disaster, and bereavement)
Chronic	Ongoing, repeated, or prolonged adversity (e.g., chronic poverty, ongoing domestic or neighborhood violence, long-term illness, and ongoing bullying)
Complex	Multiple events witnessed or experienced, particularly during vulnerable life phases such as early childhood or adolescence (e.g., caregiver abuse or neglect, repeatedly witnessing domestic violence)
Historical	Intergenerational, collective, and cumulative trauma experienced by a group (e.g., racism, systemic oppression, and community memories of genocide)

physical health (Walkley & Cox, 2013). It is the latter that characterizes trauma, and differentiates it from the more typical hardships of everyday life.

Different categories of traumatic experiences are shown below (Table 1).

These categories suggest why the concept of trauma-informed education is relevant to high-poverty schools in India: The axes of marginalization these learners face may increase their exposure to such events and experiences. While researching the risks in children's lives in the Global South and calling these developing countries the "majority-world," Boyden and Mann (2005) note that "children in the majority-world have been noted to be at particular risk" of events "beyond the normal range of human experience because they cause disturbance and upheaval" at a personal, familial, community, and societal level (p. 6). They go on to identify a gap in the literature, stating that the societal crises and inequities in Southern children's lifeworlds cause "threats to their wellbeing that are not adequately addressed" in the literature on childhood adversity (p. 6). Indeed, research on poor Indian children reveals an array of events that could potentially be traumatic, including forced labor, accidents, and debt bondage (Crivello & Morrow, 2020); being beaten in school (Jones & Pells, 2016); child marriage and early caregiver death (Boyden et al., 2019); sexual assault (Leach & Sitaram, 2007); and community discrimination (Sriprakash, 2012). Yet, research on the psychosocial costs of such risks for the well-being of poor Indian youth remains nascent.

Literature on trauma-informed education in India is scarcer still. Yet, the need for trauma-informed education is deepened by the reality that schools in this setting may be sites of trauma themselves, as shown by a substantial body of sociological research. Ethnographies of Indian children in high-poverty schools abound with examples of the shaming and exclusion children experience, since "children who confront adversity are often denigrated and excluded by others" (Boyden & Mann, 2005, p. 15). School authorities may reinforce discrimination or deficit stereotyping rather than promoting the well-being of marginalized learners: Teachers have called Indigenous tribal children "very slow" (Balagopalan, 2003a, p. 56), expressed surprise that lower caste children are "worthy" of achievement (Sarangapani, 2003, p. 7), perceived government school children as having "nothing in their

minds" (Sriprakash, 2012, p. 91), and judged "indiscriminate thrashing" the "only viable method" (Talib, 1992, p. 88). Such teacher-led deficit stereotyping fits into broader patterns of youth exclusion, such as the shaming poor rural Indian children may experience from their communities for having fewer material resources (Crivello et al., 2012).

Moreover, large-scale Human Rights Watch findings show school authorities as perpetuating abuse, neglect, and discrimination against the poorest learners – particularly lower-caste, tribal, and Muslim children – across four Indian states (Bajoria, 2014). Indian sociologists have found that poor children may be denied sufficient food (Sabharwal et al., 2014); verbally abused (Balagopalan & Subramanian, 2003); assigned menial tasks (Nambissan, 2010); and beaten more harshly by their teachers (Morrow & Singh, 2014). School violence is a persistent challenge. In one survey, 26% of 3000 poor Indian schoolchildren named "school violence," including teacher and peer physical and verbal abuse, as their main reason for disliking school (Jones & Pells, 2016). High rates of intimidation, denigration, and assault at the hands of authority figures can lead poor Indian children to report being too frightened to attend school or confide in their families about their experiences, resulting in disengagement, alienation, and the decision to leave or transfer schools (Morrow & Singh, 2014). Such findings have led poor Indian children's school environment to be labeled by sociologists as a "climate of fear" (Mukhopadhyay & Mukunda, 2018, p. 18).

Moreover, intersectional inequalities may deepen children's vulnerability to these climates of fear. Children in poverty are not a monolithic group, but multidimensional individuals whose experiences are "cross-cut by other axes of sociodemographic difference" (Crivello & van der Gaag, 2016, p. 6). Leach and Sitaram (2007) found that both gender and class worked to leave poor Indian female students neglected by teachers after they were sexually abused, while Sabharwal et al. (2014) found that being both low-income and low-caste rendered children doubly at risk of being given inadequate food supplies by their teachers. Extensive work has also been conducted on children with disabilities in India and their lack of meaningful opportunities to participate in school culture and curricula (Singal, 2008, 2016). Intersectional forms of trauma and retraumatization can thus affect children who are already marginalized. As Kurian (2020b) explores in work on "rights-protectors or rights-violators?" schools can actively perpetuate dynamics of apathy, shaming, exclusion, or prejudice against these learners.

It thus becomes germane to consider trauma-informed education a tool for making schools safer and more supportive for students who deserve compassionate, inclusive, and humane environments.

The Four Rs of Trauma-Informed Care

Trauma-informed education is based on the principles of trauma-informed services more broadly. The Substance Abuse and Mental Health Services Administration

Table 2 The four Rs of trauma-informed care

Realize	Recognize	Respond	Resist retraumatization
Realize both the presence and impact of trauma and the ways forward for healing and recovery	Recognize the signs of a person within the system exposed to a traumatic experience	Integrate awareness of the potential presence and consequences of trauma into whole-system norms, behaviors, and structures	Resist behaviors, systems, and policies that risk retraumatizing children, families, and staff and promote environments conducive to healing and Well-being

Adapted from SAMHSA (2014)

Table 3 Reproduced from Chafouleas et al. (2016), who summarize SAMHSA's six key principles of a trauma-informed approach

Principle	Brief definition
Safety	Promoting a sense of physical and psychological safety throughout the organization, including understanding How safety is defined by those served
Trustworthiness and transparency	Operations and decisions are transparent toward building and maintaining trust within the organization and those served
Peer support	Key supports in trauma recovery and healing include those individuals who have experienced traumatic events
Collaboration and mutuality	Relationships across all parties that are collaborative and meaningfully share power and decision-making
Empowerment, voice, and choice	Understanding history of diminished voice and eliminating power differentials toward supporting choice in goal-setting and cultivating self-advocacy skills
Cultural, historical, and gender issues	Organization actively rejects cultural stereotypes and biases and works to leverage access to appropriate connections as being responsive to the racial, ethnic, and cultural needs of those served

(SAMHSA) defines "The Four Rs" as integral to any trauma-informed response, as shown in the table below (Table 2).

Trauma-informed care is different from administering an intervention to stop the trauma itself: It "does not directly treat sources of trauma, but rather seeks to provide support services in a way that is accessible and appropriate for people who have faced trauma" (Choudhury, 2020, p. 67). SAMHSA has recommended six principles for manifesting the four Rs in an organizational culture. Chafouleas et al. (2016) summarize how these principles might be applied to schools in the following table (Table 3):

While India-based literature applying these six principles is still nascent, an excellent example emerges from Choudhury (2020) and Modi and Hai's (2019) studies of childcare institutions applying the trauma-informed principles of safety, choice, collaboration, trustworthiness, and empowerment. Golchha (2020) also offers an explanation of how the principles of trauma-informed care may help

children affected by abuse at home, calling attention to India's "alarming rates of domestic violence" (p. 1).

Casting a Wide Net: Trauma-Informed Education Is for All Learners and Does Not Diagnose or Assume

Sweeney and Taggart (2018, p. 384) note that the "most commonly held misconception" about trauma-informed care is that it assumes that every individual under its remit has experienced trauma or is traumatized. This is not the case. It is important not to pathologize children as being irrevocably "broken" or "damaged." Nuance is needed when speaking of young people who have suffered childhood adversity. Noting that their experiences may fit into the category of childhood trauma does not mean automatically labeling the children themselves as traumatized. More generally, experiencing a traumatic event does not mean a person will inevitably experience post-traumatic stress symptoms. In fact, research suggests that a number of potential outcomes are open to young people after experiencing a traumatic event. Some do not develop lasting or significant mental health issues, and supportive adults can become critical protective factors in recovery and healing (Perry & Szalavitz, 2017; van der Kolk, 2014).

Therefore, the purpose of trauma-informed education is to make schools more proactive in responding to the potential impact of trauma in children's lives. The principle of trauma-informed care is not to make assumptions about what a person has faced or their mental state, but simply to provide a nurturing and inclusive environment that can support the well-being of both persons exposed to trauma and those who are not (Sweeney & Taggart, 2018). A trauma-informed practitioner "understands and considers the pervasive nature of trauma and promotes environments of healing and recovery, rather than practices and services that may inadvertently re-traumatize" (Buffalo Center for Social Research, 2019). In a school setting, this also means creating more empathetic policies around discipline and classroom management by considering children's life histories: This entails "an understanding that problematic behaviors may need to be addressed as a result of the ACEs or other traumatic experiences someone has experienced, as opposed to addressing them as simply willful and/or punishable actions" (NCSEA, 2019, p. 4).

In this sense, trauma-informed care casts a wide net in aspiring to create more inclusive and supportive school climates for all students. A recent review concludes that while "such an approach has unique applications for individuals who experience trauma and those dealing with significant adversity," it "also reflects principles that have been shown to be universally beneficial for all young people" (Margolius et al., 2020, p. 4). Trauma-informed care can have universal benefits because it is committed to a whole-child, ecological systems-approach to understanding how a learner's experiences in one system "reverberate" across other settings (Margolius et al., 2020, p. 4). By building supportive adult-child relationships in school and remaining mindful of the socio-emotional, physical, and cognitive effects of adversity, trauma-informed care addresses multiple dimensions of well-being (Margolius

et al., 2020). Hence, this kind of whole-system approach to well-being assumes that "the whole community will benefit, not only those who are experiencing difficulties" (Warin, 2017, p. 190). Trauma-informed care can impact all young people by simply making schools more supportive and empathetic places in general.

The Teacher-Child Relationship

The teacher is integral to a whole-school culture of trauma-informed care. Teachers and pupils spend an average of 8 h a day together. Their shared space in the classroom is "sometimes the most stable and consistent location in a trauma-affected student's life" (Brunzell et al., 2016, p. 64). Moreover, when trauma-affected children experience a consistent pattern of safe and positive interactions with a trusted adult, new neural pathways can transform their previous patterns of distrust and hypervigilance through the brain's neuroplasticity (Fisher et al., 2020). This presents a precious opportunity for teacher-child relationships to foster post-traumatic healing and recovery. Psychiatrist Bessel van der Kolk's foundational text on trauma, *The Body Keeps the Score,* explains how "our attachment bonds are our greatest protection against threat" (van der Kolk, 2014, p. 208). Trauma-informed education has therefore championed warm teacher-child relationships, committing to a model of schooling wherein "the power of relationships will be acknowledged and practiced...in a school climate of respect and generosity of spirit" (Oehlberg, 2008, p. 3, cited in Walkley & Cox, 2013). This means "saturating a young person's system with a wealth of supports and nurturing relationships" (Margolius et al., 2020, p. 4).

Over the past decade, the principles of trauma-informed care have begun to be integrated within in-service and preservice teacher education to transmit knowledge of childhood adversity and its effects and to generate strategies for teachers to help students feel safe and supported in the classroom (e.g., Oehlberg, 2008). The trauma-informed teacher has been conceptualized as one who is, above all, mindful of how her care needs to adapt to the embodied, cognitive, and emotional effects of trauma. This means training staff to avoid accidentally retraumatizing students (Stratford et al., 2020). Consistent and well-planned responses to students in need of support can also help avoid "sanctuary trauma," a term pioneered by Silver (1986) to describe a form of retraumatization that occurs when an individual turns to another person or institution expecting support, but finds none (p. 215). In schools, sanctuary trauma can occur when students "turn to those from whom they hope to find sanctuary only to encounter a reception that is not supportive as anticipated" (Wolpow et al. 2009, p. 13). Bevington et al., (2019) discuss how dialogical spaces can support students to feel cared-for and safe to be vulnerable. As they argue, this requires "a bid to honour relationships" (p. 8) as the heart and soul of education.

Trauma-informed teacher care could also mean recognizing why children may break rules or seem disruptive or maladjusted in the classroom. Violent, punitive, or excessive forms of discipline have been known to be utilized in resource-constrained Indian classrooms, resulting in distress, fear, anxiety, and bodily harm for students

(Jones & Pells, 2016; Mukhopadhyay & Mukunda, 2018). Unduly punitive forms of discipline may be particularly psychologically damaging for students with previous histories of trauma. Seeking empathetic alternatives – see Cremin and Bevington (2017) for an in-depth overview of restorative dialogue, peer mediation, and other peaceful responses to classroom conflict – can help protect students from reliving past emotions of fear or memories of violence (Chafouleas et al., 2016; Thomas et al., 2019). Empathetic responses can involve recognizing how students' non-compliance with classroom rules or seemingly disruptive behavior may be rooted in deep-seated responses to their life experiences. Psychiatrist Bruce Perry, director of the Child Trauma Academy and a leading voice in trauma-informed care, explains that such children might struggle to regulate and articulate their emotions, be trapped in "fight, flight, or freeze" reactions and be inclined to express anger and physical aggression (Perry, 2006). As a result, Perry cautions that such children might be easily misdiagnosed by school staff as students with attention deficit disorder (ADHD), oppositional-defiant disorder, and conduct disorder. By assuming individualized and internal deficits, such labels may erode opportunities to recognize the external challenges a trauma-affected student is facing.

An example of this misunderstanding in the Indian context emerges in Malhi and Bharti's (2021) case study of a 5-year old kindergarten student in the *Indian Journal of Pediatrics.* While making the case for a trauma-informed approach to child well-being, they explain how the young girl presented with symptoms such as hyperactivity that resembled ADHD. However, these symptoms actually stemmed from her family's history of unemployment, household conflict, punitive discipline, and maternal depression. Utilizing a trauma-informed lens, Malhi and Bharti (2021) encouraged her mother to adopt a relational approach called "HEART – hug, engage, ask questions, read to, and talk to the child" to create a "safe therapeutic environment along with enhancing parent-child attachment" (p. 1). They found that the intrusive thoughts and hyperarousal caused by trauma can cause children with ACEs to appear hyperactive and impulsive, like children with ADHD. Such nuances suggest the need for educators and school support professionals to prioritize a trauma-informed lens in how they judge instances of student misbehavior or turn to referral systems.

A positive example of incorporating this empathy emerges from Choudhury's (2020) work on the Miracle Foundation, an Indian NGO that prioritizes trauma-Informed care in the childcare and family placement process. Among other examples, Choudhury explains how Miracle Foundation staff shifted their approach to children's bedwetting behaviors after understanding the principles of trauma-informed care. Previously, they were concerned with "disciplining and managing troublesome behaviours" (p. 68) and administered medication. However, after receiving guidance through a targeted mental health intervention, they "learned to listen to children beyond symptomatic behaviours, to understand root causes related to trauma" (p. 68). As a result, they supported psychotherapeutic counseling for the children and saw that "bedwetting incidents decreased significantly as the children were able to identify and express their feelings of fear, anger and guilt" (p. 68). Choudhury's study of trauma-informed social work suggests the potential of education to similarly adopt reflective, responsive, and empathetic approaches to student

behavior. Children themselves may affirm the value of being listened to and understood, for example, Golden (2020) finds that for his child-participants:

> "trauma-informed" is synonymous with a humanizing pedagogy, one in which they are not automatically assumed to be "bad kids." Within this ethos, young people can define themselves and make mistakes without their errors being seen as entrenched dispositions or commentaries on their possible life trajectories. It is a pedagogy grounded in relationships in which they are known as promising young people who have been through difficult circumstances or experiences. (Golden, 2020, p. 76)

A rising body of literature offers detailed overviews of trauma-informed pedagogical strategies to nurture students' well-being and learning, including the use of rhythm, movement, mindfulness and meditation (Brunzell & Norrish, 2021), and the weaving of social-emotional learning into the curriculum (Fisher et al., 2020).

Ecological Views of Trauma

Trauma-informed education is increasingly cognizant of the need to recognize sociostructural adversities such as poverty, violence, abuse, and discrimination (Fisher et al., 2020; Venet, 2021). Golden (2020) advocates a shift toward "understanding trauma as ecological" (p. 72) arguing that "trauma-informed pedagogy cannot be reduced to a fixed approach grounded solely in a biomedical understanding of trauma" (p. 71). Golden warns that attention to students' individual reactions (e.g., fight, flight, or freeze responses) should not cloud our awareness that trauma often stems from injustice such as racism or discrimination. Understanding the root causes of trauma can shift us to a more accurate and contextualized understanding of the ecology of well-being: "it is these severe inequities that we need to fix, and not 'bad' or 'broken' people" (Golden, 2020, p. 76). Venet's (2021) work on integrating trauma-informed and equity-centered education cautions us about the danger of labeling and stigmatization:

> There is a legitimate risk that trauma-informed education becomes a deficit model, used to label and marginalize students who are already marginalized based on their identities. When schools start identifying practices just for the trauma kids, or assign students a number based on their traumatic experiences, we have lost sight of what's important and have started doing harm. (Venet, 2021)

Working toward trauma-informed climates for marginalized groups should therefore also be a move toward greater inclusion and equity in education. As Sweeney and Taggart (2018) note, "any development of trauma-informed approaches must include a social justice component" (p. 385). If "trauma is an overwhelming experience that can undermine the individual's belief that the world is good and safe" (Brunzell et al., 2016, p. 64), then trauma-informed care can mean working to address the root causes of marginalization that makes the world feel unsafe. This seems especially important in high-poverty Indian schools, where children's ill-treatment or

experience of abuse and neglect can stem from systemic and societal factors. For example, patriarchal structures can lead to young girls being forced to leave school and be forcibly married (Bajoria, 2014) or be neglected or silenced when subjected to sexual violence in school (Leach & Sitaram, 2007). The caste system can result in low-caste learners being denied basic nutrition and dignity (Bajoria, 2014; Balagopalan, 2003a). Such dynamics need to be addressed through an ecosystemic understanding of why learners with marginalized identities are at greater risk of experiencing trauma or retraumatization in and outside of school. Kurian (2019) points out that it is this context-mindful type of "empathetic imagination" that can "spark compassionate action for change" through its "sensitivity to societal power imbalances" (p. 132).

In this regard, the social-ecological model pioneered by developmental psychologist Urie Bronfenbrenner can facilitate a societally contextualized understanding of trauma and child well-being (Bronfenbrenner, 1979). Crosby (2015) points out that trauma-informed educators "should recognize their positioning in their students' ecosystems. . . [and that] schools may only represent one microsystem in the lives of their students" (p. 227). From an ecological lens, "all school staff should strive to understand how their interactions with youths may affect other systems" (p. 227). An empirical example emerges from Jack, Chase, and Warwick's (2019) study on refugee students in university. The authors utilized the social-ecological model to explore the students' "traumatic experiences of flight" and how this trauma impacted their present-day experiences at university (p. 57). The authors examined the "different support mechanisms within their social ecology once they were in a place of safety" including families, relationships, and women's support groups (p. 58). They analyzed how these "different systems" lent students "spaces of safety and healing" (p. 58). In turn, they examined how universities' systemic arrangements (for example, a shortage of counselors) hindered refugee well-being. As Barrow (2019) aptly puts it, an ecological approach "promotes a sense of being well in the world that envisages the person in relation to their social community" (p. 29).

The social-ecological model can thus be helpful for understanding and connecting child well-being, histories of adversity, and school/institutional arrangements. Trauma-informed work in this area could build on existing India-based ecological studies of child well-being and development, for example, the effects of chronic residential crowding on the well-being of 10–12-year olds in urban India (Evans et al., 1998); the association between household sanitation and family hygiene practices with child stunting in rural India (Rah et al., 2015); risk factors for rural Indian children experiencing severe discipline (Hunter et al., 2000); the social ecology of Indian adolescents (Saraswathi & Oke, 2013); and the effect of patriarchy and discrimination upon young girls' stunting (Nahar & Pillai, 2019). The benefit of an ecological view is that "traumatized youths are not simply discarded as nuisances to the school" (Crosby, 2015, p. 229) but repositioned in a holistic and societally informed light.

Beyond Deficit Thinking: Asset-Centered Approaches

The reader has thus far been presented with talk of trauma and harm. Yet, there is another dimension of trauma-informed education: assets, hopes, strengths, and growth. George Bonnano, a foundational scholar of resilience, famously pointed out that we may "underestimate the human capacity to thrive" after adversity (Bonanno, 2004, p. 1). In fact, recent scholarship on resilience has argued that choosing to recognise the capabilities of marginalised individuals and communities may be more ethical than deficit-driven narratives that only depict them as damaged (Hajir, Clarke-Habibi & Kurian, 2021).

Early and foundational literature in the field stresses the importance of strengths-based perspectives and seeks to reject stigmatizing language; as Sweeney and Taggart (2018) note, the initial guidance from key organizations like SAMHSA sought to "reframe symptoms as coping adaptations, e.g., dissociation as an adaptive strategy to escape unbearable experiences" (p. 385). Early 2000s literature states that "trauma-informed care embraces a perspective that highlights adaptation over symptoms and resilience over pathology" (Elliott et al., 2005, p. 467). This perspective continues to undergird guidance from key organizations in the field, who stress that "trauma-related symptoms and behaviors" should be seen as "an individual's best and most resilient attempt to manage, cope with, and rise above his or her experience of trauma" (SAMHSA, 2014). This means looking for the reasons underlying behavior and emotion, rather than rushing to stigmatize or denigrate a trauma-affected individual.

However, in practice, the danger of overfocusing on adversity, harm, damage, and deficit has been pointed out by scholars of trauma-informed care across different sectors, from education to social work to youth healthcare. Galinsky (2020) points out that young people with multiple ACEs are often at risk of negative stereotyping by educators and community workers, "presumed to be doomed, with limited capacity to learn and low odds of future success" (p. 48). Moreover, a deficit-driven narrative around childhood adversity may be at odds with young people's own interpretations of their life experiences and aspirations. Shawn Ginwright, a sociologist working with youth in urban poverty, explains how one of his participants resisted being framed as a traumatized youth. While Ginwright was speaking about the effects of trauma on mental and physical health, the young man stopped him and said "I am more than what happened to me" (Ginwright, 2015, p. 5). Similarly, Fisher et al. (2020) narrate an example of a young woman framing herself as a resilient architect of her own life:

> Experience is not destiny. The relationship between ACEs and negative health, social, and learning behaviours should not be misunderstood as a fait accompli. In fact, the last thing that children who have experienced trauma need is pity and low expectations about their future. What they do need is empathy and a path forward. One student at the high school where two of us work was a reminder to us about this truth. The details of her traumatic experiences are not the point; suffice it to say that her childhood has been riddled with barriers that take our breath away. But this resilient and empowered young woman reminded us, "I am not my trauma. It doesn't define me. I define me. (Fisher et al., 2020, p. 5)

Vocabularies of hope and possibility may thus be needed. Cherry (2021) points out that although the ACE framework can help foster individuals' self-compassion, it must be solution-oriented: "if we talk about adversity without talking about how we mitigate it then we are saying that the future is hopeless" (Cherry, 2021). Growing awareness of the dangers of deficit assumptions has led to new approaches and framings. Ginwright (2015) calls for a reframing of trauma-informed care as "healing-centred engagement," in order to place the concepts of hope and healing at the center of educational policies for communities torn by poverty, violence, and helplessness. Similarly, Galinsky (2020) advocates for a shift toward "asset-informed care." She points out that "adversity is not destiny" (p. 47).

Previously, this chapter referenced the concept of toxic stress, as pioneered by the Harvard Centre on the Developing Child (National Scientific Council on the Developing Child, 2005/2014). However, Galinsky (2020) challenges the language of this foundational concept in trauma-informed education by narrating the story of an educator who problematized the term:

> She told the group how she had experienced trauma and described her recovery. . ..she said if anyone had ever used the word toxic about her experiences, she might not have believed recovery was possible; she might not have worked so hard to heal. The word toxic, she said, sounds like poison. It sounds fatal! (Galinsky, 2020, p. 47)

Earlier, the desire of some trauma-affected individuals to resist deficit-driven narratives was pointed out; in Galinsky's story (2020), it is also evident that deficit-driven narratives can actually hinder healing. This example speaks to the importance of checking in with young people (and their mentors, families, and teachers) about whether the language we use to describe their life experiences feels humanizing and respectful to them. This checking in may be particularly crucial in high-poverty Indian communities, where young people and their families may possess low levels of social power to express their voice or have their views taken seriously (Crivello et al., 2012). Students may struggle to negotiate formal education as first-generation learners from Indigenous, tribal, low-caste, or otherwise marginalized backgrounds (Balagopalan, 2003b). Teachers working in resource-constrained contexts may hold deficit or negative perceptions not only of learners but also their families, stereotyping marginalized communities as uneducated or less capable (Sriprakash, 2012). In this sense, an asset-centered view of the family – a willingness to listen, empathize, and build strong home-school partnerships – seems essential.

Inspiration may be drawn from a small but growing body of strengths-based, trauma-informed work with disadvantaged Indian communities. For example, Choudhury (2020) illustrates how "approaching both child and family with compassion for their good intentions" is crucial for trauma-informed care with orphaned children in foster placements (p. 71). Similarly, while analyzing trauma-informed care for Indian children affected by domestic violence, Golchha (2020) points out that a key purpose of a trauma-informed lens is to "bring power and agency" to victims of trauma, "adhering to their strengths instead of pathologizing their experience" (p. 1). Modi and Hai (2019) provide a practical example through their case

study of supporting a sexually abused child to be more confident and building on her strengths.

New tools have been developed in the interests of strengths-based approaches. For example, the Benevolent Childhood Experiences questionnaire (Narayan et al., 2018) traces the factors that help children thrive.

Spotlight: A Scale to Measure Protective Factors (Narayan et al., 2018)
To get a BCE score, the survey-taker is asked how many of these ten items they experienced before the age of 18. Would you respond "yes" or "no" to the prompt, "Growing up, I had..."

1. At least one caregiver with whom you felt safe?
2. At least one good friend
3. Beliefs that gave you comfort
4. Enjoyment at school
5. At least one teacher that cared
6. Good neighbors
7. An adult (not a parent/caregiver or the person from *1) who could provide you with support or advice
8. Opportunities to have a good time
9. Like yourself or feel comfortable with yourself
10. Predictable home routine, like regular meals and a regular bedtime

Positive psychology offers another asset-centered disciplinary resource for trauma-informed educators. This branch of psychology focuses on the proactive promotion of well-being rather than only "fixing" poor mental health. Positive psychologists have therefore offered strengths-based conceptualizations of trauma-informed care that urge educators to prioritize students' potential to build on strengths and capabilities. An influential example is Brunzell et al.' (2016) work; they build a "new approach for healing and growth" for trauma-affected students (p. 3). They suggest how teachers can help students cultivate psychological resources from positive education to deal with trauma. These resources include positive emotion, self-regulation, character strengths, resiliency, and gratitude. Scholarship on post-traumatic growth can also help educators cultivate hope in their students (see Joseph and Hefferon (2013) for a detailed exploration of eudaimonic well-being in the aftermath of adversity).

The asset-based approaches covered in this section might be particularly important in high-poverty Indian schools, since, as previously explored, a substantial body of evidence shows marginalized learners in this setting experiencing abuse or violence at the hands of peers and authorities (Bajoria, 2014; Jones & Pells, 2016; Mukhopadhyay & Mukunda, 2018; Leach & Sitaram, 2007; Sriprakash, 2012). The persistence of gendered, caste-based, tribal, and ethnic inequalities means that a substantial proportion of Indian students in high-poverty communities will be

carrying the scars of having been discriminated against, been made to feel unsafe or unwanted, or having their identities denigrated and mocked (Bajoria, 2014; Sabharwal et al., 2014; Sarangapani, 2003). Caring attention to students' strengths and capabilities thus becomes an ethical and practical necessity rather than a luxury. As the trauma-informed practitioner Lisa Cherry notes: "there is no place for hopelessness in our work with children and young people" (Cherry, 2021).

Barriers may exist to the implementation of trauma-informed education. Not every school will possess the material and financial resources to significantly enhance their curriculum delivery and staff training, especially high-poverty schools and those under pressure to "teach to the test." In such cases, trauma-informed care could start with simple everyday adjustments to pedagogy and school policies; see Treisman (2021) and Cherry (2021) for thorough insights into sustainable microlevel (as well as macrolevel) changes for trauma-informed praxis with young people. It is also worth recognizing and building on the innovations and best practices of schools and children's homes that have practiced trauma-informed care in under-resourced settings (e.g., Choudhury, 2020; Modi & Hai, 2019).

Socially, the type of paradigm shift that trauma-informed care requires may be met with resistance, doubts, or hesitation by school staff. In a study of Indian teachers' dilemmas of care, Kurian (2020a) explored sociocultural barriers (e.g., stigmas and taboos around gender-based violence and a lack of child-safeguarding systems) that hindered teachers from intervening to protect children at risk. Placing the onus of trauma-informed care on individual teachers is inadequate. Rather, it is crucial to secure the trust of school staff, treat them in humanizing and respectful ways, and give them the structural support to meet fresh expectations. Otherwise, policy changes may be perceived as unfeasible demands on staff who are already physically fatigued and emotionally or mentally overwhelmed in challenging circumstances. Educators may be grappling with the same inequalities and adversities students face (Kurian & Kester, 2019). Staff well-being therefore needs to be prioritized in tandem with student well-being. Culshaw and Kurian (2021) point out that the "lifeblood" of educators must be nurtured for high-quality teaching and learning to remain sustainable – that is, safe spaces must be created for educators to be able to "ask for help and support without fear of judgement" and share their "unseen and unheard moments of struggle" (p. 14). Caring for the caregiver is doubly crucial given the sensitive and emotionally demanding nature of engaging with trauma. When confronting the depth of students' struggles, the risk of vicarious or secondary trauma for staff becomes very real (Treisman, 2021). Without adequate support for their own well-being, school staff may experience trauma-informed policies as "hollow and ineffective" (Culshaw & Kurian, 2021, p. 14).

Conclusion

Trauma-informed education can be a powerful tool to help schools nurture child well-being and respond to the adversities affecting students' lives and learning. This chapter has explored the historical origins of trauma-informed education and its pioneering theories, key concepts, and terminology. It has also outlined contemporary debates and

innovations in trauma-informed education around rejecting deficit-driven approaches, centering healing-centered or asset-based engagement, and understanding the systemic factors causing trauma. While particular attention has been paid to high-poverty schools in India, the insights emerging from the international and wide-ranging body of literature reviewed may be relevant to schools around the world.

In terms of practical ways forward, the following points for reflection may be helpful when designing and practicing pedagogies, policies, and cultures of trauma-informed care for students' well-being.

- What are staff members' existing levels of knowledge around the causes and consequences of adverse events in childhood and youth? How might these levels of knowledge be enriched in ways that feel accessible and generative?
- Do students feel safe, seen, and heard at school? How do we know?
- How strong are students' relationships with the adults they encounter in school each day? Which points of contact (e.g., teachers, school leaders, librarians, and counselors) might be developed further to promote positive microinteractions and build trust and rapport?
- Are adults in school aware of students' home, family, and community contexts?
- What interpersonal, structural, and societal challenges might students be facing inside and outside of school that impact upon their learning and well-being?
- Do families and teachers regularly communicate and feel mutually safe to share concerns and work together toward students' well-being and progress? How might respectful and supportive home-school partnerships be developed?
- How are instances of student misbehavior or noncompliance dealt with? Are empathetic, dialogical, nonviolent, and humanizing responses prioritized?
- What barriers (financial, infrastructural, social, or otherwise) might hinder the implementation of trauma-informed policies? How might these barriers be addressed?
- How might school leaders protect the well-being of teachers and school-based practitioners as well as student well-being?

While this list is not comprehensive or prescriptive, it offers some starting points for thinking about trauma-informed responses to young people's life experiences. Rather than a final destination point, trauma-informed education is an ever-evolving journey that demands a commitment to reflection, growth, and humility. Thus, the chapter closes in the hope that schools can become genuine sanctuaries: In the words of a well-known trauma-informed practitioner, "schools should explicitly and implicitly convey the message of, "We want you here, and you are important to us"" (Treisman, 2021, p. 52).

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