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Exploring the Learning Experience of Higher Education Students in a Midwestern University who Suffered Childhood Trauma

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by

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at Lindenwood University by the School of Education

Dr. Susan Isenberg, Committee Chair	4-20-18 Date
Dr. Stephen Sherblom, Committee Member	4-20-18 Date
Dr. Jan Munro, Committee Member	4-20-18 Date

Declaration of Originality

I do hereby declare and attest to the fact that this is an original study based solely upon my own scholarly work here at Lindenwood University and that I have not submitted it for any other college or university course or degree here or elsewhere.

Full Legal Name: Dora Jean Washington

Signature:  Date: 4-20-18

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Dedication

I dedicate this dissertation to my Lord and Savior Jesus Christ who made all of this possible. It is because of his hand, heart, and help that I am not a statistic. He worked it all out for my good.

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Abstract

This study explored the learning experiences of higher education students who suffered childhood trauma (CT). Eleven participants both undergraduate and graduate who attended a Midwestern university self-identified as CT survivors. There was research on the negative impact of CT on learning in children and adolescents, as well as posttraumatic stress and veterans. However, the PI was unable to find research on the impact of CT on adults in higher education. Higher education institutions and professors may benefit from understanding how to help these students who often have an invisible learning disability. Research questions asked, what is the learning experience of higher education CT survivors, what can be learned that could help other CT survivors in higher education, and what do they need to be successful. Multiple case studies was the qualitative method used to explore the participants' learning experiences. Instrumentation included an Adverse Childhood Experience study (ACEs) questionnaire with self-scoring guide, 14 initial interview questions, structured ongoing journaling entries, and exit interviews.

Data analysis resulted in nine emerging themes: challenging, learning strategies, anxiety, fear, time management, support groups, determined, personal character traits, and adult learning principles. Four themes described the particpants' negative learning experiences—challenging, anxiety, time management issues, and fear. Two described the positive—determined, and personal character traits (e.g., resilient, confident). One described techniques they use to help them be successful—learning strategies (e.g., [all said] face-to-face learning). And, two described what they need from professors and higher education—support groups (that include professors) and application of adult

learning principles—attend to the characteristics of adult learners (e.g., self-directedness, immediate application to solve real-life problems), and use a learning process by which adults learn best (e.g., prepare the learner so as to avoid emotional trigger experiences, shift from subject- to performance-centeredness). The salient finding was that CT survivors in higher education are the same as any adult learner, but may benefit from an informed level of sensitivity to their learning needs. Allowing new students to self-identify as CT survivors and the general application of adult learning principles may allow all higher education learners to be successful.

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Chapter One: Introduction

Childhood trauma (CT) is defined for the purpose of this study as any event past or present which renders a child under age 18 with feelings of helplessness, phobia, torment, despair and/or extreme emotional and psychological distress.

> Traumatic events for a child include a direct or indirect experience involving a forceful sexual experience, physical [harm] being kidnapped or held captive, receiving maltreatment of any kind, manmade stressors, any accident related to maltreatment, experiences with violence or injury, being a part of, witnessing an unnatural or a sudden death, or exposure to dead body parts. (First, 2000, p. 467)

Exploring adult learning experiences of higher education students who suffered CT seems to be a topic worthy of research due to the invisible nature (Majer et al., 2010) and increased numbers of CT survivors (Mock & Arai, 2010), and learning challenges associated with it (Ziegler, 2015). Further, it seems to be a logical assumption that as higher education attendance rises (Rudgers & Peterson, 2017), so does the number of higher education students who suffered CT. Many survivors deal with long term consequences such as physical, mental, emotional, psychological, post traumatic stress disorder (PTSD), general anxiety disorders (GAD), and cognitive impairment (Afifi et al., 2014; Felitti et al.,1998; Mock & Arai, 2010).

This research topic originated from my personal experience as a survivor of CT and my observation of fellow students, both current students at the time of the study and former students, in higher education who self-disclosed that they, too, suffered CT. As a CT survivor myself and a higher education student, I have experienced learning challenges that have forced me to develop strategies to enable my successful learning.

This study explored the learning experiences of other higher education students who have suffered childhood trauma to potentially discover a pattern of successful learning strategies that could be helpful to both higher education learners who have suffered CT and the faculty members who help them learn.

Although CT may have become universally known as a result of Felitti's two-year study (1995-1997) through his Adverse Childhood Experience study (ACEs), it was well known by those who survived it (Ellen, 2012; Felitti et al., 1998). In his study, Felitti stumbled on to information that would change how the world viewed CT; thus the study became known as "the most important public health study you never heard of" (Ellen, 2012, para. 2). Participants enrolled in an obesity program were losing weight and it seemed all would be well, but many of those who were losing weight were dropping out of the program. This sudden and continuous drop caused Felitti and the others concern. He interviewed participants and found they quit because the success for the participants brought with it a new set of problems. One of the participants who lost the weight revealed, "overwieght is overlooked" (Felitti et al., 1998, para. 18). They feared what would happen if they continued to lose weight. Further, for these participants, eating soothed a deeper pain. Felitti wanted to know if his study represented the obesity population or society at large, so he partnered with the U.S. Centers for Disease Control and Prevention (CDC) to conduct the Kaiser Permanente study (Felitti et al., 1998). More than 17,000 people agreed to be a part of the study (Ellen, 2012, para. 7). This study revealed the depth of CT exposure and the long term consequences it had on the adult's mind, body, and behavior (Felitti et al., 1998; Negele, Kaufhold,

Kallenbach, & Leuzinger-Bohleber, 2015). What is more, the study reported three major revelations.

> There was a direct link between childhood trauma and adult onset of chronic disease, as well as mental illness, doing time in prison, and work issues, such as absenteeism. Second shocker: About two-thirds of the adults in the study had experienced one or more types of adverse childhood experiences. Of those, 87 percent had experienced 2 or more types. In other words, ACEs usually didn't happen in isolation. Third shocker: More adverse childhood experiences resulted in a higher risk of medical, mental and social problems as an adult. Now we see that the biological impact of ACEs transcend the traditional boundaries of our health and human service systems. Children affected by ACEs appear in all human service systems throughout their lifespan—childhood, adolescence, and adulthood—as clients with behavioral, learning, social, criminal, and chronic health problems. (Ellen, 2012, para. 36)

Felitti et al.'s 1998 study not only gave CT a name, it identified consequences as a result of having experienced it. Senator Scott Brown, Republican from Massachussetts shook the political scene in a 2011 interview with Barbara Walters where he confessed to being sexually and physically abused as a child. After reading Felitti's study on ACEs, Brown's greatest victory may not have been when he defeated his opponent in an election, it may have been when he overcame adverse childhood experiences to become a successful adult. In his book, *Against All Odds*, he captures how many adult survivors of CT experience life events differently as a result of their CT events (Brown, 2014; Carollo, Berman & Aasen, 2011).

Finkelhor, Turner, Shattluck, and Hamby (2015) conducted a national survey of children exposed to violence, crime and abuse from children one to 17 years of age. The survey revealed in a year's time, 40.9% of children had multiple direct experiences of maltreatment, violence or crime (Finkelhor et al., 2015, para. 30). Child abuse and neglect reported almost a million children are abused annually (Finkelhor et al., 2015, para. 4). These numbers suggested there is a need for more knowledge and resources on the long term effects of CT. While the overall rate of child maltreatment decreased from 2008 to 2012 by 3.3% or 30,000 fewer known cases, the number of responses from child protective services (CPS) increased by 4.7%, or 107,000 additional cases (U.S. Department of Health & Human Services Administration for Children and Families Administration on Children, Youth, and Families Children's Bureau [USDHHS-CFA], 2012, para. 8).

There was a national estimate of a 7.4% increase in child abuse investigations from 2010 to 2014 and a national estimate of "1,580 children died of abuse and neglect" (USDHHS-CFA, 2017, para 2). There are approximately five deaths occurring daily from child abuse (Finkelhor et al., 2015).

Whether a child is abused sexually, physically, emotionally, or as a result of a neglectful caregiver, the experience is traumatic for the child. Traumatic experiences during the developmental stages of the child's brain present physical, psychological, and cognitive challenges to the child (Center for Substance Abuse Treatment, 2014; Perry, 2003)—all of which can negatively impact not only the individual's lifelong health, but also his or her ability to think and learn. Organizations and agencies across the country that know the affects of CT on an survivor's quality of life and society are working to

prevent child trauma through conducting research, and implementing new initiatives that address childhood trauma, all in an effort, to eliminate childhood trauma (Child Welfare Information Gateway, 2015;Fessler, 2014; Prevent Child Abuse America, 2015). Burke in her TED (Technology, Entertainment, and Design) talk titled, "Childhood Trauma and its Effects on the Developmental Brain" said, "when we recognize it to be a public health crisis, then we can begin to use the right tool kit to come up with a solution" (Burke-Harris, 2015, 12.29-12:39).

The ACEs study was the first of its kind to elucidate the potential irreparable damage CT causes. The research surprised the world with its study on college educated, middle class Caucasians when it reported 70% of those surveyed had suffered a CT or multiple CTs (Ellen, 2012). Researcher van der Kolk (2005), confirmed Felitti's study when he wrote, "The ACEs study showed that adverse childhood experiences are vastly more common than recognized or acknowledged and that they have a powerful relation to adult health a half-century later" (para. 5).

Not all children exposed to CT will experience adverse effects because children like adults react to things differently (Hodas, 2006). Unfortunately, children exposed to CT developed ways to adjust, but oftentimes the ways they found to adjust make it difficult for them to find success (Hodas, 2006). The varied responses of why CT impacts individuals differently may be attributed to the lack of extensive research on the long term consequences of CT throughout the life span of the individual (Majer et al., 2010). At any rate, when survivors of CT enroll in higher education institutions across the country, they may have a different learning experience than those who have not experienced CT.

Background of Childhood Trauma

When an individual thinks of childhood, thoughts of love, playfulness, unalarmed, imagination, curiousity, naïvety, and fairly tale stories should come to mind. Some say those were the best times of their lives because they did not have a care in the world. Sadly, CT deprives children of normal childhood feelings and emotions and places them in adult situations (National Council on Child Abuse and Family Violence, 2017, para. 3). For children, this newfound adult position forces them to find ways to deal with feelings and emotions and sets them up for future physical, emotional, and mental problems as well as feelings of neglect, abandonment, insecurities, trust issues, and cognitive impairment (Maikoetter, 2011; Pratchett & Yehuda, 2011; Syal et al., 2014; Wilkinson & Goodyer, 2011). "Researchers have grouped Early Life Stressors (ELS) as moderate to severe adversities experienced before puberty. Some of the common early life stressors identified are sexual, physical, and emotional maltreatment" (Copeland & Gorey, 2015, para. 2), but to the child experiencing and the adult surviving the stressors, they may all be grouped as severe.

From my experience, CT is an adversity that interrupts the adult survivor's entire life. Whether the interruptions are insecurities in a personal relationship, lack of trust, constant washing of hands, social ineptness, paranoia, lack of self-confidence, insomnia, constant complaints about ailments, incessant fears, or feelings of abandonment or rejection, CT forces the individual to develop strategies or ways to cope with these interruptions. The International Societies for Traumatic Stress Studies (2018) noted it is likely survivors of CT will forget the traumatic event(s) until they are suddenly reminded of someone or something. This may trigger the actual memory of the traumatic event that

the survivor may have forgotten and may cause the individual to be overwhelmed with sudden memories (para. 3).

Trauma is an unnerving experience for an adult, but even more so for an innocent child who has not developed strategies and coping mechanisms when faced with sudden or prolonged atrocities. Trauma has such a profound affect on children because it can change their minds, bodies, how they learn and how they relate with others (Perry, 2003; (Bassuk, Konnath, & Volk 2006). Children who experinced trauma have difficulty expressing, regulating, and identifying their emotions. Van der Kolk identified trauma as transfiguring the child's peaceful place to a place of chaos and leaves them with a distorted world for the rest of their lives (2005). Children find ways to deal with the overwhelming feelings and emotions (Maikoetter, 2011).

Stress is the body and mind's response to stressors such as death, witnessing violence, divorce, exams, and failures. The hormonal system responds to stress through the Hypothalamic Pituitary-Adrenal (HPA) system—sometimes referred to as the HPA axis (Smith & Vale, 2006). When the body percieves a situation as being stressful, the hypothalamus releases stress hormones called glucocorticoids and cortisol (Smith & Vale, 2006). The HPA system then enables individuals to respond quickly to life threatening situations. The actions of the stress response ensure the body has what it needs to react quickly to life threatening situations and then return to a state of normality (Stephens & Wand, 2012). If the body does not return to homeostatis, it will remain in a heightened state of sensitivity. This creates a constant state of allostasis instead of returning to homeostasis. It has been documented that maltreated children retain high

levels of cortisol which contribute to the developing brain becoming adaptive to the heightened state (Perry et al., 1995).

Early negative experiences in a child's life with the HPA axis shape how the child views threats and how he or she responds to stress (Stephens & Wand, 2012; Tarullo & Gunnar, 2006). Traumatic events have been known to cause dysregulation of the HPA axis (Du & Pang, 2015). This can best be explained by thinking of what happens to an indiviual who is chased by a viscious dog or who unknowingly steps on a poisonous snake. The individual may panic and the heart rate increases, the blood pressure increases, and the blood sugar level drops (American Psychological Assoication, 2015a). Everything speeds up to provide the body the energy to flee. This fight-or-flight response state is designed to last until the individual escapes the danger. However, childhood survivors' stress response system may have difficulty returning to its basal pattern (McEwen, 2005). When the mind is preoccupied with thoughts of fighting, it makes it difficult for the individual to concentrate, learn, or process information. Perry (2006) reported, "fear destroys the capacity to learn" (p. 23). It is paramount that educators eliminate fear from the learning environment when teaching to ensure a safe environment where all students can learn.

Beyond physical, emotional, and mental challenges is the educational challenge for survivors of childhood trauma. Research studies have shown the traumatized child's brain experiences profound neurobiological changes that may cause lasting developments (Coates, 2010; Korten, Penninx, Pot, Deeg, & Comijs, 2014). Further, survivors of CT may have to face some physical, emotional, mental, *and* educational challenges. In spite of these challenges, many survivors enroll in higher education institutions to pursue goals

and dreams. As a result of these challenges, students who experienced CT may have a different learning experience from those who did not.

Purpose of the Study

The purpose of this qualitative study was to explore the learning experiences of higher education students who suffered CT. Specifically, a purposive sample of graduate students who attended a liberal arts Midwestern university, and who self-identified as having experienced a CT was interviewed to explore the challenges they faced academically at higher education institutions, how they see themselves in the learning environment, their success rate, coping mechanisms, learning strategies, self-efficacy, and their perceived success at forming personal and professional relationships.

Rationale

Trauma during early childhood is one of the many areas that has been largely neglected and represents "a significant gap in our understanding of trauma across the lifespan" (De Young, Kenardy, & Cobham, 2011, p. 231). One consistent research finding was the impact CT has on the individual's physical, mental, emotional, and psychological well-being (Burke-Harris, 2015; Felitti et al., 1998; Mock & Arai, 2010; Terr, 1991). Researchers determined that extreme stress during the developmental stages of the brain impacts parts of the brain that are involved in critical thinking skills and theoretical concepts, makes the child incapable of processing particulars requiring details, and contributes to brain atrophy (Syal et al., 2014). Prolonged stress known as chronic stress is the result of the mind continuously being in a hyperarousal state. Children who experienced childhood trauma have been exposed to chronic stress and are at risk of suffering from an "ongoing neurobiological adaptation, rather than an acute, adaptive

response specific to a situation" (Perry et al, 1995, p. 9). Even in adulthood, minimal stimuli reactivates the "fight or flight" state and can cause functional and cognitive impairment (Centers for Diseases and Prevention, 2014, para. 2,). In 2009, Twamley et al. found children who had been exposed to early life stress (ELS) or stressful life events (SLEs) for long periods of time did poorly on tasks that required them to use their cognitive and intellectual skills (Majer et al., 2010; Navalta, Polcari, Webster, Boghossian, & Teicher, 2006). This may be due to ELS and its association with neurocognitive dysfunction (Syal et al., 2014). This research supported the montage of experiences some survivors of CT who want to pursue a degree may encounter as well as the paucity of research surrounding this public problem. There was research literature on the impact of childhood trauma on learning in children, adolescent, and war veterans, but I have found no research on the impact of childhood trauma on learning in higher education.

Higher education students who experienced CT is significant because of the statistical data that revealed the overwhelming adversities that result from CT (Burke-Harris, 2015; De Young et al., 2011; Korori, 2013; McNay, 2010). The ACEs study found a strong relationship exists between adverse childhood experiences and depressive disorders, suicide attempts, drug abuse, sexual transmitted disease, smoking, and mental illness (Ellen, 2012). This was further supported by Andrea, Sharma, Zelechoski, and Spinazzola (2011); Anda et al. (2006); and Austin and Herrick (2014). In addition, studies revealed the more adverse childhood experiences reported, the more likely a person was to develop heart disease, cancer, stroke, diabetes, skeletal fractures, and liver disease (Afifi et al., 2014; Bremner, 2006; Cook et al., 2005; Schafer & Fisher, 2011).

This study adds to the already existing body of knowledge that adults who experienced CT are often diagnosed in adulthood with cognitive dysfunctions, PTSD, diseases, and disorders (Bremner, 1999a; Kendell, 2002; Scott, Smith, & Ellis, 2010). The intent of this study was to examine and describe the learning strategies, challenges, and successes of students in a Midwestern university who suffered childhood trauma focusing specifically on how they learn, perceive themselves, and achieve success.

Results from this study may inform higher education institutions and their professors of the learning needs of these students and the resources needed to help them be successful. Survivors of CT who enroll in higher education institutions do not walk into classrooms with signs that say they are a CT survivor. The long term consequences of the child's exposure to chronic stress may create a disability that is often invisible. The National Scientific Council on the Developing Child (2014) confirmed prolonged activation of the stress response system may lead to impairments in learning. Wildeman et al. (2014) reported "1 in 8 U.S. children will suffer maltreatment" (para. 6). These studies reaffirmed some of these children, who become adults, will undoubtedly enroll into higher education institutions. Therefore, it seems important that professors teach with the assumption that all learners have suffered CT. Professors who make this assumption are sure to attend to the learning needs of both adult students who have suffered CT as well as the adult students who have not. Although strategies, approaches, support, and positive learning environments attend to the students with learning disabilities, they will meet the needs of all learners. Restaurants, hotels, and employment agencies recognize the need for a disability friendly environment for all because it is well understood that many physical disabilities are invisible. Higher

education institutions could benefit as well by having disability friendly professors and classrooms because many learning disabilities are invisible.

Research Questions

RQ#1: What are the learning experiences of higher education students who suffered childhood trauma?

RQ#2: How do higher education students who experienced childhood trauma describe themselves?

RQ#3: What can the experiences of academically successful higher education students who experienced childhood trauma reveal that might be of use to other students who survived childhood trauma in their struggles with learning in a higher education setting?

RQ#4: What do adults who experienced childhood trauma perceive they need in order to be successful learners (resources, tools, environment, accommodations, instruction, etc.)?

RQ#5: How do participants perceive daily structured journaling during the 60-day study?

SQ1: What were the benefits, if any?

SQ2: What were the repercussions, if any?

Limitations

This study was only about adults who suffered maltreatment at the hand of a parent or caregiver, adult, or older child when they were children, and the study focused only on the four types of abuses defined by De Bellis and Abigail-Zisk (2014) as emotional, neglect, physical, and sexual (para. 1).

Little or no research has been done on CT and its impact on individuals who pursue higher education. This study was about college students who self-identifed as having experienced CT. The assessment tool was a self-reported questionnaire that could have contain biases, and participants may have suppressed memories of an event.

Delimitations

This study was not about difficulties resulting from accidents in childhood that caused severe problems such as children born with or who developed a medical illness, children with birth defects, or children who have suffered multiple surgeries.

Assumptions

There was an assumption in this study that anyone who suffered CT will be affected in some way—that no one will come out unscathed.

Definition of Terms

Anxiety disorder – "disorders that share features of excessive fear and anxiety and related behavioral disturbances" (First, 2013, p. 189).

Childhood abuse – child maltreatment is any act or series of acts of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child. The four most commonly identified types of child abuse are emotional, neglect, physical, and sexual abuse (First, 2000; Goodman et al., 2009).

Complex trauma – A child suffering multiple maltreatment concurrently within the child's caregiver or social environment. These experiences are chronic, invasive, and encompass emotional, sexual, or physical maltreatment and neglect, as well as exposure to family violence (Cook et al., 2005).

Higher education institution – defined as

> a post secondary institution of learning such as a university or college leading to an academic degree whether an undergraduate or graduate degree including programs at the associate, bachelor, master, doctoral, or certification level such as a teaching certificate. (Talbott, 2011, p. 220)

Posttraumatic Stress Disorder (PTSD) –

> anxiety disorder which may occur after exposure to terrifying events that threatened [was perceived as threatening] or caused grave physical harm to self or others and causes the individual to avoid future exposure to the event due to intense feelings. (Mohr-Almeida, 2009, p. 229)

Psychological trauma –

> Extreme stress resulting in impairment of the neuroendocrine systems in the body and regulatory process in the brain stem, the limbic brain (emotion, memory, regulation of arousal and affect), the neocortex (perception of self and the world) as well as integrative functioning across various systems in the central nervous system. Traumatic experiences are stored in the child's body/mind, and fear, arousal and dissociation associated with the original trauma may continue after the threat of danger and arousal has subsided. (Moroz, 2005, p. 4)

Stress – a "pattern of specific and nonspecific responses a person makes to stimulus events that disturb his or her equilibrium and tax or exceed his or her ability to cope" (First, 2013, p. 829).

Stressor – defined in the DSM-5 as "any emotional, physical, social, economic, or other factor that disrupts the normal physiological, cognitive, emotional, or behavioral balance of an individual" (First, 2013, p. 829).

Trauma – experiences or conditions that are emotionally upsetting and cause people to be unable to manage, thus leaving them helpless. Also, defined as circumstances outside the normal human experience (First, 2013, p. 271).

Traumatic event - for the purposes of this study is

> any event past or present that renders the individual with feelings of helplessness, phobia, torment, despair, and/or extreme emotional and psychological distress after the event. Traumatic events also include a direct or indirect experience involving a forceful sexual experience, physical harm, being kidnapped or abducted, receiving maltreatment of any kind, manmade stressors, any accident related to maltreatment, experiences with violence or injury, being a part of, witnessing unnatural or a sudden death, or exposure of dead body parts. (First, 2000, p. 467)

Although many people may assume that because a child is young in age, there will be protection from the impact of a traumatic experience. The ACEs study reports the child is not protected, and the traumatic experience may last a lifetime. Therefore, it is imperative that higher education institutions be prepared and well informed on how to help these students be successful in the educational setting.

Chapter Two: Literature Review

This chapter reviews the framing literature on the topic, the learning experiences of higher education students in a Midwestern university who suffered CT. There is a logical sequence of the topics reviewed that move from general to specific. The literature reviewed in the order of appearance are as follows: impact of CT on society and education, impact of trauma on the child, learning with an illness or disorder (physical or mental), learning in higher education, and the learning needs of adults in higher education who suffered CT.

Impact of Childhood Trauma on Society

The impact of CT is far-reaching and goes well beyond the impact on the child. Both society and its education system are impacted negatively as a result of rampant CT within a population. The following is a review of the research literature related to the impact of CT on society.

Children in the U.S. may be facing a hidden epidemic as a result of child maltreatement because not every incident of a child being abused is reported. "The United States has one of the worst records among industrialized nations for child deaths through child abuse and neglect" (American Society for Positive Care of Children, 2017, para. 2). The hidden epidemic of child maltreatment may be due partially to the breakdown in family structure, increase in single parenting, increase in divorces, and an increase in stepfamilies and unmarried childbearing (Demuth & Brown, 2004).

Childhood trauma impacts society because the most vulnerable members of society are placed in jeopardy. The role of children in a society is to grow up and make significant contributions. These would-be contributions are compromised by the exposure

to trauma. Families that exhibit strong relational bonds help to build stronger societies. Breakdowns in family structure contribute to a breakdowns in society. Noor, Gandhi, Ishak, and Wok (2014) found the breakdown of the Malaysian government as it tried to balance the economics and social agendas while disregarding the need for strong families. The authors concluded, "Children are raised to become useful members of society within the family; thus, if the family is problematic, society will suffer" (p. 280).

When a child is abused by family members, it not only creates problems for the child but for the family, and society as well. Child abuse and neglect reported "parents acting alone or with another parent were responsble for 77.7 percent of child abuse or neglect fatalities" (2015, p. 4).

According to Almond (2006), "the family is and always has been the foundation of communities in which the cherishing of each individual can flourish" (para. 2). This breakdown in family structure is like a domino affect because it is most likely to be imparted inter-generationally (Teachman, 2002). Without a strong family structure, children do not learn how to regulate their behaviors because a child learns how to internalize through the affective and cognitive relationships with caregivers (van der Kolk, 2005).

If children learn from the relationships they have with adults, and adults are abusive in those relationships, there is little wonder why children grow up and repeat the abuse to their children and other children. Many studies have focused on the cycles of repeated abuse. Research suggested, "about one-third of all individuals who were abused or neglected as children will subject their children to maltreatment (Child Welfare

Information Gateway, 2013, para. 1). Because of this self-perpetuating nature of childhood trauma, it could become insidious to a community's culture.

Children who have been maltreated are usually deficient in emotional and mental health, frequently drug abusers, and often have behavioral problems. Many children who have emotional problems have difficulty expressing their emotions and are unable to control their emotions (Feiring, 2016). A society of people who are unable to control their emotions would create pandemonium.

While child abuse usually occurs by either a family member or a friend of the family, its impact does not stop with them. All parts of society pay a price for child maltreatment directly and indirectly (Child Information Gateway, 2018). A neglected child may be antisocial because "parental neglect is associated with personality disorders" and "more than half of youth who are maltreated are at risk of repetition, substance abuse, delinquency, truancy, or pregnancy" (Child Welfare Information Gateway, 2013, p. 5). These neglected children may have not only lost their dreams to be significant contributors to society, they may have also lost their belief and trust that society is a place that could benefit from their contribution. Fang, Brown, Florence, and Mercy conducted a study that divulged the lifetime cost for abused children and fatalities per year, which is $124 billion (2012, para. 3). If society had the money to pay for it, it would remain in debt because of the damage done to the victims. Regarding CT, Zepinic (2011) argued, "the shattered sense of self in traumatised persons hightlights the importance of inteprsonal processes in mental health" (Zepinic, 2011, p. 8). When a person is deprived of a sense of self, no price could be comparable. The $124 billion cost is the price for the services society renders to the person, but there is no price recorded

for the destruction of the self. Victims pay the ultimate price with the loss of self and shattered dreams. The victim's family pays a high price because they may have to live with the loss of a loved one's mental health, physical health, and even death.

Society pays a price for CT because in some cases the victim may never be able to make positive contributions to society due to mental illnesses or physical illnesses and disorders (Felitti et al., 1998; Schafer & Fisher, 2011). The perpetrator also loses because the person in some cases is at risk of being incarcerated, killed, or forced to live as an outcast in society. Prison inmates are unable to make significant contributions to the economy (Pew Center on the States, 2011) and tax payer dollars are used to care for those incarcerated. Society has much to gain in creating and promoting early programs to help children who are maltreated. While it is unable to prevent many forms of abuse, it is well able to create, monitor, and maintain psychiatric and medical programs to help abused children understand the spectrum of the abuse and the multi-faced conditions that arise as a result of it.

Fang et al.'s study said the economically breakdown of the abused child is equivalent to the cost of the treatment of major illnesses such as stroke or diabetes. Child maltreatment seems deliberate and therefore avoidable, but this may require society to take a public approach to a private act. What is more, the "rates of physical, sexual and emotional trauma were higher in childhood than adulthood and ranged from 44.7% physical trauma in childhood to 4.5% sexual trauma in adulthood (Wolf & Shi, 2012, Abstract, para. 1). In Haugebrook, Azgoba, Maschi, Morgen and Brown's (2010) review of prision inmates, they also found "rates of physical, sexual and emotional trauma were higher in childhood than adulthood and ranged from 44.7% physical trauma in childhood

to 4.5% sexual trauma in adulthood" (p. 222). Childhood trauma sets off a range of emotions and behavioral problems that may carry over into adulthood, and "if trauma is left unrecognized and unaddressed, a "cycle of trauma" may continue filling our prisons with untreated trauma victims in need of specialized care" (Maschi, Gibson, Zgoba, & Morgen, 2011, p. 161). A significant amount of money spent on specialized prison care may be avoided if trauma during childhod is recognized, addressed, and treated in its early stages.

Rehms' (2014) guest stated, "many entered adulthood with no employable skills" (16:32). To function in today's society, a variety of employable, social, and interpersonal skills seem necessary because human-to-human behavior is unpredictable. If things go well, it is conceivable that an individual may never display societal or mental problems. However, in keeping with Rehms (2014), when one loses a job or societal pressures become too much, the individual may react with unpredicted and sometimes violent behavior toward himself or others. In Canada, "32% of the adult population has experienced physical abuse, sexual abuse, or exposure to intimate partner violence in childhood" (Afifi et al., 2014, p. 3). One could project it may be more difficult for CT survivors who are suffering from mental problems in today's society because of the technological expectations. This may limit survivors with mental problems to certain jobs and educational experiences.

Barber (1998) described a civil society as a "place for common ground where we can arbitrate our differences or survive them with civility, for places where we can govern ourselves in common" (p. 3). The common ground and common governing may be Barber's idea of a strong society where people share ideas, values and beliefs

particularly regarding child maltreatment. Yet, it is still uncomfortable for many, including parents, to listen or discuss policy, laws, and beliefs about childhood sexual abuse (Wallace, 2014). This leaves the victims of society feeling intense pain from the abuse and rejection from society because of the silence surrounding it. The results from a Canadian study of abused children revealed, "all types of child abuse were associated with mental conditions including suicidal ideations" (Affi et al., 2014, Background section, para. 1). Child abuse is more than a family and society problem; it is a global problem (World Health Organization, 2002).

Impact of Childhood Trauma on the Child

There seem to be many factors that influence an individual's response to trauma such as the following: the kind of abuse, its severity, the relationship of the abuser to the child, the child's perception of the trauma, the child's home environment, the child's relationship with her or his caregiver, and any previous history of abuse. Additionally, larger scale factors include where the child is developmentally, the cultural views and norms regarding this type of trauma, and the meaning of the trauma to the one being traumatized (Perry, 2003; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). These elements may serve to soothe or aggravate a traumatic experience (Goodman, Quas, & Ogle, 2009).

The ordinary stresses of life are expected as one lives from day to day, but trauma is an unexpected experience that causes one to feel devastated and overwhelmed (Greenwald, 2005). Childhood trauma is any circumstance that causes a child to feel great despair, powerlessness, fear, and overwhelming emotional turmoil after the experience. It is the physical, sexual, emotional, or neglectful maltreatment of a child

(First, 2000; Goodman et al., 2009). Although it has been noted, “there is a significant gap in our understanding of trauma across the lifespan" (De Young et al., 2011, p. 231), there is extensive literature that suggests trauma in early childhood affects the survivor throughout adulthood physically, emotionally, mentally, and psychologically (Felitti et al., 1998; Korori, 2013; McNay, 2010).

Research has shown that not only are school age children affected by trauma but also babies express feelings of fear as early as six months (National Scientific Council on the Developing Child [NSCDC], 2010). Prefacing the word childhood before trauma may be misleading in itself as to suggest this may be a milder or lesser form of trauma because it is experienced by a child. On the contrary, exposure to trauma might be even more unnerving for the child because the child is not familiar with or equipped to handle serious stress. Trauma is disturbing for the child for several reasons. It transfigures the serene place the child once thought safe and secure to a place of dread and pandemonium and leaves the child with a distorted world throughout life (Perry et al., 1995).

The impact of childhood trauma on a child can be physical, cognitive, psychological, physiological, and behavioral (Felitti et al., 1998; Majer et al., 2010; Mock & Arai, 2010). The phrase, out of sight out of mind, may be what the adult who suffered childhood trauma unconsciously hopes to achieve by suppressing the incident; thus, avoiding these impacts of CT. An international stress study reported that adults who suffered CT often omit the incident from their memory because the incident was traumatic until someone, an event, situation, image, or a story reminds the individual of the traumatic experience (International Society for Traumatic Stress Studies, 2015).

Trauma can be extremely shattering to a children, and it can have such an overwhelming effect that it changes how they perceive themselves and who they are, how they think, learn, feel, and how they view others (Burke-Harris, 2017; Bremner, 2006; Perry, 2003; Syal et al., 2014). This may be in part because the child's brain must try to make sense of the experience. Consequently, the child internalizes traumatic experiences (Perry et al., 1995). This explains why children use reenactments as an outward display of their emotions and what happened to them (Sinanan, 2015). Psychologists grouped childhood trauma into either type 1 or type II trauma (Terr, 1991; Hosier, 2014). Type 1 trauma is when the child incessantly tries to figure out why the event happened directly to them, and Type II trauma is when the child dwells on how to prevent it from happening again (Terr, 1991). The earlier the events happen in a child's life, the more likely the brain and the nervous system will be impacted, influencing how an individual reacts to stress later in life (National Institute of Mental Health, 2017b; Bremner, 2006; NSCDC, 2010). The child's brain experiences create profound neurobiological changes that may cause lasting developments (Coates, 2010; Majer, 2010). Researchers agreed that there are neurobiological changes, but the severity of them for each child may depend on the child's phase of development. It is also unknown whether such changes are reversible (Agarwal, 2015). However, it is very clear that early childhood adversities may influence the survivors' attitudes and behaviors (Cook et al., 2005; Felitti et al., 1998, p. 251; Wolf & Shi, 2012).

A single event of CT is said not to be as difficult to a child as multiple traumas. However, "how an event affects an individual depends on many factors, including characteristics of the individual, the type and characteristics of the event(s),

developmental processes, the meaning of the trauma, and sociocultural factors" (Center for Substance Abuse Treatment, 2014, chapter 4, para. 3). A premier study on childhood and one of the most quoted studies by researchers is the ACEs by Felitti et al. (1998), which outlined 10 childhood experiences that are risk factors for chronic disease in adulthood: emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, violent treatment towards mother, household substance abuse, household mental illness, parental separation or divorce, and having an incarcerated household member. Based on this study, one can extrapolate how an individual who experienced childhood trauma may find it more challenging in adulthood to adjust to the pressures and stresses of society. Van der Kolk (2005) confirmed Felitti et al.'s study when he reported, "the ACEs study showed that adverse childhood experiences are vastly more common than recognized or acknowledged and that they have a powerful relation to adult health a half-century later" (para 5). It is undeniable that health plays an important role in one's success, and the ACEs study revealed traumas' impact on the survivor's health and lifelong consequences. "The sooner society can grasp the true reality of how traumatic experiences affect children, the more likely we are to understand and implement changes in addressing their emotional, mental, and physical needs" (Perry, 2003, para. 3).

Children who suffer childhood trauma may experience a variety of associated psychological, physical, emotional, and mental conditions (Coates, 2010; Moroz, 2005; Perry et al, 1995). However, for the purposes of this study, I focused on three categories of research literature. The following review of literature concentrate on three categories associated with childhood trauma and its impact from childhood through adulthood: physical illness, mental illness, and learning dysfunction.

Physical illness. Excessive and prolonged stress produces a lifetime of chronic disease (Felitti et al., 1998; Mock & Arai, 2010; Moffitt, 2013). A child who is exposed to abuse is automatically at greater risk for physical illness. Whether it is a slap in the face to a child by the caregiver or an inappropriate touch to a child's *private parts,* an abusive incident involving a child may not leave a physical scar, but it is certain to leave a psychological scar. The scar may later present itself in somatic, psychological, emotional, mental, behavioral, or social ways for the child. The outcome of the abuse affects children on many levels and its impact goes beyond childhood (Perry, 2003), and the more often a child is maltreated, the more risk factors the child will have (Jaffee & Maikovich-Fong, 2011).

There is a plethora of diseases and illnesses linked to childhood abuse including high-risk behaviors such as smoking, unsafe sex, and drug and alcohol use (Leserman, Drossman, & Hu, 1998; Springer, Sheridan, Kuo, & Carnes, 2003). A study by the National Survey of Child and Adolescent Well-Being (NSCAW, 2000) revealed even years after a child abuse investigation, children may begin to have chronic health problems (2000).

Childhood trauma victims may suffer from lifelong physical illnesses. In children, physical illness may present itself emotionally or behaviorally. Children who have suffered trauma may have emotional problems manifested as intestine/bowel dysfunction, stomach aches, or troubled sleep. Behaviorally, children may become more aggressive or exhibit a constant lack of energy (Karr-Morse & Wiley, 2012). Teenagers who were abused as children may act out by being aggressive, fighting, skipping school, expressing defiant behaviors, becoming disruptive, running away from home, becoming

substance abusers, and living on the streets (Al Odhayani, Watson, & Watson, 2013). By the time the abused child becomes an adult, physical illness may become a part of everyday life. What began as a childhood problem often develops into an adult problem. The long term consequences are fully evident in adulthood through the diagnosis of various illnesses. Individuals who experience childhood trauma are also more likely to suffer from a medical illness due to the prolonged stress and anxiety from the trauma (Mock & Arai, 2010). A study done by Andrea et al. found children who are survivors of CT are at risk for increased health, psychiatric, and behaviorial problems (2011). This may be attributed to the child's early exposure to acute fear and toxic stress causing the child's body to remain in allostatic overload and to respond to regular stress as if it were life-threatening (McEwen, 2005). Allostatis overload may be described as the deleterious effects of hormones on the body as it tries to control stress levels. Adults abused as children spend more time in the hospital and have more surgeries than those who were not abused (Moeller & Bachmann, 1993; Salmon & Calderbank, 1996). Research by Felitti et al. (1998) further supported these studies when they found a compelling correlation between the amount of negative childhood experiences and the existence of specific and severe adult illnesses "including ischemic heart disease, cancer, liver disease, chronic lung disease, skeletal fractures, and liver disease" (p. 251). These findings confirm childhood trauma—a household dysfunction—contributes significantly to the development of chronic diseases.

Any kind of physical illness imposes on the quality of life of the individual because it impacts every area of the individual's life (Bassuk, Konnath, & Perry, 2017). By adulthood, many survivors of abuse may feel they never had the opportunity to

experience the promise, hope, and vitality usually associated with childhood because of all the adversities associated with their trauma.

Impact of childhood trauma on the physical brain. Research studies revealed, trauma, when experienced by a child early, causes structural damage in the brain because the child's brain is still being developed (Karr-Morse & Wiley, 1997; Syal et al., 2014). Development happens in sequence from the "bottom up" which means rudimentary parts of the brain that control breathing, blood pressure, and heart rate are formed first and the part of the brain controlling reasoning and complex thought follow. Neurodevelopment suggests there is a time during brain development when the neural system is easily influenced by activities. This senistivity is essential for healthy development because it helps the child's brain respond quickly to its environment and culture. It is because of this neurodevelopment that different genetic traits and neural networks are organized and the child is able to learn new languages and behaviors quickly. However, it is the same neurodevelopment sensitivity that makes the child vulnerable to trauma (Williams, 2011). In the case of childhood trauma where the stress response system is activated, the disruption will occur in the neural systems moderating the fight or flight response. Childhood trauma influences the developed brain, but is said to actually play a role in altering and organizing the neural system of the developing brain (Stiles & Jernigan, 2010; Williams, 2011). Alterations in the brain during developmental stages may cause neurological roadblocks in the adult's cerebral cortex (Williams, 2011).

A review of the brain and its functional areas seems to be important to understanding how the brains of children who suffered childhood trauma are changed as a result of the trauma. Figure 1 illustrates the normal brain and its functional areas.

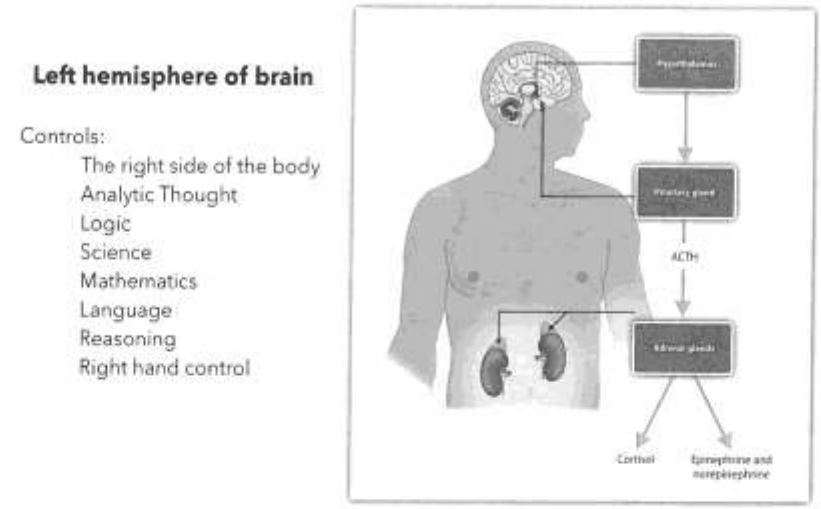

Figure 1. Brain image. Adapted from *BenGreenfieldFitness.com*, HPA Axis, and *Quora.com*, How is the hippocampus connected to the prefrontal cortex?

Every experience changes the brain, yet not every experience has the same impact on the brain. Experiences during this time are crucial because the brain is growing at such a rapid rate. It usurps every experience both negative and positive. While the child is processing an experience, there is an internalization going on of the external experience. The child is absorbing the information, the intensity of it and how often it happens. The more often a particular pattern of neural activation appears, the more deeply the child will internalize it. Perhaps this is why Perry stated "when a child experiences trauma, "she carries elements of this trauma with her every day. She carries elements of the terror into every relationship and every classroom" (Perry, 2017, para. 10). "The traumatic experience is so evasive for the child that 30% of those who are exposed to trauma develop PTSD" (Weis, 2014, p. 425). The child will now not only suffer from abuse, he will now possibility suffer from post traumatic stress disorder (PTSD). The development of PTSD introduces entirely new neuropsychiatric and physiological problems for the child.

Understanding how the brain functions and develops under threat is paramount to understanding traumatized children. Despite the on-going research of the lasting effects of CT, there are those who still believe the saying, "What doesn't kill you will make you stronger." This saying does not allow for age discrepancies, the handicapped, or the mentally ill. Using this saying, one could say anyone who goes through anything and does not die will automatically be made stronger. Coates (2010) argued this saying "minimized the traumatic events of infants and young children" (p. 392).

Children have many experiences. A traumatic experience transforms a child's tranquil place into chaos and terror and changes a child's outlook about himself, his

environment and the world. The human brain is responsible for processing information and internalizing traumatic experiences. The brain acts as a mediator in all cognitive, social, emotional, behavioral, and physiological functioning (Perry et al., 1995). Over half of the brain's synaptic structure develops after birth (Coates, 2010). The basic brain structure is already determined, yet, "the templates determining the categorization and interpretation of experience within the limbic system and frontal lobes develop gradually as a child grows" (Coates, 2010, p. 394). And, research studies reported the early events of acute trauma are extensive, disastrous, prevalent, and often tough to treat (Draper et al., 2008). Safety and security are essential in the early stages of brain organization for children, and severe stress at such a vulnerable time creates a surge of neurobiological sequelae. When a child's *secure base*—the person primarily responsible for the child's safety—is threatened, the child lives in constant emotional pandemonium and will be unable to calm down. Thus it will have a traumatic effect on the child. Healthy child growth requires a child to learn how to manage stress, but in the case of trauma, there is on-going stress where the stress system is continuously activated and cannot return to baseline levels, thus causing toxic and chronic stress for the child (National Scientific Council on the Developing Child [NSCDC], 2009).

Throughout this review of literature, numerous studies found childhood stress or on-going stress created lasting changes in the brain. If the hippocampus (the part of the brain that is used for learning and memory) is damaged by the sustained stress response system, it can impair learning. Studies, as cited by NSCDC (2009), examined two animal groups and found that (a) increased levels of stress on the mother during her pregnancy and (b) increased levels of stress on the offspring who have inattentive mothers during

their early infancy both had negative effects on offspring. "Both groups of animals also have impaired memory and learning abilities, and they experience more age-related memory and cognitive deficits in adulthood" (NSCDC, 2009, p. 3).

A large percentage of the brain abnormalities discovered in children who suffered CT are located in the left hemisphere of the brain where language and reasoning are handled, as confirmed by in a study that differentiated the electrical recordings of brain movement in abused and normal children (Teicher, 2000). Teicher found that

> In the nonabused group, left-sided EEG abnormalities were rare, whereas in the abused group they were much more common, and more than twice as common as right-sided abnormalities. In the psychologically abused group, all the EEG abnormalities were left-sided. (2000, p. 7)

Survivors of CT and PTSD may feel this cognitive deficit when they are given assignments that require higher order thinking. "The left hemisphere is used more for judgment, cognitive function, and learning" (Garrett, 2014, p. 7). A research study on the impact of stress cognitively was conducted after World War II—observing pilots during war and at peacetime. Researchers observed the effects of stress on the cognition of pilots, and concluded that during wars, cognitive errors contributed to highly qualified pilots crashing their planes (Broadbent, 1971).

Research by Adams, Wharton, Quilter, and Hirsch (2008) found college students are more likely to have chronic illnesses and increased rates of depression, stress, and anxiety. This research revealed that people entering college in general have an increased rate of anxiety. What is more, adults who suffered CT may have the increased anxiety reported by Adams et al. as well as anxiety from the adverse childhood experience. It is

well documented that anxiety and stress may prevent the prefrontal cortex from functioning properly; thus, may prevent an individual from being able to plan strategically (National Scientific Council on the developing Brain, 2014; Bremner,1999; Syal et al., 2014). Brookhart (2010) defined higher-order thinking using three terms. The first term is the transferring of information, which requires one to retain and apply what is learned to new situations. The second term is critical thinking where one is required to reason, question, explore, describe, and explain various perspectives. The third term is problem solving where one is required to solve a problem in order to reach a goal. Testing alone creates anxiety for many students, and to add an adverse experience may make thinking critically more difficult.

An abundance of complex connections of converging networks working together enable the prefrontal cortex and the other parts of the brain to act are known as the executive function (Pessoa, 2014; Ball et al., 2011). The umbrella term is part of the executive functioning that includes groups of cognitive process that interconnects for the sole purpose of obtaining goal-directed thoughts and behavior (Funahashi, 2001). It is mostly responsible for behavior, reflecting, goal setting, processing, decision making, planning, organizing, and multidimensional thinking (Best & Miller, 2010; Kostolitz, Hyman, & Gold, 2014). These cognitive processes are natural to humans, and will continue to develop and grow naturally if the child has a supporting environment (Dawson & Guare, 2004). It is also noteworthy that the association between child sexual abuse (CSA) and decreased response inhibition is consistent with other research findings documenting a decrease in executive function performance on neuropsychological tests in abuse survivors (Mezzacappa, Kindlon, & Earls, 2001). This may be in part because “the

areas of the prefrontal cortex are among the last to fully develop" (Klien, 2013, para. 2). It acts as a pathway that collects and orchestrates information, and thoughts and behaviors to and from various regions of the brain (Dawson & Guare, 2004). Strategic planning relies on executive functions, and the fundamental path of critical thinking is nearly joined with the growth of executive functions (Halpern, 1998). Children who suffered trauma may not have these skills. A lack of these executive functioning skills make planning, goal setting, decision making, and problem solving arduous (Willis, 2011). To think critically, one must be able to make a thorough decision that is based on the ability to reach a solid conclusion arrived from available data (Cash, 2011). To do this, one must have unbiased lenses and not respond emotionally.

One of the long-term effects of childhood trauma is dysregulation of the HPA axis that controls the emotions (Coates, 2010; Randall, 2010; Smith & Vale, 2006). "Executive functioning is an umbrella term that includes a group of interconnected cognitive processes accountable for purposeful-goal-directed thinking, and behavior" (Kostolitz, 2014, p. 694; Hyman & Gold, 2014). Cash (2011) concluded that when an individual is able to validate information, evaluate the source, diagnose the source's credibility, and prove its validity, there is a great chance the individual will be able to have diverse viewpoints. According to Kostolitz et al. (2014), "master thinkers have full control of their thinking processes and recognize that their thinking strategies can improve and continuously develop new insights" (p. 697).

Memory. Based on the literature, those who suffered CT may have a different learning experience than those who have not (Majer et al., 2010). Researchers revealed, "memory deficits are specifically associated with CT exposure in healthy adults" (Majer

et al., 2010, Discussion, para. 1) and revealed cognitive underperformance in tasks that involve the hippocampus. The hippocampus is used for cognitive functions such as learning and understanding. Bremner (1999) found a smaller hippocampal volume to be associated with cognitive deficits. It seems to be the case that the difficulty of learning adds to the growing challenges of those who experienced childhood trauma.

New information that is learned is stored in the working memory under new information until it can be stored in the long-term memory. Once the brain connects previous knowledge with new knowledge, it is retrievable for a later date. For the hippocampus to function properly, it must have constant neuronal activity. Therefore, the hippomcampus is especially sensitive to continuous emotional distress, because of the destructive effects of cortisol. Cortisol is recognized as a stress hormone, and is necessary to prepare the body for flight or fight when facing danger. However, once the danger has passed, the cortisol should return to homeostatis (normal state) (Torre de la, 2016; Randall, 2010; Smith & Vale, 2006).

Early trauma can (a) contribute to abnormal functioning and development of the hippocampus, the amygdala (part of the HPA axis that regulates emotions, responds to fear, and enjoys pleasures), (b) cause an undersized cortex (vast part of the brain that is associated with higher order thinking), and (c) impede the neurons (basic working units of the nervous system responsible for communicating and integrating information) from functioning properly (Shannon & Heckman, 2007). Furthermore, Syal et al. (2014) confirmed that “childhood maltreatement influenced the pattern of recognition memory in adulthood” (p. 306).

A large body of scientific knowledge on stress and the developing brain comes from a combined body of work that included animals and humans. Both categories of subjects revealed that "long-term elevations in cortisol levels can alter the function of a number of neural systems, suppress the immune response, . . . change the regions of the brain that are essential for learning and memory," and control impulses, anxiety, fear, reasoning, and planning (NSCDC, 2014, p. 3). Continuous stress influences the amount of time taken for neurons to be removed or added to the hippocampus. This impacts learning because when the neurons are confronted with cortisol, neurons are lost, and when neurons are lost, there is shrinkage of the hippocampus (Bremner, 2003; Perry et al., 1995). Cortisol may be referred to as a two-edged sword because while it stimulates the amygdala, it weakens the hippocampus. Bremner (2003) further explained how continual stress inhibits the hippocampus from producing neurotrophins—tiny proteins that are released into the nervous system to maintain the survival of cells (Huang & Reichardt, 2001), thus inhibiting the hippocampus from developing new neurons. Regular amounts of cortisol are necessary to boost cognition and attention because cortisol stimulates the prefrontal cortex, but when there are unusual levels, the brain cells degenerate (NSCDC, 2014, p. 3). Kirschbaum, Wolf, May, Wippich, and Hellhammer (1996) conducted two studies that examined the outcome of high levels of cortisol on the memory and brain of adults who were in good health. These two studies reported that increased cortisol significantly weakened the declarative memory′s function in the hippocampus (Kirschbaum et al., 1996). In summary, memory is negatively afftected by CT.

Mental illness. An adult who suffered CT may have already had to overcome extreme difficulty to survive to adulthood. As if the physical, mental, and emotional illness were not enough to overcome, the CT survivor may now have to add mental illness to the long list of difficulties because research suggested a link between CT and mental illnesses (Bendall, Alavrez-Jimnez, Nelson, & McGorry, 2013; Schafer & Fisher, 2011; Sideli, Mule, LaBarbera, & Murray, 2012; Szalavitz, 2012). The National Alliance on Mental Illness (2013) reported, "one in four adults and approximately 61.5 million Americans experience mental illness in a given year" (para. 1), and Terr (1991) concluded that "psychic trauma sets a number of different problems into motion, any of which may lead to a definable mental condition" (p. 10). According to Bendall et al. (2013), not only does CT negatively impact psychosis, but it also precedes psychosis. Individuals may not reach their maximal stress reaction directly following a traumatic event. A maximum reaction may be reached over a prolonged period of time when another traumatic or extremely stressful situation is encountered. Many of these individuals who were traumatized as children may develop a mental illness later in life (Schafer & Fisher, 2011; van der Kolk, 2005).

When an individual has a prolonged sickness, concerned friends and family follow up to ask if the loved one received treatment, and if the answer is "no" the person is encouraged to get medical help, and in some severe cases forced to get medical help. It would only seem logical that the same scenario could be applied to a loved one who is mentally ill. However, this is often not the case for individuals struggling with mental illness. This may be contributed to the stigma assoicated with mental illenss (Baun, 2009). One could say it would take an "act of congress" for them to get help, and that is

literally what President George W. Bush had in mind when he introduced his New Freedom Initiative in an effort to advance inclusion for all persons with various disabilities. This initiative sought to remove barriers that impede citizens with mental illnesses from obtaining the best health care and sought to address the "stigma that surrounds mental illness, unfair treatment and limitations of mental health benefits, and the fragmented mental health service delivery system" (Bush, 2002, Executive summary para. 1). Yet, even this act of Congress could not eradicate Americans' negative perception of the mentally ill. As Baun confirmed, "unlike physical ailments, many mental illnesses are associated with stigma" (2009, p. 31). Whether an individual is ashamed of the illness or society is afraid of the illness and what those who are diagnosed with a mental illness might do, the "shame is debilitating and interferes with daily living" (Baun, 2009, para. 3).

There are countries where there is less stigma attached to mental illness. Researchers Pescosolido, Medina, Martin, and Long (2013) studied the stigma of mental health globally from 16 countries. Even in those countries where studies were done and

> levels of recognition, acceptance of neurobiological attributions, and treatment endorsement were high, there remained negative responses that formed core foundational stigmas surrounding mental illness. The negative responses were climates of intimate settings with the mentally ill, mentally ill in positions of power, fear of interacting with them, embarrassment, and their competence. (Pescosolido et al., 2013, Results, para. 1)

From this research, one might conclude some countries like the U.S. openly acknowledge the stigmas attached to mental illness, and some countries openly deny there is a stigma

attached. Nonetheless, both actions reveal the public's negative and stubborn opinions about the mentally ill.

Mental illness is best described as a disease that originates in the mind and creates instability in an individual's thoughts or actions and renders the person unable to manage routine commands or requests (National Institute of Mental Health, 2017c, para. 4). Mental illness can be brought on by immoderate stress, a specific occurrence, multiple incidents, chemical variances, genetic factors, or other external stresses. According to the World Health Organization (WHO) (2013), "there is no health without mental health" (p. 6). Therefore, it seems likely that individuals who have mental illness will have problems with their physical health, emotional health, and psychological health. Tusaie and Fitzpatrick (2013) found, "17 percent of the adult population, had comorbid mental and medical conditions within a 12-month period" (p. 470).

A survey in 2015 by the Anxiety and Depression Association of America (ADAA) found, "nearly half of Americans think they have or have had a mental condition. Yet, "fewer than two in five receive treatment" (para. 2). Colleges and universities across the country are seeing an increase in students seeking help for their mental health. Nearly 33% of college students struggled last year with depression (APA, 2014, para. 3). As a result, "an appalling number of young adults in schools and colleges are on one form or another of psychiatric medication" (Ablow, 2013, para. 5) and "that 25 to 50 percent of U.S. college students who are seen in counseling and at student health centers are taking antidepressants" (Kadison, 2005, para. 7). These reports are disconcerting, but may paint a true picture of the mental state of our society. Equally disconcerting is "20 percent of American adults live with a mental illness, yet only 39

percent of these 45.9 million American adults received mental health services in 2010" (USDHHS-SAMHSA, 2017, Highlights, para. 1). Mental illnesses may take on various forms as discussed in the following sections.

Depression. Depression is a mental illness that affects a third of college students (APA, 2014). It could be the case that CT plays a part in the high rate of depression found among college students. Harris (2015) reported that adversities affect children's brain growth, their growing immune system, endocrine system, and the transcription of their DNA (Harris, 2017). Based on the impact that trauma has on children, it should be of little surprise that childhood trauma is notably linked to childhood depression (Negele et al., 2015). Depression is underdiagnosed in the pediatric population as well as the general public population, but this does not negate the statistics nor the reality that a significant number of children struggle with depression (Beesdo, Knappe, & Pine, 2009). It was once presumed by developmental psychologists and clinicians who work with children's mental health that younger children in school were too young to be clinically depressed (Luby, 2009). This idea continued to permeate the field of children's mental health until 1984 when Kovacs, Feinberg, Crouse-Novak, Paulauskas, and Finkelstein published "a large body of empirical data characterizing the manifestations and course of depression in school-aged children" as cited by Luby (2010, p. 1). These studies changed how doctors, parents, and the world view children and mental health. The studies further contributed to the identification and widely accepted treatment of childhood and adolescent depression. Whether childhood depression is biologically based or trauma based, the results are the same, but despite the magnitude of society's problem with depression, many of these young people do not get help (as cited in Luby, 2010).

Depression refers to a decreased desire to continue normal everyday functions (National Institute of Mental Health [NIMH], 2017b). It is a serious public health issue that is often experienced in private settings. National Collaborating Centre for Mental Health (NCCMH, 2005) described childhood depression as a change in one's mood, thinking, and activities to the extent that it impairs one in functioning normally. Ciubara et al. (2015) stated, depression "impacts the child and adolescent's functionality; psychological, cognitive, and social development" (p. 398). Children who are depressed often display a range of physical, cognitive, and behavioral symptoms. Physical symptoms of depression in children include a lack of energy, apathy, exhaustion, lethargy, inability to complete tasks, increase or decrease in eating and sleeping habits, complaints of aches and pains such as headaches, stomach aches, and limb pain. Also, cognitive symptoms of childhood depression include inability to concentrate, tendency to be critical of oneself, feelings of low self-esteem, and lack of confidence. Behavioral symptoms are withdrawal, isolation, loss of interest, and disruptive behavior (Langley, Sugar, Solis, Gonzalez & Jaycox, 2015).

Children experiencing depression must deal with the unpleasantness of the condition, and they may also have to deal with anxiety, a concurrent condition that may go along with depression. Both depression and anxiety are exacerbated by the other and have a strong effect on the other (Bittner et al., 2007). Another comorbidity among children is depression and conduct problems (CP). "Multinomial logistic regression results revealed that children with CP and depression had higher levels of anxiety and more school difficulties than children with CP only" (Poirier et al., 2015, Abstract, para. 1). The physical and cognitive symptoms of depression create undue stress surrounding

education, thus, making school more challenging for depressed children (Poirier et al., 2015).

The symptoms of childhood depression are similar to those of adults; however, the clinical manifestations vary and are connected to the child's personal development (Ciubara et al., 2005). Additionally, depression in young children is sometimes under-reported because "caregivers may fail to spontaneously report symptoms (changes in play, social interest, sleep, and so on) or may unwittingly accommodate these behaviors and thereby fail to regard them as symptoms (e.g., anxious rituals, rigidities, and social withdrawal" (Luby, 2010, p. 1). Both children and adolescents have difficulties adjusting to social and academic demands. The impact of depression often results in children being unable to concentrate, therefore, losing interest in school (National Institute of Mental Health, 2017a). There is a 'vicious cycle'—their inability to focus makes their grades drop, they begin to avoid school, and may end up failing and eventually dropping out of school. Perry reported that "traumatized children experience the added insult of doing poorly in school thereby failing within the one setting that might have been safe, predictable, and trauma-free" (Perry, 2006, p. 21).

Adults may be better able to cope with traumatic experiences, and may not find them as debilitating as children. Yet, regardless of the age of the individual, traumatic experiences can diminish one's quality of life. Studies that revealed a link between CT and chronic depression suggest numerous traumas in childhood set survivors up for depression and the addictive behaviors of drinking, smoking, and abusing drugs (Khoury, Tang, Bradley, Cubells, & Ressler, 2010; Negele et al., 2015, para. 7). If residual trauma impairs an individual to the point where she is unable to care for herself, this can lead to

suicide. The WHO,(2012) reported nearly a million people take their lives each year as a result of depression (para. 2). Based on the WHO research, it may be the case that the ability to handle depression has little to do with age. Although it is not widely accepted, many factors can contribute to depression including "genetics, biochemical, endocrine, psychological, social, and socio-economic conditions" (NCCMH, 2005, p. 6). One thing that is certain is depression is an unsettling experience for all involved regardless of age.

General anxiety disorders (GAD). Worrying excessively about things describes GAD (ADAA, 2017, para. 1). It is further described as causing extreme distress or the inability to function in a school, work, or social setting (Pantis, Sipos, Predescu, & Miclutia, 2015). The DSM-5 includes GAD under anxiety disorders because of the immoderate fear and anxiety associated with it. Pantis et al. (2015) found traumatic victimization increases a younger person's chance of having anxiety disorders. Furthermmore, Liao et al. (2013) argued, "an earlier age onset of GAD is related to maltreatment in childhood" (p. 2).

Anxiety disorders are often comorbid with other disorders (e.g., social anxiety disorder [SAD], specific phobia, panic disorder, agoraphobia). Each disorder can be distinguished from the other by the things feared or avoided: individuals with SAD have excessive fear of being judged by others, individuals with specific phobias have an irrational fear and anticipation of a distinct object, place, or situation; individuals with panic disorders have sudden panic attack and are obsessed over the fear of a recurring attack; and individuals with agoraphobia avoid places and incidents where they experienced a panic attack (American Psychiatric Association, 2017). To a child who has GAD, the situation looks overwhelming. This may, at times, render the child helpless

(First, 2013). "Anxiety disorders are the most common mental disorders among children and adolescents" (Locke, Kirst, & Shultz, 2015, para. 2). Epidemiological studies calculate GAD in neighborhood samples of children to be between 5.5% and 17.5% (Shin-Ichi, 2015, para 2).

Anxious feelings of uncertainty about things or people with whom one has had a negative experience are normal. However, some people have anxiety about things for which there is no reason. If persistent feelings of intense fear, steady uneasiness, and lurking danger avert the individual from performing normal everyday activities, it may be a GAD. It is estimated that GAD affects 6.8 million adults, or 3.1% of the U.S. population in any given year (Anxiety and Depression Association of America [ADAA] 2017, para 4). The most prevalent mental disorders in general are anxiety disorders, specific phobias, panic disorder, obsessive-compulsive disorder, and social disorders (Hofmann, 2008). While they may all seem closely related and often confusing to differentiate, each can be distinguished from the other by the things feared or avoided. Anxiety disorders could be blamed on information overload as a result of the technology era, constant bombarding of negative news from media, the loss of family structure, uncertain economy, surging debts, inadequate coping skills, or the emergence of negative and overwhelming thoughts resulting from CT. Technology may be a contributor to some of the constant anxiety felt by victims of GAD. Evans, as cited by Miller (2014), thought "technology is the direct cause of our biggest problems" (para. 4). Even researchers have yet to reach a consensus on the causes of GAD. Although there has been much elucidated regarding anxiety disorders, "the exact cause of GAD is unknown, there is evidence that biological factors, family background, and life experiences,

particularly stressful ones, play a role" (ADAA, 2017, para. 3). Despite its prevalence, it is often misdiagnosed by physicans and ascribed conditions associated with a physical problem (Locke et al., 2015).

Anxiety disorders were more prevalent in women than men (McLean, Asnaani, Litz, & Hofmann, 2011). Teenagers 13-18 years old have a lifetime prevelance of GAD as reported by the National Institute of Mental Health (2017b) among children. It seems that early adverse childhood experiences can be associated with the development of GAD in teenagers and adults.

Children, adolescents, and adults with GAD may share similar symptoms like restlessness, lethargy, irritability, inability to focus, negative temperment, shirking, and stress or tension in their bodies. A child may have all or only one of these symptoms. In addition to the symptoms children may have, teenagers and adults are more likely to find other ways to cope and may become substance abusers, drink alcohol, and smoke tobacco (Ciubara et al., 2015). Unlike adults with GAD who are able to assess the situation and respond appropriately, children and teenagers are often unable to respond appropriately to situations because they may perceive their problem as life threatening or larger than it might actually be. Helping others understand that GAD is more than a fear about a grade on an exam, an accident on the way to work, or getting robbed is important. For those with GAD, it is a perpetual nagging worry that anticipates the worse in every situation.

Panic disorders. Victims of child maltreatment may experience the long term psychological ramifications of the abuse as adults. One of the conditions that may result from child maltreatment is panic disorder. The terms panic disorders and panic attacks are used interchangeably. Panic attacks describe what people feel when they have

extremely intense fear about a particular thought, thing, or event. "Panic attacks may occur at any time, without warning and without any obvious threat or stressor" (Eachus, 2014, para. 1). Panic disorder left untreated can leave one isolated and unable to function normally. Goodwin, Fergusson, and Horwood (2005) found children who were sexually abused may experience acute fear, threats to their lives, and panic reactions as adults as a long term consequence of the abuse. They also found a 4:1 ratio for adults to have panic attacks who were sexually abused as children. Although it is possible for children to have panic disorder, it is seldom a problem for children before 14 years of age. The average age for panic disorder is 20-24 years olds (Mental health.org, 2017, para. 5), which is about the average age for students to be enrolled in college (ADAA, 2017, para. 2). Childhood experiences of sexual and physical abuse are more prevalent in panic disorders than in certain other anxiety disorders (Safren, Gershuny, Marzol, Otto, & Pollack, 2002). "Panic disorder in adolescents and adults is comorbid with other anxiety depressive and bipolar disorders" (First, 2013, pp. 210-211). About six million American adults experience panic disorder in a given year (ADAA, 2017, para. 3).

Difficulties in establishing trusting relationships. It is not shocking that children who grows up without the closeness, touch, and reliability of a loving caregiver develops a lack of trust in themselves, in their abilities to be successful and make sound decisions, and a lack of trust in others to help them. Abuse not only affects the survivor, but it also affects how the survivor communicates and interacts with others. Colman and Widom's 2004 study provided "strong support for the hypothesis early childhood maltreatment negatively influences one's capacity to maintain and form healthy relationships" (para. 2). Tackett-Kendall agreed that "past abuse can influence your

ability to trust others, make friends, and have relationships that are not exploitive" (2001, p. 12). Childhood experiences lay the foundation for how they respond and bond with others. If the foundation is damaged in childhood by a primiary caregiver, it may have emotional scars that last throughout the survivor's life (van der Kolk, 2005). Therefore, it is imperative that a child experiences nurturing relationships that model healthy guidance and appropriate behaviors, which are essential in developing healthy adult relationships (Colman & Widom, 2004).

Childhood trauma contributes to a plethora of insecurities, self-doubts and fears in one's self. Throughout this literature reivew, studies have shown children who suffered maltreatment may have some cognitive and social difficulties (Ziegler, 2015). He further stated, "misreading of the intentions of others makes it very difficult to find social success" (p. 3). Regardless of the type of abuse, it impacts how the child views himself (Schafer & Fisher, 2011). Negele et al. (2015) argued that child abuse also affects "children's inferential styles regarding consequences and self-characteristics" (p. 7). The long term consequences surrounding the abuse may give just cause for the survivor to have self-doubt, be indecisive, and be prone to emotional instability (Schafer & Fisher, 2011). After all, the child or survivor may still live with thoughts of guilt, shame, and blame for allowing one's self to engage in the incident, if it was sexual. If it is a form of non-sexual abuse, the adult survivor may still ponder why he or she caused the caregiver to abuse them.

Children must have structure, implicit boundaries, secure attachments, and a safe environment. Abused children may lack these and other fundamental emotional attachments creating childhood emotional maltreatment (CEM). Consequently, CEM

children may learn the world is an unpredictable and frightening place. It may be even more frightening for a child who is afraid to trust.

Attachment in children may come automatically as a result of their dependence on parents and caregivers. Thus, they are greatly impacted by the relationships of the parents and caregivers (Rees, 2007). Children automatically attach themselves to their caregivers, and when they are unable to do so, it may lay the groundwork for uncertainty, fear, and distrust in the child. Preoccupied attachment is associated with uncertainty, reliance, envy, apprehension, and feelings of desertion and scorn. Dismissive attachment is associated with self-doubt, uneasiness with affection, solitude, and resentment. Fearful attachment is associated with timidity, self-consciousness, and distractions (Beeney et al., 2015, 2017; van der Kolk, 2005). Whether the attachment is preoccupied, dismissive, fearful or insecure, each attachment has a corresponding consequence that sets up the child to distrust others. Children who have had attentive and supportive caregivers have secure attachments and are more confident, trusting, expressive, and receptive, and find comfort in the closeness of their caregivers (Alexander, 1993). From infancy, secure children learn to trust their feelings and their understanding of the world. It helps them to make sense of the world. Because they have had successful relationships with people, and successful things have happened in their lives, they have confidence in themselves and their abilities to make good decisions, and respond appropriately with emotion (Rees, 2007). All of these add to a growing child's ability to formulate trust in themselves, and may have left them ill prepared for adult life in the area of originality, self-rule, and conviction. In a sense, the survivor is a prisoner of his or her childhood. Perhaps the consequences of past failures, fears, negative emotions, self-doubt, irrational choices, and

feelings of helplessness make it extremely difficult for survivors to trust themselves to know what to do and then follow through and do it.

"Children with insecure attachment patterns have trouble relying on others to help them" for fear they will be rejected if they ask for help; or, they do not trust the person to follow through and help them (van der Kolk, 2005, p. 5). It has been said that if one can not trust the two people who brought them into the world, who then can they trust? When children experience damage in the most fundamental relationship, it impacts their ability to judge others and believe others will help to meet their needs. They are often unable to discern who is trustworthy; thus, causing them to continuously be a victim (Herman, 1997).

Survivors are plagued with insecurity, doubt, distrust, and feelings of rejection. These develop into serious concerns in relationships (Briere, 2002). When one's first memory of trust was when a caregiver neglected, sexually abused, emotionally abused, or beat him or her, it should not be difficult to understand why a survivor may think others might do the same. Therefore, they often resist social relationships out of fear they will become a target for more misuse and abuse (Ciubara et al., 2015). Some of survivors' greatest fears are to be rejected, abandoned, or betrayed again so they may find it easier to push others away before others push them away and they are hurt again (Center for Substance Abuse Treatment, 2000). Perhaps isolation and loneliness become unstated oaths for survivors of child maltreatment.

While researchers (Romano, 2003; Golembiewski & McConkie, 1975; Tway, 1994) may not all agree on the definition of trust and the kind of trust necessary for a given situation, they all agree trust is an important component in the organizational

setting, and it is important for the success of the organization. Golembiewski and McConkie (1975) argued that trust is the most important factor in interpersonal relationships in any setting. Tway (1994) defined trust as "the state of readiness for unguarded interaction with someone or something" (p. 7). Trust has a positive connotation and leaves those who receive it with confidence. "Studies in countries other than the United States have indicated that the concepts of trust are international" (Tway, 1994, p. 17). If trust is important in the success of organizations, and it is a global concept, it could be inferred that it is equally important for the success of individuals.

Child learners and childhood trauma. Learning as an adult can be a struggle because of all the challenges of normal daily living it brings to the learning process. Many who suffered childhood trauma may bring psychological, mental, emotional, and physcial effects of past or present trauma to the learning process. Outward manifestations involve zoning out, memory impairment, missing class, doing poorly on tests, extreme reactions to classrooms discussions, substance abuse, aggressive behaviors, and lack of motivation—all added challenges a traumatized person may bring to the learning process (Bremner, 2003; Felitti et al., 1998; Terr, 1991; Ziegler, 2015; van der Kolk, 2003, 2005). While learning may be thought to be limited only to the mind, it affects the person holistically (Rossenwasser, 2000).

Since survival skills are pertinent to staying alive, one will undoubtedly at some point feel stress. Adults have the stress that is related to caring and providing for their families, so this type of stress may be more easily understood. The stress many adult survivors of CT and children may be feeling is not true related to caring and providing. It is the stress of "fight or flight." The Compton school district is increasing the public's

awareness on the impact of stress on chilren. The Compton school district case has caused concern among educators across the nation. The ruling from the U.S. District Judge stated, students in the school district who witnessed multiple traumas are entitled to the same disability services as students who are traditionally disabled (Loundenback, 2016; Turner, 2015). This ruling forces educators to acknowledge something survivors, who attend higher learning instiututions, have had to acknowledge each time they struggled through a course. According to the ruling, students who have experienced multiple traumas will have difficulty learning. Therefore, this creates a challenge for educators as well as students. Perhaps it took such a ruling to shake the educational system that seems to think every child sitting in the classroom is ready to learn, and if the child does not learn, it is the child's fault. As a tool for motivation, it has been expressed that the only person in control of one's future, the amount of money one makes, and the neighborhood one lives in is that person, but there are many factors that could influence a child's ability to learn. Thus, making it more difficult to obtain the higher paying jobs, make higher scores on standard test, and get accepted into the more prestigious colleges. One factor is whether or not the child has been abused. Child maltreatment plays an integral role in determining the success of a child (Braver, Bumberry, Green, & Rawson, 1992). If the child was unable to learn the importance of foundational concepts regarding socialization, relationships and self-worth, all of which are compromised when a child is abused (Felitti et al., 1998; Kaplow, Saxe, Putnam, Pynoos, & Lieberman, 2006; Menard, Bandeen-Roche, & Chilcoat, 2004; Terr, 1991), then whatever influenced the child's ability to learn has potential to influence the child's ability to be successful as an adult.

If a student has difficulty learning, the student does not have the same opportunity as others. The concept of having the "same opportunity" would imply equal grounds. The student who has difficulty learning is more likely to drop out, become disruptive, or disassociate himself from classroom activities. "Research shows that abuse and neglect can affect a child's ability to learn, form relationships, and problem solve" (Child Welfare Information Gateway, 2013, p. 5; De Young et al., 2011). Ziegler posited, there has been an effort in education to "compartmentalize emotions, thoughts, and behaviors as some adults can, but the whole child comes into the classroom and either succeeds or fails based upon whether all aspects are engaged in the learning process" (2015, p. 1).

Children are asked what they want to be when they grow up. Some respond by saying, doctor, lawyer, banker, writer, producer, and so on. The purpose of this activity is to remind the students that they can reach the stars if they just believe they can. The abused student might begin to think 'what is wrong with me, I can't learn' and blame himself/herself for the struggle.

The abused student knows there are things going on in his/her mind that no one may have explained. Another thing the child knows is that whatever is happening, it is preventing learning, encouraging destructive behaviors, creating difficulty studying, and causing distrust. Coates offered an explanation for their inability to learn, "only a non-state of hyper-arousal allows the activation of the prefrontal cortex needed for learning and problem solving" (2010, p. 395). Minor irritations may be perceived by the child as threats, and thus cause the flight or fight response system to activate. The student may not understand that these behaviors may be consequences of CT. The student may end up

dropping out of school and risking his/her dream of being successful. Duncan's 2000 study followed 210 freshmen, who experienced childhood abuse (physical, sexual, or emotional) and reported less than 1/3 of those who had multiple abuses remained enrolled, 1/2 of those sexually abused remained enrolled, while 60% of nonvictims remained enrolled (2000, Abstract, para. 1). Consequently, the student may end up replacing the lifelong dream of being successful with a job that meets his need to survive. Children who has difficulty at home may have had difficulty at school because children cannot pack their things and leave a toxic environment as adults can do (Perry, 2006; Rehms, 2014).

Like adults, children develop coping skills that help them to manage their current situations. Yet, these coping skills are not sufficient to help many of these children perform academically at the level of non-maltreated children (Kinard, 1999). The reality of this is that if they do not perform well in schools, they are less likely to go to college, get the higher paying job, or live in the nicer neighborhoods (Kinard, 1999). Children who suffered childhood trauma will not only have to deal with the misfortune of suffering the trauma, many also have to deal with the stigma that comes with it such as being labeled unmotivated, defiant, rebellious, and trouble makers because educators are unaware these children have a need to adjust from the aberrant traumatic environment to the adult standards environment (van der Kolk, 2005).

Children who have been abused are often in a state of hypervigilance. The child learned to be in a constant state of survival so when the child enters the classroom, the child may look like untraumatized children outwardly, but inwardly the traumatized child may be thinking about his safety, how to avoid being ashamed, what the classmates might

say to him at recess, or being liked by the teacher. These are not things the learner can share comfortably with the teacher. Although they may not share them, it does not make these thoughts and feelings nonexistent. The lives of children who survived trauma may be altered in how they live, where they live, what type of home they live in, and where they work. Therefore, it is imperative given the research on how trauma can alter the brain that educators be made aware of how they can help these children and adults be successful in the classroom (van der Kolk, 2005). Educators can help survivors be successful by promoting an environment of trust and fostering a safe environment that promotes learning. Without these, optimum learning cannot take place (Ziegler, 2015).

Differences between trauma learning disabled adult learners and trauma learning disabled child learners. While there may be little or no difference in how children who suffered trauma learn and how adults who suffered trauma learn, there seems to be a difference in how public, society, educational system, and laws treat children with learning disabilities (LD) versus adults with learning disabilities. For children, there is an increased likelihood their trauma effects can be reduced in the learning environment because of the systems in place to test students for possible LDs. In fact, many adults are like me, and may not have been diagnosed with a LD whereas children with LDs are more likely to be diagnosed as a result of poor grades, disruptive behaviors, and social problems. Griffiths (2003) reported many schools are setting up infrastructures and creating cultures where they are now incorporating trauma sensitive programs into the school culture, and intentionally involving stakeholders in helping to plan and integrate these infrastructures into the community, train staff to be trauma sensitive, meet and review individual cases of students to make the staff more aware of

accommodations, review state and federal policies regularly for students, and are making community connections to get children help who have learning disabilities. On the other hand, adults are more likely to go undiagnosed because they are not in school every day, and adults have lives and are responsible for many things. They may never enroll in a college, but have to read extensively for their job and may be reintroduced at that time to their learning disability. Adults may also go without being diagnosed because it requires them to be self-advocates, whereas the school system or the parents are advocates for children. Adults with learning disabilities may feel inadequate to advocate for themselves and avoid seeking assistance all together, thus making it easier for them to deny they have a learning disability (Gerber, Ginsberg, & Reiff, 1992). While there are community programs for adult literacy, there is no set culture in these programs to inform the instructor which adults have learning disabilities (Cole et al., 2005, pp. 47-48).

Child learners who suffered trauma may act out behaviorally as a result of overwhelming unregulated emotions, they may be impulsive and reactive, aggressive, and defiance, withdrawn in the classroom, isolate themselves outside the classroom, set unrealistic expectations for themselves, and become perfectionists (Cole et al., 2005). It seems likely that the adult learner who suffered childhood trauma could project some of the same emotions and characteristics. They may develop PTSD, depression, behavioral disorders, think self-destructive thoughts, become involved in substance abuse, exhibit social isolation and neurobiological changes, and respond physiologically (Perry, 2006; Substance Abuse and Mental Health Services Administration, 2014). There has been extensive research conducted on teaching traumatized children, but little research on teaching adults who have been traumatized.

The public education system, as a result of the Compton School District lawsuit may be overhauled in an effort to move toward Trauma Informed Schools. That being said, if the public schools are finding it necessary to implement such programs, colleges and universities may also find it beneficial to all students for the faculty to be aware. Undoubtedly, some children who have learning disabilities go on to attend college, and the learning difficulties do not end when they leave high school—they continue throughout adulthood (Vogel & Reder, 1998). Ensuring that learners with disabilities have access to a college education has been identified as one of the key challenges in the future of secondary education and transition to higher education (National Center on Secondary Education and Transition, 2003, p. 1). Smyth, Hockemeyer, Heron, Wonderlich, and Pennebaker (2008) discovered that over half of higher education students have experienced "significant stressful or adverse life experience" (p. 74). Stressful life experiences may put students at risk for learning disabilities and repercussions of these are missed classes, poor concentration, difficulties with memory, motivation, and studying (Perkins & Graham-Bermann, 2012). The transition to college is stressful enough for students with LD. Therefore, it is imperative students with LDs learn strategies to help them be successful in pursuing their professional and academic goals.

Posttraumatic Stress Disorder (PTSD)

Individuals who experienced a traumatic event may experience insomnia, anxiety, and reoccurring thoughts of the event. These reoccurring thoughts are unwanted, obtrusive, and disruptive and may also lead to PTSD. One of the most common

conditions following a traumatic event can be PTSD (U.S. Department of Veterans Affairs, 2017).

It is normal for one to be distressed after seeing a violent crime, discovering the sudden death of a loved one, or witnessing a tragic accident, but if the unsettling continues beyond a few months, one may have PTSD. "Women are more likely to experience sexual assault, and men are more likely to expeirence accidents, physical assaults, combats, or to witness death or injury" (U.S. Department of Veterans Affairs, 2017, para. 2). Adults who were physically abused and sexually abused are more likely to develop PTSD (Draper et al., 2008). While everyone has a risk of being exposed to a traumatic situation, not everyone will suffer PTSD as discussed by Freidman (2016). In fact, "most people exposed to traumatic events do not develop PTSD, yet; others go on to develop the full-blown syndrome" (Friedman, 2016, para. 4). "For others, trauma-related symptoms will occur in the immediate period following a traumatic event" (Kataoka, Langley, Wong, Baweja, & Stien, 2012, para. 3).

Perhaps Biblical characters were among the first to experience the disorder. Noah in the flood may have suffered from PTSD after a year of being shut in with animals on the water, and after seeing the human population annihilated. After he was safe on land, he was labeled as a drunk as stated in the following verse, "After the flood, Noah began to cultivate the ground, and he planted a vineyard. One day he drank some wine he had made, and he became drunk and lay naked inside his tent" (Genesis 9: 20-21, New Living Translation). PTSD and alcohol use problems are often found together (U.S. Department of Veterans Affairs, 2017). Joseph, another Biblical character was 17-years-old when his brothers took his clothing off his back, put him in a pit, and sold him to strangers. Years

later his brothers were forced to go to Egypt for food. Joseph recognized them and invited them to dinner. While sitting at the table with his 11 brothers who had abused him, he had to leave the room abruptly three times as the Bible records so he could go and cry, "now he turned away from them and began to weep. When he regained his composure, he spoke to them again. Then he chose Simeon from among them and had him tied up right before their eyes" (Genesis 42:24, New Living Translation). He may have been reliving the past trauma of his brothers putting him in a dark and dangerous pit, and later selling him to complete strangers.

Perhaps the Greek characters were experiencing what we know today as posttraumatic stress; as early as 800 BC as they struggled internally to accept fears, death of close friends, defeat, and loneliness. This may have been evident in the change of Achilles' behavior after the death of his close friend as noted by (Tritle 2000), "Still there emerges also a picture of a valiant warrior, one who does not strike down [the] helpless . . . the death of Patroclus changed all this" (p. 36). Further, Homer's Odysseus revealed signs of instability after the Trojan War when he spent a decade wandering aimless by the Mediterranean Seashore (Fagles, 1996). Whether one supports the beliefs these Biblical and mythical characters might have been suffering from this disorder or not, researchers have found trauma and extreme stress bring about severe emotional and psychological changes (First, 2000; Cook et al., 2005; De Young et al., 2011).

"French, German, Spanish, and Swiss doctors were among the first to recognize the disorder among soldiers" (Bentley, 2005), but it was called by other names. Lasiuk and Hegadoren (2006) credited the soldiers who suffered from the psychological damages of war for bringing the illness known today as PTSD to the forefront of the

medical profession's research. Renowned psychiatrist Sigmund Freud contributed his thoughts on the disorder to the medical professional on mental disorders with his belief in War Neurosis. Doctors rejected the belief that the psychological problems experienced by soldiers were really physical problems associated with the nervous system. Rather than conclude it was a mere functional change, they could better accept the term the experience caused as a mental change in the soldiers (Freud Museum London, 2014). Yet, physical and psychological injuries associated with the war drew unprecedented attention to the medical profession and spearheaded purposeful investigations of the psychological injuries of veterans on and off the battlefield (Finger, 2006).

Mental disorders increased and so did expansions of mental health facilities, which were largely influenced by the bleak report of soldiers in World War II (Menninger, 1948). Birmes, Hatton, Brunet, and Schmitt (2003) recorded its beginning, "Nostalgia and traumatic neurosis were first identified during the American Civil War and after the first railway crashes in the 19th century" (Abstract, para. 1). As early as 1948, it was evident there were profound consequences of chronic psychological trauma.

In Brooks' 2008 study on the longstanding effects of war on soldiers, he found Veterans' health continued to decline for nearly 30 years after the war. Although the name changed many times from nostalgia, shell shock, irritable heart, and battle fatigue (Bentley, 2005; Bikel, 2014; Mullan-Gonzalez, 2012), one thing that did not change was the impact it had on those who experienced it. Whether it was a soldier experiencing extreme external stress on the physical battlefield of war or an individual experiencing extreme internal stress on the mental battlefield of the mind, stress can lead to an

increased vulnerabilities, and a range of psychological, behavioral and physiological, and biological and emotional disorders over a life time (Anda et al., 2006; Bremner, 2006).

PTSD is comorbid with other illnesses, and has its own consequences. Roberts et al.'s (2015) research study linked PTSD to Type 2 Diabetes. The U.S. Department of Veteran Affairs recorded 7-8% of people will have have PTSD as a reault of a traumatic experience (U.S. Department of Veterans Affairs, 2017, para. 4). A study by Jenkins, Langlais, Delis, and Cohen (1998) revealed "the subjects with PTSD performed significantly worse than the other groups on delayed free recall" (Abstract). A study by Lindauer et al. (2005) found that police officers with PTSD, as compared to those without PTSD, showed heightened sensitivity to interference and made more recall intrusions (recalled words not presented on the study list (p. 1). This may be contributed to how the illness consumes the person. The most clearly recognizable effects of PTSD is the impact it has on one's life and one's sleep as noted by Cavalcanti-Ribeiro et al. (2012). There is a higher risk of suicide attempts among victims of PTSD (Panagioti, Gooding, & Tarrier, 2009).

Much of students' success in higher education depends on the students' abilities to recall and think critically. For higher education students who suffer with PTSD, add the difficulty of being unable to recall simple tasks, perform activities, and think critically. Studies in humans and animals have shown long-term stress alters the architectural function of the brain and the neural systems which make it more challenging to memorize and learn new concepts (Bremner, 2006; McEwen, 2005; Perry, 2017).

In the beginning, there were those who doubted children were susceptible to PTSD. PTSD is not just an adult problem as now there is little doubt that children are

susceptible to it as well (Benedek, 1985). To support this profound discovery, "the current diagnostic criteria for PTSD Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition included criteria for children with PTSD" (First, 2000, para. 13). Researchers also discovered younger children share some of the same symptoms and impairments as adults (DeYoung et al., 2011). By the onset of adulthood, at least 25% of the population will have experienced such an event (PTSD Research Quarterly, 2013, p. 4).

Higher education students who have experienced CT may struggle with assignments and tests that involve memorization. A study done by Yehuda et al. (1995) on combat veterans revealed, "that patients with PTSD may have fairly specific deficits in the monitoring and regulation of memory information" (para. 10). It was reported that 4-6% of adolescents in the nation will meet the standards to be diagnosed for PTSD ensuing a traumatic experience, and will have difficulty concentrating; thus, interfering with school performance (Saigh & Bremner, 1999). These studies suggested to me that the learning experience of students who experienced CT and consequently developed PTSD may have a different learning experience than those who have not experienced CT and developed PTSD.

Learning with an Illness or Disability (Physical or Mental) Not Related to Childhood Trauma

Learning disabilities is a term used to describe types of specific learning challenges such as dysgraphia, dyslexia, dyscalculia, and attention deficit/hyperactivity disorders (Learning Disabilities of America [LDOA], 2017). The terms learning disability (LD) and learning problems are often used interchangeably, but perhaps should

not be because the term learning problems indicates difficulty with motor handicaps, mental retardation, emotionally disturbed, or problems with auditory or visual problems (LDOA, 2017, para. 3). There are many types of physical disabilities that can interfere with learning. The U.S. Department of Health and Human Services (USDHHS) National Institute of Health (NIH) division (2017) reported findings from several studies—one study "found that approximately 5% of children in the U.S. have learning disabilities" (para. 2). It also found that approximately 4% had both a learning disability and attention deficit/hyperactivity disorder (USDHHS-NIH, 2017, para 2). In other words, the NIH treats learning disability and ADHD as distinctly different. It also reported on a study conducted in 2006, that estimated 4.6 million school-age children in the U.S. have been diagnosed with learning disabilities (USDHHS-NIH, 2017, para. 2).

Physical disability may be the easiest to recognize. However, there are many types of disabilities that are not easily recognizable, and may make it more difficult for the individual to learn, grow, and interact with the world. Learning disabilities may develop as a result of a physical or mental disability, but "are not a prescription for failure. The origin of learning disability is still not known" (Shriver, 2017, para. 1). Illnesses relating to the mind may not be as easily recognizable. However, "with the right kinds of instruction, guidance, and support, there are no limits to what individuals with LD can achieve" (Cortiella & Horowitz, 2014, p. 3).

Physical illness and mental illness disabilities may not be as easily recognizable. This section will focus on individuals with physical and mental illnesses and the disabilities that may accompany such illnesses, *defining physical illnesses as disorders or diseases* that temporarily or permanently render a person unable to perform regular

activities—disorders or diseases such as anxiety, depression, chronic fatigue, and chronic stress—and *defining mental illness as a condition of the mind* such as eating disorders, substance abuse and addictions, PTSD, personality and behavior disorders, genetic, or stress-related illnesses that temporarily or permanently render a person unable to think or act independently. This section excludes individuals with intellectual disorders or Special Education services, which require individuals to have persistent learning difficulties in designated subject areas during the formative years of school. The type of disabilities referred to in this section are specific such as dyslexia, dyscalculia, dysgraphia, attention deficit/hyperactivity disorder as listed by Cortiella and Horowitz (2014, pp. 3-5). People with LDs are often normal or above average intelligence, but their disabilities are often "hidden disabilities because the person looks perfectly normal" (LD of America, 2017, para. 4). People diagnosed with disabilities are unique because "two people with the same disability can be affected in very different ways" (National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention, 2015, para. 3). It seems important that universities classrooms, and faculty be aware of the various disabilities, accommodations, and support needed to help these individuals become successful.

However, without this support many individuals with LDs do not know it, and end up living very difficult lives because they struggle with math, reading, and writing (Cortiella & Horowitz, 2014). The LDs for these individuals are described as "unexpected significant difficulties in academic achievement" (Cortiella & Horowitz, 2014, p. 3). Postsecondary schools are not guided by the same legal ramifications as secondary schools (National Longitudinal Transition Study-Postsecondary Education,

2011). In secondary schools, the burden of the student's education is on the school, but in postsecondary school, the burden of the student's education falls on the student to be certain appropriate services are offered. With this in mind, the learning needs of individuals with physical and mental disabilities must be reasonable and cannot result in "undue financial or administrative burden on the institution" (Duncan, 2011, para. 5). The American Disability Act of 1990 and Section 504 of the Rehabilitation Act of 1973 (Disability Rights of California, 2013) are the two predominant Federal laws that protect people with disabilities from discrimination. These laws set guidelines and require higher educational institutions to provide reasonable accommodations, adjustments, or modifications to individuals with disabilities (Disability Rights of California, 2013).

Higher educational institutions are not required to do anything above and beyond the federal requirement. Cortiella and Horowitz (2014) acknowledged a pressing issue for the National Center for Learning and Disabilities is the drop-out rate for students with LDs (p. 41). Higher educational institutions must be aware that an increasing number of individuals diagnosed with LDs are pursuing post-secondary education (Fleming & McMahon, 2012). As students with specific learning disabilities enroll in these institutions of higher learning and self-report their learning disability, their educators may have a pre-existing perception of them and what they believe these students look like and what they can do, and the students themselves may already have a pre-existing self-perception of how they view themselves before and upon enrolling in higher education classes. Whatever emerges from the two perceptions (educators and students), postsecondary programs have shown it is imperative for students with disabilities to

obtain the necessary support and accomodations to be successful as well as for the schools to combat retention (Stodden & Dowrick, 2001).

Perceptions of educators about LD learners. Educators, like the public, have their own perceptions of what students with LD look like, how they perform, and how they may use LD as a crutch to avoid hard work (Griffiths, 2003). Some may agree with Griffiths that many students with LD are average or above average in their intellectual ability. Province of British Columbia, Ministry of Education, (2011) outlined characteristics of learners with disabilities: average to above intellectual ability, difficulties processing, lack confidence in their ability to grasp information, unable to manage multiple instructions, frustrated with challenging assignments, and discouraged when they are unsucessful. Garnett and La Porta (1984) recorded educators' responses to students who had a LD, "But she seems so bright, how can she have a learning disability?", and "He's so articulate and responsive in class; what is he trying to put over on me?" (p. 14). Some students with LDs may fear the professors' disbelief of the disability as recorded by Griffiths (2003) at Cabrillo University: "Students report a wide variety of reactions from faculty, but the most common are puzzlement and even amazement" (p. 48).

While some of the literature focused on educators' perceptions of students with LDs, much of the research was on how educators perceive Special Education students. The causes of learning disabilities are not really known, and there are no definitive answers for them; but, the task of educators, who have LD students on their campus, is to learn how to appropriately accommodate such students (Griffiths, 2003). Half of middle and high school teachers reported that the learning abilities of their students were so

varied that they could not teach them effectively (Met life, 2008). Lusk, Thompson, and Daane (2008) said, "Teachers have a responsibility for the learning of all students in their classrooms" (p. 36). It seems important to include all teachers in this previous quote, including those in higher education.

Perceptions of LD learners about self. Researchers differ on the definiton of self-concept because of diverse theoretical viewpoints, but Sanchez and Roda (2003) defined it as "a set of knowledge and attributes that we have about ourselves, the perceptions that the individual assigns to himself, and characteristics or attributes that we use to describe ourselves" (p. 97). Using this definition, it is likely children's self-concept will continue to fluctuate because many things influence how they perceive themselves such as their parent(s), whether or not they possess certain things, their sibling(s), and how well they perform academically. Hayes (1993) described how learners with LD perceive themselves,

> So here we are—adults with learning disabilities . . . who may have had no choice but to accept the labels 'dingbat' or 'airhead' to cover the confusion, memory lapses, misread or misunderstood directions, or the dozens of other mean tricks our learning disability has played on us. (p. 11)

Throughout an individual's elementary, secondary, and college years, learners make choices based on how they perceive their abilities. The perception a child may have of himself/herself may be based on academic performance (Simpson, Licht, Wagner, & Stader, 1996, p. 387). This may be a huge disappointment for students who have LDs because the learning ground is not always being played fairly or equally.

Learning challenges seem to be associated with a negative self-concept (Elbaun & Vaughn, 1999, p. 92), and a negative self-concept seems to be associated with other negative life experiences. "Over 65% of young offenders have speech, language, and communication needs" (House of Commons, 2013, para. 1.4). The Committee also reported communication disability the most reported disability experienced by both children and adults. According to Jackson and Bracken (1998), fear of rejection from peers contributes to low self-concept. In their study, students who were in the "popular group" had higher self-concept. Many students with learning disabilities choose to hide them because of the negative connotations and misconceptions attached to them. Learning disabilities are only revealed by some students as a last resort or when they feel they have no choice (Griffiths, 2003). "Among students who never received help, 44% thought that some assistance would have been helpful" (Cortiella & Horowitz, 2014, p. 30).

Students with learning disabilities seem to value higher education just as much as students without learning disabilities, but lack the self-confidence to succeed in it. MetLife did a survey in 2011 that viewed differences in the needs of learning challenged students, how educators addressed their needs, and how adequately students felt their needs were being met. The survey results disclosed that students with disabilities place the same value on college education as other students, but have lower hopes regarding college; have doubts they will reach their goals; and are less likely to get support from educators or counselors regarding college preparation (as cited in Cortiella & Horowitz, 2014).

Meister's (2002) study on how Special Education students view themselves versus how regular education students view themselves supported the belief that special education students do not see themselves differently from other students. Students, however, did notice they got into trouble more than their fellow students (Meister, 2002). Although Meister's study specifically mentioned how the Special Education students viewed themselves, the same might be said for students with LD. They may not see themselves as different than other students. Yet, many students with LD are likely aware they require more assistance during certain assignments, and are less attentive during certain times. Griffiths (2003) recorded a student at Cabrillo University who has a learning disability as saying, "whenever I ask an instructor to allow me extra time on an exam, I feel dumb, slow, and stupid" (p. 31). Another was recorded as saying, "We can do just as well as other students given the proper support and accommodations. It's just so frustrating when that doesn't happen" (Griffiths, 2003, p. 49). Social groups, parents, family, and educators all play a vital role in helping the child develop self-concept (Jackson & Bracken, 1998). Therefore, it is imperative that the role players understand negative feedback may set children up for potential failure because for many disabled learners, being selected to be in the "popular group" may not be an option.

Learning in Higher Education

In a time of constant upheaval and prevalence of disruptions in contemporary society, higher education is presented with widespread change, uncertainty, and challenges from student enrollments to technological advancements. Keeling and Hersh (2012) blogged that higher education was experiencing a learning crisis. They pointed out "the fundamental problem—what brought us to the point of crisis—is the critical

deficit in higher learning. To say it as plainly as possible: students do not learn enough in college, period" (Keeling & Hersh, 2012, para. 2).

Diverse educational experiences come with adult learning because there are a plethora of ways for adults to learn: information-based, knowledge-based, rearranging of prior knowledge, noted behavioral change, application of learned information, removing, adding or deleting stored information in an individual's mental file cabinet, and adopting socially accepted behaviors and ideas (Dalkir, 2005). Whether the adult learner's education is online, continuing, face-to-face, lifelong, it seems adult learners play an important role in today's growing educational programs. Adult learners may now be defined as "students who have assumed major life responsibilities and commitments, such as work, family, and community activities, and are students who have moved beyond the role of full-time student" (Flint & Associates, 1999, p. ix). In the past, "experts were largely disinclined to consider adulthood as a period of life that has its own unique content, abilities, and representations. Learning has been considered similarly" (Hoare, 2006, p. 4). In fact, little attention has been given to the culture surrounding the adult learner and all of the problems, change, emotions and things that matter to the adult's daily environment. Undoubtedly, all of these things impact the adult learner (Hoare, 2006). As the educational system developed, assumptions grew about teaching and learning for children, but it was not until later that the unique characteristics of the adult learner were considered.

Andragogy adult learning theory. Research literature provides a variety of practice models, principles, assumptions, theories, elucidations, and speculations that contribute to the knowledge base of adult learning (Teaching Excellence in Adult

Literacy, 2011). Near the end of the 12th century, a model of assumptions about learning arose called pedagogy. "Pedagogy means, literally, the art and science of teaching children" (Knowles, 1980, p. 40). The pedagogical model limited research on learning and the traits of learners to children. It was not until after World War II that teachers of adults began pointing out the problems they were experiencing with pedagogy. Studies were conducted and the pedagogical model for teaching adults was insufficient. It was concluded that the assumptions about the characteristics of child learners were not the same as the assumptions about the characteristics of adult learners (Knowles, 1980). As knowledge continued to increase about adults as learners and about the adult learning process, theorists began compiling and comparing the new knowledge. Knowles (1980) labeled the new adult learning theory andragogy, "the art and science of helping adults learn, in contrast to pedagogy as the art and science of teaching children" (p. 43). Higher education students who have suffered CT are adult learners, and all that applies to adult learners in general applies to adult learners who suffered CT.

Assumptions about the characteristics of adult learners. Andragogy's six assumptions about the characteristics of adult learners should be used alongside the pedagogical model of assumptions "thereby providing two alternative models for testing out the assumptions as to their 'fit' with particular situations" (Knowles, 1980, p. 43). The two models provide two ends of a spectrum ranging from completely teacher-centered (pedagogy) to completely student-centered (andragogy). Some adult learners are more prepared to be self-directed learners than others. The four original "crucial assumptions about the characteristics of [adult] learners" (p. 44) are as follows:

> (a) their self-concept moves from one of being a dependent personality toward being a self-directed human being; (b) they accumulate a growing reservoir of experience that becomes an increasingly rich resource for learning; (c) their readiness to learn becomes oriented increasingly to the developmental tasks of their social roles; and (d) their time perspective changes from one of postponed application of knowledge to immediacy of application, and accordingly, their orientation toward learning shifts from one of subject-centeredness to one of performance-centeredness. (Knowles, 1980, pp. 44-45)

Later, Knowles (1990) added two additional assumptions about the characteristics of the adult learner: (a) they need to know a reason for learning that makes sense to them, and (b) they are motivated by internal incentives—curiosity. Paying attention to the assumptions about the characteristics of the adult learner seems important for educators in higher education who strive to create a student-centered approach to learning.

Adult learner learning process. According to Knowles (1973), the andragogical model is a process model, not a content model frequently used by traditional educators. Originally, Knowles (1973) described the andragogy process model as incorporating seven elements. Later, Knowles (1995) added an additional element that precludes the original seven. The eight andragogical process elements are summarized as follows:

> (a) preparation—help the learner understand what is to come; (b) climate—establish a learning climate conducive to learning that is relaxed, trusting, mutually respectful, informal, warm, collaborative, supportive, fun, open, authentic, human, and pleasurable; (c) planning—mutually by learners and facilitators; (d) setting of objectives—mutual assessment by learners and

> facilitators; (e) designing learning plans—learning contracts, learning projects, sequenced by readiness; (f) learning activities—inquiry studies, independent study, experiential techniques; and (g) evaluation—by learner-collected evidence validated by peers, facilitators, and experts. (Park, Robinson, & Bates, 2016, p. 181)

By attending to the assumptions about the characteristics of the adult learner, the eight learning process elements, by which adults learn best, seem to naturally follow to increase the likelihood that adults will be successful learners.

Higher-order thinking. Although researchers agree on the need to create standards for higher order thinking, they have not agreed on a definition for the term higher order thinking (King, Goodson, & Rohani, 1998). Higher educators want their students to be able to understand what they are learning, make inferences about what they are learning, connect what they learn, and think of complex ways to think about what they are learning (Whittington, 1995). Whatever definition educators assign to it, Whittington (1995) reported in the end, "the power to think and solve problems should be the student outcome desired by professors" (p. 2). Metacognition is an integral part of higher education because it fosters self-awareness and self-assessment. Abdellah (2015) wrote that it involves thinking about one's thoughts. Schraw and Moshman (1995) described students who think about what they are learning as metacognition. Metacognitive skills are used to assess the planning strategies, monitor the plan by intentionally assessing performance, and evaluate the plan by looking at the outcome to determine if it aligned with goals.

Halpern (1984) long criticized the educational system's way of teaching higher-order thinking when he wrote, "Traditionally, instruction in how to think has been a neglected component in American education" (p. ix). Freire (2005) condemned educators when he called them "bankers of education" where information is deposited, and students make the withdrawals on an as needed basis (p. 72). Learning how to think seems to be related to learning how to learn.

King, Goodson, and Rohani (1998) argued that there are major concepts integral to higher-order thinking based on three assumptions. The first assumption is the level of thinking and the level of learning are interdependent of each other with various levels. The second assumption is that one is able to learn to think without knowledge of a particular subject. The third assumption is higher order thinking has multiple processes of thinking that are applicable to complex circumstances and factors (King et al., 1998). Some researchers use the terms higher order thinking, critical thinking, and problem solving interchangeably (King et al., 1998). Perhaps these words may be used interchangeably because they all require a disciplined level of thought where justifiable and logical investigations are done; thus, allowing an individual to reach a reasonable conclusion.

In 1956, Bloom's Taxonomy was designed to direct teachers to make higher order thinking their focal point. He provided a hierarchy of levels to help teachers create questions—Level 1 lower-level thinking skills to Level 6 higher-level thinking skills. Each level was designed with keywords to help students think on the level of the keyword resulting in deeper comprehensions, increased problem solving, logical reasoning, reflective judgment, distinguish biases, and draw conclusions. The levels are

as follows: knowledge, comprehension, application, analysis, synthesis, and evaluation. Bloom et al. (1956) believed using higher-order thinking would require one to understand the problem, be familiar with various methods to use in the solving the problem, and take appropriate action after observing previous problems and the new problem. Higher-order thinking may be an expected skill by higher education institutions. Students are expected to be able to solve problems, distinguish biases, draw conclusions, synthesize, and evaluate information for assignments.

Pascarella and Terenzini (2005) defined thinking critically as being able to (a) recognize key issues and beliefs in an argument, (b) identify significant relationships, (c) form accurate assumptions from the data, (d) interpret results from data, (e) explicate whether conclusions are justifiable based on the data, (f) assess evidence or authority, (g) make self-corrections, and (h) resolve problems (p. 156). Critical thinking has been a target of higher education institutions. Paul (1993) asserted these skills are imperative if students are to be prepared to face the various challenges of adulthood and operate effectively in such a complex world.

Whether higher education calls it critical thinking or higher order thinking, for higher education students who suffered CT, to think critically may be another added challenge. Recall from the definition of psychological trauma in Chapter One, the neocortex is responsible for "the perception of self and the world" (Moroz, 2005, p. 4), and recall from the section in this chapter on the affects of childhood trauma on the physical brain that childhood trauma creates a "neurological roadblock in the neocortex" (Ziegler, 2015, p. 4). Childhood trauma survivors report difficulty in thinking critically (Willis, 2011; De Young et al., 2011). And, for those who were sexually abused and

developed PTSD, using higher order thinking skills to critically analyze is even more challenging (Bremner, 2006; Brownlee, 1996; Syal et al., 2014).

Most definitions of higher-order thinking focus on the "conceptualization of critical thinking, as a set of cognitive skills" (Tiruneh, Verburgh, & Elen, 2013, p. 2). There is now a consensus that critical thinking, as a broad concept, involves both skills and dispositions. The dispositions dimension includes truth-seeking, open mindedness, systematicity, analyticity, maturity, inquisitiveness, and self-confidence (Giancarlo & Facione, 2001; Pascarella & Terenzini, 2005). Facione, Sanchez, Facione, and Gainen (1995) reported "nurturing the disposition to think is an important element in the curriculum of professional programs and liberal education programs alike" (p. 13). With this in mind, cognitive skills are a necessity to be successful in higher education.

The term higher education may indicate a higher form of thinking is required because it means students must use cognitive skills that require them to think on a higher level. This sounds simple, but for an adult suffering from CT and the long term consequences, or PTSD, it may not be so simple. Critical thinking relies on executive functions, and the fundamental path of critical thinking is nearly joined with the growth of executive functions (Halpern, 1998). Children who suffered trauma may lack the skills required for higher-order thinking and without these skills, goal setting, assignments and projects that involve problem solving, decision making, synthesizing, and logical reasoning might be difficult to complete. To think critically, one must be able to make a thorough decision that is based on the ability to reach a solid conclusion arrived from available data (Cash, 2011). To do this, one must have unbiased lenses and not respond emotionally. Recall that one of the long-term effects of CT is dysregulation

of the HPA axis that controls the emotions. Based on the research studies, when an individual is able to validate information, evaluate the source, diagnose the source's credibility, and prove its validity, there is a great chance the individual will be able to have diverse viewpoints (Cash, 2011). Kostolitz, Hyman, and Gold stated, "master thinkers have full control of their thinking processes and recognize that their thinking strategies can improve and continuously develop new insights" (2014, p. 700). Past jobs and assignments usually only required one to follow directions because jobs were more task oriented like factory jobs. However, in the informational age, individuals are expected to think critically, solve problems, and make decisions. Their decisions may be communicated to managers, co-workers, constituents, the government, and the public. Therefore, it is imperative that students in higher education be able to think critically, analyze skillfully and solve problems.

Strategic planning. Strategic planning gained increased attention in the mid-2000s as it guided colleges and universities to focus on adopting the business manager's approach to competititon (Hanover Research, 2014). Few college bound students escape the inevitable question of what they plan to do after high school or college. The decision to attend college, whether two years or four years, might create uncertainty if one has not developed and envisioned a plan unfolding. It is helpful for college-bound learners to have strategies, the ability to think and plan at least three years ahead, plan a response to challenges, plan a response to opportunities, pinpoint what is necessary to achieve goals and objectives, have unwavering determination to execute the plan, and have a system in place to monitor the targeted plan (Ahoy, 1998). The approach to effectively lead, plan,

manage, and monitor one's grades, relationships, activities, and future as a college student is strategic planning.

Strategic planning requires abstract thinking and reasoning which occurs in the left hemiphere of the brain. Recall that the left hemisphere is responsible for sequencing, linear thinking, details, organization, precise thinking, analysis, and logic (Brownlee, 1996). Loehle (2010) stated, "In a coherent series of events there is some type of logic or causal dependence. A search for coherence is also a search for pattern" (p. 90). If it is challenging for survivors of childhood trauma to analyze, it might also be difficult for them to develop a strategic plan (Kostolitz et al., 2014).

Pearson (2015) listed the five components of a personal strategic plan. They are as follows: (a) vision—envisioning oneself doing well in a desired area, (b) set goals—dreams with deadlines, strategies, (c) strategies—your plan to get from where you are to where you want to go, (d) actions—steps you will take to get you closer to your vision, and (e) timeline—setting a time to have completed specific actions. A strategic plan whether personal or business could help one with the challenges of the vision by preparing for the roadblocks and detours. It caluculates these into the plan by providing another direction or step. The prefrontal part of the brain that is used in strategic planning is the executive function. "Adverse environments expose children to toxic stress, which disrupts the brain architecture and impairs the development of executive function" (Center on the Developing Child Harvard University, 2012, para. 5) and further supported by McCrory, De Brito, and Viding (2010). Therefore, survivors of childhood abuse might be at risk of losing their life long dreams, getting bettter jobs, living in better neighborhoods, or forming lasting relationships, if they are unable plan strategically.

Critical reflection. It was Dewey who first began the concept of reflection. He believed one of the most important qualities a teacher can possess is critical reflection (Yost, Senter, & Florlenza-Bailey, 2000). Dewey (1933) believed reflective thinking to be important in everyday life. He argued that the terms reflecting critically and reflecting in general are often used in the same way, but are not the same. Dewey ascribed critical reflection to be "active, persistent, and careful consideration of any belief or supposed form of knowledge in light of the grounds supporting it and future conclusions to which it tends" (Dewey, 1933, p. 6). In summation, he believed one should critically examine what one believes is known while considering the facts and what can be concluded from them.

Whether it is high school students in an advance placement class, or a higher education students in a college class, they will be required to use metacognitive skills. "Higher education students are expected to use their metagcognitive skills to synthesize and analyze" (Barnett, 1997, p. 54). Regardless of the purpose for critical reflection, there is a hope to believe or disbelieve something through proof, evidence, or facts. Ginsburg (1988) believed practical experience and knowledge based thinking is vital to critical reflection.

In order for reflection to be deemed critical reflection, "it must have as its explicit focus uncovering, and challenging the power dynamics that frame practice, and uncovering and challenging hegemonic assumptions" (Brookfield, 2009, Abstract, p. 1).

Critical reflection is important for personal growth, student growth, and academic growth (Ash, Clayton, & Atkinson, 2005). Higher education may have rediscovered what the secondary educators have known for years. Critical refelction is only recently

beginning to spread among universities. Some universities use reflective writing to collect information and use it to help broaden students' reflective writing skills (University of Bradford, 2015; University of Manchester, 2015). Gleaves, Walker, and Grey (2008) said,

> reflective journal writing can also enable students to critically review the processes of their own learning and behaviours, and to change their learning strategies as and when needed, and it provides a vehicle for inner dialogue that connects thoughts, feelings, and actions. (p. 230)

Yinger and Clark (1981) linked journal writing and reflection to a manifestation of thinking and journaling to guide new comprehension. Due to the long term consequences for those who suffered CT and developed learning disabilities as a result, it is possible these students may benefit from journaling. Additionally, critical refelection in the form of journaling may contribute to how the higher education institutions can better serve these students. I selected journal writing as a research method because it gave students who experienced childhood trauma the opportunity to reflect on their learning experiences and to think critically about what they need to help them be successful. According to Lew and Schmidt (2011), educators should move from seeing journaling as "a fanciful or indulgent suggestion" (p. 230) to seeing it instead as a learning strategy to satisfy a great need for a more in-depth, learning experience. Critical reflection through journaling may benefit higher education students who are survivors of CT because it can result in learners having a more in-depth learning experience including a better understanding of their own learning abilities and challenges**.**

Discussion as a learning strategy. As an instructional method for helping adults learn, discussion does not always support the traditional role of adult educator as teacher. Instead, an educator of adults who uses discussion to help adults learn takes on a different role, that of facilitator—one who facilitates a discussion to help adults learn. According to Knowles (1980), the six adult learning competencies (desired learning outcomes) are knowledge, understanding, skill, attitudes, values, and interest (p. 240). Discussion is an appropriate instructional method for addressing five of the six competencies—all except skill, which requires practice exercises (Knowles, 1980). Therefore, discussion seems to be a valuable instruction method in all adult learning environments, including higher education.

> The purpose of discussion as an instructional method is two-fold: (a) for the cognitive (thinking) and affective (feeling) benefits related to solving problems and investigating unconventional solutions, and (b) for the participatory learning benefits related to building trust in a safe environment, exposing learners to various perspectives and issues, helping learners express undisclosed values and beliefs, aiding learners to gain a wider outlook of the world, and infusing learners with the vast complexity of issues and topics. (Isenberg, 2005, p. 210)

The overall purpose of the discussion method is to help learners investigate their learning experience in hopes of becoming more critical thinkers (Brookfield, 1987).

In classroom discussion, the adult learner is placed in a discussant role with peers willing to participate and interact using verbal interchange with group members. Participatory learning evokes willingness within learners to invest in face-to-face discussions with one another and ideally to try without fear of being ridiculed. Combs

(1966) found "people too fearful of mistakes cannot risk trying. Without trying, self-direction, creativity, and independence cannot be discovered. To be so afraid of mistakes that we kill the desire to try is a tragedy" (p. 247). Contributing to a classroom discussion seems to represent less risk of being wrong than answering the instructor's direct question during a lecture.

Lectures seem to be the most widely used instructional method in colleges and universities, but lectures make little use of dialogue (Eng, 2017). However, the discussion method makes optimum use of dialogue and gives learners the opportunity to be involved in their instruction, receive the first-hand experience of learning, apply relevance through participatory input, and have a sense of problem-solving. Galbraith (2004) concluded that to be an effective teacher of adults, one must be "forever changing and evolving making new assumptions about our practice, our thinking, our learners, our educational purpose, and ourselves" (p. 19).

The Learning Needs of Adults in Higher Education who Suffered Childhood Trauma

Adults who suffered CT suffer the effects and long-term consequences of the trauma in educational settings such as higher education. Perry (2006) reviewed rudimentary issues that he thought would be helpful to educators who may teach survivors of CT who "have acquired cumulative educational trauma leading to fear conditioning" as a result of experiencing childhood trauma (p. 21). It is not a matter of *if* these students will end up in the classrooms, but instead a matter of *when*, higher education educators should be informed that some of the students are bringing more than pens and paper, they are bringing "a history of abuse, neglect, developmental chaos, or

violence that influences their capacity to learn" (Perry, 2006, p. 21). There is research literature earlier in this chapter linking childhood maltreatment with anxiety disorders (Rodebaugh & Heimberg, 2008). Such disorders and fear conditioning undoubtedly interfere with learning; therefore, understanding the learning needs of adults in higher education who suffered childhood trauma seems important for not only those who have suffered the trauma, but also those professors who facilitate learning in higher education classrooms. Unfortuneately, there was a gap in the research literature on the learning needs of those in a higher education setting who suffered CT. The following is a review of the research literature on this topic, though scant and not directly related to learning in higher education.

General Anxiety Disorder seldom occurs alone, it is usually found with cormorbid conditons such as depression, substance abuse, or specific types of anxiety disorder (Alegria et al., 2010, para. 6; Ciubara et al., 2015; McLean et al., 2011). Langley et al. (2015) posited depression and anxiety "impairs academic functioning" (p. 854). McLean et al. (2011) and Ciubara et al. (2015) further mentioned the cognitive impact of depression and anxiety on the individual, thus having educational implications because it impairs academic functioning. Whatever the age, the symptoms of GAD, make it more challenging to learn.

Adults who have panic disorders share the following symptoms: continuous sweating, heart pounding, shortness of breath, pains in the chest, dizzy, and fear of death. As with depression and anxiety, panic disorders impact the individuals' quality of life, especially in the education environment. Although online classes have reduced the embarrassment and shame of having to suddenly run from the college classroom, it does

not erase the learner's fear of being isolated. In or out of the classroom, panic attacks and anxiety disorders may present a constant and ongoing problem for adult learners in higher education who suffered CT. When children develop a fear of having panic attacks, their attendance at school may be hindered and they may find it more difficult to concentrate on their studies (Ingul & Nordahl, 2013). Unless it is treated, little or no learning may take place. It seems logical to assume that when adults develop a fear of having panic attacks, their attendance at *college* may, too, be hindered.

Based on Perry's (2006) research earlier in this chapter regarding the difficulty survivors have in developing trusting relationships, it may be the case that lack of trust by adult survivors of CT is carried over to the higher education learning environment. Survivors of CT enter higher education classrooms with hopes of being successful despite their distrust. Educators awareness of this distrust may offer adult survivors of CT help and support when struggling with assignments, fears, rejection, and inadequacies. Survivors distrust of others may be the obverse of United States law where everyone is now presumed guilty, that is, untrustworthy, until proven innocent, that is, trustworthy.

Throughout this review of literature, numerous studies reported childhood stress or on-going stress creates lasting changes in the brain (Bremner, 2006; Ziegler, 2002; Williams, 2011; Syal, 2014; Burke-Harris, 2015; Center on Developing Child Harvard University, 2012). The hippocampus (part of the brain that is used for learning and memory) that is damaged by the sustained stress response system can result in impaired learning.

Cognitive deficits may be felt by adult survivors of CT when they are given assignments in higher education that require higher order thinking. "The prefrontal

cortex is used more for judgment, cognitive function, and learning" (Garrett, 2014, p. 7). Early studies on the impact of stress on soldiers cognitively were conducted after World War II. The study observed pilots during war and during peacetime. Results found exceptionally skilled pilots during times of peace frequently crashed their planes during times of stress, it was said to be stress from the battle that led to mental errors (Broadbent, 1971). It could be the case that adult survivors in higher education perform well under normal conditions, but in times of added stress such as exams, projects, and major assignments, they too may find it difficult to perform well as a result of mental errors. Ounsted, Oppenheimer, and Lindsay (1974) argued that stress may trigger the stress response system and keep children focusing on potential dangers; thus, leaving them unable to focus on learning. This must all be the case in adult survivors of CT experiencing stress.

Research by Adams et al. (2008) found college students are more likely to be suffer from chronic illnesses, depression, and anxiety (para. 5). This research revealed that students entering college in general have an increased rate of anxiety. What is more, adult students who suffered childhood trauma may have the increased anxiety reported by Adams et al. as well as anxiety from the adverse childhood experience (2008). It was well documented that anxiety and stress may prevent the prefrontal cortex from functioning properly; thus, preventing an individual from using higher-order thinking skills (Burke-Harris, 2015; Majer et al., 2010; Perry, 2006).

The brain hemispheres control a specific set of tasks. A conglomerate of converging networks work together enabling the prefrontal cortex and the other parts of the brain—cerebrum, cerebellum, and brainstem—to act are known as the executive

function (Ball et al., 2011; They are natural to humans, and will continue to develop and grow naturally if the child has a supporting environment (Dawson & Guare, 2004).

It is also noteworthy that research supports a relationship exist among child sexual abuse (CSA) survivors and poor impulse control, decrease in the executive function on neuropsychological tests and behavioral problems (Mezzacappa et al., 2001).

This may be in part because "the areas of the prefrontal cortex are among the last to fully develop" (Dawson & Guare, 2004, p. 4) and are a key pathway that manages information from various regions of the brain (Dawson & Guare, 2004). The prefrontal cortex (cognitive functioning) is part of the brain used to problem solve, think critically, draw conclusions, learn new concepts, and make judgments. If the prefrontal cortex is impaired, it can have profound effects on learning (Klein, 2013; Broadbent, 1971). Simply stated, trauma alters the brain, and adult survivors' brains may have been altered due to the abuse. Therefore, adult educators in higher education need to be prepared to offer adults who suffered CT alternative ways to complete assignments to determine proficiencies.

Many adult learners are doubly stressed as they return to the classroom setting. Perry (2006) aligned adult learning principles with the learning needs of adults who suffered CT: (a) the adult learner's environment must be a safe place free of fear because "fear destroys the capacity to learn" (p. 23)—the learner may feel threatened by internal or external threats, (b) the learner may have been humiliated as a child; therefore, there is a need for mutual respect—a need to be treated as an equal in experience and knowledge, and (c) lecturing (passive learning) may not be the best strategies for learning—"the capacity to internalize new verbal cognitive information depends on having portions of

the frontal and related cortical areas activated" (p. 25)—(active learning). Furthermore, research by Freeman et al. (2014) reported "that students in classes with traditional lecturing were 1.5 times more likely to fail that were students in classes with active learning" (Abstract, para. 2). Adult learners may need alternative ways to process information and demonstrate proficiency/learning. Recall that adult learners who suffered CT may suffer from a "neurological roadblock in the neocortex" (Ziegler, 2015, p. 4). Therefore, they may need options for both of these important elements (passive and active learning) in higher education teaching and learning.

Recall that PTSD can be the result of childhood trauma (Draper et al., 2008). Bremner (2006) argued that "patients who had PTSD and child maltreatment were deficient in short-term memory and declarative memory" (p. 4). This fact has implications for the learners ability to process information and demonstrate proficiency/learning. In summary, research seemed to support the lifelong consequences of childhood trauma on learning as a child and as an adult.

It seemes important for educators of adult students to have a better understanding of adult learning theory and the learning needs of all adult learners. Learning difficulties due to CT are invisible to the educator in a higher education classroom. Therefore, the higher education educator must assume some adults who have suffered CT are in each class of adult learners. An understanding of the assumptions of the characteristics of all adult learners (Knowles, 1973, 1980) and the process by which they learn best (Knowles, 1973) may benefit higher education educators who are interested in helping all adult learners in their classrooms be successful learners.

Advocacy centers and school districts have implemented trauma informed care to address the needs of children who have experienced trauma. It is equally important for universities to give adult learners the support they need to pursue their academic dreams. Trauma sensitive schools and universities are a benefit to everyone.

Children who are traumatized often grow up to be adults with chronic illnesses, and psychological and emotional problems. Undoubtedly, many of these adults go on to colleges, and are seated in classrooms around the world. Colleges that are prepared for traumatized students who may yet be prone to “fight or flight” create a learning environment where all students are able to learn.

Chapter Three: Methodology

The purpose of this qualitative study was to explore the learning experiences of higher education students who suffered CT. Data were collected from a purposive sample of graduate students who attended a liberal arts Midwestern university, and who self-identified as having experienced a childhood trauma. In addition, the study explored the challenges they face academically at higher education institutions, how they see themselves in the learning environment, their success rate, coping mechanisms, learning strategies, self-efficacy, and their perceived success at forming personal and professional relationships.

Problem Statement

Prior to this research study, I was unable to find research on the learning experiences of students in higher education who suffered CT. However, there was extensive research literature on the psychological, emotional, physiological, and biological impact of trauma on children, adolescents, and adults in general. As a CT survivor in higher education, I have struggled with the academic work and the classroom environment. I have, in the past and at the time of this writing, developed coping skills and learning strategies to be successful in higher education, and I posited that others like me have done the same. Higher education CT survivor students are a yet untapped rich resource for learning how to help CT survivors like themselves be successful learners in higher education and for helping universities learn how to create a learning climate that is conducive to learning for all students, including CT survivors.

The research questions and sub-questions were as follows:

RQ#1: What are the learning experiences of higher education students who suffered childhood trauma?

RQ#2: How do higher education students who experienced childhood trauma describe themselves?

RQ#3: What can the experiences of academically successful higher education students who experienced childhood trauma reveal that might be of use to other students who survived childhood trauma in their struggles with learning in a higher education setting?

RQ#4: What do adults who experienced childhood trauma perceive they need in order to be successful learners (resources, tools, environment, accommodations, instruction, etc.)?

RQ#5: How do participants perceive daily structured journaling during the 60-day study?

SQ1: What were the benefits, if any?

SQ2: What were the repercussions, if any?

The research questions were answered by collecting data from the initial interview, journaling, and the exit interview. This chapter recounts the setting, limitations, research method, subjects, procedure, data collection, and data analysis.

Setting

This study was conducted in the Fall semester of 2016 at a Midwestern university of approximately 10,000 students from 45 of the 50 states seeking to obtain a bachelor's degree, master's degree, or a doctor of education degree. The student population was represented by 60 foreign countries. The university offered individual and group

counseling to students through the Student Wellness center. However the wellness center is only designed to assist college students with common problems as reported by college students.

Limitations

There were four limitations to the research design. First, the participants in the study were not screened for CT—they self-identified based on a publicly posted flyer calling for participants who experienced CT to email the counselor (Appendix F). Once they were enrolled in the study, participants were asked to take the self-assessment ACEs questionnaire (Appendix A). No participants were excluded, even after taking the ACEs questionnaire. Participants' memories of CT events may have been inaccurate or suppressed. Second, I used a purposive sample of convenience; therefore, the results may not accurately represent the population of university students who have suffered CT and cannot be generalized to all university students who suffered CT. Third, some of the experiences reported in the individual interviews were not in agreement with that person's ACEs score. These participants may have experienced cognitive dissonance (Festinger, 1957)—disagreement between one's beliefs and one's reality—when they completed the ACEs questionnaire (Appendix A); thus, producing tension that caused them to answer the questions in a way that made the trauma seem less in their effort to relieve the tension by seeking cognitive consonance (agreement between one's beliefs and one's reality). The fourth and last limitation of this study was its time frame, which was only one and half semesters (November-February). It was in the middle of one semester and ended immediately after the following semester began. A longer study may have resulted in different outcomes.

Research Method

The multiple case study method seemed to be the best fit to answer my research questions. The participants who all shared the experience of having suffered CT met criterion for the multiple case study method. The interviews of the participants' learning experiences validated the multiple case study method as well as the emerging themes intertwined throughout the study. Face-to-face interviews were conducted with consent (Appendix H) by a licensed counselor at the university and I transcribed the audiorecordings with the help of an outside academic. The transcriptions were turned into the stories listed as case studies for each participant. A case study is an indepth analysis and appreciation of an issue that would provide further insight and thus, elucidate broader lessons that may be derived from the study (Crowe et al., 2011). It consisted of an interview where the participants were asked 14 questions (Appendix C). The interviews ranged from 45 minutes to one hour.

It further afforded me the opportunity to investigate the thoughts, actions, behaviors, relationships, perceptions, insights, and the learning experiences of the participants. The participants shared a past or/and current CT, and were all current students in higher education. The case study method has illuminated topics in the educational field for years (Merriam, 1988), and is also widely used in the medical field (Fraenkel, Wallen, & Hyun, 2015). There is much to learn from studying individual case studies that share a phenomenon. From these individual case studies, insights and foresight may be gained on various ways to help others (Fraenkel et al., 2015) such as higher education students who suffered CT. Multiple case study method seemed to be the best fit for this study not only because it allowed me to "explore differences in and

between cases" (Baxter & Jack, 2008, p. 550), but also because multiple case studies are "more likely to lend themselves to valid generalizations" (Fraenkel et al., 2015, p. 433).

Participants

The research study involved 11 participants over the age of 18 who self-identified as having suffered CT. The participants were interested in the study because they had suffered a CT during childhood. Their CT included emotional abuse, physical abuse, sexual abuse, and neglect. There were 10 females and one male consisting of undergraduate, graduate, and doctoral students. Participation in the study was completely voluntary. Their stories varied—the severity and length of the trauma, their age at the time of the trauma, and whether they had protective risk factors such as a calm and steady temperment, a secure parental relationship, outside support, and the resilience to bounce back (Condly, 2006) after CT.

Several participants indicated, in the initial interview, their gratitude for the study. This indicated the need for this type of study. Several students who were interviewed did not return for the gift card (given to all participants who participated in the study). This could indicate the students were more concerned with their perceived personal benefit from participating in the study than their monetary reward for participating. Purposive sampling method was used to enroll participants who could provide information-rich data to yield a better understanding of the phenomenon (Palinkas et al., 2015)—CT survivors in higher education.

Procedure

The prodecure is described in chronological order—what was done, when it was done, and by whom. I obtained permission from the university provost to conduct the

study (Appendix G). Upon approval, the student activities office posted the flyer announcing the study (Appendix F), and for interested students to contact the interviewer (counselor) by email. The counselor then scheduled an interview with interested participants. There were students who contacted me by email as a result of a professor or friend telling them about the study. When they contacted me, I immediately forwarded their information to the interviewer. This was done to eliminate any possible biases I might bring into the interview process because of my past CT experiences. I did not have any further contact with the participants after forwarding their contact information to Dr. Munro, a retired couselor at the university who volunteered to conduct the study.

In the meeting with Dr. Munro, participants signed a consent form (Appendix H), completed a short 10 minute ACEs self-scoring Questionnaire (Appendix B), used in the study with permission from author (Appendix I), engaged in a 30-45 minute initial interview (Appendix C), and were issued a 60-day structured journaling guidelines (Appendix D). Journals were issued to collect the thoughts of students about their day for the duration of the study. At the beginning of the study, participants were issued journals to help them be open to their own thoughts and feelings that could arise upon revisiting the traumatic experience. At the end of the study the counselor scheduled a return visit to instruct them on the email exit interview,,collect the journals, and reflect upon the benefits, if any, and/or repercussions of journaling throughout the study.

During the initial interview, the participants were informed they could contact the counselor at any time throughout the study for free counseling should the study cause bad feelings, emotions, or residuals to resurface. Participants were offered a $10 gift card as a thank you gift for participating in the study. At the end of the study, Dr. Munro

emailed participants exit interview questions (Appendix E) to reflect upon their research study experience. Participants emailed Dr. Munro their exit interview responses, and she then emailed them to me.

Instrumentation

The data collected were based on each participant's perception; therefore, no known research instrument existed that could be used to explore the learning experience of higher education students who suffered CT. Consequently, an original initial interview instrument was required in order to fully capture the perceptions, understanding, emotions, feelings, and concerns of CT survivors (Appendix C). In generating an orignal instrument for the purpose of collecting pertinent information for this study, various questions concerning higher education students who suffered CT. From the collection of questions, 14 questions were selected that were thought to best answer the research questions.

The learning experience of higher education students who suffered CT was explored by collecting information about participants' backgrounds, asking them questions regarding their learning experience to obtain their perception of their strengths, weakensses, challenges, learning environment, strategies for learning, why they were successful, and their coping mechanisms.

Reliability. Reliability is pertinent in addressing the steadiness of inferences researchers find of data generated around time, location, and circumstances (Fraenkel et al., 2015). Using the initial interview questions instrument for this qualitative study strengthened reliability because each participant was given duplicate questions (Fraenkel et al., 2015). In qualitative research, bias exists because the researcher and participants

may see and perceive questions differently, thus, affecting the reliability of the data received (Maxwell, 2013).

Validity. Validity is important in understanding why research participants articulate their insight, and it aides in clarifying their responses to interview questions (Fraenkel et al., 2015). In addition, validity is the "meaningfulness and usefulness of the inferences researchers make when conducting research" (Fraenkel et al., 2015, p. 456). Four instruments were used in this study to collect four different measurements: ACEs questionnaire, initial interview questions, structured journaling assignment, and exit interview questions. The instrumentation was different, but all the measurements (data) were used to triangulate the results for the purpose of strengthening the findings. Triangulation of the multiple data sources helped develop a more thorough understanding of the phenomenon, and converge the information collected from the various sources (Patton, 1990. Triangulation aided in validating the participants' information (Creswell et al., 2002).

The first instrument was the ACEs questionnaire (Appendix A) consisting of 10 questions assessing adults exposure to 10 types of chidlhood trauma—physical abuse, verbal abuse, sexual abuse, physical neglect, emotional neglect, a parent who was an alcoholic, a mother who was a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through a divorce, death, or abandonment. The ACEs questionnaire was created by Robert Anda for Vincent Felitti in partnership with the Centers for Disease Control to document the prevalance of ACEs and to study the implications of it during clinical observations. The ACEs questionnaire has a self-scoring guide to interpret results

(Appendix B). The first instrument helped me group the participants scores to assess the level of CT exposure.

The second instrument was the set of initial interview questions consisting of 14 open-ended questions (Appendix C). Interview questions were shaped to elicit participants' perceptions of their learning environment (Austin & Sutton, 2014). The interview questions were designed to collect data to address the research questions 1-4.

The third instrument was the structured journaling assignment (Appendix D). Participants were issued 8 X 10 hardback 100 page journals with structured guidelines. Participants were asked to journal twice a day—answer two questions in the morning and one question in the evening. Participants chose their journal. Some were multi-colored with various designs and marks on the front in bold orange, red, blue, and pink. Others were simple with no designs on the front. Structured journaling was used to capture the participants' reflective thinking about their beliefs, values, emotions, learning strategies, and reactions to various situations in their learning environment including the day-to-day stresses of school. Journaling addressed research question 5 and sub-questions—How do participants perceive daily structured journaling during the 60-day period?

The fourth instrument was the set of exit interview questions (Appendix E) that was electronically mailed to all participants at the end of the semester. The purpose of the questions was to follow-up with how, if at all, the study impacted them, and to gain insight into the benefits, if any, or the repercussions of journaling, and to find out whether the study provoked their awareness of CT and its impact on them. The exit interviews questions answered research question 4.

Data Collection

The counselor, Dr. Munro, collected all of the data. She began interviewing participants in the Fall 2016 semester. She assigned numbers to all participants to maintain their confidentiality and anonymity before releasing the data to me. I assigned participants a pseudonym from the numbers she provided. All identifiable information was kept by the counselor in a locked cabinet in a locked room where she alone had acesss.

Interviews were conducted by the couselor on campus in an agreed upon place. I was not privy to any of the meetings, dates, nor times of the interviews involving participants. Interviews were audio-recorded and released to me on CDs labeled with the participant's number only. I transcribed the interviews with help, then assigned pseudnonyms to the numbers to make the participants more personal and real to me as I analyzed the data. I found something memorable for each participant, and thus gave them a corresponding name. There was only one male so I gave him a male name John T. One liked to write in her journal so I called her Paige. The pseudonym identification numbers were examined by me against the recorded interview questions to ensure the questions corresponded with each participant number. This was done to ensure accurate transcriptions as well as each participants' answers were correctly reflected (Fraenkel et al., 2015).

Each participant was interviewed individually. My dissertation committee addressed the sensitivity and possible stress of participants in revisiting the topic of their CT. Therefore, the counselor agreed to provide participants free counseling during the study and one month after the study was completed if they desired. My role was to

communicate any concerns regarding the participants as I reviewed and analyzed the data.

Four data sets were collected for the research study. The first data set was the ACEs scores. The second data set was the initial interview transcripts, which were audio-recorded answering open-ended questions to describe their individual learning experience. The third set of data was the journal notebooks. They were given to participants for them to write in morning and evening to gain insight into their thoughts and behaviors. The last set of data collected was the exit interview questions to gain insight into how, if at all, the study impacted the participants.

Data Analysis

All data were analyzed except the ACEs scores, which were included in the case studies and used only to further describe participants. Participants used the self-scoring guide to analyze their own ACEs questionnaire results. During the interviews, all participants were given the ACEs scoring guide so they could analyze their score along with the counselor. They were allowed to address concerns with the counselor regarding their score.

The interview questions were open-ended; I transcribed the audio-recording, and the transcripts of the responses were analyzed using open coding to determine patterns and emerging themes. Strauss (1987) defined open coding as "the initial, unrestricted coding of data" (p. 28). Although participants shared a common experience of CT, they then expounded on the personal ways CT has impacted them in an academic setting. I used a multiple case study design because it afforded the reader a richer context (Zach, 2005). Analyzing interview responses for similarities and dissimilarities is normal, and

reviewing conflicting sections of the data by marking them with relevant labels for further analysis was my method and is commonplace for qualitative research, according to Seidel (1998). I used different colored markers to identify each emerging theme. Open coding allowed me to search for patterns and themes, so that data were presented in a more meaningful way (Charmaz, 1983; Seidel, 1998).

While transcribing, I wrote down key words and phrases in the paper margins for each participant's response to each interview question. Although the interviews were conducted by a counselor, listening to their voices as I transcribed them was difficult because of the shared experierience of CT. The shared experiences caused me to reflect and recall, perhaps more than usual.

Though not all participants participated in the journaling, it was an integral part of the study because it allowed particpants to provide day by day candid reflections regarding their struggles, strategies, strengths, and successes as they occurred that would not have been captured otherwise. Open coding method was again used to analyze the journal entries. Nine themes emerged as a result of open coding all three data sets.

Summary

A qualitative approach allowed me to discover perceptions on the struggles, learning strategies, and successes of higher education students who suffered CT. The multiple case study design was used to explore the learning experiences of higher education students who suffered CT in a Midwestern university. Data were collected from four sources: the ACEs questionnaire scores, initial interviews, journal notebooks, and exit interviews. Open-coding was used to analyze the qualitative data—the initial interviews, the journal entries, and the exit interviews.

Chapter Four: Results

In this chapter, 11 case studies provided insight into the lives of survivors of CT. The case studies included each participant's perceptions of what they found was needed to be successful in their learning experience: how they overcame obstacles, developed coping strategies, and identified learning strategies; advice for incoming students; a sense of the day-to-day struggles of a childhood trauma survivor; and best instructional strategies for helping people like themselves learn.

There were five research questions and two subquestions addressing the learning experience of the students:

RQ#1: What are the learning experiences of higher education students who suffered childhood trauma?

RQ#2: How do higher education students who experienced childhood trauma describe themselves?

RQ#3: What can the experiences of academically successful higher education students who experienced childhood trauma reveal that might be of use to other students who survived childhood trauma in their struggles with learning in a higher education setting?

RQ#4: What do adults who experienced childhood trauma perceive they need in order to be successful learners (resources, tools, environment, accommodations, instruction, etc.)?

RQ#5: How do participants perceive daily structured journaling during the 60-day study?

SQ#1: What were the benefits, if any?

SQ#2: What were the repercussions, if any?

There were 14 face-to-face interview questions (Appendix C) that addressed the participants' learning experiences. Research question one and two were addressed in interview questions 1-4 as survivors discussed their learning experiences and described themselves; interview questions 5 and 6 addressed the particpants strengths, challenges, and the possible role CT played in their learning experience. Research questions 3 and 4 were addressed in interview questions 7-9 where students revealed their academic successes and the resources CT survivors need to be successful. Interview questions 10-12 addressed the daily challenges of college students who survived CT. Interview questions 13 and 14 addressed their involvement in the study and any suggestions they believed would have made the study stronger. Research question 5 was addressed in the exit interview (Appendix E) and focused on the benefits and/or repercussions of structured journaling (Appendix D).

The case studies were created from the following data sets: ACEs questionnaire (Appendix A & B) score, face-to-face interviews (Appendix C), journal entries (Appendix D), and exit interviews (Appendix E). Only some participated in all four. All took the ACEs questionnaire and scored themselves using the self-scoring guidelines (Appendix B), and all participated in the initial interview. Each case study begins with the participant's ACEs score.

Case Studies

John T. John T's ACEs score was three. I used his initial interview results, journal results, and exit interview results to create his case study.

Interview results. John T was, at the time of the study, a senior in the adult accelerated learning program. He described himself as 'very independent and I don't like to ask for help.' He determined success by his ability to be promoted. His previous college experience was one where he 'did too much partying.' He attributed his parent's divorce to much of the instability in his elementary and secondary studies because his family moved multiple times. He said there were times he studied hard, but it was not because he was so assiduous. Rather it was because he had moved to a new place and had not made new friends. John T said, 'I studied harder because 'I didn't have much else to do,' and when he had friends he 'went overboard and stopped studying.' He said it was difficult to 'find that in-between place.' He was now taking college more seriously.

As a CT survivor, he denoted a typical day 'is trying to find a little time to decompress at the end of the day.' He said getting the children to and from school, having dinner with the family, and trying to find time to do the homework assignments are all part of his daily schedule. For John,T, it was more manageable now because he sees a difference in how he manages his time as opposed to how he handled it before he resolved some CT issues. 'I was more selfish back then. It was about me, and I wanted to have fun.' John T believed his disdain for school and failure in his first college experience contributed to his being 'morphed into something.' He said returning home and working with his dad made him realize he did not have his own identity. It may have been his tipping point. Something happened that changed him. He decided to go back to school after 20 years. He knew it would be a challenge, but felt he was ready. John T described his first learning experience as a non-traditional student as being 'a weed out

class' where he was determined to not be weeded out. Although he survived the weeding out class, John T was then faced with writing a series of essays and tests. He said, 'you seem to learn more when you can do research on a topic that applies to your own life.'

To improve the learning experience for college students who have experienced CT, John T suggested a 'a website of frequently asked questions.' The website as John T described it would include a seminar for students who have experienced CT. The purpose of the website would be to help ease any concerns of CT survivors, and it would provide them an opportunity to hear 'how I've accomplished these classes and the homework assignments.' His overall learning experience was great because much of what he did for his school assignments was applicable to his own life.

When asked about his worst learning experience, he replied, 'I just finished it. It was statistics. I hadn't had math in 20 years.' He believed his poor grade may have something to do with the teacher being new to the cluster program, and not really understanding how to teach it. He did not believe the childhood trauma interfered with his frustration with the class.

John T's advice to incoming CT survivors: there will be trepidation 'especially if you're re-entering college after a long period off.' He said although survivors may want to do the minimum, it would not help them reach their professional goal. He said CT and his role as a college student do not impact him as much because it is something he worked on over time. He said, 'I learn best in face-to-face classrooms so I can focus.' He needed the type of learning environment where he can engage in learning without any distractions, so he went to the library when he needed to focus. He needed guidance, clear guidelines for assignment due dates, the research tools in the online library, and a

quiet place to work to be a successful learner. At the end of the interview he acknowledged he knew his ACEs score was lower than others who had CT, and said he did not receive any counseling for the CT. Instead he worked the issues out by himself.

Journal results. In his journal, John T wrote about his strategies for success, struggles with managing his time and procrastination, goal setting, candid feelings, fears, struggles, anxieties, stress, emotional frustrations, and desire for retribution. John T was not thrilled about the journal writing in the beginning, but stated after writing a few entries that journaling is 'a great way to think about the day's activity.'

John T wrote about his success strategies in his journal. He said, 'The best way to look at a large assignment is to understand what you want to write about, and then create an outline.' At night he wrote, 'another strategy is to be open and accepting of ideas as you read articles.' John T wrote, 'I need to take a PTO [paid time off] day to help with the time it is going to take' and 'staying up watching the Walking Dead on Netflix doesn't help either.' At night he wrote, 'I use a reward to help me turn my paper in on time, so I said to myself I had to get the draft done before I was able to go.'
John T wrote, 'I'm ready to complete my paper, but I have to run my daughter to Missouri Science & Technology first. I should be back in plenty of time.' He also wrote about his college experience— 'I'm not the smartest person, but I do get my work done on time.' At night he wrote, 'the professor is straight forward about telling us what will be on the test. I will be preparing for that throughout the week. I plan to start memorizing this weekend.'

John T revealed his struggles with time management, 'I totally intended to study for the assessment exam, but I never got to it. I can be a bit of a procrastinator.' John T

wrote, ‘utilizing new learning tools. I think this is where [being] open to learning is important. If you internally shun the learning objective, then you will never be open to using new tools and skills you have learned.’ At night he wrote, ‘I plan to get back on the studying bandwagon, so I can ace the test on Tuesday.’ Further, he wrote, ‘I will be studying notes for assessment. I used to be sure I knew at least 75% of material to at least get a C grade and maybe guess my way to a B. Now I shoot for As.’

He admitted, ‘I’ve fallen behind in my journal writing. I have left this journal aside. I had to plan for the home stretch for the Healthcare Economics finance class.’ John T reported on his test results, ‘I received a 95% on one test, and a 93% on another test. I did better than I thought I would.’ At night he wrote, ‘I’ve been able to accomplish a lot of things except for writing in this journal. I should be good these final two weeks.’

Exit interview results. John T answered the three exit interview questions as follows:

> The study helped me reflect on how I persevered throughout my issues, and it reaffirmed that anyone can make it through the toughest times of their lives.
>
> I would be willing to facilitate, and lead a support group of childhood trauma. I really hadn't thought about promoting awareness to this issue.
>
> From a Christian perspective, I would say that my beliefs in Jesus Christ as my Lord and Savior, and the help he has provided me throughout my life, confirms that when we call out to him, he does listen.

Candace. Candace's ACEs score was an eight. Her case study was created using only the interview. She did not complete the journal and exit interview sections of the study.

Interview results. Candace was a sophomore. She described herself as being 'strong and responsible.' Her strength was her ability to manage her time, and her challenge was she lacks motivation. She contributed her success in college to her determination and her ability to do her work by herself. Candace continued to struggle with the memories and thoughts of the childhood trauma. When she has difficulty focusing, she said, 'I don't dwell on it.' Her determination was evident in her voice when she discussed her move to Missouri and the importance of not trying to go through the struggles by herself. 'Find someone you feel comfortable talking with.'

Candace was proud of herself for how she has been able to stay focused and manage her time in spite of the persistent memories. She was motivated by challenges. A typical day described by her was one where she deals with the problems. Talking about her past helps her to be able to release persistent negativity, 'I talk about it constantly and try to figure out what I want to do to be happy, because it used to impact my life daily.'

Candace's best learning experiences were her theatre classes with improvisation. She did not elaborate why it was her best experience. When asked what she would do to improve the learning experiences for college students who have CT she replied, 'support groups or coping mechanisms.' Candace believed support groups would improve the learning experience for those who experienced CT. When asked if she would be in it, she replied, 'no, but I would be a peer leader of the group because the path I've taken could

help me help someone else.' Her overall learning experience was better because she has made friends. She said 'having a solid support group helped.' In fact, she said she joined a sports team so she could have more friends.

Candace's worst learning experience was a Statistics class. Neither the work she did in class work nor the homework prepared her for the exams. She said that it was difficult because she studied all the information, yet, it was not on the exam. She concluded, 'my way of studying is to have multiple sources saying the same thing.' When asked about advice to incoming students who experienced CT, she said, 'have someone you can talk to. I talk to my best friend, my grandparents. I don't talk to my mom about it much since she was involved in it [her CT].' She said CT does not impact her as much as a college student because 'I've had the issues for so long, I've just learned to deal with it.' Candace learned best by doing hands on because it 'fleshes it out like seeing a similar example and applying it to my real world experience.'

Candace needed 'support from friends and consistency among faculty' to be successful. She took medication for anxiety and went to counseling. She used to go weekly before she moved to Missouri. She did not want to retell her story repeatedly, so she continued going to her counselor in the state she lived. She called her counselor when she needed to talk. Candace said she needs additional strategies to help her succeed. She thought finding out how people with CT deal with it over long periods of time, for example up to 15 years, would be helpful to this study.

Andrea. Andrea's ACEs score was a three. Her case study was created using the initial interview and the exit interview. She did not complete the journal assignment.

Interview results. Andrea was a sophomore who described herself as capable and one who has overcome many adversities. She missed some years of high school as a result of the childhood trauma, but said, 'I got right back up.' She stayed afloat in college by recalling how far she has come.

Andrea ascribed the thing that will determine her success as her ability to stay healthy and reach out to others. Her strength was her openess with her professors. When she needed an extension on an assignment, she went to the professor and asked for an extension. It did not come natural for her—it was something she learned to do. Andrea never needed the extension, but said, 'it's nice to have it.' Although she could do it, she said, 'I have to know I can have the extension.'

Andrea's greatest challenge was staying in the dorm because she worried about her parents. She said, 'balancing everything is a real problem.' A typical day in her life as a childhood trauma survivor was one of 'constant anxiety, second guessing myself, and having everything laid out.' She said, 'having social relationships is hard because I take everything to heart.' She ruminated over the things she said to people wondering if she said something awkward—'my days are spent with anxiety.'

Her best learning experience was the result of the college having the same scheule as the block schedule she had in high school. It was something familiar and it did not require a change in her schedule. She was able to continue planning, working, and babysitting.

Andrea suggested support groups to improve the learning experience of childhood trauma survivors. She believed the groups should be separated by those who are just now

beginning to experience the after-effects of CT, and those who been experiencing it and have worked through some of the issues around it.

Her learning experience was challenging because she was recovering from anorexia, taking care of her parents who drink, and driving back and forth to care for them. She said, 'I always want to be home, but I'm supposed to stay here all week and then go home on the weekend. I just want to be there for them.' She said anxiety keeps her organized and focused, and she does well once she gets into her school work.

Andrea's worst learning experience was a mandatory college class called Safe Haven where it showed a video on sexual abuse. She said, 'I started freaking out because I didn't feel like I need to go through it again. I don't need to sit down and do it all over again, and making it mandatory can be really bad for someone.' She went on to say she hoped the professor changed her requirements for the next students entering who may have experienced sexual abuse. She continued to say she would not want anyone else to have that experience. For Andrea, there was another college class called the Freshmen Experience where she had a similar experience, and 'had a seizure because of it, and these things cause triggers.'

Andrea would advise incoming students to get accommodations if they need help, establish great relationships with their professors, and seek professional help before going to college. She had a counselor, and took medication at night to fall asleep. In order to be successful at the university level, having a separate testing room was important, stressing the importance of accommodations and having professors who understand. She said the study gave her anxiety, but she looked forward to it because she wanted to help people. She said, I knew 'it wasn't going to hurt me, and I'm in a good place, better than

most people.' She also said, 'I've been doing things to help myself by staying on my pills and breathing.'

One thing Andrea wanted to discuss that she initially forgot was that she was sexually abused by her childhood friend. She said, kids try things, but what she thought was just kids trying things turned in to him doing them to her all the time. She said, 'it never stopped.' When she told his mom, she did not believe it. She thought she was pregnant in fifth grade. She said, 'his family supports him although they know he's capable of this stuff.'

Exit interview results. Andrea answered the three exit interview questions as follows:

> Going into the study and attending the first interview was extremely anxiety provoking. I found it incredibly difficult to share my history of abuse with an individual I didn't know and had never spoken to prior to the interview. I didn't end up following through with the journaling and participating further in the study. Journaling and thinking about the abuse creates a lot of extra stress and anxiety in addition to my already high level of anxiety. When I would sit down to write the journal, I would feel so much that it was unbearable to continue with the journaling.
>
> I'm not sure I would be able to participate in a support group throughout college. I feel it would have a negative impact on my studies.
>
> Educators need to be knowledgeable on possible signs a child who is being abused might display in his/her classroom. If an educator suspects abuse, he/she should not hesitate to report their concern.

Dallis. Dallis's ACEs score was a seven. Her case study was created using the initial interview and the journal data. She did not complete the exit interview section of the study.

Interview results. Dallis was a junior, and described herself as being resilient and 'pretty school-oriented.' She was active in clubs and organizations, and said she was the one person others lean on. Safety was the determining factor whether or not she was successful in the program. She believed she was this way because 'you can learn anywhere, but you can't feel safe. The safe environment really fosters learning because you want to be there.'

Her strength was she loves learning. It may be because she came from a background where the focus was on having an education background. She recalled the reaction from her classmates when she said, 'We did math over the summer.' One of her challenges was, 'if I butt heads with the professor, I have to decide whether or not I will go to class today or not.'

Dallis's worst learning experience was in a psychology class. She was a freshman and they were reviewing the outcomes of child abuse, and her professor inadvertently became her motivation. She recalled his comments, 'They'll become drug addicts and abusers of themselves.' She recalled her thoughts after he said that, 'not really, I won't. That's not going to happen to me.' She said his comments pushed her to do all kinds of research on it, and made her want to 'get the best education she could to prove him wrong.'

According to Dallis, it is possible for someone who experienced CT to 'have a normal life, however normal is defined. This may involve a class or group therapy where

people could attend and be in a safe place like they have in elementary and secondary schools. These would be places where students feel safe, and free to discuss their feelings and concerns in a judgment-free zone.' The best learning experiences for Dallis have been in her major psychology classes because she said, 'every class I take sort of pushes me forward of what I want to take or what I want to ultimately do.' She said the classes provided her with knowledge of how things will impact her daily life. She wrote things down and how it reminds her of something.

Dallis's worst learning experience was in a criminal justice class where part of the instruction was she had to watch a video on a rape case, and the professor and the class commented, 'she wanted it, and that doesn't happen anymore.' I said 'It does!' She said the professor began to argue with her and they went back and forth in conversation regarding the rape case. She said 'it does happen because it happened to me four years ago.' It made her want to switch to a different class or professor, and made her reconsider her minor of criminal justice. She said, they remained 'at opposite ends of the spectrum and continued to butt heads.'

Advice to incoming college students was to find a support group. Dallis said the support group could go two ways, 'they will say it's not a big deal. I don't believe you or they will treat you like a broken baby bird syndrome.' It was CT that made her interested in psychology and the study of trauma. She said, CT is difficult 'when it's brought up in class and people make certain comments, and you have to bite your tongue because my case isn't everyone else's case, be humble about your experience and not universalize it.'

She was a kinesthetic learner and had to move as she learns. She also learned best by hearing the experiences of others about a particular subject. Again, she returned to the

importance of safety as essential for her to be successful as a student. She said, 'it's a constant struggle with security because they're not always there for us.' She created her own personal strategies for maintaining a safe secure learning environment on campus. The interview caused discomfort when she mentioned the police. She said not feeling protected, 'is worse than anything my dad ever did. That's a lot harder to have someone say I don't believe you.' She was not in counseling. At the end of the interview, she was asked if she thought compulsory training or some basic understanding of CT would be good, and she replied yes.

Journal results. Dallis' first entry described her political fear that impacted her personally, 'As someone who was raped, the idea of a rapist being in power is sickening.' She wrote, 'I need safety. . . . six hundred steps backwards in all the progress toward recovery I've made. . . . I'm scared and I feel alone.' Dallis was doing a presentation . . . and expressed fear of her classmates' reaction. She said, 'Dr. Roberts needs to be a good moderator and back me up with facts.'

Mental struggles about whether or not she should attend class when her brain is exhausted were reflected in her journal entry, 'I think it's important to take mental health days in order to be a better student.'

After a class where child abuse was discussed, she wrote, 'Nothing like feeling like that one kid who has a deep dark secret.' That night she recorded 'it's really frustrating to hear 'kids want to be with their parents so we should let them.' 'Okay, sorry Karen, a six-year-old doesn't get to choose where the safest place for her to be is.' Then she put in parenthesis '(massive eye roll)'.

School was a frustration for Dallis, ‘when literally everything is due on the same day, so you’re extremely frustrated and worn out. . . . Why is everything due on the same day?’ Dallis recorded her feeling of not being accepted by her professor and her classmates, ‘Would prefer not to go to class where I don’t feel welcomed, but the desire to pass class wins, I’ll go.’

Dallis said she received multiple compliments about her drag show, and recorded ‘If my dad could see me now, he’d probably crap in his pants.’

Regarding her presentation on PTSD, Dallis wrote, ‘Feeling extremely anxious and nervous about questions they may ask.’ At night, she recorded results of her PTSD presentation by writing, ‘there were a few uncomfortable questions, but I diverted them well.’

Dallis wrote, ‘I have to get ready to go to a court case for my criminal law class.’ Later that night, she wrote, ‘hearing the little girl take the stand to talk about her dad, it brought up some memories. Hopefully, she will get more closure than I did.’ Dallis had a second court class. She said a prayer for the little girl, ‘Please let this little girl get the closure I never did.’ At night she wrote, ‘I had to leave before sentencing. Hope to hear a good report.’

Dallis proudly recorded her semester grades, Child Welfare-B, Psychology of Parenting-A, Child Psychology-A, Cognitive Psychology-A, Gender Studies-A, and Criminal Law-A, but admitted, ‘having a night class is literal hell.’

Waiting for her next semester classes to begin (among them was a psychotherapy course), Dallis wrote, ‘I’m interested to see how my Psychotherapy class goes. It seems like there’s going to be a lot of conversation. I’m not sure I’ll be ok.’

Dallis recorded uplifting events and emotions, ‘My research proposal got approved. Time to start the IRB process . . . super excited to see students and professors walking hand in hand for equality in the march.’

Dallis recorded negative events and emotions in greater number,

> Hit by a drunk driver. My car is totalled. . . . can’t concentrate. Pretty sure I failed yesterday’s exam. Excuse me while I go cry. . . . Super stressed out and exhausted. . . . The more I’m in psychotherapy class the less I like it. I feel like a total outsider. I am the Lone wolf. . . . Left feeling like an idiot and failure for having a different opinion. . . . Hated Psychotherapy today. I was under attack for my beliefs and optimism.

Dallis provided insight into her learning strategies, ‘Thank goodness for cool advisors who encourage you and make you feel better about your grades. . . . The urge to skip psychotherapy is high, but the desire to get an A is higher.’ Dallis was feeling ‘pretty nervous’ before class. That night she said, ‘she let us use the book for 10 minutes. Crisis averted.’

Dana. Dana’s ACEs score was a four. I used the initial interview and the exit interview to write her case study. She did not complete the journal section of the study.

Interview results. Dana was in her first year of the doctoral program. She described herself as determined. She said CT motivated her to keep going. She said, ‘I refused to give my children the opportunity to say she couldn’t do any more.’ Her mother got pregnant early and raised them by herself. ‘She couldn’t do any better. You can do anything you want. I am getting my doctorate and I’m in my 50’s.’ According to Dana, success in the doctoral program was determined by whether or not she recieves the

support of her family and children. She wanted to leave a legacy 'void of jail and prison records.'

Dana described her strengths and a weakness. Her strengths were as follows: she is amicable and never meets a stranger. No one would ever know she was talking to a stranger because of her closeness in conversation. She identified herself as having the gift of gab (can easily talk with people). She did not do drugs or alcohol, but smoked cigarettes. A typical day in the life of someone who experienced CT was described by Dana as needing 'prayer to get through it peacefully.' She started every day with a 'prayer and giving thanks and asks for strength to get through the day he set for me.' She felt empowered after she prays, 'I feel like nothing is going to come along that I can't handle, that he won't work out for me.' A weakness, according to Dana, was that she is working on being more tactful and considerate to people from different cultures—it was challenging for her to not say certain things.

Dana's worst learning experience was when she went to a class at the beginning of the semester and heard an instructor say, 'I am the instructor. I don't care what you think about me. You're going to do it and do what I say.' She immediately went to the education office to find out if she was in that class. Thankfully, she was not in that class. She said, 'he called students imbeciles.'

Dana's best learning experience was in the Master's program where she met a blind student, Victoria, in her psychology class. She said Victoria could hear and understand. Her tests were in Braille, but 'she aced the class.' During the class when she could not hear or understand what was going on, she would reach out to me and say, 'Dana, could you read that for me? I can hear your voice clearly.' She discussed the

struggle Victoria had in getting to and from school everyday, but said Victoria was determined to succeed. Dana attributed Victoria's determination and positive attitude to her motivation to keep going. 'She didn't let blindness stop her. Her model really inspired you to go beyond your barriers.' She recalled when she would try to assist Victoria, without her asking for it, saying 'I got it, Dana, now move.' She questioned how anyone could feel justified in making complaints in comparison to Victoria's struggles.

Regarding what to add to the learning experience of CT survivors, Dana suggested a support team. She recalled how she was overwhelmed in the Master's program. She is a 100% disabled veteran, (impairment resulting in the veteran's inability to be gainfully employed) and seldom has consecutive days without pain. When she was overwhelmed, she reached out to her girlfriend who would remind her 'Dana, you have one more semester. If you give up, you won't go back.' She said some of the feelings of being overwhelming may not have come from CT, it may be from 'women being afraid to follow their dream because they don't want to intimidate their partner. I am of a different mindset.' She believed people dislike you for something they see in you that they do not see in themselves. She said, 'counseling and support group, maybe they could build something like that into the program.'

Her advice to incoming students was 'to be true to yourself, and to face it if you need assistance.' She said if you do not get assistance and you step into a marriage or anything else, 'it won't work out.' Dana said CT did not interfere with her role as a college student. However, as a teenager she was a single parent, and struggled in her relationship with her second child's father because she said she married him to help her

get over the first husband. 'It was like the worst dream and horror story you could have, marrying somebody you don't even like.'

Her overall learning experience may be desribed as diverse and enlightening. Dana atttributed this experience to her vast military travel to countries like Germany and Malaysia. When asked if she ever met someone from another country who had CT, she said, 'It's right here in America.' Dana steered the conversation again to teenage pregnancy and how she was determined to not allow it to stop her. She said, 'if you get an education, no one can take that from you.' Dana was determined to be the first in her family to graduate with her master's and doctoral degrees. She won a bet over her grandson that she would graduate with her master's before him. They both went to college at the same time—he won the bet. He was her inspiration. She also felt she had to prove to her mother that she was better than who she said she was and that she would excel. That was the reason she chose to go into the military. When asked about the present relationship with her mother, she replied, 'I don't like her. If she were not my mother, I'd pass her by and that would be it. I don't like her as a person, but my grandmother raised us to know that oldest meant some responsibility got laid on your doorstep.'

Dana learned best by problem solving. It might be because it takes her back to 'handling my kids and juggling everything.' Her mother gave birth to her baby brother on her 10th birthday. That was more traumatic for Dana than when she had her own child at 14. About her mother, Dana said, 'she was never home. I raised several of my sisters and brothers, so oftentimes, I would have to miss school. My sister would come back and say the teacher said, you got an A but you got a test tomorrow.' When Dana's

brother was five, Dana had her own daughter, so her grandmother took her brother and raised him. The mother-role Dana played to her younger brother established a bond between them that they still have today. Dana's relationship with her mother went downhill when her mother forced Dana and her younger brother to put on pajamas and allowed Dana's uncle to wait in the room until they were naked. Dana knew this behavior would not be approved by her grandmother so she would wrap herself up and wait in the chair with her clothes on. She said, 'when threat comes your way, you strategize how to care for yourself.' Dana's uncle would then tell her, 'if you tell Momma, I will choke you' . . . When he died, I had to handle all of his affairs because I was the oldest niece.' Dana's story suggested that she has been problem-solving since childhood.

To be a successful learner, Dana needed to be able to trust faculty members. It was recommended that she get an online degree, but she said, 'I need someone I could look in the face, and the first class I got was [with] Dr. Henschke. He made me feel so comfortable at this level. It's not overpowering. It's an easy smooth transition.' She said, no one put fear in her by saying, 'one out of every nine won't make it!' Instead, 'Dr. H said, 'Every one of you in here has the opportunity to become something greater than you are right now.'

The interview did not cause Dana discomfort. In fact, she said, 'it makes me feel good. It's not just about me.' She would like to add to this study, 'ask people how they feel about themselves today.' She got here without a clear cut detailed plan, but had a basic plan, and it was 'to keep moving forward.'

Exit interview results. Dana answered the three exit interview questions as follows:

> The study did not impact me in any way, because my childhood trauma has been my driving force since I was 14 years old. She, my oldest daughter, is now 42 years old. Trauma, to me is a temporary situation. Trauma does not define who you are nor who you were intended to be, everyone experiences some level of discomfort in a bad situation, what matters is how you, that person deals with it and comes out of it. I would like to come out smelling like a ROSE!
>
> Because of my attitude about putting your best foot forward, and nothing should have more control over anyone than they have over themselves, I give off a sense of apathy, but actually I am very sympathetic to any negative impact that anyone has experienced, but I refuse to allow myself to help a person wallow in self pity. Therefore, I do not think I could be a part of the support group in any capacity.
>
> I speak to women that have experienced severe trauma, in childhood and are still fighting the issues as an adult at the YWCA. I let them know that I am a walking, breathing testimony that God, lives and will bring anyone seeking change out of whatever, but first you must want it.

Freida. Frieda's ACEs score was a five. I used only the initial interview to write her case study. She did not complete the journal interview and the exit interview portions.

Interview results. Freida was a freshman, and described herself as doing pretty well, but 'lacking the ability to push herself.' She said her mind races and she has other

kinds of thoughts like, ‘you can’t do this. You’re never good enough.’ Her mind was filled with thoughts that something bad may happen at any moment, and she said it is because her ‘whole life has been filled with bad moments.’ The thing that will determine her success as a college student is a change in her behavior if she becomes unhappy with her actions.

Frieda’s strength was her comfort in ‘asking people for help,’ which helps motivate and encourage her to keep going. One of Freida’s challenges was that she does not believe in herself. This discouraged her from believing in what she is doing.

A typical day for Frieda was described as ‘pretty normal to average, [like] someone who didn’t go through childhood trauma.’ She said the typical day involves her overthinking, dealing with problems from the past, reminding herself to live in the present, talking herself through problems, lots of deep breathing exercises, and grounding techniques.

Survivors of traumas use grounding techniques to help maintain focus on the present when they feel overwhelmed and extremely emotional. Frieda said, “if it gets too bad or I get too disconnected, I will have an anxiety or panic attack,” lasting from 15 minutes to hours. She has more anxiety attacks than panic attacks. Nothing has to happen to bring about a panic attack. She said, “they just come.”

Freida’s best learning experience at this university was ‘feeling like the professors care and that they are willing to work with me. And, feeling free to ask questions.’ She stressed again that she was not afraid to ask. She said, if she could improve the learning experience of others who experienced CT, ‘a support group would be nice.’ Her overall learning experience so far has been short because this was her first year. She spent a lot

of her time motivating herself, 'because of the way I was raised. I wasn't raised to believe in myself, so I have a lot of problems pushing myself to get things done.'

The worst learning experience for Frieda was on some assignments when she did not do well. She said, 'there was no one there to say it's ok. So I feel like if I mess up now, I will mess up on everything.' Her advice to incoming college students was 'get as much support as you need. Know what you need, and whatever you need, go get it. It's ok for you to need things that help you.'

Frieda said her family played a significant role in her going away to college, but not in a good way. She felt she got away from the influence. She learned best from professors who engage their students. To help her study, Frieda listened to music. She learned better when she studies by herself, because she was unable to focus when in a group of people.

To be successful in her studies, Freida needed 'professors and staff members to care.' She said she needed a lot of support and reassurance— someone to tell her 'you're doing fine.' Frieda went to counseling twice a week, so the study did not bother her as much—'I am numb to it so it doesn't freak me out as much.' She could not think of anything she would like to add to the study.

Jennie. Jennie's ACEs score was four. I used her initial interview results, journal results, and exit interview to create her case study.

Interview results. Jennie was a sophomore, described herself as a leader, had traits of an extrovert and an introvert, and was outgoing. The thing that will determine her success is whether or not she can remain motivated to keep going. Her main goal was to graduate.

According to Jennie, her strengths as a college student were writing and feeling compelled to be honest, and her challenges were managing her time, her leadership roles, her student role, and her relationship role with family members. Her mom lived in another state and was only here a few days a month, but she said, 'those two days I'm always fighting with her.'

A typical day in her life would be to wake up disturbed and stressed from the dreams about her abuser and people who hurt her. She said, 'I have dreams within dreams so it's like it's real and I'm experiencing it. It's horrible waking up sometimes. I am not able to get back to sleep after that.'

Jennie's best learning experience at the university was when she was in a psychological testing class and they were learning about different types of tests people use for children who were abused. She said, 'it helped me to understand what they did to me as a child.' She described it as interesting because she could identify with the various tests. Jennie's worst learning experiences were when she did not complete a task.

To improve the learning experience of students who experienced CT, Jennie would 'give them a support group. Publicize it like they do in the counseling center.' Her overall learning experience at the university has been difficult because she said, 'I'm a psych major, and I was abused until about 19. It's really hard writing those introspective papers.' Jennie wanted to be as honest as possible, but said, 'it's stressful revisiting some of those things, but if you want to make a good grade you're forced to revisit some of them.' She had to write some, step away, write some more, and step away and continue until the paper is written. By stepping away, she meant, 'I just stop thinking about it and do something else. I always cry about it.' She would advise

incoming students who experienced CT to be prepared to do some self-reflection, be prepared to cry, do not disclose anything you do not want to disclose, and find a support group.

The relationship between CT and Jennie's role as a college student can best be described by her decision to major in psychology. As a result of that decision, she was forced to think about her CT all the time. She said, 'we continually talk about our stories and how we grew up.'

Jennie learned best through visuals, small groups, and by herself. In order to be successful, she needed confidentiality and trust. She said, 'when they say that [say that they provide confidentiality and trust], I am going to tell you everything.' She said she has to balance the psych courses with other courses because of how they affect her. The interview caused her discomfort because she 'had to reveal this to other people yet again. I'm feeling close to tears and don't want to cry with someone new.' Before exiting the interview, Jennie thought it would have been helpful to know if there are differences among those who have been emotionally abused, those who have been physically abused, and those who have been physically and emotionally abused; and helpful to know their coping strategies. She wanted to know this because she was physically and emotionally abused.

Journal results. In her journal, Jennie demonstrated anticipation of the day's events and challenges in her morning journal entries, once with excitement, but mostly with dread. The following was her journal entry of excitement, albeit measured: 'I'm nervous about presenting, but excited about the data on Psych testing.' The following were morning journal entries of dread:

> Today, as a psychology major, I have to do an introspective paper that delves into my past. The assignment asks us identify, describe, and analyze specific life scenes. I have to talk myself through the writing of it. . . . I dreamt about a friend that I'm holding a grudge against. It might get in the way of my learning since I tend to drift off during lectures. . . . I'm pretty anxious today. I don't have class, but I have last minute homework. . . . I'm anxious today because I finally finished my personality paper. I'm anxious because it had things about my childhood. . . . Sometimes in class I drift and think about my personal life. . . . I dread waking up today.

Jennie's journal entries at the end of the day demonstrate reflections on the day—some positive, some negative. Positive reflections included coping/learning strategies and are more abundant than negative. They were as follows:

> Thanks for having me in your study. I'm having my own study soon. . . . I have a drag show rehearsal. I am performing, 'Bellus Finals, Ballad of Mona Lisa, gives you hell' and stick to the status quo. I'm channeling my aggression into "give you hell. . . . The idea that my teacher knows that I've been abused, and the fear that comes with still being a psychology major and having to hear about child abuse. I no longer wince about it. . . . I took my learning and memory test. I'm so glad I passed because it was on learning and memory. I repeated it, kept writing the information down until I got it, and I visualized it. . . . Today I learned I learn best by listening, taking notes, visualization, repeating, and continually editing things. . . . My strategy today was using my hands today with crafts, writing, hauling equipment etc. . . . It was a good day I visualized what I

> was taught. . . . I had to write my life story. I write and step away and repeat until finished. . . . I think it would be nice if there were a group for people like me on campus to talk with. . . . I did a PSA for my class on Child abuse. I honestly didn't think about my own experience until I was editing it. It made me proud to do a PSA advocating for children. . . . Interestingly enough, my last exam for the semester was a PSA for child abuse. Seems ironic and a bit like a movie in itself to do this.

Negative reflections at the end of the day were as follows:

> Today in class we talked about memory and learning in relation to child abuse, and that made me uncomfortable. . . . I didn't learn anything, but I just tried to be confident in the presentation. . . . I blocked it all out, and I stopped listening when my instructor brought up childhood abuse. I kept my mouth shut when I got angry when she said "there was the possibility of child abuse being fake". I'm so glad it's Thanksgiving. . . . I'm mentally tired, and ready for this semester to be over. . . . I had to write a paper on my history of child abuse. I had to recall all that. I just had to take it one day at a time. I let everything bad flood in and I cried a lot. . . . My brother and mom talked about my abuser yesterday over dinner, I retreated to myself. . . . I'm worried about the upcoming test and not having enough time to do everything.

Jennie demonstrated how she used journaling as a coping/learning strategy.

> My personality instructor talked about child abuse and it made me sick. I'm so sick of talking about this. It just makes me feel uncomfortable. On top of that,

my abuser tried to friend me on Face Book. My strategy is to ignore all of it and write in my journal.

Exit interview results. Jennie answered the three exit interview questions as follows:

My participation in this study made me more self-aware of my study habits and how my trauma has affected me as a person.

If my university started a support, group I'd like to participate—be a member of the support group and all of us be able to talk to each other, so we won't feel scared or alone. Another trauma survivor and I were talking online on Reddit and we were considering making a forum for people to talk there because there are barely any online resources for people to talk about this with each other. But, we didn't end up actually doing it and we fell out of contact.

I've also made a PSA on child abuse in one of my film classes, and I plan to become a school counselor so that maybe I can help people who are or did go through the things I did as well.

Paige. Paige's ACEs score was nine. I used her initial interview, journal results, and exit interview results to create her case study.

Interview results. Paige was in the doctoral program, and described herself as confident and self-assured. The things that will determine her success are whether or not she has the tenacity, attitude, and resilience. Her strengths were writing and learning; her challenges were CT itself and all the problems that come with it, and trusting people. She did not easily trust people so when something happened she had to be careful not go into

fight or flight while around that person. A typical day in Paige's life before she learned how to process things was one filled with anxiousness, nervousness, and fearfulness.

Paige's best learning experience was with a professor in the doctoral program. When she had questions about the qualitative research, he made her feel like he wanted her to succeed. Thus, creating an environment of trust where she felt comfortable asking him for help.

Paige's worst learning experience as a doctoral student was, 'I'll try not to cry.' She grabbed a tissue from the box, and gave a sigh. 'It was in a Capstone class where the professor told us we had to memorize a part of the APA manual for the tests. My heart sank because I knew I could not do those assignments. I developed PTSD, and I could not memorize information as easily as I could in the past.' Paige wanted to disappear, but said she could not, so she sat in the classroom with tears in her eyes too ashamed to leave the room because she was afraid her classmates might think she could not do the work, so she left. Points were deducted because she never learned the APA manual, and to this day she still has not learned it.

> I could find it in the book, but I couldn't remember how to do it from memory. I felt like a complete failure the entire semester, and it was the only class where I felt that, and my grade proved it.

According to Paige, this experience was not only the worst learning experience for her in the doctoral program, it was the worst learning experience ever. In fact, she said, 'it was during this class that I decided I needed professional counseling.' She said getting counseling was the best thing for her, but she resented being driven to get it.

To improve the learning experience of students who experienced CT, Paige would increase awareness of the issues that come as a result of CT. She described her learning experience as challenging and alone. She said, 'no one else understood or experienced what I went through, and if they did they wouldn't talk about it, so I would still be alone.'

Paige would advise incoming college students to find a professor every semester or one that will 'go with you throughout your college life that you can trust and talk to, confide in, support you, and you will get through it. You will make it.' She described the relationship between her current role as doctoral student and CT as 'both were extremely stressful.' She said because of CT, she learned determination and resistance, and believes 'if it hadn't been for CT, I never would have able to get through this program.'

Paige learned best in a classroom with students. She said, 'some professors are naturally creative with helping students who they know have difficulty. I am thankful to have had one in the doctoral program. Although he understood, he maintained a high level of expectation for all of his students.' To be successful in the doctoral program, Paige said, 'I need self-confidence, faith and trust in God, and something people can't get a degree in—caring professors. I need professors to understand not all students want a hand out, but would appreciate a hand that reaches out.'

The interview caused her discomfort because the name itself, childhood trauma, can make one uneasy. She described CT as 'a big bear' and the after affects as 'you can't tell anyone you were even attacked, much less by a big bear.' She believed it would be helpful to have distinguished those who experience CT by family, friend, or stranger.

Journal results. Paige seemed to use the journal writing for general reflections, conversations with herself about what was on her mind including struggles with CT.

Paige began with expressions of fear and sadness related to the Fall 2016 presidential election outcomes:

> It's election week and I have so many emotions and feelings when Donald Trump speaks. Silently praying he don't win. . . . It's election day. Lots of sadness on my job today, mostly women. I wonder if they had been abused by men. I not only feel let down by society by its apathetic behavior towards men who are disrespectful to women, but now I feel let down by an entire nation.

Paige expressed feelings of self-doubt and guilt:

> It's really difficult forgiving myself for my past although it wasn't my fault. I feel like it was. . . . Feeling guilty when I choose to live life rather than write. Why can't I do both? I am struggling because I don't get a second chance to see my child graduate with a Bachelor's degree. I will finish, but I will not finish at the expense of my family. . . . Sometimes I wish I had the courage of the little train that thought he could. . . . Yesterday, I thought I would. Today, I believe I can. The closer I get to tomorrow; I wonder if I will. Right now, I am doing it. Yes!!!!!

Paige wrote about her understanding of abuse and its impact:

> It hurts so much to get attached to people and they hurt you. Abuse is hurtful. . . . I wish more people would like themselves because people change or try to be who they think others want them to be. . . . Learning how to be in a relationship is extremely difficult because it takes maturity. . . . On Thanksgiving Day I had to

be rushed to the hospital. I am feeling better. School and relationship-tough to balance.

Last, Paige seems hopeful as she opines on things going well and ends on a high note. I have a surge of energy to write so I am taking advantage of it. . . . Got better understanding on what is needed for my dissertation. What a relief. It's discouraging to try and try and try and still don't understand. And on top of that have a professor who punishes you for not understanding. . . . To another successful week of writing! I can see a speck while I walk this maze. . . . Being a part of the study has made me rethink my behaviors, thoughts, beliefs, and relationships. I often wonder how much of what happened to me became me. . . . noticing a change in my behavior. No longer feeling like I need to be always surrounded by people. I think I'm beginning to like me.

Exit interview results. Paige answered the three exit interview questions as follows: Participating in the study did not impact me. I know if things are ever going to change, someone has to begin the change. Perhaps the study will reveal something that will help ease some of the stress of survivors. . . . If the university were to get a support group, I would be willing to be a facilitator, leader, or participate in another way as needed. I believe survivors are in different stages so my role would have to be clear defining whether I would be speaking to survivors of childhood trauma in last year, three years, or five years or more. . . . I have spoken in open forums, participated in community outreach programs, and offered peer support to increase awareness of childhood trauma. As more opportunities arise, I will continue to increase awareness.

Susan. Susan's ACEs score was zero. I used her initial interview, journal results, and exit interview results to create her case study.

Interview results. Susan was a doctoral student, and described herself as independent and self-driven. She determined success by whether or not she graduates. She says she has a choice whether or not she will make it, 'you have to keep going to get the quality of life you want to have.'

Susan's strengths were determination and persistence. She liked school and believed that it contributes to her being a good student. A typical day for her depended on the severity of it in relation to her controlling her thoughts—being able to manage her thoughts and what people tell her to do, and figure out what she believes she should be doing. She said, 'from the outside, you probably would not say it was trauma. There's still the residue of how my family operated.' In other words, Susan perceives that her determination and persistence give her the appearance of someone who has not experienced CT.

Her best learning experience was after she completed a master's degree, and a professor encouraged her to go into the doctoral program, 'I wasn't sure I could do it here, so he said we could do a contract degree and individualized it for me.'

Susan would improve the learning experience of students who experienced CT, 'I would be sure the students have a strong relationship with someone on campus.' She recalled her undergraduate experience being the most challenging. Her mom did not go with her dad to take her to college so she lacked that family unity. Her grandfather went instead, so she did not have the support she needed. Her grades suffered. She did not want to be told she could not return to school. She said, 'at that point I had a reversal. I had to be successful.' From that point on, she improved and graduated with a bachelor's

degree, two master's degrees, and is now earning a doctorate. Her challenge was to do well, and she did.

She said her worst learning experience was isolated. Nonetheless, it happened. It occurred while she was in a doctoral class where the professor said, 'I shouldn't use the word juvenile. It was just the instructor's teaching and learning method of running the class.' Susan could identify the instructor's intimidation, but 'I've had those other experiences, so I said I will get this done. No, this won't stop me.' She said, in some kind of way, her background experience of trauma prepared her for this experience.

Susan's advice to incoming students who experienced CT is to admit whatever happened, and if they need help to get it. She said,

> it doesn't matter if it happened 50 years ago, if it interferes with your daily living, you need to acknowledge that and be ok with it. There is a level of stress that comes with being in this program, and if you have other issues, it's going to directly affect it. You have to be open and honest with yourself.

The relationship between CT and her role as college student was managing her time with her new grandbaby and being disciplined to sit down and write. Susan said, 'I have to discipline myself, but not beat myself up at the same time because of a task I didn't do.'

She learned best through face-to-face interactions. She likes to be engaged in the learning process and 'not sit and have someone lecturing to me.' She also learned best by doing. If the lesson is on citing, she said, 'have me do it and not quiz me like a drill or a test.' She said she can learn if the instructor uses the adult learning principles.

To be a successful learner, Susan needed support groups, maybe mentors or mentees, because 'doctoral students are all at different levels in education.' She said, the support group may come through the counseling center or an outreach program, but it is important. 'It would be good if there were a section added in the handbook about students who experienced CT and have these symptoms.'

The only discomfort this interview caused was 'trying to figure out the behavior of someone else and why they behaved the way they behaved, like my mom.' She wondered if she had her own issues, but said she never figured it out. She said to this day, she still wonders why, but at this age, she is learning to move forward. Although she got a zero on her ACEs questionnaire, Susan wanted to add, she could have gotten a one or two.

She added a few things she believes will be helpful to the study.

> One is, trauma comes in different forms. Another is, there could be subtle trauma that's embedded in someone's life that's just there and it's not so big, and it could be something like how you were raised that began as a little thing that could build to something bigger.

Susan continued to question her mom, why didn't she like her? Why did her mom act like she had to compete against her own daughter? Why was her mother not the doting mother? Why did her dad raise them? Why did she think her mom would never come back? She said she often wondered what her mom may have been missing and thought 'she caused her own demise, but that was judging like she had the perfect world.' Even in the end, Susan said she would have liked for things to have been difference between her mom and her. 'I was her daughter.'

Journal results. Susan's journal entries demonstrated her internal struggles in writing her dissertation and her determination to overcome them.

> I get anxious and somewhat overwhelmed with my thoughts and it feels like information overload. . . . I always make a daily schedule. I feel guilty. The thought of writing haunts me daily until a goal is reached with my writing. Sometimes I have to tell myself, it's ok if you don't make your daily goal, but push towards the big goal-completing it. . . . Time + mindset = writing. . . . I will get some writing done today, but the anxiety is <u>always</u> there like a teacher on a Sunday preparing lesson plans for the week. . . . I did commit to writing for one hour. Felt a sense of success. . . . I will try daily to complete something towards my dissertation. I set a writing goal each time I write. . . . Pacing myself and not rushing and beating myself up. Balance is essential not the guilt of that I continued to live life especially when a professor always implies you're a failure if you don't do otherwise. . . . My daughter called with a mean spirit this morning upsetting me and blaming me for my past calling me a victim—all of these issues/feeling effect my drive to write. . . . Today should be a good day. No writing anxiety. . . . Organized some final thoughts before going to bed and reaffirmed my doubts and fears of writing and finishing on time. . . . Preparing to celebrate—the half way point. I almost look forward to writing.

Last, Susan gave herself permission to not exercise. 'Too cold to walk, acknowledged it's ok to miss a couple of days.'

Exit interview results. Susan's responses to the three exit interview questions were short and direct, '[Journaling] allowed me to re-examine and reflect on some of my

adult's behaviors that may be related to some of my childhood experiences.' Second, if the university would form a support group for CT survivors, Susan would volunteer to be a facilitator and participant. Last, to increase awareness of CT in schools, Susan said, "I have been trained and am part of my school district's Trauma Team.

Tamara. Tamara's ACEs score was eight. I created her case study from the intiial interview only. She did not complete the journal and exit interview.

Interview results. Tamara was a graduate student in the Education specialist program, and described herself as tough and a self-starter. Her success in the program will be determined by whether or not she completes the program. Her strength was that she is always up for the challenge. She said, 'I believe God let me make it here, I can do it.' But, she has difficulty in finding time to get it all done.

A typical day in Tamara's life was a mix of good and bad days. She said, bad days might be when she's angry at the world or does not want to do it today. 'You feel alone even among thousand's of students.' A good day 'comes as a surprise but they get better. It makes you have to relearn how to live.'

Tamara's best learning experience was when a problem was solved. To improve the learning experience of students who experienced CT, she would minimize lectures. She said when she came to college, she expected the adults learning principles to be put in practice.

She described her overall learning experience as typical. She lost both of her parents before going to college, 'I learned how to adapt, be an adult really fast, be responsible, and a self-starter all in one semester. I went from 0-100 really quick.' Tamara believed her CT experience helped to prepare her for such difficulties. She told

herself, 'I have to make this work. There is no plan B. I felt like, if I can get through this, I can definitely get through college.'

Tamara's worst learning experience was an instructor who lectured. She said, 'she had a hard time teaching me.' She would advise incoming students to 'take it one day at a time because you have to relearn how to live in the world.'

The relationship between CT and and her current college role was 'as a result of losing them [her parents]. I want to have a non-profit organization that works with at-risk children who experienced trauma.'

Tamara learned best with student-teacher interaction. She said, 'definitely not by lecturing.' To be a successful learner, she said, she needs 'support from faculty and peers, mainly faculty.' Participating in this study did not cause her any discomfort. She would like to add to this study that she is empathetic towards undergraduate students and thinks about how many of them will benefit from this study.

Depree. Depree's ACEs score was nine. I wrote her case study using the initial interview, journal results, and exit interview results.

Interview results. Depree was a graduate student, and described herself as accomplished. 'I'm on the other side now.' She recalled her mother drinking so much she was unable to care for them, and her father left them. She said she was the only person she could depend on. She was responsible for taking care of her mother and her two siblings. She said 'at eight, I was learning how to depend on myself and how to provide for those who were depending on me.' The person who will determine her success is her. Depree was once intimidated whenever it was up to her whether she failed or succeeded, and she would ask herself, 'why is everything on me?' She recalled

questions and statements like that made her feel people were being ‘unsupportive and brusque,’ but now says, ‘I don’t want to say it’s up to you, because you have a choice.’ She had to decide who she was going to allow to control her life. Depree asked herself if it would be her father, mother, other family, or what happened to her that controls her life. Then she decided, ‘I was either going to let everything that happened to me take me down or I was going to fight back for myself like I couldn’t before.’ Whenever she has moments where she feels she does not deserve a good life, she reminded herself ‘no, I’m a person, and I deserve to be happy.’

Her strength was her high expectations of herself. That was what kept her moving forward in the direction of her goals. Depression and anxiety challenged and made it more difficult for her. Fearing triggers was a typical day for Depree. There were many things that may cause daily triggers. She recalled, ‘one of my biggest things is the smell of certain foods, and the other is physical characteristics or the demeanor of a person. This brings back certain memories.’ She recalled eating dinner with her family after a three-month stay in the hospital. She tried several times to join in the conversation to no avail. She saw she was being ignored, and described herself as ‘crying silently in her food.’ As a result, one of her biggest challenges is certain foods like ‘chicken, green beans, corn, and mashed potatoes because I saw that constantly on my dinner plate.’ She said with all of this, she has had to have more self-awareness.

Depree’s best learning experience was when a professor retrurned her phone call after hours. She had a deadline, and she knew she could not meet it for an assignment, so she called the professor. The professor returned her call within five minutes. She said all the professors in the criminal justice department are very understanding, ‘I can walk

down the criminal justice hall and talk with anybody down there.' Depree received the best support from them.

To improve the learning experience for those who experienced CT, she would bring back a program called Still Standing, an organization that supports survivors of abuse (Concordia, 2013). According to Depree, the support can come from students, peer groups, and is essential whether it is facilitated by a trained person or a counseling intern. She said it is essential. To increase awareness, she created an informal organization called the Poster Project 2013, [no details provided] and they have reached over 145 countries excluding Facebook. She has helped to organize the program For the Love of Pete [no details provided] for professors to place verbal or written warning symbols on a particular section, workshop, or video. She said some professors say, 'that's babying them, but they don't understand why we are doing it.' When professors said this, Depree responded with 'it works out for the both of you because you are giving them an opportunity to be a part of their education and be sure they are mentally ready to be in your classroom.'

She described her university learning experience as being tough. Depree said, 'trying to go to school and get your work done when you're depressed is really tough.' The depression contributed to her not going to class and it made her get further behind. She went through an addiction with self-harm, and said the medical professionals did not help her feel better while she was going through that stage. She said the addiction 'added to a whole ball of problems.'

Academics and extra-curricular have always been extremely important to Depree. They made her do her homework and keep good grades. However, when she came to

college, she became depressed and the things that were once important to her were not important anymore. Depression made her sleep more than normal, and then she had to spend the rest of the semester catching up. Her professors have high expectations of Depree, and she wants to keep it that way so she does not discuss the depression with them. She said, 'a few days ago, I suffered a bout of depression. I had two assignments, but I couldn't do them so I sat all weekend trying to think. I was so frustrated. I wanted to quit, but I knew I can't because I will fail the class so I keep trying.' She said there were times 'I had to get up and walk out of class.' Then she would tell the professor later why she had to leave class. There were times she wanted to leave class, but she felt compelled to stay for fear that everyone would know why she left.

Depree recalled an incident where the professor was on Major K Squad [no details provided] for a significant amount of time, and one day in class 'he had crime scene photos of a crime scene totally uncensored [and] was a suicide by shotgun.' She said it was difficult because 'I was already struggling with depression and suicidal ideation most of my life.' She said she continued to sit in the class because she did not want to be seen as someone who couldn't take the image because it was too much for her to handle, 'I just had to sit there and take it.' After that incident, she said 'I had to go put on some headphones and I walked around aimlessly for a while because I didn't know what else to do.' Depree said that incident was her worst learning experience.

Depree's advice to incoming college students was to 'take care of yourself first'. 'You don't have to keep putting yourself through trauma after trauma to get your degree. You don't have to sacrifice your mental health to get a degree.' She believed the root

cause of students who do drugs is they may have experienced some type of CT that they do not want to confront.

The relationship between CT and her role as college student is that she is motivated by the thought of her having a better way of life. She wants the life that she believes only education can give her. Depree wants her life to look completely different than the one she had in her childhood.

She learned best face-to-face, seeing, and hearing. She needed multiple reinforcements. Strategies that worked for her were listening to instrumental music, wrting reminders on post-it notes, and using a multiple reinforcement approach. To be a successful learner, she needed support.

This study brought up feelings and unpleasant memories. She described it as it 'has made the movie wheels start playing' but said she is willing to be uncomfortable if it means it will help someone else be more comfortable.

Journal results. Depree made frequent journal entires. She reflected on her challenges in school.

> Balancing life, school and work is hard. I am consistently stressed by the amount of things to do especially in school. . . . I am feeling anxious. I need more time and less to do. Professor pile stuff on expecting us to devote so much time when many of us graduate students have full-time jobs. . . . I hate this online class. It leaves me feeling anxious. . . . I am really bad at this journaling thing. Maybe because it used to be a catharsis for me and it isn't anymore. I almost feel like I'm letting the student doing this study down. . . . The problem is my depression is worsening and I have very little energy to do anything. So I only do what I

> have to do. I have given up on class. Somehow, my professor thought the paper was good. . . . I managed to accomplish a similar feat in another class. I made an A on a paper. . . . my only motivation is to not fail. Somehow I manage to get good comments from my professors. . . . I don't want to fail, but this professor makes it extremely hard to get much better. . . . Professors became authority figures for people I want to please. . . . My father instilled get good grades no matter what. That translated later into no matter the cost, including your mental health.
>
> I feel like my journaling has been an ultimate failure, but I do hope that something in all this helps to make sense of the barriers adult students who experience childhood trauma face in their daily lives—triggers, anxiety, depression, self-harm, sleeping issues, motivation barriers, inabilities such as consistency or overly OCD. All these things I struggle with. . . . life balance with full-time school, work, and an adult life outside those things is hard enough to manage.
>
> I haven't journaled in a while. I apologize. It could be a treatment to the effects of childhood trauma on them being inconsistent and lack of structure. I am having this trouble in my classes. I personally think consistency is one of the first abilities adults with a history of childhood trauma lose.

Journaling provoked reflective thinking in Depree regarding her CT beyond school challenges:

> It's not that I'm incapable, it's just that it's all much too overwhelming in my current state of mental health. I am dealing with the anniversary of a sexual

> assault. . . . holidays consistently bring up my childhood trauma even as far removed and 'recovered' as I am, the holidays bring back the struggles as if they were brand new. . . . It's amazing how abusers seem to be so knowledgeable aware, and yet are so blind. . . . The holidays are now just constant reminders of the disconnects in my life.
>
> I suppose there is a benefit to writing all this down. Writing all this down has opened up the floodgates on more revelations. . . . I remember my mother threatening to tell our father. Then being whistled to the top of the stairs and told to come down. He lined us up along the wall and screamed and screamed. He said, if we ever do whatever it was he said we did, he would bash our heads against the wall. The rejection no matter how hard I tried—never being good enough. I suppose that translated into my academic career and how hard I'm constantly pushing myself. . . . I suppose I'm still seeking affirmation—the affirmation I never received from my parents. . . . The self-criticism doesn't give you anymore motivation and the cycle continues. . . . My professor is arrogant and unhelpful and reminds me of my father. It brings up a lot, and managing the triggers is hard.

Last, Depree articulated what she needs and perhaps what other survivors of CT need in order to be successful learners in higher education:

> I have to walk to the historic side of campus and back behind the outdoor track field and climb the lone tree. I need nature. . . . I need nature. Perhaps it's because it was the only place I could escape as a kid. . . . I've learned structure is vital for me. It enables me to focus on one thing at a time. Mindfulness to do the

> next thing next. Focus on what you're doing then and not worry about what's next until you're working on it. . . . I thrive on structure, but childhood trauma creates depression, anxiety, and PTSD—structure is almost impossible to create. I've learned a few things that helped me set up structure like creating a daily schedule, being very intentional with the time. I created my schedule on an Excel spreadsheet. . . . 54321 [a program that keeps you focused on what is going on in your life presently] keeps me grounded and pulls me back into the physical present. Identify five things you see, four things you hear, three things you physically feel, two things you smell, and one thing you taste (or like the taste of). I love it because it forces me to focus on what's around me and not what's going on in my head. Music is the only thing that activates both sides of the brain so I figure that's good when studying. . . . Support and accommodations have been helpful. A professor willing to work with a student is imperative, in my opinion. An understanding professor makes a world of difference. . . . accommodations like a few extra days when my depression is extremely high gives me the opportunity to work through coping mechanisms and find motivation to complete assignments.

Students' well-being is often on the back burner in institutions compared to student attendance, performance, and course work completion. All are important, but student well-being must be placed above the others in order for students to succeed. I hope something in these pages winds up being helpful. That someone is attempting to understand the later effects of childhood trauma on adult students is an immense

undertaking I wholeheartedly appreciate. I truly believe if we first seek to understand and then treat root causes that great things are possible.

Exit interview results. Depree answered the three exit interview questions as follows:

> Growing up, I never put much thought into how much my trauma impacted me. I didn't have the time or the emotional capability to stop and ponder the injustices and really feel them—I had to survive. Being a part of the childhood trauma research study forced me to think about how every facet of my life has been affected. It did routinely pull out some uncomfortable memories and PTSD, but it was tolerable because I hoped I was contributing to something that may impact the way childhood trauma is approached.
>
> I would absolutely love to help with a childhood trauma group, or at the very least participate. The need for childhood trauma survivors to sit with other trauma survivors is massive. I feel it's imperative. As children, we don't have emotional capabilities to understand what is going on. We're told to follow authority (sometimes, and often in abusive situations, blindly), so the things that are said and done (in my case it was child abuse and neglect) are taken to heart. Since my parents were my abusers, I was torn between following authority, feeling betrayed by the people who were supposed to love me unconditionally, and feeling as if there was something wrong with me because they didn't have the capacity to love me the way a child needed to be loved. It took me many years (and I'm still working on it) to realize that my parents had their own problems, and it had nothing to do with me. Though I am several years removed from my

> trauma, I am still picking up the pieces and learning to give myself affirmations. I am having to build a foundation that was destroyed before it was ever built, and struggle with the fact that I never had a childhood. I believe a great deal of childhood trauma survivors feel the same way. Having the affirmation of others, while not what should be sought first, is instrumental in recovering from childhood trauma. You feel so much less alone and more 'normal'.
>
> I have been active and vocal on social media about childhood trauma (specifically child abuse) for many years. I am a part of a few groups where childhood trauma survivors can talk, and even volunteered for a child advocacy center. I am always available to my friends to talk, and have had the opportunity to listen to more than a few of them tell me their stories. Should something (such as a group) come out at the university, I would very much like to be involved in any capacity I am capable. I will always be vocal about the reality of my childhood and how it has affected me, and always remain open to listening to others. Empathy is needed now more than ever.

These case studies share a CT, but their experiences and perceptions vary. Commonalities are expressed in the emerging themes as follows:

Emerging Themes

Participants were asked about their learning experiences. Their responses were recorded through the use of interviews, journal entries, and exit interviews. These three data sets were analyzed using open-coding method. Nine themes emerged: challenging, learning strategies, anxiety, time management, fears, support groups, determined, personal character traits, and adult learning principles. Each is supported in this section

with participant responses. These themes emerged in a majority of case studies. There were two overarching themes for adults who suffered CT and attending a higher education institution. The participants in the study all desired face-to-face learning and all expressed they were determined to succeed.

Challenging. Participants described their university learning experience as challenging. Of the 11 responses, eight said it was challenging. Both John T and Susan said after returning to college from time off, they took their success more seriously. John T admitted he knew it would be a challenge, but said the first time 'I did too much partying.' Susan said part of her challenge was the way her family did things, 'there's still the residue of how my family operated.' Andrea said, 'balancing everything is a real problem.'

One of Dallis' challenges was unique. Due to the abuse involved with the CT, she was quite concerned about safety. She mentioned it in her interview questions, and her journal. She shared, 'it's a constant struggle with [LU] security because they're not always there for us.' After experiencing trauma, feeling unsafe is a concern for many survivors. However, Dallis was the only participant who discussed it several times. It may be that the incident occurred recently, or she may yet be experiencing the CT event. This would explain the repeated mention and concern of safety. She compared feeling unsafe to 'worse than anything my dad ever did.'

Dana described her experience as diverse and enlightening but challenging. She added, 'some of the feelings of being overwhelmed may have come from childhood trauma.' Dana also shared how a friend persuaded her not to quit, 'if you give up, you won't go back.'

Freida's learning experience was challenging because of her mental struggles. Paige said her experience was challenging because of the impact of childhood trauma, 'I could not memorize information as easily as I could in the past because I had PTSD.' Tamara said she has difficulty finding time to get everything done. In her journal, Depree shared,

> balancing life, school, and work is hard. I am consistently stressed by the amount of things to do, especially in school. It's not that I'm incapable, it's just that it's all too overwhelming in my current state of mental health.

Learning in higher education was described as a challenge by the majority of participants, though the challenges varied.

Learning strategies. All of the participants said they learn best in face-to-face classroom experiences. Several of the participants specifically stated 'no lecturing.' Each participant had a unique and somewhat interesting strategy to help them be sucessful. John T goes to the county library to maintain the same level of focus that he has when he is in the classroom. John T also has writing strategies, 'the best way to look at large assignments is to understand what you want to write about, and then create an outline and be open and accepting of ideas as you read articles.' He said it helps him to reward himself to help him turn in his paper on time.

Dallis' learning strategies included her creating her own safe and secure learning environment. When something happens that bothers Dallis, she records it in a journal, and reflects. Later, she will call someone to tell them what bothered her. Before going to bed, Dallis reassures herself that she is safe, and no one bothered her. Susan described her learning strategy, 'I always make a daily schedule because the thought of writing

haunts me until a goal is reached with my writing. . . . you have to not beat yourself up because it's a task.'

One of Jennie's learning strategies is to be sure her classes are balanced. Classes that require her to reflect impact her, so she said, 'I balance my courses with [courses from] my other area, so it doesn't bother me so much.' Another strategy is 'stepping away, I just stop thinking about it and do something else. I have to talk myself through it.' Jennie said, it also helps her to write things down and visualize.

Paige said, she prays, and it helps her get through the day, and she talks to a caring professor who will rephrase things as many times as necessary to help her better understand. Depree found listening to accapella music instrumentals, and using post-it notes are especially helpful when studying. She said, 'music is the only thing that activates both sides of the brain so I figure that's good when studying.' When Depree focuses on the CT, she uses a strategy as well as a coping skill called '54321 to pull me back in to the physical present. Identify five things you see, four things you hear, three things you feel, two things you smell, and one thing you taste. I love it because it forces me to focus on what's around me and not what's going on in my head.'

Andrea said she has had to learn how to balance. Class schedules presented a challenge to her, but learning to be organized has helped her. Candace said being organized helped her, too. When Candace can not study and is distracted by thoughts, 'I don't dwell on it. I go talk with someone.' Dana said, she, too, prays. She said, 'I start every morning with a prayer, and giving thanks gives me strength to get through the day he set for me.'

Anxiety. During the interview, six of the participants shared they were anxious. Candace takes medication for anxiety, and goes to counseling. She said, 'I've had issues for so long, I've just learned to deal with it.' She said she has difficulty motivating herself.

Freida described her anxiety by saying her mind races, and she struggles with the thoughts of low-esteem and negative self-talk in her head that say, 'you can't do this, and you're never good enough.' Freida lives her life each day anxiously awaiting for something bad to happen. She has anxiety attacks.

In the interview, Andrea said, 'my days are spent with constant anxiety.' Paige's anxiousness comes from feeling like no one understands, and from a professor who did not care. Paige wrote in her journal, 'It's discouraging to try and try and try and still I don't understand. And on top of that, have a professor who punishes you for not understanding.' Susan said, 'I get anxious and somewhat overwhelmed with my thoughts and information overload.' Depree said, 'I'm feeling anxious. I need more time and less to do. Professors pile stuff on expecting us to devote so much time when many of us graduate students have full-time jobs.' The study participants seemed to be aware of and in touch with their anxiety, but unable to control it.

Time management. Five participants described having issues with time management, though often did not use the term. John T, Susan, Jennie, Tamara, and Andrea all described having difficulty managing their time and balancing everything. John T said, he manages his time better now, but there is evidence of his struggles in his journal. He recorded, 'I plan to start memorizing this weekend. I totally intended to study for the assessment exam, but I never got to it.'

Susan recorded in her journal a struggle with herself and time management versus her beliefs and principles that were in opposition to what a professor expressed, 'pacing myself and not rushing and beating myself up—balance is essential, not the guilt of that. I continued to live especially when a professor always implied you're a failure if you don't do [this or choose to do] otherwise.' Susan said, 'sometimes I have to keep telling myself , it's ok if you don't make your daily goal, but push towards the big goal—completing it.'

Jennie is a psychology major, and she said the courses often make her anxious because the curriculum for those classes require her to reflect. She recorded in her journal, 'I'm pretty anxious today. I'm worried about upcoming test and not having enough time to do everything.' Jennie linked her anxiety to not having enough time to do everything.

Fears. While not all participants participated in the journaling or exit interviews, all of the participants expressed fear of failure in their classes. The fears were due to physical illnesses, time management, anxieties, feeling unsafe, mental challenges, political fears, conflicts with the professor, lack of preparation, or lack of support by faculty and family. Several participants had fear along with anxiety. Susan said the fear is 'like a teacher on a Sunday preparing lesson plans for the week,' and when she finalized some thoughts, her doubts and fears of writing were confirmed. Dallis was candid about her personal fears during the presidental election when she said, 'I need safety', and 'I took six hundred steps backwards in all the progress toward recovery I've made.' She ended one journal entry with, 'I'm scared and I feel alone.'

Freida's fear is ongoing as she is tormented with the fear that something bad is going to happen. Jennie's nights are filled with fears and anxieties, 'I have dreams within dreams so it's like it's real and I'm experiencing it. I dread waking up today.'

Depree struggles with depression so she fears triggers because much of her daily life, including a person's physical characteristics or demeanor, can cause triggers, 'this brings back certain memories.' Although there are times in Depree's class when watching a film or lesson clip causes triggers and she wants to leave the class, she does not because she 'fears everyone will know why I left.'

Support groups. All but one of the participants expressed a need for a support group. Six of the particpants specifically stated they needed support from their faculty in addition to the support of their family and friends. Dallis went so far as to state, 'I wish there was a class available that people could attend.' That class would be a safe place where students could go and not have to worry about what is going to trigger them. Dana remembered, it was her support group that helped her when it was overwhelming. She said her friend called and said, 'what's wrong with you, you have one semester left. If you leave, you won't come back.' Some participants like Jennie are so sure of the need for support groups, she further suggested how to advertise the support group so students will know where it is. She said, 'publicize it like they do in the counseling center.' Susan said, 'at this level, you have to have a relationship with someone on campus.' Depree elaborated on a previous program that provided support for students who suffered CT called Still Standing. John T was the only participant who did not express a need for a support group. He stated he needs clear guidelines and guidance on what is expected.

Determined. An overarching theme of all the participants was their determination. John T talked about a class where the students were being weeded out, but he said, 'I was determined not to be weeded out, and I used to be sure I knew at least 75% of the material to get at least a C grade.' Candace contributed her college success to her determination and 'ability to do work by myself.' Andrea missed several years of high school due to her struggle with childhood trauma. She said, 'I got right back up.' Dallis was determined to not use an excuse although she may have had one. After Dallis was hit by drunk driver, she went on to class and took an exam. She wrote, 'the urge to skip psychotherapy is high, but the desire to get an A is higher.' Dana described herself as determined in the first year of the doctoral program. She ascribed CT as the thing that keeps her going, 'I refuse to give my children the opportuntiy to say she couldn't do any more.' Frieda said she was not raised to believe in herself so, 'I have a lot of problems pushing myself to get things done.' Jennie shared about her difficulty as a psychology major constantly revisiting the abuse. Yet, she recalled, 'it's stressful revisting some of the things, but if you want to make a good grade you are forced to revisit some of them.' Paige described her success would only be attained through her 'tenacity, attitude, and resilience.' Susan also ascribed her strength to 'determination and persistence.' After being forced to leave school the first time, she never wanted to be told she could not return to school again, so she said, 'at that point I had a reversal. I had to be successful.' Tamara is determined. She believed CT helped prepare her for adversities. She told herself, 'I have to make this work. There is no plan B and I was so frustrated I wanted to quit, but I knew I can't because I will fail the class, so I keep trying.'

Personal character traits. Participants of chilhood trauma used positive language to describe themselves. John T described himself as independent and being capable of doing things on his own. Candace described herself as 'strong and responsible.' Andrea believed she is 'capable' as a result of her obtaining help in high school. Dallis described herself as 'resilient because she is the one everyone leans on.' Dana sees herself as 'determined', and Jennie described herself as 'a leader who doesn't like distractions.' Paige said, 'I am different than I once was, and now I see myself as self-assured and confident.' Susan said, 'I am independent and self-driven. I want to see where I was, so can see where I want to go.' When Depree was asked to described herself she said, 'when I first got here, it was overwhelming. I think I am on the other side now that I can use the word accomplished.' Tamara and Freida described themselves a little differently. Tamara said she was 'tough but a self-starter,' but Freida was 'unmotivated.'

Adult learning principles. All of the participants stated in some form they preferred instruction using what they referred to as adult learning principles. The adult learning principles specifically mentioned in the study were using past experience to self-learn and to learn from each other, practicing for mastery, self-directing, and problem-solving. Candace said, it helps her to 'flesh it out like seeing a similar example and applying it to my real world experience.' Freida's best learning experience was when her professors worked collaboratively with her. Jennie preferred learning is in small learning groups when she is not working independently. Tamara's best learning experience involved problem solving, a typical characteristic of adult learners. Andrea was concerned about 'having an environment that's comfortable and you can talk to them

[instructors].' John T said, 'you seem to learn more when you can do a topic that applies to your own life.' Dallis liked the interaction with others through discussion. She said, 'I like a dialoging environment, and a PPt doesn't leave room for that in the imagination.' Susan described her instructor's teaching and learning method as 'juvenile and intimidating.' Depree liked a learning environment like the one she has in the criminal justice department where she is free to 'walk down the criminal justice hall and talk with anybody.' Dana learned best when she solves problems. She liked problem solving because she said it was similar to 'handling my kids and juggling everything.' Dana also said she prefers a class where she is 'comfortable and it's not overpowering, a class where someone didn't put the fear in me and tell me getting a doctorate is hard and only 1 out of 9 make it.' Her professor left an indelible mark on her when he said, 'every one of you in here has the opportunity to become something greater than you are right now.' Jennie learned best 'alone or in small groups' while Susan learned best 'by making it practical—pretty typical, those adult learning principles, and engaged in the process rather than someone lecturing to me.' Frieda said she likes professors who are 'approachable, engaging, and share the love for their subject.' Paige said, a 'partnership with a professor helps.' A professor supported her in her learning by making up creative ways to help her when she had difficulty grasping ideas and concepts, 'He may have said something 10 times if he said it once, I keep getting stuck.

The participants' stories reaffirmed childhood trauma may impact an individual's quality of life even in everyday occurrences like sleeping, studying, eating, and working. Colleges that provide resources, support, and trauma-informed training to the faculty help these students be successful.

Chapter Five: Discussion, Recommenations, and Conclusion

Although there was minimal to no research documenting the number of students enrolled in higher education programs despite having experienced CT, the case studies from this Midwestern study university suggested the number may be large. With minimal recruitment effort, 11 participants enrolled in the study. The purpose of this study was to explore the learning experiences of higher education students who experienced CT. In this chapter, I make new meaning of the results (case studies that include the interviews, journal entries, and exit interviews; and emerging themes) reported in Chapter Four through a discussion of the results' alignment or lack of alignment with the research literature reviewed in Chapter Two. Also included in Chapter Five are the following sections: answering the research questions, recommendations for higher education, recommendations for future research, and a conclusion.

Discussion

The following section provides a discussion of the alignment (or lack of alignment) of the results (case studies and emerging themes) in Chapter Four with the research literature in Chapter Two.

Alignment of the case study results (interviews, journal entries, and exit interviews) with the research literature in Chapter Two.

In keeping with the literature, a few participants shared they had some form of physical and psychological illness. One particpant shared her story of anorexia, an illness associated with CT (Mock & Arai, 2010). According to Felitti et al. (1998), by adulthood, physical illness may be a part of everyday life for survivors of CT. It is not

uncommon for adults who suffered CT to experience the deleterious effects of CT through depression (Locke, 2015; Luby, 2009, Luby 2010; Negele, 2015) as reported by three participants who find it difficult to motivate themselves—a symptom of depression. The majority of the participants reported they did not receive counseling. This aligns with the literature that many individuals choose not to get help (Luby, 2010).

Only two participants said prayer was an important part of their routine for daily success. Recent research by Newberg as cited by Hagerty was done on the activity of the brain during prayer and mediatation suggested "you can change your brain with experience and training" (5:29) and the more you focus on something that becomes your reality, the more it becomes written into the neural connections of your brain, (2:14). At any rate, prayer is considered by many to be a private matter, and participants may not have felt comfortable sharing private things in a public setting. There seemed to be a lack of research literature that supports CT survivors including prayer as part of their routine to increase daily success.

Two participants stated they had suffered from PTSD, but a vast majority of the participants alluded to symptoms of the disorder without calling it PTSD, such as fear and anxiety (two of the emerging themes). This supports research that PTSD is a major illness that occurs after a traumatic event (PTSD Research Quarterly, 2013).

Only two participants said they need support from the faculty members. More participants than not alluded to a distrust of faculty members' actions, but did not list the ability to trust faculty as one of the things they need to be successful. However, the inability to trust others and to believe that relationships exist that are not exploitive aligns with Tackett-Kendall (2001). It seems that trust is not dicotamous—trust or distrust—for

CT survivors in higher education; but, instead plotted daily along a spectrum based on behaviors and congruency between what is said and what is done. "Doing what you say you will do" is the mark of credibility (Kouzes & Posner, 1993, p. 47) and builds trusting relationships. The importance of a consistently trusting learning climate is in keeping with Knowles' 1973 and 1980 second adult learning process element, climate—establish a learning climate conducive to learning that is relaxed, *trusting*, mutually respectful, informal, warm, collaborative, supportive, fun, open authentic, human, and pleasurable. Without a perceived trusting learning climate (or one that is perceived as inconsistently trusting), survivors of CT seem to find it difficult to learn in higher education.

Several participants did not favor journal writing in the beginning, but found value in it by the end of the study. The belief that critical reflections and journaling help writers to be more intune with their feelings and experiences is supported by Raab (2016). Nearly half of participants said participating in the study caused them to have self-awareness, a positive outcome of journal writing. In support of this finding, Whittington (1995) found that higher education professors want their students to be able to understand what they are learning, make inferences about what they are learning, connect what they learn, and think of complex ways to think about what they are learning.

Alignment of the emerging themes with the research literature. There were nine emerging themes: challenging, learning strategies, anxiety, time management, fears, support groups, determined, personal character traits, and adult learning principles. Anxiety and fear are grouped together as one emerging theme for the purpose of this section because they are often grouped together in the literature. Roughly half of the

emerging themes aligned directly with the research literature. Regarding the other half of emerging themes, research literature indirectly aligned or was not found. A discussion of the alignment, lack of direct alignment, or lack of literature regarding the nine themes with the research literature follows.

Challenging. All of the participants described their learning experience as challenging. One used the word 'tough.' Another participant described life as a big circle where you cannot seem to get out. One participant said she had been struggling with a bout of depression. In a like manner, a particpant admitted to having PTSD and found school difficult because she could not memorize things like others. This is in keeping with the literature stating that survivors of CT deal with long term consequences that can make learning environments challenging (emotional, physical, mental, psychological, GAD, PTSD, and cognitive impairment) (Afifi et al., 2014; Felitti et al., 1998; Mock & Arai, 2010; Negele et al., 2015).

Learning challenges seem to be associated with a negative self-concept (Elbaun & Vaughn, 1999) and a negative self-concept seems to be associated with other negative life experiences (House of Commons, 2013, para. 1.4). Therefore, it seems logical to assume that at least some of this study's participants may have a negative self-concept. Another emerging theme was the participants' desire for support groups, a way perhaps for those who have learning challenges and perhaps a negative self-concept to find comfort and inspiration in knowing they are not alone and what works for other CT survivors.

Learning strategies. There is supporting literature on the difficulties experienced by individuals with LDs and learning strategies that help them learn (Cortiella & Horowitz, 2014), but none specific for CT survivors to be successful learners.

Noteworthy is the fact that most of the participants' learning strategies were common learning strategies found among all successful learners such as avoid lecture classes (if possible), use of outlines to organize writing assignments, keep a journal, find a quiet place to focus on school work such as a library, make a daily schedule, listen to music, use Postit notes, balance class load with a mix of hard-for-you and not so hard-for-you courses, be organized, pray (for those who have a religious background), and go talk to someone when distracted by something. It seems that CT survivors and non CT survivors in higher education are more alike than different in what they perceive they need in order to learn.

Three learning strategies are discussed here because they seem to be unique to CT survivors: face-to-face learning, safe and secure learning environments (assumed by non CT learners), and 54321 when focused on CT—identify five things you see, four things you hear, three things you feel, two things you smell, and one thing you taste, which moves one's focus from inside of self to outside of self.

A learning strategy that all participants preferred was face-to-face learning. This is in keeping with Herman (1997) and van der Kolk (2005) who argued that CT survivors have difficulty trusting people to follow through and help them because of their impacted ability to judge others—often leaving them unable to discern who is trustworthy. According to one of the participants of this study, having face-to-face classes and interaction with other students, ensures you will complete tasks. Perhaps face-to-face learning helps CT survivors better discern who is trustworthy. Regarding communication, Mehrabian (1981) found 7% of communication is words, 38% voice, and 55% nonverbal (para. 4). Communication disability is the most reported disability

experienced by both children and adults (House of Commons, 2013). Therefore, perhaps face-to-face learning helps CT survivors, who often struggle with a communication disability, discern which learning environments are trustworthy and psychologically safe for them to learn.

Perl (2016) argued, trauma survivors often misread the intention of others. Face-to-face interaction would make it easier to read the professors. This was supported by Bremner's (2003) finding—damage done to the hippocampus from stress causes problems with memories and learning. In keeping with Kirschbaum et al. (1996), an increase in the cortisol level as a result of stress from CT significantly weakens memory. Hearing information multiple times, and in different ways face-to-face may help students with memory problems retain information and learn. In summary, memory is negatively afftected by childhood trauma.

A safe and secure learning environment is assumed by non CT learners in higher education, but an emerging theme among CT survivors. Ziegler may agree that educators can help CT survivors be successful by promoting an environment of trust and by fostering a safe environment that promotes learning (2015). Without these, optimum learning cannot take place. This preferred learning strategy aligns with Knowles (1973, 1995) second adult learning process element, climate—establish a learning climate conducive to learning that is relaxed, trusting, mutually respectful, informal, warm, collaborative, supportive, fun, open, authentic, human, and pleasurable. This learning strategy is further strengthened by Golembiewski and McConkie (1975), who argued that trust is the most important factor in interpersonal relationships in any setting and Tway (1994) who defined trust as "the state of readiness for unguarded interaction with

someone or something" (p. 7). Trust has a positive connotation and leaves those who receive it with confidence.

If CT survivors who are too focused on their CT use 54321 as a journal writing strategy (as well as a reflective thinking strategy), Gleaves et al. (2008) said it may create an inner dialogue that connects thoughts, feelings, and actions. Some universities use reflective writing to help broaden students' reflective writing skills (University of Bradford, 2015; University of Manchester, 2015).

Anxiety and fear. There is literature that supports the fear and anxiety among survivors of childhood trauma. These are comorbid disorders (American Psychiatric Association, 2017; Schäfer & Fisher, 2011). All of the participants expressed some type of anxiety or fear relating to their studies (Ziegler, 2007). Yet, there is a lack of literature on the fear and anxiety among CT survivors in higher education and how it impacts them. A participant reported a professor intimidated the students by telling them 'getting a doctorate is hard and 1 out of 9 make it.' Survivors of CT may already be in a heightened state of hypervigilence with fear and anxiety. Therefore, it creates more stress for them to have an intimidating and threatening learning environment. Recall it is impossible to learn while experiencing fear (Perry, 2006).

Time management. Children who suffer CT have difficulty with the executive function of their brain and therefore have difficulty making decisions (Willis, 2011). Difficulties in making a decision could result in difficulties managing time. There is literature supporting the importance of time management to be a successful learner (Ahoy, 1998; Brownlee, 1996; Hanvover Research, 2014), but no research was found on time management as a strategies among CT survivors in higher education. However, the

issue of time management among successful higher education learners is in keeping with four of the assumptions about the characteristics of adult learners (Knowles, 1980, 1990: (a) they are increasingly self-directed moving from dependency to independency as a learner, (b) they want to apply immediately what they learn, (c) they need a reason for learning that makes sense to them, and (c) they are motivated by internal incentives—curiosity. If adult learners can be self-directing in a learner-centered classroom, can immediately apply what they learn, know the reason for learning that makes sense to them, and are internally motivated, perhaps time management issues melt away. Adult learners (CT survivors and non CT survivors) seem to find time to learn when educators attend to the assumptions about their characteristics.

Support groups. The participants expressed a need for support groups at the university for students who have suffered CT. They said that students may or may not opt to participate in one, but it is necessary that they be available for those who need support. Only one participant did not express the need for a support group, and he was male. Not only did the participants indicate a need for support groups, but they specifically included 'faculty support.' This was enlightening because one may think higher education students do not need support from faculty. From my experience as a higher education student, there seems to be an unseen and unspoken expectation in higher education that one is expected to be independent and self-sufficient. The results of this study suggest there is a need for more support from faculty of students who suffered CT. According to one participant in this study, having a faculty member as part of your support helps you complete the tasks. This need may be because some higher education students who suffered CT lack the family support and desire to have the need for support

met, so they reach out to the faculty. Or, it could be the case that these students lack confidence in themselves that they can achieve such an academic feat without support of the faculty.

Support groups are based on discussion among participants. In adult learning, discussion is an appropriate instructional method for addressing five of the six learning competencies (knowledge, understanding, attitudes, values, and interest)—all except skill, which requires practice exercises (Knowles, 1980) and commonly used in higher education classrooms. Perhaps a support group was preferred by the participants because it presents an opportunity to learn from each other—CT survivors accumulate a growing reservoir of experience that becomes an increasingly rich resource for other CT survivors, a characteristic of adult learners (Knowles, 1980). A support group would be a place for facilitated discussion on the challenges of higher education for CT survivors. I found no literature aligning with CT survivors in higher education needing or wanting support groups, which are discussion based; however, discussion is an effective learning strategy in higher education (Brookfield as cited in Galbraith, 2004).

Determined. All of the participants described themselves using positive language. Research addresses Early Life Stress (ELS) and the negativity that engulfs the child (Copeland & Gorey, 2015). It is interesting that the participants were able to be positive after sometimes severe and tumultuous childhoods. One participant stated, 'it's almost as if your background experience of the trauma sort of girded you up for this trite experience.' One participant reported when her professor said survivors of CT become drug addicts, and abusers of themselves, 'I guess I was kind of like, not really. That's not going to happen.' Several participants expressed the need to not let their professors

down. One of the participants talked about how she worked hard because she did not want to let her professor down because her professor believed in her. The results of this study suggest for some survivors of CT, it is more a relational and emotional experience than an educational one. Another participant reacted after a difficult experience with her professor, 'I told her I couldn't do it. I tried.' Again, there seemed to be a feeling that she let her professor down. Emotional deregulation is a part of the impact of CT (Schafer & Fisher, 2011). They have maintained a high level of hypervigilence since childhood, and it did not go away in adulthood. It may now be released through a self-inflicted emotion to please. This desire to please may be an example of determination. I found no supporting literature for the determination of higher education students who survived CT. However, the positive language participants used to describe themselves (personal character traits emerging theme) seems to align with being determined.

Personal character traits. Almost all the participants used positive terms to describe themselves—terms such as independent, capable, resilient, asks for help, leader, self-assured, confident, and self-driven. There are many variables that influence the impact CT has on a child (Perry, 2003; SAMHSA, 2014), and the experience itself has long-term consequences that are carried into adulthood (Felitti et al., 1998). However, even though all CT experiences are different, perhaps these self-ascribed positive personal character traits create a sameness among them that is *a* reason, if not *the* reason, why these CT survivors have been successful enough as learners to be in higher education.

According to Kinard (1999), CT survivors in higher education are an aberrancy. The participants in this study seem to have beat the odds according to Kinard (1999), who

found that even if CT survivors develop coping skills to perform well in primary and secondary schools, they are less likely to go to college.

Adult learning principles. All of the participants suggested, stated, or inferred they need an engaging learning environment where the need for respect, relevancy, self-direction, and collaboration are addressed. There is extensive research literature that provides various practice models, principles, theories, speculations, and assumptions surrounding adult learning (Teaching Excellence in Adult Literacy, 2011; Knowles, 1973, 1980, 1984, 1995). Some of the participants used the term adult learning principles with confidence and seemed to understand the meaning. However, most simply described principles of adult learning that help them be successful learners that align with Knowles, et al. (2011) such as using past real world experience to self-learn, learning from each other, tailoring the learning experiences, facilitating self-directedness, engaging in real life problem-solving, and focusing on adult learner's abilities to perform rather than memorize—this last one is further supported by Knowles (1980) when he described adult learners' orientation shifting from subject-centeredness to performance-centeredness.

Recall the Compton school district case and the associated ruling from the U.S. District Judge that students in the school district who witnessed multiple traumas are entitled to the same disability services as students who are traditionally disabled (Turner, 2015). According to the ruling, students who have witnessed multiple traumas will have difficulty learning. This supports Griffiths'study on how students felt about their academics when having to ask for help and/or extra time on an exam. Griffiths (2003) recalled a student saying, "We can do just as well as other students given the proper

support and accommodations" (p. 31). One participant in *this* study recalled a disrespectful learning experience where the professor called the students imbicels. This aligns with Knowles (1973, 1995), second adult learning process element climate—establish a learning climate conducive to learning that is relaxed, trusting, mutually respectful, informal, warm, collaborative, supportive, fun, open, authentic, human, and pleasurable. It seems likely that all high education adult learners (learning disabled, non learning disabled, CT survivors, non CT survivors) would benefit from respect, proper support, and accommodations.

Participants preferred a detailed description of upcoming classes to be able to opt out of those that could potentially trigger emotions. Two participants were forced to watch explicit videos in class on rape and suicide that made them choose between their academic success (stay in the class) and their mental health (walk out of the class). This preference aligns with the first of Knowles (1973, 1995) eight learning process elements, preparation—help the learner understand what is to come. Detailed syllabi describing the planned classroom activities may help CT survivors opt out ahead of time to avoid an emotional trigger.

Answering the Research Questions

Research question #1. What are the learning experiences of higher education students who suffered childhood trauma? The learning experiences of CT survivors in higher education were described in the case studies. In general, they perceived their higher education learning experince as challenging, the first emerging theme. The participants expressed a perceived need for face-to-face classroom interaction as a learning strategy as well as they developed their own personal learning strategies to help

them be successful, the second emerging theme. They also, in general, described their fear and anxiety as higher education students, themes 3 and 5. In general, participants shared their struggle with time management and their difficulty balancing time for, family, school, and social life—the fourth emerging theme. Additonally, the participants perceived a need for not only support groups, but also support from faculty, the sixth emerging theme. Generally, they all experienced a determined mindset to succeed, perhaps a reason why they were in higher education, the seventh emerging theme. In spite of their childhood adversities, the participants in general used positive language as a personal character traits to describe themselves, the eight emerging theme. Generally, the students perceived that application of what they called adult learning principles helps them to be more successful, the last theme.

Research question # 2. How do higher education students who experienced CT describe themselves? This research question was answered in Chapter Four in the eighth emerging theme—personal character traits. Recall from chapter 4 that nine of the participants used mostly positive language to describe themselves:

> independent . . . capable of doing things on own . . . strong and responsible . . . capable . . . resilient . . . determined . . . doesn't like distractions . . . self-assured and confident . . . independent and self-driven . . . I want to see where I was, so I can see where I want to go . . . accomplished

Recall from Chapter Four that two of the participants used less than positive language to describe themselves: 'tough but a self-starter . . . unmotivated.'

Research question #3. What can the experience of academically successful higher education students who experienced childhood trauma reveal that might be of use

to other students who survived childhood trauma in their struggles with learning in a higher education setting? Participants revealed they might benefit from counseling, creating a daily schedule, developing some learning strategies, participating in educational support groups at universities, face-to-face classes, the application of adult learning principles among the higher education faculty, receiving preparation for upcoming classes such as professors marking 'sensitive' on their syllabi when a video on rape will be shown in class that could trigger anxiety or a panic attack for someone who was traumatized by rape, a determined mindset, and the opportunity to self-identify during new student orientation in order to receive help if they need it.

Research question #4. What do adults who experienced childhood trama perceive they need in order to be successful learners? (resources, tools, environment, accommodations, instructions, etc.) The nine themes that emerged are either direct or indirect perceived needs and are described as follows.

Emerging themes as perceived needs (directly or indirectly) to be successful learners. The following section elaborates on how the nine themes either directly or indirectly describe perceived needs of adult survivors of CT in order to be successful learners.

Challenging. Because in general, the participants find higher education challenging, perhaps giving CT survivors an opportunity to self-report upon admission to higher education would be helpful, so that licensed professional counselors could be assigned to each not only as counselor, but also as confident and coach.

Learning strategies. Participants perceived they need the following to be successful learners:

-face-to-face classroom experiences, no lecturing

-find a place away from home to study such as the county library

-start with an outline for big assignments

-reward self for turning work in on time

-create a safe and secure learning environment

-record in a journal and reflect on things that are bothersome

-tell a friend about things that are bothersome

-engage in reassuring positive self-talk at the end of the day

-make a daily schedule for school work

-be sure class schedules each semester are balanced (equal numbers of perceived difficult and not so difficult classes)

-step away—to stop thinking about something difficult, do something else

-write things down and visualize what needs to be done

-pray to get through the day

-talk to a caring professor who will paraphrase things as many times as necessary for understanding

-listen to music instrumentals when studying

-use Postit notes when studying

-use 54321 strategy to stop focusing on the past CT by start focusing on the physical present (identify five things you see, four things you hear, three things you feel, two things you smell, and one thing you taste)

-be organized

Anxiety. Because participants seemed to be aware of their anxiety but were unable to control it, higher education CT survivors may benefit from professional counseling offered at the university where they could also receive a referral to physician or psychiatric care for treatment. An early opportunity to self-report CT would help connect students to professional resources at the start of their higher education experience. They may also benefit from professors who establish a classroom climate that is conducive to learning—one that is relaxed, trusting, mutually respectful, informal, warm, collaborative, supportive, fun, open, authentic, human, and pleasureable (Knowles, 1973, 1995).

Time management. Because participants expressed difficulty with time management, higher education CT survivors may benefit from a class- or self-organized study group where members track each other. They may also benefit from faculty who help students learn using a process model that is student-centered (andragogy) instead of the traditional content model that is teacher-centered (pedagogy) (Knowles, 1973).

Fears. Because participants expressed general feelings of fear and dread over what will happen next, an early opportunity to self-report CT would help connect students to professional counseling and care at the start. They may also benefit from professors who attend to the assumptions of the adult learner (Knowles, 1980, 1990) and the process by which adults learn best (Knowles 1973, 1995) beginning with preparing the learner—help the learner understand what is to come.

Support groups. Participants perceived they need support groups that could be university established or student established. Perhaps focus groups could help determine how best to set up and run support groups.

Determined. Because all participants expressed determination, helping them be successful learners may best be accomplished by removing barriers to their learning. Perhaps if their anxiety, time management issues, and fears were attended to through an opportunity to early self-report, support groups, professional counseling and care access, and an andragogical approach by professors, this group of higher education students would graduate at a faster and/or higher rate than currently.

Personal character traits as positive. Because participants used mostly positive language to describe themselves, it may be the case that higher education CT survivors have the same needs (Flannery, 2016, para 10) as any adult learner (attention to the assumption of their characteristics as an adult learner and to the process by which they learn best) to be successful learners, only more—more sensitivity to their propensity for anxiety, time management problems, and fears. Therefore, it seems important to provide all new higher education students an opportunity to self-report as a survivor of CT, so the university can provide the added sensitivity through counseling, support groups, and an andragogical approach to teaching and learning.

Adult learning principles. Because all participants expressed a preference for instruction using what they referred to as adult learning principles, it is logical to assume that they perceive they need an andragogical approach to their higher education classrooms to succeed in learning. Thus, an effort to educate faculty in the andragogical process may be a strategy that would benefit survivors of CT.

Research question # 5. How do participants perceive daily structured journaling during the 60-day study? Not all particpants participated in journaling. The participants

who did perceived it as a great way to get in touch with one's self, attributed it to an increase in their self-awareness. Others stated they had difficulty finding time to journal.

SQ1: What were the benefits if any? Some described journaling as rewarding while some saw it as one more thing to do. Although the participants may have found it overwhelming in the beginning, several expressed or wrote how it made them think things through and better deal with stressful situations.

SQ2: What were the repercussions if any? Several participants did not participate in journaling. Several participated but did not complete the 60-day period, and others said it was too difficult for them emotionally to participate because it caused unpleasant memories to resurface. Then there were those who completed the 60-day writing period, but stated it was extremely difficult and caused them problems. Yet, they said for the sake of the study and in hopes it would help others; they completed the journaling.

Recommendations for Higher Education

The following are recommendations for higher education based on the study results.

1. Attend to the needs of adult learners using adult learning theory, a learner-centered andragogical approach
2. Offer courses as both on ground and online—CT survivors perceive they need face-to-face classes
3. Provide professional development for faculty on application of adult learning principles related to this study's results.
4. Establish a support groups for students who self-identify as CT survivors.

5. Use warning labels on syllabi to alert CT survivors of classes that will include material that could trigger an emotional response. If CT survivors opt out of a class that may trigger an emotional response, provide them with an alternative way to learn missed material.
6. Offer appropriate accommodations for those who self-identify as a CT survivor.
7. Provide a representative at freshmen orientation to speak on the results of this research and give students the option to self-identify as a CT survivor in order to participate in a support group of CT survivors and to receive appropriate accommodations.
8. Because of the prevalence of CT that often results in an invisible learning disability with unique challenges and learning needs, assume there are CT survivors in all classes.

Recommendations for Future Research

Based on the limitations of this study, I recommend future researchers design an experimental study that compares the learning experiences and outcomes of two like classes (same syllabus, course content, ojective)—both with self-identified CT survivors, one control class where the professor uses a teacher-centered approach and one experimental class where the professor applies adult learning principles (attends to the assumptions of the characteristics of the adult learner and follows the process by which adults learn best), a student-centered approach.

I further recommend conducting an action research study on planning, implementing, and evaluating a support group for self-identified higher education CT survivors. Using participant demographic information such as type of childhood trauma;

number of years of abuse; and perpetrator as family member, family friend, stranger, or someone in authority (if authority, what role the authority played) study results may lead to CT survivor categories identifying levels of academic risk.

Personal Reflection

The following is a personal reflection on the experience of designing and conducting the study as a CT survivor in higher education. In one of my overwhelming moments, I recall going to my professor, Dr. Sherblom, asking him why I chose this topic to study and saying to him that it may have been too much because it was too personal. What he said was paramount to my continuing the study. He said, 'you didn't choose this study, it chose you.' Those words solidified in my mind why I had to do this study. After I left his office, I finally accepted the pain of reliving my past, the particpants' past, and all the disquieting thoughts and tumultuous emotions that would come with reading and researching about those who had experienced childhood adversities similar to mine. Often times, I was so consumed with visuals of their abuse, I could not continue. There were times I did not read the research literature for days, weeks, and months wishing it would go away, and that someone else would come and rescue me. I felt my professors and my colleague were wrong; they had too much faith in thinking I could do this research. Each time I read the literature, I fought back the tears, the pain, and the urge to give up. I thought this study could not possibly benefit me. Yet, I felt strongly that it would benefit others, so I continued. I was more willing to risk the study taking me to to a place of no return than I was living in a place of safety where I could always return. In fact, Dr. Isenberg, my chair, and Dr. Munro, the counselor, were in agreement with Dr. Sherblom that I could and I would do this. They all balanced the sensitivity of

encouraging me, but not pushing me. It was as if they knew I would bounce back. I did bounce back each time after each struggle.

My quest to help participants who had overcome brain-altering life-changing adversities motivated me to finish the study. As painstaking as this was, I envisioned how great it would be to help everyone who survived CT in higher education, but I shamefully admit, I hoped and prayed that if I could help at least one, this study and all the emotional turmoil and painful memories that came with it would have been well worth it. Deep inside there was a desire in me to help make at least one participant's academic experience a little less stressful and a little more successful.

In retrospect, the help of Dr. Munro, a licensed professional counselor and who volunteered to conduct the interviews, was paramount to my sanity. It was also important to my committee and me to maintain the validity of the study as well as remove emotional biases. When my committee suggested that I not be involved for fear of the repercussions, I thought they were wrong, and that I needed to conduct the interviews. They were correct in their belief that it would be too much for me. Just transcribing the interviews was extremely difficult and emotional. I could not imagine how I could have interviewed them. I suspect it would have taken hours and hours for me to get through each interview and hours to recover after each. I am uncertain the role the licensed counselor played in their responses, but if I had conducted the interviews, the study may have had different results.

Conclusion

Eleven case studies of adults in higher education who suffered CT revealed helpful learning strategies; the value of reflective thinking through journaling; a

commitment to increase awareness about challenges and coping strategies; and eagerness to participate in a study to shed light on their learning experience. Consequently, all contributed to a consideration of a new approach to higher education students who suffered CT to help them be successful. Acknowledgement that one out of every three students show up in higher education with this invisible disability may lead to an acknowledgement that educators could benefit from professional development to help them know how to help CT survivors learn.

Three findings were most common in the participant data. First, the results of this study found that adult learning principles (an andragogical approach) help address the learning needs of CT survivors in higher education. Universities and colleges seek higher graduation rates and this seems to be a strategy that may help this population of learners succeed in graduating.

Another most common finding was that CT survivors need face-to-face classes to be successful. This is a time where technology and online courses seem to better fit the needs of the masses. However, the study revealed CT survivors need to see their professor. Perhaps face-to-face classes could always be an option.

The last most common finding was the need for survivors to be a part of a support group. Several participants indicated they would like to know how someone else that suffered a childhood trauma handled a particular situation. Some childhood survivors may not have any kind of support system, and a support group may be the difference between success and failure.

The salient finding is that CT survivors in higher education are the same as any adult learner, but may benefit from an informed level of sensitivity among professors and

higher education institutions to their additional challenges and learning needs. Ziegler's statement regarding the educational system and children seems to also apply to adults in higher education. "One area that has received little or no attention has been the ability of our educational system to meet the needs of children who are living with the effects of trauma in their past or present" (Ziegler, 2007, p. 1). Allowing new students to self-identify as CT survivors and the general application of adult learning principles may allow all higher education learners to be more successful.

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Appendices

Appendix A

ACE Study Self-scoring Questionnaire

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
   No___If Yes, enter 1 ___
2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   No___If Yes, enter 1 ___
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
   No___If Yes, enter 1 ___
4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
   No___If Yes, enter 1 ___
5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   No___If Yes, enter 1 ___
6. Were your parents ever separated or divorced?
   No___If Yes, enter 1 ___
7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   No___If Yes, enter 1 ___
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No___If Yes, enter 1 ___
9. Was a household member depressed or mentally ill, or did a household member attempt suicide? No___If Yes, enter 1 ___
10. Did a household member go to prison?
    No___If Yes, enter 1 __

Now add up your "Yes" answers: ___ This is your ACE Score.

Appendix B

Taken from Aces Too High

Now that you've got your ACE score, what does it mean?

First….a tiny bit of background to help you figure this out…..(if you want the back story about the fascinating origins of the ACE Study, read The Adverse Childhood Experiences Study — the largest, most important public health study you never heard of — began in an obesity clinic.)

The CDC's Adverse Childhood Experiences Study (ACE Study) uncovered a stunning link between childhood trauma and the chronic diseases people develop as adults, as well as social and emotional problems. This includes heart disease, lung cancer, diabetes and many autoimmune diseases, as well as depression, violence, being a victim of violence, and suicide. The first research results were published in 1998, followed by 57 other publications through 2011. They showed that:

- childhood trauma was very common, even in employed white middle-class, college-educated people with great health insurance;
- there was a direct link between childhood trauma and adult onset of chronic disease, as well as depression, suicide, being violent and a victim of violence;
- more types of trauma increased the risk of health, social and emotional problems.
- people usually experience more than one type of trauma – rarely is it only sex abuse or only verbal abuse.

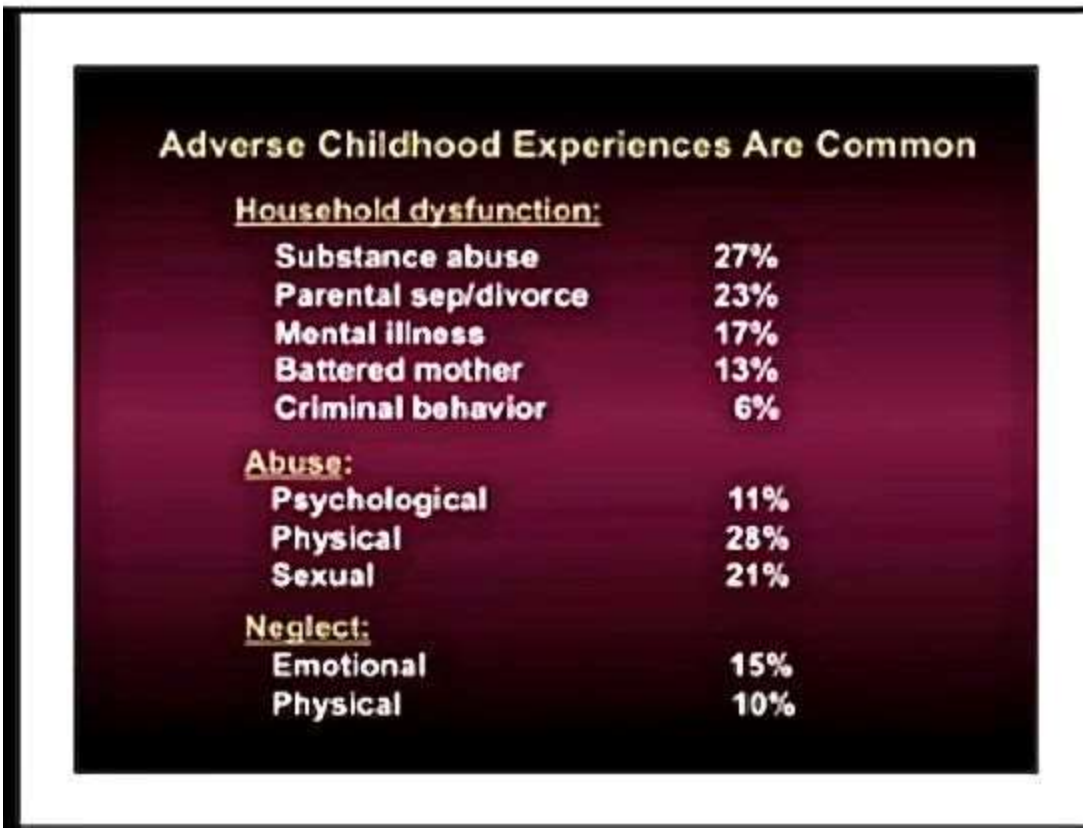
A whopping two thirds of the 17,000 people in the ACE Study had an ACE score of at least one — 87 percent of those had more than one. Eighteen states have done their own ACE surveys; their results are similar to the CDC's ACE Study.

Number of Adverse Childhood Experiences (ACE Score)	Women	Men	Total
0	34.5	38.0	36.1
1	24.5	27.9	26.0
2	15.5	16.4	15.9
3	10.3	8.6	9.5
4 or more	15.2	9.2	12.5

The study's researchers came up with an ACE score to explain a person's risk for chronic disease. Think of it as a cholesterol score for childhood toxic stress. You get one point for each type of trauma. The higher your ACE score, the higher your risk of health and social problems. (Of course, other types of trauma exist that could contribute to an ACE score, so it is conceivable that people could have ACE scores higher than 10; however, the ACE Study measured only 10 types.)

As your ACE score increases, so does the risk of disease, social and emotional problems. With an ACE score of 4 or more, things start getting serious. The likelihood of chronic pulmonary lung disease increases 390 percent; hepatitis, 240 percent; depression 460 percent; suicide, 1,220 percent.

(By the way, lest you think that the ACE Study was yet another involving inner-city poor people of color, take note: The study's participants were 17,000 mostly white, middle and upper-middle class college-educated San Diegans with good jobs and great health care – they all belonged to the Kaiser Permanente health maintenance organization.)



Here are some specific graphic examples of how increasing ACE scores increase the risk of some diseases, social and emotional problems. All of these graphs come from "The relationship of adverse childhood experiences to adult health, well being, social function and health care", a book chapter by Drs. Vincent Felitti and Robert Anda, co-founders of the ACE Study, in "The Hidden Epidemic: The Impact of Early Life Trauma on Health and Disease."

Appendix C

Interview Questions for Participants

1. As someone who has experienced childhood trauma, please describe your university learning experience.
2. Please describe your best learning experience at the university and why.
3. Please describe your worst learning experience at the university and why.
4. As someone who has experienced childhood trauma and is now a college student, how would describe yourself?
5. What are your strengths and challenges as a college student?
6. What is the relationship, if any, between your childhood trauma and your current role as a college student?
7. As someone who experienced childhood trauma, what do you need in order to be a successful learner at the university level? (faculty members, staff, resources, tools, activities, etc.)
8. How do you learn best? (settings, instructors, co-learners, strategies, approaches, etc.)
9. If you could, what would you do to improve the learning experience for college students who have experienced childhood trauma?
10. What is a typical day in the life of a college student who has experienced childhood trauma?
11. What, if any, advice would you give to incoming college students who have experienced childhood trauma
12. What , if at all, is the single most important factor that will determined your success or lack of success in the program?
13. In what ways, if at all, has this study caused you discomfort?
14. Is there something you would like to add that I have not discussed that you believe would be helpful to this study?

Appendix D

Structured Journaling Guidelines

Questions 1 & 2 (MORNING JOURNALING)

1. What do you need to be a successful learner (resources, tools, environment, accommodations, instructions etc.)?
2. What emotions are you experiencing as you prepare for school (assignments, projects, readings, test, presentations or other)?

Question 3 (EVENING JOURNALING)

3. What strategies did you use today to be a successful learner? How do you describe yourself as a Higher Ed student?

Appendix E

Exit Interview Questions

1. In what ways did your participation in the childhood trauma research study impact you?

2. One thing the childhood trauma research study has revealed is the need for a support group of some kind for survivors of childhood trauma. If the university were to get a support group, what role would you be willing to play in the group? The roles may be facilitator, leader, participant, etc.

3. What have you done or plan to do to increase awareness of childhood trauma in your school, community, or organization? There are many ways one can increase awareness on trauma and its consequences, such as

-Creating programs for childhood trauma survivors through open forums
-Community outreach programs
-Peer support

Appendix F

VOLUNTEERS NEEDED FOR RESEARCH STUDY

Success Strategies of Adult College Students who Suffered Childhood Trauma

Who: 18 or over

What: Research study involving participating in an interview and writing structured weekly journal entries

When: To Be Announced

Where: Lindenwood University St. Charles campus

Why: To compile success strategies of adult college students who have suffered childhood trauma

Benefits: Contribute to the understanding of the learning experiences of higher education students who suffered childhood trauma

If you are interested, please contact Dr. Jan Munro, Adjunct Faculty Department of Counseling LU by email at jmunro@lindenwood.edu

Appendix G

Wallace, Dora J. <djw244@lionmail.lindenwood.edu> Feb 11

to emann, Susan

Dear Dr. Mann,

My name is Dora Wallace, and I am a Doctoral student at Lindenwood Main Campus. Dr. Susan Isenberg is my Chair and Dr. Jan Munro is my committee member. I just got my Prospectus approved and working on my IRB application. I am requesting permission to use St. Charles campus students along with the other two campuses for my study on the learning needs of adults with childhood trauma. Dr. Munro will be conducting the interviews with study volunteers and will make herself available to counsel students who may need it after discussing this sensitive topic. I have attached my Prospectus for your review should you want more details.

In summary, if permission is granted, I would post information (flyers) at a location of your choice inviting students to participate in the study.

Thank you for your consideration.

Sincerely,

Dora Wallace

314-315-1779

Abbott, Marilyn <MAbbott@lindenwood.edu> Feb 22

to me, Susan

Dear Ms. Wallace,

We do not permit investigators to contact our students directly. I normally ask that the investigator send me a description of the study and the type of student who should participate. I then send this to our student activities director who includes the study invitation in her weekly summary of announcements that goes out to all students. Any interested student will then contact you.

Once you have full approval from the IRB to conduct your study please contact me again to request posting of the announcement.

Marilyn S Abbott, PhD

Provost & VP for Academic Affairs

Appendix H

LINDENWOOD

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

"The learning experience of higher education students who suffered childhood trauma"

Principal Investigator Dora Wallace

Telephone: 314-315-1779 E-mail: djw244@lionmail.lindenwood.edu

Participant_____Contact info_____

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1. You are invited to participate in a research study conducted by Dora Wallace under the guidance of Dr. Susan Isenberg). The purpose of this research is to discover strategies, success tips, and coping skills of higher education students who suffered a childhood trauma.

2. Your participation will involve

   - Signing a consent form to participate
   - Completing the ACES Self-scoring Questionnaire (10 minutes)
   - Answering interview questions with counselor (30-45 minutes)

The interviews will be conducted on Lindenwood university main campus in the Counselor's office.

An LU counselor will interview you on the Lindenwood University campus to discover how you after having suffered childhood trauma, interface with the world by sharing your challenges, learning strategies, and how you were able, despite overwhelming circumstances, to attend college, pursue your goals. You will have access to free counseling after the study if you experience discomfort answering the questions interview. This research will add to the already existing body of knowledge surrounding the long term consequences of childhood trauma. It will add the challenges, strategies, and successes of higher education students to this body of knowledge. It will be published for the interested public, and may be used by faculty and students. My goal is to share and discuss your learning experience, challenges, strategies, successes and any skills you may have acquired to help you be successful.

1. You will complete the Adverse Childhood Experience Study (ACES) Self-Scoring Guide.
2. You will be interviewed by the counselor.
3. You will receive a $10 gift card for your participation in this study.
4. There will be 10-20 participants will be involved in this research.
5. There may be certain risks or discomforts associated with this research. They include residuals, thoughts, memories associated with the childhood trauma, or arousal of feelings or emotions. You are encouraged to contact the counselor anytime during the study, if you feel discomfort.
6. There are no direct benefits for you participating in this study. However, your participation will contribute to the knowledge about the learning experience of higher education students who suffered childhood trauma as well as their coping strategies, learning techniques, and success tips.
7. Your participation is voluntary and you may choose not to participate in this research study or to withdraw your consent at any time. You may choose not to answer any questions that you do not want to answer. You will NOT be penalized in any way should you choose not to participate or to withdraw.

8. I will do everything I can to protect your privacy. As part of this effort, your identity will not be revealed in any publication or presentation that may result from this study and the information collected will remain in my possession in a safe location. Your data will be assigned a code number and pseudonym by the counselor who collects it to protect your privacy and ensure confidentiality.

9. If you have any questions or concerns regarding this study, or if any problems arise, you may call me at 314-315-1779 or the Supervising Faculty, Dr. Susan Isenberg at 314.495.9478. You may also ask questions of or state concerns regarding your participation to the Lindenwood Institutional Review Board (IRB) through contacting Dr. Marilyn Abbott, Provost at mabbott@lindenwood.edu or 636-949-4912.

I have read this consent form and have been given the opportunity to ask questions. I will also be given a copy of this consent form for my records. I consent to my participation in the research described above.

_____		_____
Participant's Signature	Date	Participant's Printed Name
_____		_____
Signature of Principal Investigator	Date	Investigator Printed Name

Appendix I

Revised 8-8-2012

Email communication requesting permission to use ACEs Score sheet September 2015

Jane Stevens <jstevens@acesconnection.com> Sep 12

to me

Hi, Dora:

The ACE questionnaire can be used by anyone, because it came out of the CDC-Kaiser Permanente ACE Study, which was funded by our tax dollars. Just provide the link to the CDC's ACE Study site.

Cheers, Jane

Jane Stevens <jstevens@acesconnection.com> Sep 14

to me

Hi, Dora:

Sorry I wasn't clear — was trying to go through email while on a conference call!

Yes, you can also use the resilience questionnaire. It was put together by a group of researchers & clinicians in Maine several years ago. It wasn't part of the ACE Study, but put together to give people some hope, and is available for anyone to use.

Cheers, Jane

Vitae

Dora J. Washington earned her Bachelor of Science Degree in (1988) and her Master's Degree in Education (2006) from the University of Central Arkansas. In her quest for professional and personal excellence, she received her National Board Certification in 2007 from the Little Rock School District. She went on to work with the National Education Association because she believes in its core values that professional educators are vital to the success of students. Over the past years, she has worked with individuals, community leaders, organizations, and school districts to increase public awareness on the long-term consequences of childhood trauma. She mangages Tower of Hope, a business that teaches adults and children using the tenets (hope, overcome, perserverence, and educate) to help them live an abundant life after childhood adversities. She currently conducts trainings and workshops offering support, knowledge, and a step-by-step approach to helping survivors of childhood trauma. Ms.Washington's area of expertise is public speaking where she has been the keynote speaker for organizations and businesses for more than 20 years. She is currently pursuing a Doctor of Education Degree in Instructional Leadership in Higher Education from Lindenwood University School of Education. She anticipates completion in 2018. Ms. Washington lives in Missouri.