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Re-patterning Attachments at School and Beyond: An Exploration of the
Healing Power of Relationships and School Community

Sophia Sherman

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ABSTRACT

This thesis will explore ways that a child's educational experience can repattern a child's disrupted attachment with a caregiver. By using school as the framework for which attachment theory is examined, I will present research on school based behavioral health and intervention models. By integrating research on attachment theory, social emotional learning, resilience, strategies for strong school climate, and the role of school based behavioral health, the thesis will explore the ways in which to better support children who are struggling to succeed within their school environment. A specific case example will be presented in order to illustrate these important concepts. The thesis will present a series of recommendations aimed at mitigating disrupted attachment as it relates to a child's school environment.

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I. Introduction

Attachment bonds are arguably the most important aspect of the human experience. These bonds are at the center of what it means to be human, forming before birth and continuing to develop in the first years of life. If a child is able to positively attach to his/her caregiver, it is highly likely that they will be able to securely attach to other important people and systems in their lives such as school and their larger communities.

Outside the family, school offers the most important relational experiences for most children. Children's ability to positively attach to teachers, peers, and administrators is essential. By using the school as the framework in which I look at attachment, I will pose that as a system, school has the power to mitigate, and in some cases, "re-pattern" insecure, or disorganized attachments.

This thesis attempts to integrate attachment theory, socio-emotional learning, resilience, strategies for strong school climate, and the role of school-based behavioral health. The thesis begins with a review of basic attachment theory and discusses ways that school-based behavioral health can help mitigate attachment difficulties. From there, reflections on a clinical example from my caseload this year explore the ways in which an insecure attachment can be improved through therapy. Following that, a discussion of school-based strategies focused on resilience, socio-emotional learning, and school climate help bring into focus what schools are able to do to improve student outcomes by focusing on relationship-based approaches. Finally, a recommendation section brings

these concepts together and discusses one very important school-based intervention: restorative justice.

Schools can take steps to create a warm, inclusive community that can help children create new attachments and mitigate experiences of stress, adversity, and trauma. By addressing the psychological and social elements of a child's lived experience, schools can provide children with the support, warmth and appreciation that they might not be receiving at home.

II. Attachment Theory

Attachment theory identifies three fundamental styles: secure attachment, ambivalent-insecure attachment, and avoidant-insecure attachment. When a child develops a secure attachment with a primary caregiver, s/he operates with a basic sense of trust, feeling, for example, that s/he will not be left alone for too long, or that their basic needs will be met. With ambivalent-insecure attachment, there is room for a sense of uncertainty that the primary caregiver will meet basic needs. A child with this type of attachment often is wary of strangers, and can become extremely upset when their primary caregiver leaves, as s/he does not trust that their caregiver will come back. An avoidant- attachment child is prone to avoiding caregivers. S/he may have a difficult time distinguishing between a primary attachment figure and strangers, and does not display a preference for either one (Dyka, Cassidy, 2013).

Modern focus on attachment began with the work of psychologist John Bowlby, who hypothesized that babies come into the world with a central need to attach to primary figures who provide security, love and consistency (Bowlby, 1988). This instinctual need serves fundamental evolutionary goals of survival and thriving – caregivers provide safety and predictability for young children because they cannot take care of themselves independently.

Bowlby hypothesized that an internal working model develops for each child that facilitates and maintains mental representations of the self and of those around depending on whether a child has a secure or insecure attachment bond with his/her caregiver, (Pietromoaco and Feldman, 2002). The authors elaborate:

"Working models are thought to include specific content about attachment figures and the self that is stored within a well-organized representational structure. Furthermore, their content is believed to include knowledge about the details (what happened, where, and with whom) of interpersonal experiences as well as affect (e.g., happiness, fear, and anger) associated with those experiences. Working models also are assumed to involve processes that influence what information individuals attend to, how they interpret events in their world, and what they remember. Furthermore, these processes are hypothesized to operate primarily outside of conscious awareness (p.156)".

These inner representational structures allow a child to create expectations for future interpersonal situations. Internal working models serve the purpose of helping children know that those closest to them are available, responsible, and will meet their basic needs – or not. Early positive predictable experiences with a caregiver can give a sense of the world as safe and secure. These children tend to trust adults more easily than those who have had inconsistent early caretaking.

Internal working models directly inform attachment behaviors. When a child is feeling secure, s/he is likely to explore away from their caregiver more easily. When a child is alarmed, anxious or tired, s/he of course strongly hopes to be close to the caretaker (Bowlby, 1988). If a child is unsure that his/her caregiver will be there to soothe them when they are experiencing these uncomfortable feelings, less secure attachment behaviors result from the child's less favorable internal working model. The world might seem unsafe, a place where basic needs might not be met (Bowlby, 1988).

The most hopeful aspect of internal working models is that they can evolve and change as time progresses (Pietromoaco and Feldman, 2002). Children get a chance to catch up. Even if a child does not have a secure attachment bond with a caregiver early on, his/her internal working model can still evolve to allow for trust in others to develop.

New, positive experiences with adults and peers can modify and improve a child's

internal working model. (Pietromoaco and Feldman, 2002).

III. The Setting: a public school with a School-Based Behavioral Health program

This year, I am placed at a hospital's school-based behavioral health department. The school is located in one of New York City's least heterogeneous neighborhoods—its population is primarily Latino (Puerto Rican, Mexican, other Hispanic), with a growing Chinese population. According to the 2000 United States Census, the median household income for families residing in this district is around $35,000, reflecting the low socio-economic status of most of its families. Many of our clients come from single-parent families with multiple children. Most of these families fall below the poverty line and struggle to make ends meet. Therefore, financial and emotional strain on these families is high. The hospital hoped to respond to these difficult circumstances by expanding services into schools. We have an overall goal of reducing some of these stressors if possible.

Our school-based behavioral health centers offer onsite medical, mental health, and dental services in public schools located throughout the borough. This school-based behavioral health program began operating in 1984 in one school. It has now grown into a comprehensive and successful program in schools all around the borough. Our school is a "full service school," meaning that it partners with community agencies to provide mental health and physical health services onsite to students (Brooks, 2006). The Medical school hospital is the school's key social service provider.

The integrated care team within each school consists of nurse practitioners, social workers, dental professionals and patient services associates. The goal of the school-based behavioral health department is to provide comprehensive, integrated medical and psychological care for each student, whether or not they have medical coverage (many do

not). While the school-based behavioral health department does not replace a child's primary care doctor, the teams do try to coordinate with students' regular doctors, and provide as needed care during the school day.

The school employs three social workers from the hospital. Each social worker has a caseload of 25 clients who come for therapy sessions once or twice a week for 30 minutes. We aim to have therapy become a normalized, standard part of the client's school day, making it fairly easy to physically see clients. Normalization of therapeutic services during school is important for a variety of reasons. First, clients and their families are more likely to utilize the services if they are embedded in the place where the child goes to school. Second, having therapy be a "regular" part of the school day, reduces its stigma or the idea that getting help is "wrong" or "weak". Much of the school community has had limited previous exposure to therapy, and clients are naturally wary about utilizing the services at the school. This relates to aspects of traditional Hispanic culture. As Dingfelder (2005) asserts:

" For many Hispanic clients who seek psychotherapy, their first contact with a mental health professional is also their last—50 percent never return to a psychologist after their first session. In comparison, Caucasians drop out at a rate of about 30 percent, in comparison. Several factors play into this access disparity—including the cost of health care for a disproportionately low-income population. Many Latinos quit therapy simply because they do not feel understood. Many Hispanic clients are not completely comfortable speaking in English and sometimes the values of psychotherapy—or the therapist—are antithetical of the Hispanic client (p.58).

Because these clients' first language is Spanish, it makes sense that they would prefer a Spanish speaking clinician. While it is true that most Latino students at the school are bilingual, research suggests that these clients may find it easier to recount episodes from their early childhoods, or talk more comfortably about emotions in their native language (Dingelder, 2005). The hospital is highly aware of the population it

serves, and the necessity to employ Spanish-speaking social workers. Over half of the

social workers at the hospital are in fact bilingual. By providing counseling in Spanish,

we not only help the client feel more relaxed, but show a level of respect for the client's

culture and language.

  Another central reason the hospital expanded its school-based behavioral program

was to address the overwhelming number of co-occurring disorders discovered in

children and adults in the neighborhood. The hospital became aware that it sees many

parents who bring their children into the emergency room not only for physical

symptoms, but also for behavioral health conditions as well. These co-existing conditions

frequently include depression, anxiety, adjustment disorder, ADD, and ADHD. Many

parents turn to the emergency rooms because they don't know where else to turn. Thus,

many of the visits involve limited psycho-education from doctors and nurses, as well as a

referral to an outside specialist. In an effort to unclog emergency rooms and help

children in the neighborhood address these behavioral health conditions, the hospital

expanded its behavioral health program into schools. Emergency room care is the most

expensive kind, and is not well suited to ongoing psychosocial developmental needs.

  As we know, troubling behavioral health conditions among children and youth

occur at a disturbing rate today. These impact overall growth, leading to higher mortality

rates as children reach adulthood. Studies have shown that adults with mental illness

who are served by the public mental health system in fact have a shortened life

expectancy by 11-25 years on average (Hoge et al, 2014). The hospital adopted its

integrative behavioral health model to reduce these devastating statistics. By focusing on

prevention and early intervention, it has helped with a dramatic improvement in

behavioral health in children in its target neighborhoods. A prominent reason for this is

because the integrated care system for children with behavioral health conditions

addresses the primary care, behavioral health, specialty care, and social support in a

manner that is continuous and family-centered *within the school,* where children are

already in place (SAMHSA-HRSA, Center for Integrated Health Solutions, 2014).

IV. The Intervention Model: At this school, the therapeutic services provided center not only on the individual client, but also the nuclear family. Therapy through this program requires weekly therapy sessions with the client, and a monthly collateral session with the client's primary caregiver. This caregiver might be a biological parent, grandparent, foster parent, or kinship foster parent. The idea behind engaging the larger caregiving system is simple: one cannot treat the child without treating the family as well. The child is one player within a family system. Moreover, the majority of clients being treated have experienced trauma of some sort. Specific cases might include: a child witnessing a violent incident, losing a parent, witnessing or experiencing domestic violence, lack of parental involvement, living in a shelter, or frequent moving from home to home. From the brief introduction to attachment theory above, it follows that a child and caregiver who has experienced trauma might well have an insecure or disrupted attachment, and the distorted internal working model that it can lead to. Pearlman (2003) elaborates: " because the traumatic life experiences in early life are so pervasive and complex, they affect the victim's entire psychology, including defenses, coping styles, experience of self and others, self-capacities, ego resources, psychological needs, ways of relating to others, worldview, and identity (p. 3). For this reason it is crucially important that social workers use an attachment-informed lens when working with a child and his/her caretaker. If the attachment bond is not secure between parent and caregiver, the therapists should first take the approach of trying to empathize and understand what happened during early childhood that led to this attachment style. Once the therapist begins to understand the relational pattern between child and caregiver, s/he can begin to heal the broken attachment.

In order to treat a child who has been traumatized, its important to recognize that the caregiver has *also* experienced this trauma. Working closely with the caregiver to understand and express the profound ways in which trauma (a single event, a life circumstance, even poverty or food insecurity itself) has affected not only their child, but also themselves. This understanding allows them to begins to shape a more accurate narrative of their life, one in which they can take ownership of their story. The therapist's key job is to provide a safe space to process thoughts, feelings, and sensations that are might well feel "shameful" and "wrong," emotions sometimes associated with needing and seeking help. Because many of these caregivers have never had experience with therapy, it can be incredibly challenging for them to open up.

Setting up mandatory monthly meetings and providing psycho-education to help alleviate the stigma of therapy can often allow the caregiver to begin to feel more comfortable sharing his/her inner life with the therapist. Because the therapy is provided with a key focus on the child, caregivers are often more willing to be active participants, feeling the focus is on their child and because they know it is in their own best interest as well. An early goal is for the caregiver to pinpoint and understand his/her own stressors, or recognize limitations in their caregiving abilities. As Paul Tough (2012) explains: " Children can be buffered from surrounding stresses by attentive, responsive caretaking, but the adults in these children's lives are often too burdened by their own problems to offer such care" (p.57). If the therapist doesn't address the adult stressors that Tough mentions, the therapeutic work will only go so far. It is important that therapists empathize and validate trauma and life stressors that have made it difficult to be fully

present and care for the child. Not surprisingly, this can be stabilizing for adults, finally

able to confront their specific challenges.

   Clients are often referred to therapy by a teacher for "acting out" in class. Some of

the most common examples of acting out behaviors reported involve: calling out in class,

frequently getting up from ones seat, talking with peers, defiance when the teacher asks

the child to do a task, and emotional outbursts in the form of crying or screaming. It is

important that social workers educate teachers on the impact of stress and adversity on

levels of functioning. They see it, and most probably understand it intuitively. Yet with

responsibility for a full class a teacher may simply seek to "solve the problem" with a

referral. Tough (2012) offers help in explaining stress and trauma. He writes,

eloquently:

  " The part of the brain most affected by stress is the prefrontal cortex, which is
critical in self-regulatory activities of all kinds, both emotional and cognitive. As a result,
children who grow up in stressful environments general find it harder to concentrate,
harder to sit still, harder to rebound from disappointments, and harder to follow
directions. When you are overwhelmed by uncontrollable impulses and distracted by
negative feelings, it is hard to learn the alphabet" (P. 53).

   The quote above captures the experiences of so many clients who have

experienced trauma and chaos during their early years. It is simply impossible to expect a

child with a history of stress and trauma to self-regulate in the classroom the same way as

a child who has not experienced these stressors. Cognitive ability is most often also

compromised, further complicating the picture. More often then not, deep and painful

issues at play in the child's life are dictating these less-than-optimal behaviors at school

(and probably at home also). It can be difficult for a teacher and caregiver to come to

terms with the fact that a child acting out at home and at school is not fully under their, or

anyone else's control. Often, behavioral outbursts are a performed response to deep and painful emotions that a child is harboring, either deep inside or sometimes raw and evident on the surface. Feelings of shame, inadequacy, guilt or anxiety are frequently at the root of outbursts. More often than not, the "acting out" behavior is a clear cry for help. Like all children, these traumatized students want positive validation and the support of caregivers that believe in them. Yet, frequently, these outbursts are the only way that a child has reliably received adult attention in the past. These children desperately want – and need -- the adults' attention, but their behavior, paradoxically pushes helpful adults away. The results of fractured and insecure attachment, surely a result of trauma and stress, were touched on above.

In this way, a vicious negative cycle begins in which the adults start to harbor resentment and frustration towards a child, leaving the child struggling to understand why. Constantly negative feedback from important adults in their lives increases feelings of shame and inadequacy (interestingly, the same feelings experienced by adult caregivers beginning therapy). If the caregiver and the teacher are not taught appropriate ways to first understand, and then address these behaviors by reframing their responses in a more positive supportive way, the child will continue to feel as if they are inherently "bad."   It takes patience, time and flexibility to help break this cycle and teach the adults in the child's life new ways to manage difficult moments. Hopefully, the child's experience in therapy will start to provide them with an "emotional toolbox," the internal "tools" needed to self-soothe and regulate emotions and behaviors. If the school staff can create a warm, inclusive, and trusting environment, the child will have a much greater

chance of reaching inside this toolbox. And they'll want to, once they become aware.

Intrinsically, everyone wants to be accepted and to succeed.

V. Reflections on a clinical example

One of the clients I am working with this year exemplifies a child whose disrupted attachment to their caregivers have made it extremely difficult for them to thrive at school. Many of our clients has had traumatic experiences that threatened their internal sense of safety, negatively affected their self–esteem, and made it extremely difficult for them to regulate and focus during the school day.

Z, a 7-year-old Hispanic female, was referred for services by the school guidance counselor after a call was put in to The Administration of Child Services suggesting potential child abuse. Z reported an incident of child abuse to her teacher, who then reached out to the school to look into the issue further. According to Z's mother, the incident involved Z "not listening when she was asked to get off the computer" and then being punished by her father by being forced to kneel on rice.

Z's mother reports that leading up to this incident and after, Z experienced frequent crying spells, at least once a day. She gets easily upset and frustrated and has been exhibiting symptoms of low mood, fatigue, and excessive crying. In school, Z has difficulty making and maintaining friendships, and often isolates herself from her peers. Her mother reports that she has been struggling to keep up in school and has low academic performance, with particular difficulties reading. Her mother believes that Z's low mood and sadness heightened considerably three years ago, when she witnessed her father cheating on her mother. Her father denies what she saw, and punished her for telling her mother. Ever since this incident, Z's mother has noticed that her daughter is more guarded, withdrawn, and quiet. These traits bother the mother, who wishes she was more outgoing and talkative, and less anxious.

During the intake, Z's mother revealed that this cheating incident was followed by a domestic dispute in which her husband hit her. After the incident, her husband left the apartment the family shares for a year and one month. Z's mother reports that although her husband has a temper, he has not hit hers or the children since that incident. She reports that she allowed her husband to move back into the home after he completed an anger management class.

When I first began working with Z, she presented as extremely anxious and on edge. Loud noises would startle her, and she struggled to return to baseline when experiencing something that provoked her fears. She struggled to identify and verbalize feelings, and to connect these feeling to an experience. Much of our early work involved building trust. The modality being used was child-centered play therapy, which really allowed us the freedom to take our time in cultivating a therapeutic relationship built on consistency and expectation. When we first began working together, she struggled to accept the idea that I would be coming each week at the same time to pick her up. She frequently questioned why I was picking her up. Was it because she had done something wrong? I saw that she was both anxious and prone to blame herself..

It took months for Z to become comfortable in the therapy room with me. Slowly, she began showing an interest in playing with the dollhouse. At first, she would play all the characters herself. But eventually she began assigning me the roles of the character's sister or the grandmother. Through these narratives expressed in her play, a picture of Z's life began to emerge. She began to compose narratives in which the older male doll would "design" the house, choosing where all the furniture and other dolls went. The older male doll would sometimes let Z play with her sister and her mother, but oftentimes

he told the other dolls to stay at home while he left the house to go to work. Z's doll would often express anxiety and concern over the fact that the older male doll might not come back.

It became apparent through repetition (and knowing some of the history) that Z was using the dollhouse to act out her experiences at home. She began to tell me little anecdotes here or there of how she was scared to say or touch something, worrying that she would get in trouble. She finally told me that her parents often fought very loudly, particularly when it involved her mother going out of the house to work in the evenings.

It took months, but Z no longer questions why I pick her up from class. She has begun to open up to me about her fears, particularly related to her family life. It has become evident through our work together that Z does not benefit from a secure attachment with either of her primary caregivers. I would assess that Z has an ambivalent/anxious attachment style with her caregivers. In infancy, this attachment style involves the child experiencing separation anxiety when separated from the caregiver, and a lack of reassurance when the caregiver returns to the infant (Bowlby, 1988).

While Z's caregivers are able to meet her basic needs for food, shelter, and getting her to school, they struggle to relate to her on an emotional level or help her feel consistently safe. Exposure to domestic violence as well as witnessing her father's infidelity and being told it never happened has made her extremely distrusting of adults in her life. But while she deeply feels this distrust, another striving part of her craves her parent's love and validation. I was able to see this clearly when once she did well on a spelling test, and then asked me if I could tell them for her. When I explored why she would prefer to have me tell her parents, she expressed that even though she knows she

did well, she knew from experience that her father would want her to have gotten all the spelling words correct. Z so wanted the validation of hearing that her parents were proud of her, but was also frightened of a negative reaction. This fear was so intense that she wanted to simply shield herself from the potential threat of her father's anger. That she wanted to put me in the middle was a sign of the trust we were building.

While Z's attachment at home is not fully secure, there are a few ways in which I am working to re-pattern this attachment and help her build up her self-esteem and self worth. Through consistent weekly therapy sessions using a child-centered play therapy model, Z has begun to safely process some of these traumatic experiences with the support of an accepting, consistent and patient adult. The open-ended nature of the play therapy modality gives Z some of agency that she has struggled to assert as she's gotten older. She knows that when she's in therapy, she chooses exactly what we do and when we do it. At first, she struggled with all these choices as they overwhelmed her. But I've watched as she has begun to savor these moments of choice and autonomy. When she asserts herself, even in the smallest way, I make sure to validate her actions and feelings.

Additionally, providing psycho-educational guidance from time to time to her teacher about the impact of her family life on her functioning in school has been extremely helpful. Many teachers simply do not understand the complexities of trauma and how they inform a child's behavior in the classroom. In Z's case, being distrusting of adults and peers, socially isolating herself from peers, and heightened reactions to perceived threats are all visible. Her teacher and I have brainstormed ways to better support Z when her anxiety is rising. This usually involves taking her out of the classroom, bringing her out for a short walk in the halls, or allowing her to have a drink

of water. Her teacher also noticed that increasing positive reinforcement and validation helps Z feel more comfortable in the classroom. Small steps like these can have had a profound impact on repatterning Z's attachment experiences. The therapy room, and even the school, can become places of repair and progress.

Another central part of healing this broken attachment has come through deepening our understanding of how Z's internal working model shapes the way she experiences the world around her. Here again, secure vs. insecure attachment comes into play. Internal working models are a product of the level of security an infant experiences in relation to their caregiver. Secure attachment between child and caregiver shows that the child is able to trust that their caregiver will fulfill their emotional and psychological needs. (Pietromonaco and Feldman, 2000). They trust that their caregiver is in close proximity and they will have their needs met in a loving and attentive way.

If internal working models are indeed informed by attachment styles, then it makes sense that Z's internal working model would be distorted—even at 8 years old, she still does not fully trust her primary caretakers. This distrust has contributed to a heightened state of anxiety that makes it extremely difficult for her to work through these painful experiences. In therapy, we are working to re-pattern this attachment style. By cultivating a supportive and warm relationship with her therapist, she is unconsciously challenging and working through these past interpersonal experiences that have caused these feelings of fear and inadequacy. By helping Z put words to her emotions, she slowly becomes better able to articulate what exactly is making her feel a certain way. This allows her caretakers both at home and at school to better understand and meet her needs.

VI. Social and Emotional Learning in Schools and Resilience

When psychologists discuss socio-emotional development, they refer to a child's

growth in emotional, personal and social capacities (CASEL guide, 2013). These

capacities go far beyond academic skills. They have more to do with self-awareness, the

ability recognize and manage emotions, solve problems effectively, establish positive

relationships with others, self regulate, and effectively communicate (CASEL guide,

2013). Greenberg (2003) elaborates on this idea when he writes:

> " Genuinely effective schools- those that prepare students not only to pass tests at
> school but also to pass the tests of life--- are finding that socio-emotional
> competence and academic achievement are interwoven and that integrated,
> coordinated instruction in both areas maximizes students potential to succeed in
> school and throughout their lives" (p.1).

Further, according to the National Center for Education Statistics (2002), students cite

socio-emotional factors such as not getting along with peers, feeling left out, and not

feeling safe as some of the major reasons for dropping out of school. Because emotional

development and academic skills are fully intertwined, socio-emotional learning in

schools becomes crucially important.

To elaborate on this framework, researchers have established five core

competencies that they believe make up socio-emotional development (CASEL guide,

2013). These five are: self-awareness, self- management, social awareness, relationship

skills, and responsible decision-making (CASEL guide, 2013). Self-awareness involves

the recognition of one's own emotions, recognition of strengths in self and others, sense

of self-efficacy, and self-confidence Social awareness involves cultivating empathy and

respect for others, as well as the ability to take on another person's perspective.

Responsible decision-making involves evaluating and reflecting on personal choices and

ethical responsibility ((CASEL guide, 2013). Self-management involves learning impulse

control, stress management techniques, persistence, goal setting, and intrinsic motivation

(CASEL guide, 2013). Finally, relationship skills, which involve the ability to cooperate,

effectively ask for help when needed, and effective communication. These competencies

develop most effectively within caring, supportive, and well-managed learning

environments (CASEL guide, 2013).

Many argue that these core competencies are a parents' job to "teach" their

children. However, beyond a child's experience at home, schools arguably play the

second largest role in cultivating and enhancing a child's socio-emotional development.

Just as each family operates with different emotional climates and different values, each

school does too. Every school and classroom has parts that define its "social character",

including teacher attitudes, school values, and school-classroom climate (Greenberg et al,

2003). These attitudes, values, and climate all contribute to how comfortable a child

feels at school. A supportive school climate will help students develop positive

relationships with peers and their adult teachers, which in turn makes students feel safe,

secure, and not fearful of making mistakes (Greenberg et al, 2003). This is another way

of saying that a child gets a second chance at school to develop important capacities that

were not fully developed at home. Therapy is yet another chance. And children in high

stress situations require all the chances they can get.

When researchers discuss school climate, they are referring to the quality and

character of school life. Climate includes norms, values, and expectations that support

people in feeling socially, emotionally, and physically safe. In a positive school climate,

students, teachers and administrators are engaged and feel respected. Students' families

and educators work together to develop, live and contribute to a shared school vision

(Cohen, McCabe, 2009).

      As touched on earlier, relationships are at the center of a positive school climate.

This means that within the school with an effective and supportive climate, there are

positive adult-adult relationships between and among teachers, administrators and staff.

There are positive student-student relationships, and shared decision-making between

teachers and administrators. Most importantly, diversity is valued where climate is strong

(Cohen and McCabe, 2009). In a school with healthy school climate, administrators know

how to support teachers to do their best work, and such support is welcomed and

appreciated by teachers. Teachers believe that they are influential in affecting what

happens both in their classroom but in the larger school community. (Cohen and

McCabe, 2009). Simply put, teachers feel like they have agency and autonomy in their

jobs.

      As authors Cohen and McCabe (2009) summarize, school climate really involves

how "attached" and connected individuals are to their school. This applies for

administrators, teachers, students and all staff. The authors elaborate on the importance of

school connectedness when they write:

> "One of the fundamentally important dimensions of school climate is relational, and involves how "connected people feel to one another at school. School connectedness, or to what extent students feel attached to at least one caring and responsible adult at school, has become an area of growing research. School connected ness is a powerful predictor of adolescent health and academic outcomes, violence prevention and a protective factors in risky sexual, violence and drug use behaviors" (p. 185). Check quotation marks here

      This idea of having at least one caring and responsible adult in the school that a

child feels connected to highlights the importance of attachment theory in relation to a

child's school experience. If a child does not have an adult at school that they feel is rooting for them, they are less likely to want engage deeply and meaningfully in the process of learning or participating.

This realization of how important relationships are to climate, job functioning and student learning is another reason why school-based behavioral health is so imperative. For children who struggle to attach to their teachers, the one-on-one therapeutic relationship can repattern a broken attachment with a primary caregiver. The therapeutic relationship is all about building an attachment with a therapist who accepts and appreciates the child for exactly who they are, without judgment or recrimination. Good individual relationships between adults and children build feelings of connectedness to school, which in turn bolsters a sense of positive school community.

Schools with strong school climates build other capacities as well. Resilience is commonly thought of as an *internal* set of qualities found within a child. Resilience can be seen as character trait that is fostered or inhibited by a set of protective and risk factors. Thus, resilience is the set of attributes that provides people with the ability – the strength and fortitude -- to confront the (sometimes overwhelming) obstacles they are bound to face in both in day-to-day life and long term (Sagor, 2000).

Resilience often refers to those different factors and processes that limit negative behaviors associated with stress and result in adaptive outcomes, even in the presence of adversity (Bernard, 1995, p.4). Some people seem to have more of it than others. The discussion above leads to a key question: why or how is it that some students achieve at high levels, even when they encounter or routinely live with difficult situations and

pressures, while other students do not thrive nearly as well? Many children face

adversity, yet some thrive more easily. How and why is that?

 Paul Tough's groundbreaking book, *How Children Succeed*, attempts to answer

this question. He asserts a powerful idea: that qualities such as grit and resilience are not

formed or promoted through traditional methods of teaching primarily, but rather are

shaped by environmental forces both in the classroom and at home such as stress,

adversity, trauma, and poverty (2012). He argues that educators focus way too much on

the development of cognitive, academic skills, and not enough on the conditions which

shape a child's inner world and behavior. Educators, he asserts, have not yet found a

reliable way to teach children to be more resilient. Furthermore, American pedagogy as a

whole has ignored socio-emotional learning and also the science of adversity and stress

as it relates to a child's overall learning (Tough, 2012).

 Educators and administrators all over the country are failing to understand or take

into account the ways in which students' early adverse childhood experiences inform

their behavior. As Tough (2016) elaborates in an article in The Atlantic Magazine,

> " For children who grow up without significant experiences of adversity, the skill-development process leading up to kindergarten generally works the way it's supposed to: Calm, consistent, responsive interactions in infancy with parents and other caregivers create neural connections that lay the foundation for a healthy array of attention and concentration skills. Just as early stress sends signals to the nervous system to maintain constant vigilance and prepare for a lifetime of trouble, early warmth and responsiveness send the opposite signals: *You're safe; life is going to be fine. Let down your guard; the people around you will protect you and provide for you. Be curious about the world; it's full of fascinating surprises.* These messages trigger adaptations in children's brains that allow them to slow down and consider problems and decisions more carefully, to focus their attention for longer periods, and to more willingly trade immediate gratification for promises of long-term benefits" (Tough, 2016, Para. 17).

The quote speaks to the painfully unrealistic expectation that a child who has experienced early trauma, stress, or insecure attachments, will be able to function in school the same way as peer who has grown up without significant experiences of adversity. The internal "messages" that Tough highlights such as " you're safe, let your guard down, people will protect you" simply don't exist for many children. These internal messages need to be taught and *cultivated* over time, with the help of supportive adults. And if a child didn't come armed with these messages to school, then that is the environment which must provide them.

Neurocognitive limitations that stem from these early experiences of broken attachments, stress, and poverty make it more and more difficult for a child to succeed academically. These students often do not learn to read on time because it is hard for them to set fears and other strong feelings aside so that they can concentrate on words on a page. These children often don't learn the basics of number sense because they are too distracted by the emotions and anxieties overloading their nervous systems (Tough, 2016). Tough explains: " the more they fall behind, the worse they feel about themselves and about school. This creates more stress, which tends to feed into behavioral problems, which leads to stigmatization and punishment in the classroom, which keep their stress levels elevated- all, which makes it harder to concentrate on the task at hand (Tough, 2016, Para. 18).

If we truly understand and accept that children's non-cognitive capacities are informed by past experiences and especially by adversity, how can we break the negative cycle that Tough outlines? The answer once again lies in a child positively attaching to school and to people within the school. Tough asserts that students will be more likely to

acquire and display positive academic habits in an environment where they feel a sense of belonging, independence, growth, autonomy and competence (Tough, 2016, Para. 30).. Interestingly, these buzzwords all relate back to attachment theory. Children grow, establish autonomy, and feel a sense of belonging all within the context of the early attachment relationship with a caregiver. These are all crucial facets of the attachment experience. Tough and other researchers assert that we need to get back to the central concepts of attachment theory when working with children who have experienced adversity. Teachers need to act warmly and lovingly towards their students and build positive relationships. The school environment, overall, needs to feel safe and predictable. And most importantly, students need to feel that the adults in their lives know who they are, appreciate them, believe in them and want them to be successful.

VII. Conclusions and Recommendations:

The school described in this thesis has taken some significant steps to help its students attach more positively to the school. First, the school has linked up with the hospital's school-based behavioral health program that provides therapy in the school, free of charge. By addressing behavioral health concerns at school, children get the care they need to help them heal early experiences of trauma and adversity. Second, about a third of the teachers set aside time in the school day to cultivate socio-emotional skills. Quite a few teaching practices help teachers adopt and strengthen these skills. The first of these practices involves using student-centered discipline. Student-centered discipline refers to a type of classroom-management that involves teachers setting aside highly punitive ways to get students to behave. Students and teachers must develop shared norms and values in the classroom, as well as clear expectations for safety and behavior. This specific strategy allows students to connect the rules to the vision of how the classroom is run (Yoder, 2014, p. 11).

Another important aspect of socio-emotional teaching/learning is teacher language. Teachers should not simply praise how well students perform (e.g, you did a great job!), though of course positive feedback when deserved is welcome. Instead, research has shown that it is more important to encourage their efforts (e.g., "I see you worked hard on your math assignment. When you really think about your work and explain your thinking, you get more correct answers") (Yoder, 2014, p. 12). Emphasizing that hard work pays off takes students much farther than simply praising achievement. Teachers should use language and the right concepts to encourage students to monitor and regulate their own behavior.

The last socio-emotional teaching recommendation is arguably the most important one, having to do with warmth and support on both the teacher and peer ends. As mentioned throughout, this involves teachers creating a classroom where students know that teachers care about them (Yoder, 2014). Teachers can demonstrate that they care by asking students questions (academic and nonacademic), following up with students when they have a problem and concern, providing the teacher's own anecdotes or stories, and acting in ways in which students know that taking risk and asking questions are safe in the classroom (Yoder, 2014). Warmth and support humanizes the teacher and student to one another, which in turn makes the student feel positively attached to their class.

Additionally, high expectations for students are central to bolstering feelings of attachment and self worth for vulnerable students. High expectations can be communicated through simple encouragements such as "I know you can do it!". Having a rich and challenging (not boring) curriculum increases student participation. Cooperative teaching strategies directed towards multiple intelligences, diverse learning styles, active interest in student performance, and constructive feedback all bolster a student's feelings of self worth (Brooks, 2006). The student feels capable and smart, as well as safe enough to take risks even if they know there is a chance they may fail. Failure can promote learning and engagement if it can come to be viewed as a chance to learn to solve a problem better.

In addition to providing more socio-emotional learning opportunities in school, the implementation of restorative justice is another key way that schools can bolster community and strengthen attachment. "Restorative justice" seeks to redirect problem solving when something has gone wrong and a person (youth or adult) gets hurt

(emotionally or physically). The focus is on repairing harm done in relationships and

people, not assigning blame and dispensing punishment (Hopkins, 2002). As Hopkins

asserts:

> "This approach to conflict resolution challenges many notions deeply embedded
> in western society at least, and enacted in many homes, schools and institutions.
> These notions include the idea that misbehavior should be punished, and that the
> threat of punishment is required to ensure that potential wrongdoers comply with
> society's rules" (p.144).

Extensive research shows that suspensions and expulsions are often linked with

higher rates of future involvement with the criminal justice system (Bintliff, 2014).

Restorative justice has evolved as a more effective way to address the school-to-prison

pipeline by keeping discipline in a positive place of learning and repairing, rather than

punishment and sentence (for example, suspension or expulsion). It is important to keep

in mind that minorities are the most heavily overrepresented among those most harshly

sanctioned in schools (Wald, Losen, 2003). Many of these students will enter this "school

to prison pipeline", which can be seen as

> " A journey through school that is increasingly punitive and isolating for its
> travellers—many of whom will be placed in restrictive special education
> programs, held back in grade, banished to alternative "outplacements" before
> finally dropping or getting "pushed out" of school all together" (Wald, Losen,
> 2003, p. 3).

Thus, restorative justice is an alternative approach that challenges this deeply

flawed notion that misbehavior needs to be punished-- especially for children of

minorities and/or children with already existing emotional or behavioral difficulties.

Instead, it recognizes the deep need for new alternatives in the way we address conflict.

Here again, school can become the place where past attachment problems, challenges to

socio-emotional development, and poorly regulated behavior begin to be addressed.

Resetting attachments, connecting strongly to people and to school, and becoming a

higher succeeding student are all parts of a human development process. Teachers play a

part – everyone does. And those working in behavioral health have their own roles to

follow.

So what do these new alternatives look like in practice? Restorative justice

circles (also known as "talking circles") involve inviting students who have been

involved in an interpersonal conflict in school to participate in the school, instead of

separating them from the community (through suspension or expulsion). Students who

were involved in a conflict (and their teachers, also known as "circle keepers") sit down

and confidentially explore all angles of the conflict (Wald, Losen, 2003). Only one

person speaks at a time- this is established by having a "talking piece" that is passed

around the circle (Zehr, 2015).

Restorative justice circles focus on *needs* rather than punishments. The process

allows a dialogue to form that attempts to understand why a conflict has occurred and

what factors have contributed to it (Zehr, 2015). It also focuses on the idea of

"restorying," in which each member of the conflict recounts how it impacted him or her

personally, provides balance and understanding to all involved (Zehr, 2015). This

provides transcendence of one's experience through public acknowledgement, and gives

each member a sense of empowerment (Zehr, 2015). Within the safe space of the circle,

students can begin to understand the impact of their behavior on others.

The most important aspect of restorative justice circles is that they are

relationship based. Instead of isolating and punishing a student who has misbehaved,

these circles help students work with their peers to help deepen their understanding of a

conflict. These circles can almost be seen as a type of group therapy, healing fractured

relationships between peers and building trust between students and their broader school

community. When a student is not frightened of being punished, s/he are more likely to

engage in open conversations about their thoughts and feelings. Of course, this is similar

to the safety and non-punitive nature of the therapy relationship.

        Therefore, it can be argued that restorative justice circles should be the primary

way that school staff handles conflict management. These circles should be a routine part

of the school day, as they help both students and teachers relate to one another more

authentically.

        Other recommendations include school social workers taking a more active role in

educating teachers and administrators on the profound impact of childhood trauma,

adversity, and stress as it relates to a child's level of functioning in the classroom. By

educating teachers about the ways difficulties in a child's home life cross over into a

child's school experience, teachers cultivate empathy and hopefully gain more flexibility

when it comes to understanding a student's specific needs. Monthly workshops with

teachers, administrators, and social workers in which concepts such as attachment theory,

trauma, and poverty are discussed would be helpful to all. Perhaps teachers might

discuss their own experiences growing up, and how these experiences inform the ways in

which they engage with their students. Social workers could even offer to meet with

individual teachers who are struggling to manage their classes, and work with them to

brainstorm more flexible, creative ways to address these difficulties.

        It is also important that social workers continue to educate school staff on the

prevalence of co-occurring disorders, examples of which were given above for students at

the school at which I worked. By providing psycho-education about the ways in which

health and behavioral conditions overlap, teachers can cultivate more empathy for

students who are struggling to cope.

There needs to be a fundamental shift in our understanding of how children learn.

Schools that are the most successful focus primarily on *relationships*. These schools have

an understanding of child development and attachment theory. They recognize that in

order for children to succeed academically, they need to thrive emotionally. When

children's emotional needs are met, only *then* are they are able to focus productively on

academics.

Relationships between student's school staff should be positive, warm and

respectful. By creating secure attachments between the children and the school, everyone

begins to trust in their own autonomy and potential success. Everyone will feel as if they

belong to a larger community, which in turn will promote feelings of trust and safety. It

is the responsibility of teachers, school therapists, and school administrators to make sure

each child feels cared for and appreciated. All children, no matter who they are, have the

capacity for resilience and positive attachment. School staff has an obligation to tap into

these capacities and support students in a kind and loving way. To repeat a point made

above: family experience might be a first chance, but a second chance can come with

school, and still others with healing modalities such as therapy or restorative justice.

In our current public school system, teachers are overworked, underpaid, and

underappreciated. They are pressured to "teach to the test" and have less and less time to

cultivate meaningful relationships with their students. In order for students to succeed

academically, they need to feel securely attached to their school. For many students at our

school, broken attachments with a primary caregiver make it nearly impossible for them to positively attach to their school environment. Many of these children struggle with anxiety, depression, ADD, and other challenges that inhibit their ability to positively attach to their school community. By creating a warm school community in which teachers, social workers and families are equally engaged and committed to relationship building, students will thrive both academically and emotionally.

By utilizing therapeutic resources within the school, students and their caregivers can begin to heal from broken attachments and begin to treat underlying emotional issues that hold them back from succeeding in school.

By expanding socio-emotional learning in classrooms, children gain the skills necessary to recognize and manage their emotions, develop caring and concern for others, and establish positive relationships. These skills are necessary to positively relate and attach to not only their family and peers, but also their larger school community.

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