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A Quantitative Study Examining Intentional Teaching of Social Emotional Skills

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by

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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.

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Abstract

In a world where children are likely to experience early-life trauma, relationships matter, and trust is a key in forming healthy working relationships. Intentionally teaching adults and teachers how to evoke calmness in ourselves and breathe to handle negative situations, trusted educators can then teach children to do the same. It is important that educational leaders, and other stakeholders, explore what works best to help children overcome trauma and become resilient and productive adults. This study examined the relationship between social, emotional, and behavioral skills of students entering kindergarten who have been intentionally taught skills needed for resiliency by highly trained teachers, as incorporated into everyday activities, and students without this opportunity. The teachers who intentionally taught social/emotional skills to preschool-age children were trained in Conscious Discipline, a comprehensive classroom management program and a social-emotional curriculum based on current brain research, child development information, and developmentally appropriate practices.

This study's main sample consisted of 126 students with identified delay(s) and an Individualized Education Program (IEP), who attended a preschool where these skills were intentionally taught, 71 neurotypical students who attended the same preschool, and a random sample of 70 students who did not attend the same preschool. The Social, Academic, and Emotional Behavior Risk Screener (SAEBRS) assessed student skills from each sample category in social behavior, academic behavior, and emotional behavior. Analysis of variance (ANOVA) data and *t*-test statistical analyses appear to indicate children who have an opportunity to attend an early childhood program with teachers trained to implement a science-backed and research-based curriculum designed

to teach strategies for improving self-regulation, resiliency, and peer interaction skills may not score statistically higher in all areas than their peer counterparts who have not attended such a program. However, there is enough evidence to indicate the benefit of attendance in such a program as overall scores generally reflected positive outcomes. The information indicated children who were intentionally taught how to deal with stress, whether that be traumatic stress caused by abuse or family dysfunction, or day-to-day stressors, will exhibit maladaptive behaviors to a lesser degree.

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Chapter One: Introduction

Introduction

Trauma is generally thought to be defined as a deeply distressing event. Forbes (2012) states in her book, *Help for Billy*, trauma is

> any event that is more overwhelming than which is ordinarily expected. Such an event puts a child in the place of feeling out of control, scared, terrified, worthless, unlovable, insecure, and even endangered. When a child is belittled, degraded, ridiculed, threatened physically, threatened to be abandoned, withheld affection, withheld care and love, or neglected emotionally or physically, trauma has occurred. (p. 11)

Trauma and stress can occur in utero, causing an impact to the child's nervous system and ability to self-regulate (Forbes, 2012, p. 11). After birth and during the early childhood years, children continue to be vulnerable to the effects of toxic stress and adversity. Traumatic childhood events may include, but are not limited to, neglect, divorce, separation from a parent or parents, car accidents, foster care, deaths, parental mental health issues, witnessing violence, and more. Most children will experience some trauma in childhood; however, the impact of traumatic experiences is related to the child's support and connection to safe and trusted adults. Forbes (2012) states, "When children are given environments of support, love, and attention and when needs are met, the impact of traumatic experiences is minimized, and in many cases, avoided" (p. 13).

Inherently, people want to do the best they can at any given time. The United States Declaration of Independence guarantees humans' right to life, liberty, and the pursuit of happiness. All people desire happiness, wholeness, and contentment for their

families. To avoid trauma and psychological stress is not something anyone thinks of as a goal on their way to or during adulthood. However, this is an area needing more open and honest discussion. Discussion is difficult, as much of the trauma people experience from an early age are generally thought of as private or rare, and often, individuals have been encouraged to keep it to themselves by the perpetrators of the trauma and/or other well-meaning people without understanding the gravity of what trauma does to the brain and inherently changes the way humans process events, thoughts, feelings, and actions. As individuals are learning, avoiding the personal consequences of trauma does not help heal mental health issues, nor the ability to be resilient adults, nor competence in later modeling positive strategies for children and other young people for being emotionally healthy.

Hamby et al. (2016) reported that Alfred Kinsey was one of the first social scientists to begin this process. He was able to begin to collect the first systematic data on child sex offenders. Due to his efforts in the 1970s, he began understanding family violence and adverse childhood experiences. Hamby et al. (2016) wrote issues of family violence were "no longer seen as a rare problem affecting a deviant few, but a huge social problem that touched the lives of many" (p. 4). Another concern is that research has not converged in overlapping similar issues. For example, Hamby et al. (2016) also wrote

> researchers studying sexual abuse are a different group than those studying rape; scientists who study exposure to domestic violence are different than those who study dating violence; experts who study adolescent dating violence are often different from those who study bullying and other peer victimization. This

> separation limits the potential of the field, as those are not independent phenomena; they are all closely interrelated (p. 5).

Thankfully, this single style of looking at adverse experiences has begun to change. Many now recognize it is important for many disciplines and professions to work together to learn more to help those who have suffered violence and trauma become emotionally healthy and resilient individuals. The National Survey of Children's Exposure to Violence has monitored youth victimization for the last decade. Prior to this information, there was no systematic collection of data to measure crimes against children under the age of 12 that were not reported to authorities (Hamby et al., 2016, p. 5). In the 1990s, Felitti and his team (1998) conducted the Adverse Childhood Experiences (ACEs) study. They identified a correlation between early life trauma and maladaptive behaviors, such as addiction and other unhealthy habits and health issues, such as liver disease or cancer (p. 205). Based on this historical information and the current research, it is important for educational and medical professionals to begin the important work of making a sustained effort to work together to identify children and families exposed to and experiencing domestic violence, trauma, and addiction, as well as death of close family members, etc., in hopes of helping young children become resilient adults who can stop the cycle of violence and trauma in their lives and live healthy, productive adult lives.

At the time of the writing of this study, our nation and the world, have experienced the global pandemic termed COVID-19 (Chinese Originated Viral Infectious Disease; SARS-CoV-2). Due to the shuttering of businesses, churches, schools and other normal and routine activities, individuals have had to navigate precarious experiences.

Children have been left without the comfort of school, and many parents have not taken them out of the house. Doctor appointments and communication with grandparents and other extended family members have become impersonal and replaced by virtual Zoom-style meetings. Gone are the personal hugs, kisses, and affection of loved ones. Gone are the play dates, sports activities, visitors in our homes, and possibly the most educationally impactful, in-person learning. Many have now been through the past year without the structure, human interaction, nor opportunities in person attendance at school provides. Many children have a good support system and emotionally healthy families; however, they are having difficulty dealing with the separation from loved ones and friends. People need fellowship with others. Humans were made to move through life events as a community with families and friends. Unfortunately, many children have suffered adverse experiences and trauma even before this global pandemic swept the world. Now, they are struggling even more. Due to the nature of virtual meetings and appointments, it has become more difficult to identify, much less support, these families and the children battered in their aftermath of unhealthy habits and destruction.

What do educators need to improve to identify and support students who have suffered through adverse experiences and give them tools for resiliency? This is the underlying question to which many in the education field desire an answer. This study desires to find correlating evidence in intentionally teaching skills for resiliency to actuate best processes and practices in helping children socialize appropriately, develop healthy relationships, and mature into productive members of society as adults.

Mental health–related disabilities (e.g., depression, anxiety) are a leading cause of health issues worldwide, affecting around 450 million adults and adolescents, two-

thirds of whom will not access help from a health professional (World Health Organization, 2018). In the United States, one in five adults and one in five adolescents will experience some form of mental health issue (National Alliance on Mental Illness, n.d.). Based on the increasing number of students with behavioral concerns, mental health screenings and multi-tiered systems of support in schools should be a primary topic of discussion and progression in today's educational system. Based on results gathered from the School Health Policies and Practices Study (2016), 63.4% of districts provided funding for or offered professional development in emotional and mental health; however, only 41.2% required staff to participate in professional development on the topic of emotional and mental health (Centers for Disease Control and Prevention, 2016, p. 13), let alone conduct universal mental health screenings. Teacher training in mental health needs of students and accessible services is of utmost importance, since teachers are usually the first to interact with students and need to be prepared to refer students to other school personnel, such as counselors and school psychologists who are generally the school personnel tasked with referring students for mental health services.

In February 2021, Ao (2021) of TCA Regional News interviewed Steven Shapiro, Pediatric Chair at Abington Hospital in Pennsylvania, regarding his patients' mental health one year into the COVID-19 pandemic. Dr. Shapiro stated he has "observed an increase in depressive and anxiety symptoms, as well as thoughts of suicide. Because of that his practice has shifted to more proactive and preventative care when dealing with behavioral and mental health" (para. 9). Additionally, Katie Lockwood, a pediatrician at the Children's Hospital of Philadelphia, in her discussion with Ao, indicated overall general pediatric visits had decreased; however, "behavioral health visits have increased,

showing the negative impact of the pandemic on the mental health of children and adolescents" (para. 12). Both indicated families are now moving to telehealth visits, which offer an additional level of screening (para. 13). Based on recent experiences, Lockwood noted her practice has partnered with schools, nurses, and teachers to manage testing and screen for mental health symptoms (para. 14). Although it has taken the pandemic for more physicians to understand the importance of mental health screening, sanguinely, screening for mental health concerns and symptoms should become universal for all well-visits in the future, enabling families and children to get the support and treatment needed early.

Based on the researcher's most recent Professional Growth Plan required by the school district, results of tracking social/emotional educational referrals, specifically regarding known trauma history, to make informed decisions regarding educational eligibility determinations, special education placements, and the need for additional supports, such as Social Worker involvement follows. Trauma history of children included, but may not be limited to, prenatal/in-utero birth trauma, child abuse, neglect, household mental illness, parent or household substance abuse or alcoholism, witnessing violent crime, domestic violence, and having teen/young parent, etc. Results revealed 100% of the children who completed a developmental screening or participated in early intervention services and were referred for an early childhood special education evaluation in the area of social/emotional skills, coupled with having experienced early life trauma or were currently living in dysfunctional situations, met Missouri Department of Elementary and Secondary Education's (DESE) initial eligibility criteria to be identified as a Young Child with a Developmental Delay in the area of Social/Emotional

(as well as other areas of delay – communication, adaptive behavior, physical skills, cognitive skills). Twenty percent of those who have had medical trauma met initial eligibility criteria to be identified as a student requiring special education services in at least the social/emotional area. Conversely, of children who had not experienced any early life trauma, only 28% of those students were identified as students requiring early childhood special education services, including the area of social/emotional skills. It should be noted that of those identified with the need for special education services, 16% of those children who received special instruction in school readiness, including social skills, were deficient in the areas of attention and focus, and 8% of those children had a medical diagnosis of Autism Spectrum Disorder. Based on this informal tracking of recent caseload of educational evaluations, the majority of students identified as requiring support in the area of social/emotional/behavioral development experienced adverse childhood experiences in early life, resulting in inability to advance in skill development, as expected for a child of his or her chronological age.

Because our future as a nation depends upon it, it is imperative that physicians, educators, and other stakeholders in our communities begin to understand what toxic stress does to the early-developing brain. Jack Shonkoff, Founding Director of Center of the Developing Child at Harvard, stated in the movie, *No Small Matter*, “If stress hormones stay elevated, it starts to disrupt the development of the brain” (Woodard, 2019, 43:50). As more professionals study adverse childhood experiences, it is increasingly noted that adversity and stress in early childhood years impact health, behavior, and life outcomes (Woodard, 2019, 40:22) if not mitigated during important brain development in the early years. According to Nadine Burke Harris, Pediatrician and

founder of the Center for Youth Wellness, “experiencing high doses of adversity doubles your risk for seven out of ten of the leading causes of death in the United States” (Woodard, 2019, 45:17). The impact of childhood toxic stress is cumulative. Additionally, Mission: Readiness - Council for a Strong America, made up of over 800 top retired, military brass purports, at this time, 71% of 17 to 24-year-olds in the United States are ineligible to join the military (Maxey et al., 2018). They are not healthy, are poorly educated, and have committed one or more criminal offenses (Maxey et al., 2018; Woodard, 2019). In one of the group member’s blog posts, by General John Allen and General Lester Lyles, the men wrote,

> The U.S. faces an array of threats to its national security. . . . Here at home, our nation is facing a threat that doesn’t generate many headlines but that also poses clear and growing risks to the future of our county: the lack of affordable, accessible child care. As retired generals with more than seven decades of combined service, we don’t lightly decry the state of child care in America and its impact on parents, especially women and members of communities of color. (Allen & Lyles, 2021, paras. 1-3)

Early childhood is a time of important brain development. Fear and adversity in children’s lives, without the buffering of supportive caregivers and ability to be resilient, cause high levels of adrenaline and cortisol. Again, as stated earlier by Shonkoff, “If stress hormones stay elevated, it starts to disrupt the development of the brain” (Woodard, 2019, 43:50). This, then, undermines a child’s ability to attend and get along with others. A biological problem that becomes a behavior problem (Woodard, 2019, 44:13).

Rationale of the Study

"People not programs change people" is a compelling statement made in a book written by psychiatrist, Perry, regarding his experiences with children who experienced early trauma (Perry & Szalavitz, 2018). By intentionally teaching adults and teachers how to evoke calmness and utilize breathing strategies to handle negative situations, trusted educators can teach children to do the same. According to Conscious Discipline (2015, p. 15), adults should look inward at themselves first before teaching children. Conscious Discipline also stresses the importance in development of good relationships and trust. Conscious Discipline has been proven what works best to help children overcome trauma and become resilient can be situational and in a place the child can have the healthiest of relationships (Perry & Szalavitz, 2018). Relationships matter and trust is key in forming healthy working relationships.

According to the National Alliance on Mental Illness (NAMI, n.d.) website, current information reported estimates about 16.5% of youth aged six to 17, experience a mental health disorder; about 7.7 million children (NAMI, You Are Not Alone, para. 3). However, only about 50% of those diagnosed with mental health disorder received treatment in 2016 (NAMI, Mental Health Matters, para. 3) . Additionally, 70% of youth in the juvenile justice system have been diagnosed with a mental illness. Factors contributing to these problems include income, family, relationships, and adversity. As indicated, in 2015, only 2% of schools actively screened for mental health issues (Romer & McIntosh, 2005, para. 51). Results of a 2019 study in the *Journal of Pediatrics* revealed most physicians preferred to screen for mental, behavioral, and developmental

delays from birth through age eight years. Recommendations were made to extend these screenings to include all well visits, and any other visits, as needed (Glascoe et al., 2019).

In 1998 in San Diego, researchers developed a questionnaire to address adverse childhood experiences (ACEs) and sent it to 13,494 adults (Felitti et al., 1998). A strong correlation between exposure to abuse, trauma, or dysfunction during childhood and multiple risk factors for causes of death were noted. Adults who had experienced four or more categories of childhood trauma (psychological, physical/sexual abuse, violence against mother, mental illness, substance abuse, criminal behavior in household, imprisonment), and compared to those who had experienced none were much more likely for alcoholism, drug abuse, depression, smoking, poor health, and suicide attempts, etc. The more exposure to trauma, or the higher the ACEs score, the more likely the adult's health status was impacted negatively (Felitti et al., 1998). This was a landmark study in the area of childhood trauma and future long-term implications on adult health and risk factors. The findings suggest the impact of these adverse childhood experiences on adult health status is strong and cumulative (Felitti et al., 1998). This study is a cornerstone to the current study. Twenty-plus years later, more and more children are experiencing significant trauma, from prenatally to postnatally, and beyond.

Although primary prevention of childhood trauma has been difficult, it is important for trusted and trained adults to intentionally teach children strategies of resilience, in hopes they avoid maladaptive coping habits, such as alcohol/drug abuse, overeating, smoking, or unhealthy sexual behaviors. Felitti (1998) reported

> High levels of exposure to adverse childhood experiences would expectedly produce anxiety, anger, and depression in children. To the degree that behaviors

> such as smoking, alcohol, or drug use are found to be effective as coping devices, they would tend to be used chronically. For example, nicotine is recognized as having beneficial psychoactive effects in terms of regulating affect and persons who are depressed are more likely to smoke. Thus, persons exposed to adverse childhood experiences may benefit from using drugs such as nicotine to regulate their mood. (Felitti, 1998, pp. 253-254)

These behaviors then lead to declining health factors, hence the correlation between ACES and declining health status. Current research suggested health professionals are now acknowledging childhood trauma in treatment and etiology of health issues. Van der Kolk (2014) wrote in his book, *The Body Keeps the Score:*

> When the surgeon general's report on smoking and health was published in 1964, it unleased a decades-long legal and medical campaign that changed daily life and long-term health prospects. The number of American smokers fell from 42 percent in 1965 to 19 percent in 2010. The ACE study; however, had had no such effect. (p. 180)

Currently, clinicians and educators are beginning to see the effects of childhood trauma, yet the numbers continue to rise in mental illness, developmental delay, and behavior problems. It is time educators acknowledge traumatic childhood environments and give children healthy and effective tools to use instead of maladaptive coping strategies they learn through negative experiences. As indicated, in 2015, only 2% of schools actively screened for mental health issues (Romer & McIntosh, 2005, para. 51). Furthermore, historically, the average teacher may have never had a lecture or attended an instructional in-service on trauma. Today, in society, it is imperative teachers and

physicians, in addition to community stakeholders, understand the devastating effects trauma can have on individuals and society as a whole. Individuals need to see the human and be understanding of toxic early life experiences, not the problem or maladaptive behaviors.

Purpose of Study

A major outcome of this proposed project is to contribute to the knowledge base of the literature within the fields of early intervention, screening for a variety of mental health issues, identification of adverse childhood experiences, and the importance of actively teaching social/emotional skills and giving young children tools for resilience. The Study District requires each kindergarten teacher to complete the Social, Academic, and Emotional Behavior Risk Screener (SAEBRS) on each student. These data will be de-identified and mined into categories, such as students who attended the Study District Early Childhood Center (ECC), without an Individualized Education Program (IEP) specifically taught using strategies based in Conscious Discipline (CD), students who attended ECC on an IEP specifically taught using strategies based in CD, and those students who did not attend ECC, etc. Therefore, in this respect, purpose is also constructed in trauma-informed, evidence-based practices which are thought to increase skills in young children when teachers use evidenced-based methodology to intentionally teach students appropriate social/emotional skills, discipline, and self-regulation; skills needed for resiliency and mental wellness far beyond early childhood. To this end, demonstrating how universal mental health screening in early childhood is important to determine which students need support and to what extent will be of utmost importance.

An additional objective is to use this study's results to derive ways to extend this instruction into elementary schools and beyond, giving children effective tools to use for themselves and to help peers. For example, the Study District is committed to providing opportunities for Positive Peer Influence (PPI) among District students. The following statement is provided on the district website:

> Positive Peer Influence is a powerful force, offering a good chance for addressing problems characteristically experienced in pre-adolescent and adolescent development. These influences also can dramatically affect the growth of positive self-esteem.
>
> Alcohol/substance abuse and bullying in particular have been singled out as problems that can be addressed through the exertion of more positive influence by students upon their peers. Strategies and activities to improve Positive Peer Influence in the schools have been strategically implemented since the 1989-1990 school year and continue to be expanded annually. (Study District, 2020, Mission, Vision, History, Positive Peer Influence section, para. 1)

Questions and Hypotheses

Research Question: What is the difference in social/emotional skills between children who attended Study District ECC and the children who did not attend Study District ECC, as measured by the SAEBRS (Social, Academic, and Emotional Behavior Risk Screener)?

Null Hypothesis 1: The social/emotional scores of children who are intentionally taught social- emotional skills are not higher than those who are not, as measured by the SAEBRS.

a. The overall Total scores of children who are intentionally taught social emotional skills are not higher than those who are not, as measured by the SAEBRS.
b. The Social Behavior scores of children who are intentionally taught social emotional skills are not higher than those who are not, as measured by the SAEBRS.
c. The Academic Behavior scores of children who are intentionally taught social emotional skills are not higher than those who are not, as measured by the SAEBRS.
d. The Emotional Behavior scores of children who are intentionally taught social emotional skills are not higher than those who are not, as measured by the SAEBRS.

Null Hypothesis 2: The social/emotional scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS.

a. The Total scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS.
b. The Social Behavior scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS.
c. The Academic Behavior scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS.
d. The Emotional Behavior scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS.

Null Hypothesis 3: The students' subtest scores (cooperation) of those who have an IEP are not lower than the scores of those who do not have any identified developmental delays as measured by the SAEBRS.

a. The Cooperation subtest scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS, given both groups attended the Early Childhood Center where these skills are intentionally taught.
b. The Cooperation subtest scores of children who have an IEP and attended the Early Childhood Center are not lower than those who do not have an IEP and did not attend the Early Childhood Center where these skills were intentionally taught, as measured by the SAEBRS.
c. The Cooperation subtest scores of children who are intentionally taught social emotional skills are not higher than those who are not, as measured by the SAEBRS.

Null Hypothesis 4: The students' subtest scores (adaptability) of those who have an IEP are not lower than the scores of those who do not have any identified developmental delays as measured by the SAEBRS.

a. The Adaptable to Change Subtest scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS, given both groups attended the Early Childhood Center where these skills are intentionally taught.
b. The Adaptable to Change Subtest scores of children who have an IEP and attended the Early Childhood Center are not lower than those who do not have

an IEP and did not attend the Early Childhood Center where these skills were intentionally taught, as measured by the SAEBRS.

c. The Adaptable to Change Subtest scores of children who are intentionally taught social emotional skills by highly trained teachers are not higher than those who are not, as measured by the SAEBRS.

Null Hypothesis 5: The students' subtest scores (ability to recover after setback) of those who have an IEP are not lower than the scores of those who do not have any identified developmental delays as measured by the SAEBRS.

a. The Ability to Rebound Subtest scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS, given both groups attend the Early Childhood Center where these skills are intentionally taught by highly trained teachers.

b. The Ability to Rebound Subtest scores of children who do not have an IEP and attended the Early Childhood Center are not lower than those who do not have an IEP and did not attend the Early Childhood Center where these skills were intentionally taught, as measured by the SAEBRS.

c. The Ability to Rebound Subtest scores of children who are intentionally taught social/emotional skills by highly trained teacher are not higher than those who are not, as measured by the SAEBRS.

Null Hypothesis 6: There is no difference between the social/emotional scores of students who did not attend ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.

a. There is no difference between the Total scores of students who did not attend ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.
b. There is not difference between the Social Behavior scores of students who did not attend ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.
c. There is not difference between the Academic Behavior scores of students who did not attend ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.
d. There is not difference between the Emotional Behavior scores of students who did not attend ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.

Null Hypothesis 7: There is no difference between subtest scores (Cooperation; Adaptability to Change; Ability to Rebound) of students who did not attend ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.

a. There is no difference between the Cooperation Subtest scores of students who did not attend ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.
b. There is no difference between the Adaptable to Change Subtest scores of students who did not attend ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS

c. There is no difference between the Ability to Rebound Subtest scores of students who did not attend ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS

Independent variable – The independent variables for *t*-test analyses was student attendance. Random samples were taken of the following groups: neurotypical students who did not attend a preschool or daycare where social/emotional skills were intentionally taught by highly trained teachers using a science-based, research-backed curriculum, neurotypical students attended the Study District's Early Childhood Center where social/emotional skills were intentionally taught by highly-trained teachers using a science-based, research-backed curriculum, and students who attended and identified with developmental delays based, on DESE's guidelines with an Individualized Education Program in place at the Study District's Early Childhood Center. The independent variable for ANOVA analyses was years of attendance at the Study District's Early Childhood Center; more than one year, one year only, or no attendance at the school.

Dependent variable. The dependent variable for all statistical analyses were scores obtained from the Social, Academic, and Emotional Behavior Rating Scale (SAEBRS). Kindergarten students in the Study District are rated by their teacher using this measure. The researcher was permitted by the Study District Superintendent to access this secondary data for this study.

Definition of Terms

Adverse Childhood Experiences (ACEs) study – A landmark study completed in 1998 used to connect childhood abuse and household dysfunction to leading causes of

death in adults. Authors developed a questionnaire to determine risk factors (Felitti et al., 1998).

Behavior – The technical definition of a behavior is that portion of an organism's interaction with its environment that is characterized by detectable displacement in space through time of some part of the organism and that results in a measurable change in at least one aspect of the environment (Cooper et al., 2014).

Conscious Discipline - Conscious Discipline is a comprehensive classroom management program and a social-emotional curriculum. It is based on current brain research, child development information, and developmentally appropriate practices. Conscious Discipline has been specifically designed to make changes in the lives of adults first. The adults, in turn, change the lives of children. Children and adults learn the skills needed to successfully manage life tasks, such as learning, forming relationships, communicating effectively, being sensitive to others' needs and getting along with others. Strategies are intentionally taught and modeled (Bailey, 2015).

Early Childhood – For this dissertation, "early childhood" will be defined as the following: According to the National Association for the Education of Young Children (NAEYC, n.d.), early childhood years are those of development from birth through age eight.

Epigenetics – "Epigenetics is the study of how your behaviors and environment can cause changes that affect the way your genes work. Unlike genetic changes, epigenetic changes are reversible and do not change your DNA sequence, but they can change how your body reads a DNA sequence" (Centers for Disease Control and Prevention, 2020, para 1).

Maladaptive Behavior – For this dissertation, a maladaptive behavior is defined as a behavior marked by poor or inadequate adaptation; behaviors that inhibit one's ability to adjust to situations.

Mental Health – According to the World Health Organization (n.d.) a person's condition with regard to their psychological and emotional well-being; Mental health is defined as

> a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. (Mental Health: strengthening our response data sheet, para. 3)

Multidisciplinary - involving one or more disciplines or fields of study (Merriam-Webster, n.d.).

Preschooler – For the purpose of this dissertation, a preschooler will be defined as a child not old enough to attend kindergarten, falling between the ages of three and five years.

Social, Academic, and Emotional Behavior Risk Screener (SAEBRS) - The SAEBRS is a brief tool supported by research for use in universal screening for behavioral and emotional risk. The measure falls within a broad class of highly efficient tools, suitable for teacher use in evaluating and rating all students on common behavioral criteria (Severson et al., 2007). The SAEBRS is designed for use in the K-12 setting and grounded within a conceptual model, which states that a student's success in school is not only related to his or her academic achievement, but also success within multiple behavioral domains. Research suggested the SAEBRS may be used to evaluate student

functioning in terms of overall general behavior, as assessed by a broad Total Behavior (19 items). Research further suggested the SAEBRS may be used to evaluate student behavior within multiple inter-related narrow domains, as assessed by the Social Behavior (6 items), Academic Behavior (6 items), and Emotional Behavior (7 items) subscales (Kilgus et al., 2013).

Trauma – For this dissertation, trauma is defined as a deeply distressing experience. There are three types of trauma. Acute trauma from a single incident, chronic trauma which is prolonged or repeated, such as abuse, and complex trauma; multiple events often relational.

Trauma Informed – A team of educators defines "trauma informed" as pertaining to the practices that educators put in place in a school – practices which recognize the prevalence of trauma and adversity in a student population. Its focus is to help students feel safe and stay emotional regulated. Trauma-informed can also describe an organizational change process. In a trauma-informed school, there is not only an understanding that students have to feel safe to learn, but also teachers have to feel safe to teach (Cox et al. 2017).

Summary

In conclusion, understanding trauma, types of stressors, and adverse childhood experiences should be a top priority in our country today. Previously, traumatic experiences were rare and were not perceived to have negative, long-term effects, because these experiences were not discussed openly. However, Felitti et al.'s (2018) study of adverse childhood experiences began to change how trauma is viewed. Felitti et al.'s (2018) study showed adverse childhood experiences are more common than

previously presumed. Due to the correlation between exposure to traumatic experiences in childhood and maladaptive behaviors, it is increasingly important that multiple disciplines come together to elucidate these consequences and subsequently work to find helpful resources and effective tools for resiliency in those who have experienced such hardships.

The leading causes of health issues in our world today are mental illnesses. With the current COVID-19 pandemic and restrictive policies, more and more children and families are struggling than ever before. Therefore, it is imperative teachers, physicians, counselors, and community stakeholders understand the devastating effects trauma can have on individuals and society as a whole. The purpose of this study is to investigate differences in social/emotional skills between children who attended a preschool where positive connection and healthy relationships resulted in the ability to intentionally teach skills for resiliency and children who have not had such an opportunity. It is imperative teachers, physicians, counselors, and community stakeholders understand the devastating effects trauma can have on individuals and society as a whole and, because of this, the researcher believed this topic was critical to current practices and deserved further study. A review of literature including history, special education, trauma, mental health issues, screening, assessments, and evidence-based strategies for mitigation was completed and reported in the following chapter.

Chapter Two: Review of Literature

Brief History of Early Childhood Education

Early childhood education and childcare became important during the American Revolution in 1840. Changes involved the use of new materials, use of new energy sources, the invention of new machines, developments in transportation, and factory systems (Wallace, 2021). During this time, American women were forced into textile mills, which raised challenges in caring for their young children. Due to almost 75% of the workforce being women, their needs were met in the first infant schools (A Brief History, Part 1, 2017a, 0:13). About 40% of young children attended infant school in Massachusetts around 1840 (Wallace, 2021) until Amariah Brigham, Psychiatrist and the first Medical Superintendent of the New York State Lunatic Asylum at Utica, expressed concerns early life stimulation caused insanity. He wrote the following in Remarks on the Influence of Mental Cultivation and Mental Excitement Upon Health in 1836,

> It is, therefore, deeply important that the natural action of the nervous system should not be much increased, either by too much exercise of the mind, or by strong excitement of the feelings, lest at the same time the liability of children to nervous diseases be increased, and such a predominance given to this system as to make it always excited, and disposed to sympathize with disorder in any part of the body; thus generating a predisposition to hypochondrias [sic] and numerous afflicting nervous affections. (Brigham, 1833, Section II, para 5)

Due to his opinion, childcare outside the home and early childhood education disappeared until the early 1900s when Americans began the fight against equalities, such as length of workday, voting rights, and child labor. Out of these fights, Americans

advocated for the importance of educating our nation's young children. During the first 20 years of the century, nursery schools and kindergartens began to open nationwide (A Brief History, Part 1, 2017a, 0:54).

As Americans prioritized the education of young children, the National Association for the Education of Young Children was founded and established in 1926 (Educational Consumers Foundation, n.d., p. 3). By 1931, 74 colleges in the United States offered early childhood majors (A Brief History, Part 1, 2017a, 1:02). By World War II and the 1940s, there was another childcare crisis due to the number of women in the workforce as 16 million men were in the armed forces at the time. Six million women entered the workforce due to the extremely large number of men gone and fighting for the country resulting in public outcry as children were then unsupervised while mothers worked to support their families (A Brief History, Part 1a, 2017, 1:14).

In 1940, President Harry Truman signed the Lanham Act. As stated on the Friends of the National World War II Monument website, "the law was designed to assist communities with water sewer, housing, schools and other local facilities' needs related to war and industry growth" (Ertman, 2019, para. 3). Betsy Stevenson wrote in the White House article, An "Experiment" in Universal Child Care in the United States: Lessons from the Lanham Act, the Lanham Act provided immediate help for families and positive long-term results for children (Ertman, 2019, para. 7). In 1942, during World War II, the United States began to offer universal childcare and emergency nursery schools were able to be established resulting from Lanham Act approval.

In the 1947 study in California reference by Stevenson (Koshuk,1947), the records of 500 nursery school children were gathered and examined, and then

supplemented with developmental history and teacher reports of progress. The researcher, Koshuk, reported at the time of the study at least 10 states, other than California, had begun to establish nursery schools within the public education system. However, some difficulties occurred due to a shortage of trained teachers and staff and inadequate financial funds. In evaluating the records, Koshuk (1947) attempted to prove "good nursery schools and childcare centers strengthen family living" (p. 3). Analysis revealed effects of the childcare experience, at home and school, was favorable. Koshuk reported records showed "more than four-fifths are considered to have made good or excellent general progress, especially in emotional and social growth" (1947, p. 16) which contradicted previous statements by Brigham (1833) as discussed earlier in this chapter. Koshuk (1947) concluded the program for "under-fives had reduced tensions, lessened friction in the home and insecurity in non-home situations, and so benefitted the children and strengthened family living" (p. 16).

Although the childcare experience during World War II proved favorable in many ways, in 1945, men returned home from the war, leading culture back to previous norms with women returning to tend to and work at the home as they did prior. In 1946, the Lanham Act expired resulting in loss of childcare opportunities for those who needed them which also forced women back into the home as they were no longer able to work outside the home and leave their children in someone else's care. Around the same time, the United States experienced a baby boom and by 1958 there were two million children of preschool age in the country. Before 1960, only 4% were placed in daycare by their mothers (A Brief History, Part 2, 2017b, 0:24). Shonkoff and Meisels (1990) noted "without public resources, nursery schools drifted from their early mission of serving

poor children and became increasingly available only to those who could afford private tuition" (p. 6). A shift in attitudes and practices in education children happened and in 1961, Hunt and Bloom began to focus on brain growth related to early life experiences (A Brief History, Part 2, 2017b, 0:35). They reported cognition is not completely genetic and about 50% of our intellectual skills are developed before age four years; however, there was very little research at the time to support this supposition. Due to their opinions, thoughts that early childhood education could help cultivate cognition and healthy brains, and in addition, could help families needing childcare began to rise (A Brief History, Part 2, 2017b, 0:50). As time and opinions progressed, in 1964, President Lyndon Johnson declared war on poverty and, as a result, the Head Start program was initiated. In the summer of 1965, over a half a million preschool-aged children (3-4 years old) entered 11,000 Head Start centers serving low-income families, making this a very popular program for working families (A Brief History, Part 2, 2017b, 1:00)

1n 1971, congress passed the Comprehensive Child Development Act in response to America's desire for universal child-care of high quality. However, in 1972, President Nixon vetoed the childcare legislation due to his assertions it was similar to Soviet Russia's communal child-rearing programs (A Brief History, Part 2, 2017b, 1:20). In Clawson's 1973 article, "Political Socialization of Children in the USSR," he discussed that although child-rearing in the Soviet Union largely rested within the family unit, there were radical-communalists advocating for child-rearing in a communal, regime sponsored, environment. This idea was one President Nixon appeared to reject in his veto of the 1971 Comprehensive Development Act. Nixon indicated in his opinion childcare

would weaken the American family (A Brief History, Part 2, 2017b, 1:27). At this time, Head Start only covered a fraction of families across our country.

Based on the 2020 National Head Start Profile, only 36% of eligible children ages three to five years had access to Head Start and 11% of those under age three who were eligible had access to Head Start. An estimated 4.6 million home visits were conducted and 63,508 parents struggling with low income and poverty received job training for employment. The profile also stated 37 million children have participated in the program since its inception, 55 years ago ("2020 national head start profile – Maryland families engage," n.d.). Head Start has been geared to families in low-income situations leaving other families to find private childcare and preschool options. Today, childcare is expensive and many families, although not considered low income based on government standards, cannot afford quality childcare or preschool. Additionally, Head Start offers other support services such as housing, food assistance, health care for physical and mental wellness ("Family support and well-being," 2021, para. 1).

Special Education and Missouri Criteria for Eligibility

Regarding special education, before 1961 "the United States did not publicly educate students with disabilities" (Arkansas State University, para 1). Instead, parents had to pay for private education and services (Arkansas State University, para 1). In 1975, the Education for All Handicapped Children Act was born, now known as the Individuals with Disabilities Education Act (IDEA) (Arkansas State University, para 2). This law requires public school districts to provide a free and appropriate public education to students with disabilities in the least restrictive environment needed to help students progress in skills and meet educational goals (About IDEA, 2020a, para. 1). By

the 2000s, revisions and updates were included for early intervention services for infants, toddlers and preschoolers (About IDEA, 2020b, paras, 1, 8, 12, 13).

The Missouri State Plan for Special Education under Part B of IDEA "specifies the process that all school districts are required to follow in identifying, evaluating, and serving all children with disabilities who live in the school district" (Missouri Department of Elementary & Secondary Education [DESE], 2018, p. 5). Children who show evidence of delayed skills in any area may be identified with a disabling condition, making them eligible to receive a variety of special education services and related therapies. Once a student is found to have a disability, an Individualized Education Program (IEP) is developed to support the student's needed specialized instruction in any areas of need (DESE, 2018). For example, in the area of social, emotional, and behavioral skills, young children may be identified as a Young Child with a Developmental Delay in early childhood. As the student moves into elementary school, a re-evaluation will take place prior to the end of their kindergarten year. At that time, school staff will determine if the student meets initial eligibility criteria for any of the following identification areas: Other Health Impairment, Emotional Disturbance, or possible Traumatic Brain Injury, or any other appropriate special education category of identification. The educational evaluation must document how the child's delays adversely affect their educational performance (DESE, 2018). Examples of categories, and specific eligibility criteria, a student may be identified in pertaining to the area of social/emotional/behavioral development follow.

To be identified as a Young Child with a Developmental Delay in one of the developmental areas; cognitive, adaptive behavior, physical, communication, and/or social/emotional, the student must show a significant delay based on educational

evaluation results documenting performance at or below 2.0 standard deviations from the mean in one developmental area or 1.5 standard deviations from the mean in two areas. Additionally, a multidisciplinary team of educators may determine that although test scores appear to be above these thresholds and do not meet stated criterion levels, a significant discrepancy may exist; however, substantial documentation must be present. Such information may include previous therapy and/or intervention, early intervention services including type, frequency, and duration of such. Additionally, the team can consider a child may experience regression of skills due to termination of previous intensive early intervention services (Strange, 2021d, pp. 1-2).

To be identified as a student with Other Health Impairment, a multidisciplinary team must document limited strength, vitality and alertness, including emotional stamina, lack of endurance for motor activities, sustained energy and effort, and mental processing, attention, and focus. Additionally, the student must have a comprehensive health evaluation by a licensed physician resulting in a diagnosis of a chronic or acute problem such attention deficit hyperactivity disorder or another medical diagnosis. For children who have not been diagnosed with such, an evaluation by a licensed psychologist, psychiatrist, counselor or social worker is required (Strange, 2021b, p. 1).

To be identified as a student with an Emotional Disturbance the multidisciplinary team must complete a comprehensive evaluation demonstrating the student's inability to learn, build or maintain relationships with peers and teachers, inappropriate types of behavior or feelings under normal circumstances, a general pervasive mood of unhappiness or depression, and/or a tendency to emulate somatic complaints. The

evaluation must also include an in-depth social history along with observations of the student's maladaptive behavior in different environments. (Strange, 2021a, pp. 1-2).

Strange (2021) also included Traumatic Brain Injury as an area of identification for special education as it is a classification whereas physical trauma may have been the cause for the student's social, emotional, and/or physical deficits. To be identified in this area, the evaluation report must document a licensed physician's diagnosis of a traumatic brain injury or a neuropsychological assessment identifying such. If the multidisciplinary team agrees, in absence of documentation by a physician, the report may include "substantial data to document the medical basis for a head injury" even though a medical diagnosis has not yet been made. Additionally, the educational evaluation report must include substantiative evidence documenting "deficits in acquisition, retention, and/or generalization of skills resulting from the brain injury" as well as deficits in other areas such as social competence and daily living skills (Strange, 2021c, pp. 1).

Individualized Education Programs (IEP)

When children show developmental delays or health impairments adversely affecting educational performance, the child may be eligible to receive intervention services and related therapies. To access special education services, they must meet eligibility criteria to be identified as a student with a disabling condition first. Once the identification area of delay is agreed upon, an Individualized Education Program is written which further indicates present level of educational performance including area of identification, learning standards expected of same age peers the student is likely to have difficulty meeting, the child's strengths and weaknesses, parent concerns regarding the child's educational performance, along with any modification needed for state or district

wide assessments. The plan also includes information regarding the student's primary language, living arrangements, and needs for transportation, technology, summer school participation if needed, and type of placement (i.e., regular education, early childhood special education, itinerant, etc.) along with goals and objectives the student will be working toward and any therapy needed such as occupational therapy, language therapy and others. Additionally, there are times some children may not meet the criteria to be identified as a student with a disabling condition, yet school staff continue to have significant concerns regarding the child's educational performance. At that time, a 504 Plan may be considered. A 504 Plan is not considered a part of special education; however, it can bridge the gap. These plans are covered under Section 504 of the Rehabilitation Act of 1973, civil rights law. Although these plans are covered by different laws, schools are not mandated to write these plans as they are required to develop IEPs. End goals tend to be the same as the plan provides for needed accommodations, to remove barriers and provide better access to students for their individual learning styles and/or challenges (Public notice: 504, n.d., para. 2). In addition to IEPs and 504 plans, school districts are becoming focused on being more trauma-informed by understanding how the brain processes and reacts to trauma, resulting in dysregulated behaviors such as decreased focus, aggression, non-compliance, withdrawal, anxiety, impulsivity, and more (Forbes, 2012)

Effects of Trauma on Brain Development

Alongside a colleague, Van der Kolk (2014), founder and medical director of the Trauma Center in Brookline, Massachusetts, performed a study on the brains of people who had experienced stressful situations and adverse experiences, suffering from

flashbacks by looking at their brains in a neuroimaging lab. Results of the study revealed "when traumatized people are presented with images, sounds, or thoughts related to their particular experience, the amygdala reacts with alarm. Blood pressure, heart rate, and oxygen intake is triggered by nerve impulses and stress hormones" (Van der Kolk, p. 42, para. 3). Additionally, the speech area of the brain, Broca's area, experienced a significant decrease in activity (Van der Kolk, p. 43, para. 2). The decrease impacted the ability for people to tell others what had happened to them to the extent of the impact. Van Der Kolk's (2014) study also indicated past trauma roused the right side of the brain and interrupted processing by the left hemisphere (p. 44). The left brain stores facts and statistics, while the right side of the brain holds memories of experiences such as emotions, touch, smell, etc. (Van der Kolk, p. 45). When people are reminded of trauma, they essentially do not realize they are reexperiencing the toxic situation because their left brain is not activated and they experience emotions such as anger, shame, etc. due to the prominence of the right brain control (Van der Kolk, p. 45).

Early critical periods for neurological development take place in utero until around age five. Healthy children are more likely to grow into healthy adults. Positive experience in the early years strengthens the developing biological systems, yet these systems are weakened with adverse childhood experiences. As written in the 2010 report by the Center on the Developing Child at Harvard University,

> Health is more than merely the absence of disease – it is an evolving human resource that helps children and adults adapt to the challenges of everyday life, resist infections, cope with adversity, feel a sense of personal well-being, and interact with their surroundings in ways that promote successful development" (p.

> 2, para. 2). …Health, physical well-being, and development are impacted by toxic, unsafe environments, including abuse, neglect, and chemical toxins. Early exposure to these kinds of stress impacts the vulnerability of the brain in the early years, prompting changes in other systems as well and leading to life-long deficits and disease. (p. 10)

Environment often affects the brain and body's genetic expression. "Epigenetics is the study of how your behaviors and environment can cause changes that affect the way your genes work. Unlike genetic changes, epigenetic changes are reversible and do not change your DNA sequence, but they can change how your body reads a DNA sequence" (Centers for Disease Control and Prevention, 2020). Ryan et al. (2016) reported those who have developed post-traumatic stress disorder (PTSD) after an adverse experience also have children who are likely to develop PTSD after traumatic experiences as well (p. 1554, para. 1). Childhood trauma is a well-documented risk factor for many concerns, including developmental delays, disease, and mental health issues. Although more research is needed, it is thought not all epigenetic changes are permanent. Some epigenetic changes can be added or removed in response to changes in behavior or environment (CDC, 2020). Ryan et al. (2016) also stated, "Given that epigenetic processes are dynamic and highly sensitive to environmental cues, there is great promise that appropriate interventions could help counteract or reverse the negative effects of trauma, building resilience through changes in gene activity" (p. 1563, para. 2).

Additionally, advances have been made in understanding the development of the human brain in the last decade due to functional magnetic resonance imaging and other gains in human neuroscience. Nelson et al. (2013) wrote "For the first time, scientists

have begun to understand the complex processes whereby people's thoughts and feelings which are intimately related to their social experiences, influence interactions between neurological, endocrine, immune and metabolic systems" (p. 240). Based on recent brain research, scientists have discovered the scans of brains in traumatized children do not look like brains of children who have not experienced chronic trauma. Trauma is not the bad thing that happened to you, but instead is the internal result of disconnection due to painful feelings (Benazzo & Benazzo, 2021). Humans were not meant to go through life alone, but with connection to others. In the case of school success and well-being, healthy peer relationships and nurturing caregivers promote positive outcomes, including brain development.

Treatment of Trauma

Research in mental health issues in early childhood has, historically, been limited. More have contributed to the literature and understanding of trauma in early childhood in the last two decades. In the past, psychologists, therapists, counselors, may have worked with an adult who had experienced traumatic events and toxic stress; however, children in the situation were not likely to be considered for support services (Buss et al., 2015). Based on research, there is information to support the more frequent the exposure to early childhood trauma, the higher the risk of poor health outcomes in adulthood (Felitti et al., 1998), in addition to a vast array of mental health issues. It was previously thought infants and young children could not process trauma and lacked the ability to process those types of events. Physicians, educators, and support personnel now understand children do process trauma and frequently require support for healthy ways to work

through those toxic experiences. Additionally, there has been a lack of clear diagnostic criteria, and a lack of tools for gathering that type of information (Buss et al., 2015).

In the community of educators, there is recognition treatment and early intervention has the ability to minimize the impact of toxic stress on a child's physical, developmental, social, and emotional systems. Several evidence-based measures have become available to clinicians in supporting children coping with these adverse situations in the recent past. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), child-parent psychotherapy (CPP), attachment and biobehavioral catch-up (ABC), and parent-child interaction therapy (PCIT) are geared to young children and incorporate play. Buss et al. (2015) also discussed emerging treatments Ways of Seeing, combining movement and dance, Honoring Children, Mending the Circle (HC-MC), addressing spiritual needs of young Native American and Alaska Native children, and Trauma Assessment Pathway, incorporating referral to community resources for additional family supports (Buss et al., 2015). Many studies indicated experiences of trauma in young children are a good predictor of academic failure and discipline issues in later years (Dutil, 2020); therefore, it is imperative children and families have access to the most current strategies, tools, and supports that best meets those individual needs.

Adverse Childhood Experiences Study (Felitti) and Implications

Prior to Felitti conducting the well-known Adverse Childhood Experiences or ACE study, he began to see individuals in his San Diego clinic in 1985. He was chief of Kaiser Permanente's Department of Preventive Medicine and was overseeing an obesity clinic. Between 1990 and 1998, Felitti and collaborators spent more than a year formulating questions covering "carefully defined categories of adverse childhood

experiences" (Van der Kolk, 2015, p. 146, para. 5) based on thousands of medical questionnaires completed by individuals moving through the Department of Preventative Medicine (Van der Kolk, 2015) resulting in the ACE study.

After 13,494 adults completed the questionnaire, a strong correlation between exposure to abuse, trauma, or dysfunction during childhood and multiple risk factors for causes of death was noted. Adults who had experienced four or more categories of childhood trauma (psychological, physical/sexual abuse, violence against mother, mental illness, substance abuse, criminal behavior in household/ imprisonment) compared to those who had experienced none were much more likely (4 to 12-fold increase) for alcoholism, drug abuse, depression, smoking, poor health, suicide attempts etc. The more exposure to trauma, or the higher the ACEs score, the more likely the adult's health status was impacted negatively (Felitti et al., 1998).

Felitti et al.'s (1998) study in childhood trauma and its future long-term implication on adult health and risk factors is considered a landmark study by many in psychology and education. The findings suggested that the impact of these adverse childhood experiences on adult health status was strong and cumulative (Felitti et al., 1998). The Felitti et al. (1998) study is important to the current study regarding intentional teaching of social skills and tools needed for resiliency in adulthood as childhood trauma continues to exist. Twenty-plus years later, more and more children are experiencing significant trauma, from prenatally to postnatally and beyond. These children are at higher risk of poor health outcomes in adulthood (Felitti et al., 1998), in addition to a vast array of mental health issues. Additionally, the ACE study revealed traumatic experiences were more common than anticipated (Van der Kolk, 2015). Felitti

et al.'s study (1998) focused on the correlation between adverse experiences and health issues into adulthood. However, more research has been conducted regarding the effects of trauma and toxic stress on children's development in the ability to learn needed for academic success (Sharkins et al., 2016; Wichstrøm, 2011).

Effects of Parenting Styles, Trauma, Violence and COVID-19

Childhood poverty, including low levels of family income and parental education, can negatively affect development in areas such as language and cognition. This scenario often results in deficits in academic achievement and social interactions. When parents also suffer from mental health issues, these problems can be compounded. As children grow and develop, the quality and quantity of parental and/or caregiver interactions they are exposed to strongly influences their cognitive development (Sharkins et al., 2016, p. 493). Additionally, children also discover their own emotions and learn to manage their own behavior. The parent-child interaction is important in these developmental milestones and when a parent is unable to promote positive social relationships, children fall behind. In the Sharkins et al. (2016) study, caregivers and children were selected from an Early Head Start Program. Head Start and Early Head Start is a program serving children birth through age five, along with prenatal services, in the home or center-based settings whose families meet Federal Income guidelines. Both offer education, vision, hearing and developmental screenings, and other services such as nutrition, parent education, health services and information regarding other community resources as needed (Early Head Start, n.d.). Sharkins et al. (2016) stated their study extends the work of Gilliam (2005) finding the children's difficulty regulating their emotions and behavior was a primary component contributing to expulsion in early childhood. On average,

Gilliam (2005) found that preschoolers were more than three times likely to be expelled from a school than children in elementary and secondary settings (Sharkins et al., p. 497). Sharkins et al. (2016) study results indicated lack of development of adequate social-emotional skills could result in negative consequences and impact the ability to learn in preschool and beyond. To diminish effects of childhood poverty and increase positive social/emotional competence and maximize educational outcomes, it is important for caregivers and professionals to focus on providing positive experiences and providing opportunities for growth in social and emotional competence which is likely to impact future developmental and educational outcomes (Sharkins et al., 2016, p. 497).

Hastings' (2003) study found that mothers are more affected by the child's behavior than fathers. Fathers are typically less involved in the daily care of their children and, therefore, may be less affected by their children's problems. Additionally, it was noted "if [mother's] rely on their husband for social and practical support, then this may be reduced when he is feeling anxious or depressed" (Hastings, p. 235, para. 2). Consequently, if low economic and educational correlates are involved as studied by Sharkins et al. (2016), children may have less positive modeling of dealing with stress and anxiety effectively.

A staff editor for Pediatrics Week discussed a 2019 Canadian study of more than 2,400 families that assessed the amount of screen time related to behavioral problems in young children. Piush Mandhane, researcher, was interviewed by the editor and revealed results indicated clinically significant negative outcomes for children spending two or more hours per day on a screen. This group was more than five times more likely to exhibit clinically significant externalizing behaviors such as decreased attention and they

were more likely to meet criteria for ADHD (attention deficit hyperactivity disorder) (Pediatrics Week, 2019). Another Canadian study (Tamana et al., 2019) also using the Child Behavior Checklist (CBCL) completed by parents about behaviors of their five-year-old children. The study showed increased screen time, above two hours daily, correlated with clinically significant externalizing problems (Tamana, et al., p. 8). In addition to parental feelings of inadequacy and lack of support, which leads to consequences in the parent child relationship as Hastings (2003) discussed, children may experience technological neglect as parents' primary attention is directed at a phone, laptop or computer. Christakis (2018) stated, "When it comes to children's development, parents should worry less about kids' screen time and more about their own" (para, 1). The phrase "continuous partial attention" was coined by writer and author, Stone in 1998 (About, 2020). Twenty years ago, she was able to see the effects of cumulative partial attention to many things in the lives of people. Specifically, the harm it can do to our children in the areas of communication and emotions (Christakis, 2018, para. 7). Lastly, with children and parents home due to jobs requiring working from home as well as quarantines from school, parents are becoming burnt out and oftentimes, children and youth lack the supervision required to mitigate consequences of excessive screen time. Parent-child and sibling relationships also suffer due to other family member preoccupation with screens on a routine basis.

In a 2012 detailed workshop summary published by the Board on Children, Youth, and Families (National Center for Biotechnology Information, 2012), regarding social trends and child maltreatment trends, broad social and economic factors can influence trends in child maltreatment (Ch. 4). There are multiple data sources on child

maltreatment; however, more longitudinal data is needed to understand how family structure is related to maltreatment, and how social/emotional development is affected. As the novel coronavirus (COVID-19) has spread across the United States, infecting almost two million people and leading to over 110,000 deaths (as of June 9, 2020), over 96% of Americans have experienced orders to shelter in place (CDC, 2020). These changes have quickly led to significant changes in the daily lives of families, disruption in schedules and routines at home, daycare, and school. During times without such disruption, parents can often experience times of stress related to their children based on physical, developmental, and emotional concerns. In the current COVID-19 climate, many families are also experiencing additional stresses such as financial insecurity, unemployment, lack of social support (family, church, friends, etc.) due to quarantines and stay at home orders, as well as a lack of resources such as free and reduced lunches. Due to decreases in these resources, especially social supports, parents now have even less time for leisure activities of their own which, in the past, may have decreased their stress making them more patient and understanding with their children. When a parent is stressed and without proper resources, the potential increases for adults to engage in child abuse and neglect become ubiquitous (Griffith, 2020). Additionally, these experiences may reduce the possibility children have fully present and caring adults to connect with them and buffer toxic stress.

Mental Health Issues in Young Children

Not many empirical studies currently exist on the prevalence of psychiatric disorders in the early childhood years. A study by Wichstrøm et al. (2011) in Norway the regular community check-ups for four-year-old children who were screened for

behavioral and emotional problems with the Strengths and Difficulties Questionnaire (SDQ). The SDQ is made up of 20 items used to screen for psychiatric problems. Wichstrøm et al. (2011) also used the Preschool Age Psychiatric Assessment (PAPA) as follow-up diagnostic interview during the study. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) was subsequently used to diagnose in each case where needed. Results indicated encopresis was common among participants which increased the prevalence of psychiatric disorder in the group to 12.5%. Findings were as follows:

"Emotional and behavioral disorders were much more common among children whose parents did not live together or who had low socioeconomic status. Comorbidity was the norm; when a child had ADHD (attention deficit hyperactivity disorder), ODD (oppositional defiant disorder), CD (conduct disorder), or a depressive disorder, but to a lesser extent anxiety, it was more likely than not that she or he had another emotional or behavioral disorder" (Wichstrøm et al., 2012, p. 701, para. 2). Additionally, Wichstrøm et al. (2011) purported prevalence was higher in the United States based on previous American studies possibly due to the lower poverty rate in Norwegian regions. More recently in the United States, Oh et al. (2018) conducted a systematic review of pediatric health outcomes associated with ACEs to develop a clinical risk profile of children affected by toxic stress. Findings indicated

> biological changes in children were primarily neurological (e.g., gray matter volume) and hormonal (e.g., cortisol). Clinical outcomes were primarily neurologic (e.g., executive function). Children affected by ACEs manifest alterations in biology and health in distinct ways. However, the Oh et al. (2018)

> study did not use the DSM-IV to diagnose psychiatric disorders. Instead, Oh et al, (2011) indicated a "standardized pediatric risk profile would allow for more precise diagnosis and effective treatment of children affected by ACEs". (Oh et al., 2018, para. 1)

Dubowitz et al. (2016) completed a research study examining resilience in high-risk preschoolers, and considering factors in their adaptive functioning. Many of the families in the study had been reported to Child Protective Services before the child was four years of age with some placed in foster care. Results indicated 48% of the sample appeared to be resilient. However, caregiver depressive symptoms and maltreatment were heavily correlated with poor outcomes. The authors defined resilience as broad and a "concept that describes adaptive functioning, over time and in multiple domains, in a context of adversity" (p. 233). Shiner and Matson (2012) noted resilience indicates a child is meeting societal expectations, and in the context of the educational setting related to peer interactions and relationships, following rules and social expectations, along with academic performance. The main finding showing resilience in early childhood despite maltreatment indicates possibilities many can adjust or make up for adversity in the early years. Based on current literature, there is evidence to show children can recover from toxic stress and trauma when provided with adults who have the skills to establish healthy relationships with them. The following section reviews research-based strategies found to be effective in caring for and treating young children who have experienced significant trauma.

Evidence and Research-Based Strategies

Banks (2021) defined social-emotional learning as the "process of developing the required skills for the student to engage with other people as they grow. These skills are crucial for forming interpersonal relationships. It helps students manage social challenges that come along with work, school, and day to day life" (empathy, emotional control, impulse control, communication skills) (para. 5). Conscious Discipline is a comprehensive classroom management program and a social-emotional curriculum. It is based on current brain research, child development information, and developmentally appropriate practices. Conscious Discipline has been specifically designed to make changes in the lives of adults first. The adults, in turn, change the lives of children. Children and adults learn the skills needed to successfully manage life tasks such as learning, forming relationships, communicating effectively, being sensitive to others' needs and getting along with others (Bailey, 2015). Dr. Becky Bailey developed the Conscious Discipline curriculum to attempt to discover core principles needed to facilitate learning regardless of ethnicity, economic status, language, cognitive ability, age or gender. She also had a motivating desire to help children, seeming "unreachable," to live a happy and productive life with healthy relationships (Bailey, 2017). Bailey (2017) described Conscious Discipline to be the cumulative effect of her journey experiencing great cultural and economic diversity, and working with parents and caregivers unable to see assistance. Bailey (2017) stated,

> it is an attempt to bring together the best of what we know about learning, teaching, mental health, human development and neuroscience, and put it all in concrete terms. It is called "Conscious" Discipline because it fosters the

> development of a person's consciousness of his/her own mental models of learning, of teaching and of self. Without conscious awareness of your current mental models, change is impossible. Conscious Discipline does not force, coerce, bribe or manipulate children or adults to change. Rather, it is an educational process of helping adults and children become aware of their goals, their actions and the consequences of their choices. (p. 1)

Conscious Discipline is based on theorists Jean Baker-Miller, Jean Piaget, Lev Vygotsky, Eric Erickson, Carl Rogers, Abraham Maslow, Arnold Gesell, B.F. Skinner, Albert Bandura, and the following theories and science: attachment, child psychotherapy, physics, neuroscience, neuro-cardiology (Bailey, 2017).

Bailey (2015) wrote in the book, *Conscious Discipline Building Resilient Classrooms,*

> Conscious Discipline is a comprehensive, multidisciplinary self-regulation program that integrates social-emotional learning, school culture, and discipline. It helps teachers and administrators build schools based on the internal resources of safety, connection, and problem solving instead of external rewards and punishments. Its goal is to provide systematic changes in schools by fostering the emotional intelligence of teachers first and children second. Simply put, as we become more emotionally intelligent, we are better equipped to create positive, health educational climates that help create and maintain optimal learning states. (p. 12)

Additionally, seizing conflict as an opportunity to teach life skills is integral to Conscious Discipline (Bailey, 2015, p. 13). According to Dr. Bailey (2015), the health of a

relationship and the skill sets of those involved are the two parts of discipline. Based on the underpinnings of Conscious Discipline, opportunities to teach skills for resiliency occur in everyday events and conflicts, and are more powerful within healthy and connected relationships.

Play therapy differs from regular play as the therapist or counselor helps children discuss and address their problems through play. There are many treatment methods termed play therapy; however, each applies the therapeutic benefits of play during these sessions. Specifically, the Association of Play Therapy (APT) defines play as "the systematic use of a theoretical model to establish an interpersonal process wherein trained Play Therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (Guidelines, n.d., para. 2). A pilot study completed in 2012 investigated effectiveness in child-centered play therapy (CCPT), based on Carl Roger's person-centered theory, with 54 low-income preschool children who were participating in a Head Start program (Bratton et al., 2013. The children had been identified with "clinical levels of disruptive behaviors" (Bratton et al., 2013, p. 1, para. 1) prior to being assigned play therapy or to a control group. The final analysis, including teacher information regarding specific concerns, demonstrated children participating in CCPT demonstrated "significant decreases in aggression and attention problems" (Bratton et al., 2013, p. 1, para. 1). As another notable tool in fostering resilience in children, Bratton et al. (2013) stated "CCPT is a developmentally-responsive intervention that is based on a deep respect for children's innate ability for self-directed growth and healing given a therapeutic relationship characterized by nonjudgmental acceptance, empathy, and genuineness" (p. 37, para. 3). Again, the core of

efficacious tools and research- based practices is connection, relationship, and acceptance.

Another approach to teaching children and decreasing maladaptive behaviors is through Applied Behavior Analysis (ABA), a therapy based on the science of learning and behavior. Historically, it has been used more in teaching children with Autism Spectrum Disorder. However, it is becoming an increasingly popular strategy and tool for learning in many areas of interest, from athletic skill improvement to weight loss and more. ABA is adapted to meet individual needs in multiple environments. An individual's program is the understanding of specific problematic behaviors needing remediations, which entails antecedents and consequences to targeted behaviors. ABA is often provided by Behavior Specialists/Board Certified Behavior Analyst (BCBA) (ABA, n.d.). For the aforementioned evidence-based strategies to be effective with students, school staff should be regulated themselves and be able to implement such emotional supports efficaciously. The next section highlights research relating to trauma-informed care in the schools.

Trauma Informed Care

Teachers must understand of the implications of early life trauma to see the importance of giving students tools for resiliency. Resilience is the "ability to bounce back from stress, adversity, failure, challenges, and even trauma. It's not something that kids either have or don't have; it's a skill that kids develop as they grow" (Hurley, 2020, para. 1). Miljevic-Ridicki et al. (2017) described "two basic criteria in most definitions, namely, a significant threat or serious difficulties/adversity on the one hand, and positive adaptation or a positive developmental outcome/growth on the other hand" (p. 31).

Resilience is often described as an interactive concept, process, or construct. Conscious Discipline (CD) provides adults seven discipline skills (composure, assertiveness, encouragement, free will, empathy, positive intent, consequences) needed to effectively transform a problem into a life lesson (Bailey, 2015). Teachers are taught how to address their own internal state first. Understanding and recognizing brain states, executive state, emotional state, and survival state, enables adults to self-regulate and subsequently teacher children to do the same.

Miljevic-Ridicki et al. (2017) suggested parents, teachers, and students oftentimes have a different perspective of resiliency. These researchers wanted to find out how the different parts of the child's microsystem understood resilience (Miljevic-Ridicki, et al. 2017. p. 33). For the importance to the current study, teacher attitudes have been the primary focus here, in that there is new realization teachers need to begin implementation of teaching and modeling skills needed for resiliency and the ability to overcome adversities. This is not to indicate parental skills and involvement is not important as it very much is essential. The hope is teachers can provide tools and strategies to parents so carryover in skills is noted, and vice versa. It has been recognized that adults often need to learn these strategies to model and teach them to their students (Bailey, 2015). Additionally, teachers must learn how to keep themselves calm and emotionally regulated when dealing with stressors, both personally and when a student in their classroom becomes emotionally dysregulated or exhibits maladaptive behaviors. Through qualitative analysis using focus groups, and quantitative analysis using the Scale of Socio-emotional Wellbeing and Resilience in Preschool Children standardized on young

children in Croatia, Miljevic-Ridicki et al. (2017) reported the following summary in their study regarding perspectives on resilience:

> The qualitative data of our research show parents and teachers have different views on what defines resilience. Both groups perceive resilience as something positive, but teachers are more context oriented (cooperation, concrete help and support, etc.), while parents emphasize more personal characteristics, such as activity rather than passivity, realistic expectations of self and others, which could help them increase resilience. Children find the help and guidance of adults very helpful in increasing resilience. Our quantitative data show parents evaluate all aspects of children's resilience more positively than teachers. (p. 42)

De la Pena (2016) completed a systematic literature review on recent studies on resilience in young children. In summary, outcomes found "great importance of supportive relationships, developing within a certain environment and having a positive self-perception as influencers of the development of resilience" (p. 27). Cox brilliantly stated in Cox et al. (2017) "Students have to be emotionally available to learn. Teachers have to emotionally available to teach" (p. 6).

Summary

The history of assumptions regarding brain development began with people of influence such as Amariah Brigham, Psychiatrist, in 1836 reporting stimulation and activity in young children was too much for growing minds and resulted in mental illnesses. However, research over the last century has shown that positive stimulation, activity, and connection foster brain development in the early years. At times, the government has prioritized early childhood learning and childcare. Additionally, the

beginning of IDEA was born enabling school-age children with disabilities to access a free and appropriate public education. By the 2000s, early intervention services were added for toddlers and preschool age children.

In the last decade, advancements have been made in understanding brain development. Due to new research and progress in neurodevelopment, more understanding has surfaced regarding the negative effects of trauma and toxic stress on the brain during the early years of life. Furthermore, more has been discovered regarding experiences needed to buffer stress and trauma, and protect the growing brain. However, more awareness is needed regarding adverse childhood experiences and how trusted and caring adults can help buffer toxic stress interrupting health brain development, enabling children to learn skills for resiliency as they grow. Shonkoff stated in the *In Brief: Early Childhood Mental Health* (2020) video "most potential mental health problems will not become mental health problems if we respond to them early" (In Brief, 2020, 0:36). Significant adversity impairs growth in the first three years of life, in all areas of development.

Chapter Three: Research Method and Design/ Methodology

The purpose of the study is the possible relationship between student attendance at a preschool where social skills including resiliency are intentionally taught by highly trained teachers and higher scores on a screening assessment, Social, Academic, and Emotional Behavior Rating Scale (SAEBRS) targeting kindergarten readiness. Moreover, the researcher sought to compare neurotypical children, children with identified developmental delays based on the Study District's state DESE guidelines, as well as time in attendance including students attending Study District Early Childhood Center (ECC) one year, more than one year, or non-attendance. The Study District ECC requires all kindergarten teachers in the district to complete the SAEBRS for each student in the fall of a new school year. The researcher used this secondary data, acquired in 2020, for the current study, along with student years in attendance at the Study District ECC

As more research needs to be done relating to brain development and traumatic experiences in young children, it is important to investigate effective strategies to teach children skills for resiliency and correlation with tools that could be used to screen for these deficits. In the documentary, *The Wisdom of Trauma,* Mate stated that the brains of traumatized children do not look like those of non-trauma children (as cited in Benazzo & Benazzo, 2021). There is no ability to predict when children will experience adverse experiences and if these situations/experiences will be repeated; therefore, putting the child into a hypervigilant state. Mate further stated "children get traumatized because they are alone with the hurt, not because they got hurt" (as cited in Benazzo & Benazzo, 2021, 23:30). Attachment is non-negotiable and the Study District's curriculum,

Conscious Discipline, based on current brain research, child development and developmentally appropriate practices, emphasizes relationships.

For this research, the researcher developed one comprehensive research question regarding the study in its entirety and seven null hypotheses. Five of the seven null hypotheses address the SAEBRS scores and comparisons between student groups, students with an IEP who attended Study District ECC, neurotypical students who attended Study District ECC, and students who reside in the Study District, yet did not attend Study District ECC; therefore, without opportunity to receive intentional teaching of social skills including skills for resiliency. The last two null hypotheses addressed comparisons of the SAEBRS scores of students who have attended Study District ECC one year, attended Study District ECC more than one year, and those students who reside in Study District, yet never attended Study District ECC.

The researcher chose a quantitative method of study as it is deductive, focused and structured, rather than exploratory in nature, as are qualitative studies. Quantitative methods are generally less biased; however, in this particular study a possibility of implicit teacher bias may have existed (Cate & Glock, 2019), as Study District ECC envelopes a range of demographics.

Quantitative methods can be replicated; therefore, measuring trends is possible year-to-year if stakeholders decide a longer study, and increasing reliability and validity of the study. Additionally, a quantitative study was chosen as the information may be useful for decision making by district and community stakeholders regarding expansion of a particular curriculum into higher grade levels (Bhattacherjee, 2012; Butin, 2010), along with more in-depth trauma informed practices.

The research site for this study was an Early Childhood Center included in a midwestern United States public school district. Secondary data were collected from the SAEBRS, and student attendance or non-attendance at the Study District ECC. Information was also provided regarding student development. For example, students with an IEP were placed in a data group and neurotypical students, or students with no identified delays, were placed in another data set. Neurotypical student groups were then further split into two groups, those children who attended the Study District ECC for any length of time and children who had never attended Study District ECC. Typically, students requiring special education have lagging developmental skills which was likely to skew results; therefore, these student scores were a single data set in each statistical analysis. Since data were deidentified prior to researcher randomization of data sets and statistical analyses completed, the anonymity of students is assumed. Once data were deidentified, there was no way for the researcher to determine the results of individuals, kindergarten classrooms, or specific elementary schools. Furthermore, in the continued interest of anonymity, once the current study has concluded, secondary data will be destroyed at the time indicated on IRB approval, unless return is requested by the Study District administration.

Screening and Assessment of Social/Emotional Skills

The Social, Academic, and Emotional Behavior Risk Screener (SAEBRS) is a brief tool supported by research for use in universal screening for behavioral and emotional risk. The measure falls within a broad class of highly efficient tools, suitable for teacher use in evaluating and rating all students on common behavioral criteria (Severson et al., 2007). The SAEBRS is designed for use in the K-12 setting. It is

grounded within a conceptual model, which states that a student's success in school is related to his or her academic achievement, success within multiple behavioral domains. Research suggested the SAEBRS may be used to evaluate student functioning in terms of overall general behavior, as assessed by a broad Total Behavior (19 items). Research further suggested the SAEBRS may be used to evaluate student behavior within multiple inter-related narrow domains, as assessed by the Social Behavior (6 items), Academic Behavior (6 items), and Emotional Behavior (7 items) subscales (Fastbridge Learning Support, n.d.). The SAEBRS was chosen as the measurement tool for this research because it is the one used in Study District to measure these skills in kindergarten aged children.

The *Developmental Indicators for the Assessment of Learning,* Fourth Edition (DIAL-4), is the third updated product of the DIAL, first published in 1975 (Mardell & Goldenberg, 2011, p. 5). Currently, the assessment is used to determine developmental skills levels for children aged two years, six months to five years, 11 months, in English and Spanish. A teacher questionnaire was also added to the most recent version, the *DIAL-4*. The *DIAL-4* assesses the following areas of development: Motor, Concepts, Language, along with behavioral observations (Mardell & Goldenberg, 2011, pp. 7-12). Parent and teacher questionnaires are also available for supplemental use if the need arises, assessing social/emotional development along with self-help development (Mardell & Goldenberg, 2011, pp. 12-13). Trained educational staff members, called operators, administer the *DIAL-4* in a one-on-one situation (Mardell & Goldenberg, 2011, p. 17). However, the student may sit with only one adult to complete tasks or rotate between three for each area of assessment, Motor, Concepts, and Language (Mardell &

Goldenberg, 2011, p. 15). During administration, adults also make any necessary behavior observations, positive or negative (Mardell & Goldenberg, 2011, p. 25).

The *Ages and Stages Questionnaire: Social Emotional, Second Edition* (ASQ:SE-2) is a screening used by educational professionals to initially assess young children's social/emotional skills. If concerns arise on this screener, the child is then referred for a more in-depth educational evaluation. The original *ASQ:SE* began to be used in 2002 and was developed to "complement the *Ages and Stages Questionnaire,* Third Edition (ASQ-3) (Squires et al., 2015, p. 4). The *ASQ-3* is an overall screening of developmental skills for children ages two through 60 months, with assessments at various intervals (Squires et al., 2015, p. 5). The *ASQ:SE-2* is completed by parents, with a follow-up interview by an educational professional to answer questions and to determine if further evaluation is warranted, based on scores and information provided by parents. The *ASQ* system does not only offer forms in English, yet Spanish versions are also available when needed and supported by other materials included in the program (Squires et al., 2015, p. 8). The *ASQ* system is often used in addition to other screening situations when a child is unable to complete tasks administered and parent report is needed. However, parents must be willing to complete the form and give information and honest insight regarding their child's skills in all areas of development. Screenings such as the *DIAL-4* and *ASQ:SE-2* are important in the early identification of children with developmental or behavioral problems. Additionally, it is important to note authors of both systems of assessment report adequate reliability and validity in manuals (Mardell & Goldenberg, 2011; Squires et al., 2015, pp. 204-206).

Coterminous with screening, such as the *DIAL-4* and *ASQ:SE-2*, are the more in-depth assessments, such as the *Behavior Assessment System for Children,* Third Edition (BASC-3). Compared to the previously discussed screening instruments, the *BASC-3* is a much more thorough evaluation. Reynolds and Kamphaus (2015) stated this instrument is "a multimethod, multidimensional system used to evaluate the behavior and self-perceptions of children and young adults ages 2 through 25 years" (p. 1). In addition to a Teacher Rating Scale and Parent Rating Scale, a self-report, observation system, behavior intervention guide, etc. may be utilized if necessary (Reynolds & Kamphaus, 2015, p. 1); therefore, making it a much more comprehensive evaluation of clinical skills and adaptive skills. The resources included make evaluating children's behavioral skills across a variety of settings, such as home, school, and/or daycare more obtainable. Age and gender differences are reflected in standardization and norms development (Reynolds & Kamphaus, 2015, p. 113). In addition to adequate reliability and validity, correlations between scales (Teacher Rating Scale, Parent Rating Scale) is also adequate (pp. 273-289).

Reliability and Measurement

Regarding reliability in this study, secondary data for the current study was drawn from the Study District that served 18,000+ students during the study period. During 2017 and 2020, only Kindergarten teachers of the study district completed the SAEBRs on their students. A sample population was randomly chosen from the total SAEBRS sample of 1,042. The population breakdown is as follows: 71 students who attended the Study District early childhood program by paying tuition and considered neurotypical, 70 students who did not attend the Study District early childhood program, and 126 students

who attended the Study District early childhood program and received special education services. Additionally, for the ANOVA test, the sample was broken into the following three groups: 35 students who attended the Study District early childhood program more than one year, 34 students who attended the Study District early childhood program for one year only, and 35 students who did not attend the Study District early childhood program. Additionally, although teachers have been using the SAEBRS to rate skills of their kindergarten students for four years in the Study District, the three most current years were used. However, data from the earliest of the three years was only used in the ANOVA test as only Total Scores were available for that particular year. The school years of 2018/2019 and 2019/2020 were complete and used in the ANOVA and *t*-tests.

The SAEBRS is a standardized assessment developed by Kilgus and his colleagues (2013) to identify if students were at risk for social behavior problems, academic behavior problem, or emotional behavior problems. Students with social behavior problems may exhibit difficulty maintaining relationships with adults and peers. Students with academic behavior problems may display difficulty participating in and progressing in academic instruction. Students with emotional behavior problems have limited ability to adapt to changing situations, respond to stressful situations and events, and keeping emotions appropriately regulated (Fastbridge Learning Support, n.d.). Based on recent research conducted by Whitley and Cuenca-Carlina (2019), results showed evidence of test-retest reliability. Concurrent and predictive validity were also noted to be positive.

The first five hypotheses were analyzed using *t*-tests. *T*-tests were used to determine if there was a significant difference in various SAEBRS scores between the

two groups. Hypotheses 6 and 7 were analyzed using the One-way ANOVA test because more than two conditions, length of attendance, were compared. Reliability measures the ability to reproduce the results of a study in repeated trials.

Independent variable – The independent variable for *t*-test analyses was student attendance. Random samples were taken of the following groups: neurotypical students who did not attend a preschool or daycare where social/emotional skills were intentionally taught by highly trained teachers using a science-based, research-backed curriculum, neurotypical students attended the Study District's Early Childhood Center where social/emotional skills were intentionally taught by highly trained teachers using a science-based, research-backed curriculum, and students who attended and identified with developmental delays based on the state's DESE guidelines with an Individualized Education Program in place at the Study District's Early Childhood Center. The independent variable for ANOVA analyses was years of attendance at the Study District's Early Childhood Center; more than one year, one year only, or no attendance at the school.

Dependent variable. The dependent variable for all statistical analyses were scores obtained from the Social, Academic, and Emotional Behavior Rating Scale (SAEBRS). Kindergarten students in the Study District are rated by their teacher using this measure. The researcher was given permission by the Study District Superintendent to access this secondary data for this study.

Questions and Null Hypotheses

Research Question: What is the difference in social/emotional skills between children who attended Study District ECC and those who did not attend Study District

ECC, as measured by the SAEBRS (Social, Academic, and Emotional Behavior Risk Screener)?

Null Hypothesis 1: The social/emotional scores of children intentionally taught social emotional skills are not higher than those of children who are not, as measured by the SAEBRS.

a. The overall Total scores of children intentionally taught social emotional skills are not higher than those of children who are not, as measured by the SAEBRS.
b. The Social Behavior scores of children who are intentionally taught social emotional skills are not higher than those of children who are not, as measured by the SAEBRS.
c. The Academic Behavior scores of children who are intentionally taught social emotional skills are not higher than those of children who are not, as measured by the SAEBRS.
d. The Emotional Behavior scores of children who are intentionally taught social emotional skills are not higher than those of children who are not, as measured by the SAEBRS.

Null Hypothesis 2: The social/emotional scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS.

a. The Total scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS.
b. The Social Behavior scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS.

c. The Academic Behavior scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS.

d. The Emotional Behavior scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS.

Null Hypothesis 3: The students' subtest scores, Cooperation Subtest, of those who have an IEP are not lower than those of children who do not have any identified developmental delays as measured by the SAEBRS.

a. The Cooperation subtest scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS, given that both groups attended the Early Childhood Center where these skills are intentionally taught.

b. The Cooperation subtest scores of children who have an IEP and attended the Early Childhood Center are not lower than those of children who do not have an IEP and did not attend the Early Childhood Center where these skills were intentionally taught, as measured by the SAEBRS.

c. The Cooperation subtest scores of children intentionally taught social emotional skills are not higher than those of children who are not, as measured by the SAEBRS.

Null Hypothesis 4: The students' subtest scores, Adaptable to Change Subtest, of those who have an IEP are not lower than the scores of children who do not have any identified developmental delays as measured by the SAEBRS.

a. The Adaptable to Change Subtest scores of children who have an IEP are not lower than those of children without an IEP, as measured by the SAEBRS,

given both groups attended the Early Childhood Center where these skills are intentionally taught.

b. The Adaptable to Change Subtest scores of children who have an IEP and attended the Early Childhood Center are not lower than those of children who do not have an IEP and did not attend the Early Childhood Center where these skills were intentionally taught, as measured by the SAEBRS.

c. The Adaptable to Change Subtest scores of children who are intentionally taught social emotional skills by highly trained teachers are not higher than those of children who are not, as measured by the SAEBRS.

Null Hypothesis 5: The students' subtest scores (ability to recover after setback) of those who have an IEP are not lower than the scores of children who do not have any identified developmental delays as measured by the SAEBRS.

a. The Ability to Rebound Subtest scores of children who have an IEP are not lower than those of children without an IEP, as measured by the SAEBRS, given both groups attend the Early Childhood Center where these skills are intentionally taught by highly trained teachers.

b. The Ability to Rebound Subtest scores of children who do not have an IEP and attended the Early Childhood Center are not lower than those of children who do not have an IEP and did not attend the Early Childhood Center where these skills were intentionally taught, as measured by the SAEBRS.

c. The Ability to Rebound Subtest scores of children intentionally taught social/emotional skills by highly trained teacher are not higher than those of children who are not, as measured by the SAEBRS.

Null Hypothesis 6: There is no difference between the social/emotional scores of students who did not attend ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.

a. There is no difference between the Total scores of students who did not attend ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.
b. There is no difference between the Social Behavior scores of students who did not attend ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.
c. There is no difference between the Academic Behavior scores of students who did not attend ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.
d. There is no difference between the Emotional Behavior scores of students who did not attend ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.

Null Hypothesis 7: There is no difference between subtest scores (Cooperation; Adaptability to Change; Ability to Rebound) of students who did not attend ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.

a. There is no difference between the Cooperation Subtest scores of students who did not attend ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.

b. There is no difference between the Adaptable to Change Subtest scores of students who did not attend ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS
c. There is no difference between the Ability to Rebound Subtest scores of students who did not attend ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS

The researcher will make results available to Study District administrators and Board of Education, and will accept any invitation to a scheduled monthly board meeting to discuss study results. Dependent upon results, recommendations may be made to Study District administration and Board of Education to continue use of Conscious Discipline in the Study District ECC, or any other similar curriculum recognizing need for intentional teaching of social/emotional skills, and extend same instruction in age-appropriate practices to Study District elementary schools district-wide. Additionally, the data will be destroyed at the time indicated on IRB approval, unless the Study District Executive Director of Early Learning requests they be returned.

Summary

The current quantitative study investigates the relationship between intentional teaching of social-emotional skills, including skills for resiliency and kindergarten readiness skills, as related to areas of social behavior, academic behavior, and emotional behavior. For the study, scores gathered as secondary data from the SAEBRS rated for each student by Study District kindergarten teachers in the Fall 2020 were utilized to assess significance between groups, students with an IEP who attended Study District ECC, neurotypical students who attended the Study District ECC, and those students who

did not attend Study District ECC. Additionally, neurotypical students were minded into groups based on length of attendance at Study District ECC, children who attended for more than one year, children who attended for one year only, and children who had never attended Study District ECC. The researcher analyzed SAEBRS scores in the areas of Total overall score, Social Behavior, Academic Behavior, and Emotional Behavior, in addition to the following test items: Cooperation, Adaptable to Change, and Ability to Rebound. Descriptive quantitative methods allowed the researcher to determine if a relationship existed between intentional teaching of social skills by highly trained teachers using a science-backed and researched-based curriculum and kindergarten readiness in the areas of social behavior, academic behavior, and emotional behavior, length of attendance using such a curriculum, and correlations between students with identified delays and those whose skills are within age expectations. The aforementioned items from the SAEBRS were chosen as each can be linked back to student skills for resiliency in the following ways. Cooperation reflects interactions with others and human connection. Being adaptable to change enables one to tolerate changes in their environment, such as transitions, enabling a better ability to recover after a setback and rebound after a stressful situation leads to resiliency.

In Chapter Four, statistical analyses based on secondary data are recapitulated using *t*-tests and *p*-values to determine relationships between independent and dependent variables. ANOVA and *F*-values were calculated to determine probable differences between time in attendance at Study District ECC. Calculations were derived from SAEBRS Total Scores and Subtest Scores, student development or lack thereof, and length of attendance at Study District ECC. Regarding SAEBRS Subtest scores, the

researcher chose three of 19 items to compare detailed statistical results of this study based on analysis of secondary data followed in Chapter Four.

Chapter Four: Analysis

Independent variable – The independent variable for *t*-test analyses was student attendance. Random samples were taken of the following groups: neurotypical students who did not attend a preschool or daycare where social/emotional skills were intentionally taught by highly trained teachers using a science-based, research-backed curriculum; neurotypical students who attended the Study District's Early Childhood Center where social/emotional skills were intentionally taught by highly trained teachers using a science-based, research-backed curriculum; and students who attended and identified with developmental delays based on the state's DESE guidelines with an Individualized Education Program in place at the Study District's Early Childhood Center. The independent variable for ANOVA analyses was years of attendance at the Study District's Early Childhood Center; more than one year, one year only, or no attendance at the school.

Dependent variable. The dependent variable for all statistical analyses were scores obtained from the Social, Academic and Emotional Behavior Rating Scale (SAEBRS). Kindergarten students in the Study District are rated by their teacher using this measure. The researcher was given permission by the Study District Superintendent to access this secondary data for this study.

Research Question 1: What is the difference in social/emotional skills between the children who attended Study District ECC and the children who did not attend Study District ECC, as measured by the SAEBRS (Social, Academic, Emotional Behavior Risk Screener).

Null Hypothesis 1: The social/emotional scores of children intentionally taught social emotional skills are not higher than those who are not, as measured by the SAEBRS.

Null Hypothesis 1a: The overall Total scores of children intentionally taught social emotional skills are not higher than those who are not, as measured by the SAEBRS.

A *t*-test of two means was conducted to determine if neurotypical students who have been intentionally taught social/emotional skills received higher Total scores on the SAEBRS, as rated by kindergarten teachers, than those who did not attend a center where highly trained teachers intentionally taught social skills. A preliminary test of variances revealed the variances were equal. The analysis revealed the SAEBRS scores for students intentionally taught social emotional skills (M = 48.62; SD = 8.97) were significantly higher than students who did not receive the intentional instruction (M = 45.69; SD = 10.15); $t(139) = 1.82$, $p = .035$. This information supports rejecting the null hypothesis, suggesting a difference in Total scores between students who have been intentionally taught social-emotional skills and those who have not had such instruction.

Null Hypothesis 1b: The Social Behavior scores of children intentionally taught social emotional skills are not higher than those who are not, as measured by the SAEBRS.

A *t*-test of two means was conducted to determine if neurotypical students who have been intentionally taught social/emotional skills received higher Social Behavior scores on the SAEBRS as rated by kindergarten teachers, than those who did not attend a center where highly trained teachers intentionally taught social skills. A preliminary test

of variances revealed the variances were not equal. The analysis revealed the SAEBRS scores for students intentionally taught social emotional skills (M = 15.56; SD = 3.02) were not significantly higher than students who did not receive the intentional instruction (M = 14.64; SD = 4.16); $t(69) = 1.50$, $p = .069$. This information supports failing to reject the null hypothesis, indicating students who have been intentionally taught these skills do not have significantly higher Total scores on the SAEBRS.

Null Hypothesis 1c: The Academic Behavior scores of children intentionally taught social emotional skills are not higher than those who are not, as measured by the SAEBRS.

A *t*-test of two means was conducted to determine if neurotypical students who have been intentionally taught social/emotional skills received higher Academic Behavior scores on the SAEBRS as rated by kindergarten teachers, than those who did not attend a center where highly trained teachers intentionally taught social skills. A preliminary test of variances revealed the variances were equal. The analysis revealed the Academic subtest of SAEBRS scores for students intentionally taught social emotional skills (M = 14.11; SD = 4.26) were significantly higher than students who did not receive the intentional instruction (M = 12.80; SD = 4.13); $t(139) = 1.86$, $p = .033$. This information supports rejecting the null hypothesis, suggesting that the Academic Behavior scores on the SAEBRS of students who have been intentionally taught these skills are higher than those who have not had such instruction.

Null Hypothesis 1d: The Emotional Behavior scores of children intentionally taught social emotional skills are not higher than those children who are not, as measured by the SAEBRS.

A *t*-test of two means was conducted to determine if neurotypical students who have been intentionally taught social/emotional skills received higher Emotional Behavior scores on the SAEBRS as rated by kindergarten teachers, than those who did not attend a center where social skills were intentionally taught by highly trained teachers. A preliminary test of variances revealed the variances were equal. The analysis revealed the Emotional Behaviors subtest of SAEBRS scores for students intentionally taught social emotional skills (M = 18.94; SD = 3.21) were not significantly higher than students who did not receive the intentional instruction (M = 18.24; SD = 3.37); $t(139) = 127$, $p = .104$. This information supports failing to reject the null hypothesis, suggesting students who have been intentionally taught social emotional skills do not have higher Emotional Behavior subtest scores on the SAEBRS.

Table 1 summarizes the results of the analyses related to Hypothesis 1.

Table 1

Summary of Results for Hypothesis 1

SAEBRS Score	*p*-Value	Conclusion
Overall Total Score	.035	ECC students had significantly higher overall scores on the SAEBRS than non-ECC students
Social Behavior Subtest	.069	Moderate evidence that ECC students had significantly higher Social Behavior scores than non-ECC students
Academic Behavior Subtest	.033	ECC students had significantly higher Academic Behavior scores than non-ECC students
Emotional Behavior Subtest	.104	ECC students did not have higher Emotional Behavior scores than non-ECC students

Null Hypothesis 2: The social/emotional scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS.

Null Hypothesis 2a: The total scores of children who have an IEP are not lower than those of children without an IEP, as measured by the SAEBRS.

A *t*-test of two means was conducted to determine if children who have an IEP have lower Total scores on the SAEBRS as rated by kindergarten teachers, than those who attended the same Early Childhood Center where social skills were intentionally

taught by highly trained teachers, but have no identified delays. A preliminary test of variances revealed the variances were not equal. The analysis revealed the Total SAEBRS scores for students with an IEP (M=39.66; SD = 12.32) were significantly lower than students with no identified delays or without an IEP (M=48.62; SD – 8.97); $t(70) = -5.86$, $p = < .001$. This information supports rejecting the null hypothesis, suggesting that the overall scores on the SAEBRS of students with IEPs were lower than those without IEPs, given that both groups attended Study District ECC.

Null Hypothesis 2b: The Social Behavior scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS.

A *t*-test of two means was conducted to determine if children who have an IEP have lower Social Behavior scores on the SAEBRS as rated by kindergarten teachers, than those who attended the same Early Childhood Center where social skills were intentionally taught by highly trained teachers, but have no identified developmental delays. A preliminary test of variances revealed the variances were not equal. The analysis revealed the Social Behavior SAEBRS scores for students with an IEP (M=12.83; SD = 4.71) were significantly lower than students with no identified delays or without an IEP (M=15.56; SD = 3.02); $t(70) = -4.94$, $p = < .001$. This information supports rejecting the null hypothesis, suggesting that the Social Behavioral scores on the SAEBRS of students with IEPs were lower than those without IEPs, given that both groups attended Study District ECC.

Null Hypothesis 2c: The Academic Behavior scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS.

A *t*-test of two means was conducted to determine if children who have an IEP have lower Academic Behavior scores on the SAEBRS as rated by kindergarten teachers, than those who attended the same Early Childhood Center where social skills were intentionally taught by highly trained teachers, but have no identified developmental delays. A preliminary test of variances revealed the variances were equal. The analysis revealed the Academic Behavior SAEBRS scores for students with an IEP (M=10.33; SD = 5.16) were significantly lower than students with no identified delays or without an IEP (M=14.11; SD = 4.26); $t(195) = -5.26$, $p = < .001$. This information supports rejecting the null hypothesis, suggesting that the Academic Behavior scores on the SAEBRS of students with IEPs were lower than those without IEPs, given that both groups attended Study District ECC.

Null Hypothesis 2d: The Emotional Behavior scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS.

A *t*-test of two means was conducted to determine if children who have an IEP have lower Emotional Behavior scores on the SAEBRS as rated by kindergarten teachers, than those who attended the same Early Childhood Center where social skills were intentionally taught by highly trained teachers, but have no identified developmental delays. A preliminary test of variances revealed the variances were not equal. The analysis revealed the Emotional Behavior SAEBRS scores for students with an IEP (M=16.50; SD = 4.45) were significantly lower than students with no identified delays or without an IEP (M=18.94; SD = 3.21); $t(70) = -4.44$, $p = < .001$. This information supports rejecting the null hypothesis, suggesting that the Emotional Behavior scores on

the SAEBRS of students with IEPs were lower than those without IEPs, given that both groups attended Study District ECC.

Table 2 summarizes the results of the analyses related to Hypothesis 2.

Table 2

Summary of Results for Hypothesis 2

SAEBRS Score	*p*-Value	Conclusion
Overall Total Score	< .001	Students with IEPs had significantly lower scores than students who attended ECC without IEPs
Social Behavior Subtest	< .001	Students with IEPs had significantly lower scores than students who attended ECC without IEPs
Academic Behavior Subtest	< .001	Students with IEPs had significantly lower scores than students who attended ECC without IEPs
Emotional Behavior Subtest	< .001	Students with IEPs had significantly lower scores than students who attended ECC without IEPs

Null Hypothesis 3: The students' subtest scores (cooperation) of those who have an IEP are not lower than the scores of those who do not have any identified developmental delays as measured by the SAEBRS

Null Hypothesis 3a: The Cooperation Subtest scores of children who have an IEP are not lower than those without an IEP, as measured by the SAEBRS, given both groups attended the Early Childhood Center where these skills are intentionally taught.

A *t*-test of two means was conducted to determine if children who have an IEP have lower Cooperation Subtest scores on the SAEBRS as rated by kindergarten teachers, than those who attended the same Early Childhood Center where these skills were intentionally taught by highly trained teachers, but have no identified developmental delays. A preliminary test of variances revealed the variances were equal. The analysis revealed the Cooperation Subtest SAEBRS scores for students with an IEP (M= 1.89; SD = 1.03) were significantly lower than students with no identified delays or without an IEP (M= 2.41; SD = .90); $t(195) = -3.55$, $p = < .001$. This information supports rejecting the null hypothesis, suggesting that the Cooperation Subtest scores on the SAEBRS of students with IEPs were lower than those without IEPs, given that both groups attended Study District ECC.

Null Hypothesis 3b: The Cooperation Subtest scores of children who have an IEP and attended the Early Childhood Center are not lower than those who do not have an IEP and did not attend the Early Childhood Center where these skills were intentionally taught, as measured by the SAEBRS.

A *t*-test of two means was conducted to determine if children who have an IEP and attend the Early Childhood Center (ECC)where these skills are intentionally taught have lower Cooperation Subtest scores on the SAEBRS as rated by kindergarten teachers, than those who did not attend the ECC. A preliminary test of variances revealed the variances were equal. The analysis revealed the Cooperation Subtest SAEBRS scores for

students with an IEP (M= 1.89; SD = 1.03) were significantly lower than students who did not attend the ECC (M= 2.31; SD = .91); $t(194) = -3.55$, $p = .002$ This information supports rejecting the null hypothesis, suggesting that the Cooperation Subtest scores on the SAEBRS of students with IEPs who attended the Study District ECC were lower than those of students who did not attend the Study District ECC.

Null Hypothesis 3c: The Cooperation Subtest scores of children intentionally taught social emotional skills are not higher than those of children who are not, as measured by the SAEBRS.

A *t*-test of two means was conducted to determine if neurotypical students who have been intentionally taught social/emotional skills received higher Cooperation Subtest scores on the SAEBRS as rated by kindergarten teachers, than those who did not attend a center where highly trained teachers intentionally taught social skills. A preliminary test of variances revealed the variances were equal. The analysis revealed the SAEBRS Cooperation Subtest scores for students intentionally taught these skills (M = 2.41; SD = .90) were not significantly higher than students who did not receive the intentional instruction (M = 2.31; SD = .91); $t(139) = .62$, $p = .269$. This information supports failing to reject the null hypothesis, suggesting that the Cooperation Subtest scores on the SAEBRS of students who were intentionally taught social/emotional skills were not different from those who were not intentionally taught these skills.

Table 3 summarizes the results of the analyses related to Hypothesis 3.

Table 3

Summary of Results for Hypothesis 3

SAEBRS Score	*p*-Value	Conclusion
Cooperation Subtest	< .001	Students with IEPs had significantly lower scores than students who attended ECC without IEPs
Cooperation Subtest	.002	Students with IEPs had significantly lower scores than non-ECC students
Cooperation Subtest	.269	ECC students did not have significantly higher Cooperation Subtest scores than non-ECC students

Null Hypothesis 4: The students' subtest scores (adaptability) of those who have an IEP are lower than those who do not have any identified developmental delays as measured by the SAEBRS.

Null Hypothesis 4a: The Adaptable to Change Subtest scores of children who have an IEP are not lower than those of children without an IEP, as measured by the SAEBRS, given both groups attended the Early Childhood Center where these skills are intentionally taught.

A *t*-test of two means was conducted to determine if children who have an IEP have lower Adaptable to Change Subtest scores on the SAEBRS as rated by kindergarten teachers, than those who attended the same Early Childhood Center where these skills were intentionally taught by highly trained teachers, but have no identified developmental

delays. A preliminary test of variances revealed the variances were not equal. The analysis revealed the SAEBRS Adaptable to Change subtest scores for students with an IEP (M= 1.898; SD = 1.98) were significantly lower than students with no identified delays or without an IEP (M= 2.61; SD = .64); $t(70) = -5.29$, $p = < .001$. This information supports rejecting the null hypothesis, suggesting that the Adaptable to Change Subtest scores on the SAEBRS of students with IEPs were lower those without IEPs, given that both groups attended Study District ECC.

Null Hypothesis 4b: The Adaptable to Change Subtest scores of children who have an IEP and attended the Early Childhood Center are not lower than those who do not have an IEP and did not attend the Early Childhood Center where these skills were intentionally taught, as measured by the SAEBRS.

A *t*-test of two means was conducted to determine if children who have an IEP and attend the Early Childhood Center (ECC)where these skills are intentionally taught have lower SAEBRS Adaptable to Change Subtest scores as rated by kindergarten teachers, than those who did not attend the ECC. A preliminary test of variances revealed the variances were equal. The analysis revealed the SAEBRS Adaptable to Change Subtest scores for students with an IEP (M= 1.98; SD = 1.02) were significantly lower than students who did not attend the ECC (M= 2.27; SD = .93); $t(194) = -2.00$, $p = .024$. This information supports rejecting the null hypothesis, suggesting that the Adaptable to Change Subtest scores on the SAEBRS of students with IEPs who attended the Study District ECC were lower than those of students who did not attend the Study District ECC.

Null Hypothesis 4c: The Adaptable to Change subtest scores of children where highly trained teachers intentionally taught social-emotional skills are not higher than those who are not, as measured by the SAEBRS.

A *t*-test of two means was conducted to determine if neurotypical students who have been intentionally taught social/emotional skills received higher Adaptable to Change Subtest scores on the SAEBRS as rated by kindergarten teachers, than those who did not attend a center where highly trained teachers intentionally taught social skills. A preliminary test of variances revealed the variances were unequal. The analysis revealed the SAEBRS Adaptable to Change Subtest scores for students intentionally taught these skills (M = 2.61; SD = .64) were significantly higher than those of students who did not receive the intentional instruction (M = 2.27; SD = .93); $t(69) = 2.48$, $p = .008$. This information supports rejecting the null hypothesis, suggesting that the Adaptable to Change Subtest scores on the SAEBRS of students who were intentionally taught social/emotional skills were significantly higher than those of students who were not intentionally taught these skills.

Table 4 summarizes the results of the analyses related to Hypothesis 4.

Table 4

Summary of Results for Hypothesis 4

SAEBRS Score	*p*-Value	Conclusion
Adaptable to Change Subtest	< .001	Students with IEPs had significantly lower scores than students who attended ECC without IEPs
Adaptable to Change Subtest	.024	Students with IEPs had significantly lower scores than non-ECC students
Adaptable to Change Subtest	.008	ECC students did have higher Adaptable to Change Subtest scores significantly higher than non-ECC students

Null Hypothesis 5: The students' subtest scores (ability to rebound) of those who have an IEP are lower than those who do not have any identified developmental delays as measured by the SAEBRS.

Null Hypothesis 5a: The Ability to Rebound Subtest scores of children who have an IEP are not lower than those of children without an IEP, as measured by the SAEBRS, given both groups attend the Early Childhood Center where these skills are intentionally taught by highly trained teachers.

A *t*-test of two means was conducted to determine if children who have an IEP have lower Ability to Rebound Subtest scores on the SAEBRS as rated by kindergarten teachers, than those who attended the same Early Childhood Center where these skills were intentionally taught by highly trained teachers, but have no identified developmental

delays. A preliminary test of variances revealed the variances were unequal. The analysis revealed the SAEBRS Ability to Rebound Subtest scores for students with an IEP (M= 2.18; SD = 1.04) were significantly lower than students with no identified delays or without an IEP (M= 2.63; SD = .74); $t(70) = -3.53$, $p = < .001$. This information supports rejecting the null hypothesis, suggesting the Ability to Rebound scores on the SAEBRS of students with IEPs have less ability to recover after setbacks than those without IEPs, given both groups attended Study District ECC.

Null Hypothesis 5b: The Ability to Rebound Subtest scores of children who have an IEP and attended the Early Childhood Center are not lower than those who do not have an IEP and did not attend the Early Childhood Center where these skills were intentionally taught, as measured by the SAEBRS.

A *t*-test of two means was conducted to determine if children who have an IEP and attend the Early Childhood Center (ECC)where these skills are intentionally taught have lower Ability to Rebound Subtest scores on the SAEBRS as rated by kindergarten teachers, than those who did not attend the ECC. A preliminary test of variances revealed the variances were unequal. The analysis revealed the SAEBRS Ability to Rebound Subtest scores for students with an IEP (M= 2.18; SD = 1.04) were significantly lower than students who did not attend the ECC (M= 2.57; SD = .79); $t(69) = -2.94$, $p = .002$. This information supports rejecting the null hypothesis, suggesting the Ability to Rebound scores on the SAEBRS of students with IEPs who attended the Study District ECC were lower than those who did not attend the Study District ECC.

Null Hypothesis 5c: The Ability to Rebound Subtest scores of children where highly trained teachers intentionally taught social-emotional skills are not higher than those of children who are not, as measured by the SAEBRS.

A *t*-test of two means was conducted to determine if neurotypical students who have been intentionally taught social/emotional skills received higher Ability to Rebound Subtest scores on the SAEBRS as rated by kindergarten teachers, than those who did not attend a center where highly trained teachers intentionally taught social skills. A preliminary test of variances revealed the variances were equal. The analysis revealed the SAEBRS Ability to Rebound Subtest scores for students intentionally taught these skills (M = 2.63; SD = .74) were not significantly higher than students who did not receive the intentional instruction (M = 2.57; SD = .79); $t(139) = .48$, $p = .315$. This information supports failing to reject the null hypothesis, suggesting that the Ability to Rebound scores on the SAEBRS of students where highly trained teacher intentionally taught do not have higher scores than those who did not have the same opportunity.

Table 5 summarizes the results of the analyses related to Hypothesis 5.

Table 5

Summary of Results for Hypothesis 5

SAEBRS Score	*p*-Value	Conclusion
Ability to Rebound Subtest	< .001	Students with IEPs had significantly lower scores than students who attended ECC without IEPs
Ability to Rebound Subtest	.002	Students with IEPs had significantly lower scores than non-ECC students
Ability to Rebound Subtest	.315	ECC students did not have higher Ability to Rebound Subtest scores than non-ECC students

Null Hypothesis 6: There is no difference between the social/emotional scores of students who did not attend a Midwestern school district's early childhood program given highly trained teachers who intentionally taught social/emotional skills for resiliency, those who attended such a school for one year, and those who attended for more than one year, as measured by the SAEBRS.

Null Hypothesis 6a: There is no difference between the Total scores of students who did not attend Study District ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.

To determine if there were differences in Total Scores, as measured by the SAEBRS, between students who attended an early childhood program intentionally

teaching skills for resiliency and those who did not, the researcher conducted an ANOVA. The descriptive statistics associated with this analysis are displayed in Table 6.

Table 6

Students by Attendance – Total Scores

Attendance	***N***	***Mean***	***Std. Deviation***
More than one year	35	48.43	9.87
One Year	34	48.76	8.22
None	35	44.37	6.66

The results of the analysis revealed there were no significant differences between the means of the three groups. The researcher failed to reject the null hypothesis and concluded there were no differences in Total Scores, as measured by the SAEBRS, based on attendance. Table 7 displays the results of this analysis.

Table 7

One-Way ANOVA by Attendance – Total Scores

Source of variation	***Sum of squares***	***Df***	***Mean square***	***F***	***P-value***	***F critical***
Between Groups	416.02	2	208.01	2.34	.101	3.086
Within Groups	8976.86	101	88.88			
Total	9392.88	103				

Null Hypothesis 6b: There is no difference between the Social Behavior Scores of students who did not attend Study District ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.

To determine if there were differences in Social Behavior scores, as measured by the SAEBRS, between students who attended an early childhood program intentionally teaching skills for resiliency and those who did not, the researcher conducted an ANOVA. The descriptive statistics associated with this analysis are displayed in Table 8.

Table 8

Students by Attendance – Social Behavior Scores

Attendance	***N***	***Mean***	***Std. Deviation***
More than one year	35	15.57	3.04
One Year	34	15.59	3.05
None	35	14.14	3.88

The results of the analysis revealed there were no significant differences between the means of the three groups. The researcher failed to reject the null hypothesis and concluded there were no differences in Social Behavior Scores, as measured by the SAEBRS, based on attendance. Table 9 displays the results of this analysis.

Table 9

One-Way ANOVA by Attendance – Social Behavior Scores

Source of variation	***Sum of squares***	***Df***	***Mean square***	***F***	***P-value***	***F critical***
Between Groups	47.95	2	23.97	2.14	.123	3.086
Within Groups	1133.09	101	11.22			
Total	1181.04	103				

Null Hypothesis 6c: There is no difference between the Academic Behavior Scores of students who did not attend Study District ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.

To determine if there were differences in Academic Behavior scores, as measured by the SAEBRS, between students who attended an early childhood program intentionally teaching skills for resiliency and those who did not, the researcher conducted an ANOVA. The descriptive statistics associated with this analysis are displayed in Table 10.

Table 10

Students by Attendance – Academic Behavior Scores

Attendance	***N***	***Mean***	***Std. Deviation***
More than one year	35	14.29	4.56
One Year	34	13.94	4.01
None	35	12.40	4.34

The results of the analysis revealed there were no significant differences between the means of the three groups. The researcher failed to reject the null hypothesis and concluded there were no differences in Academic Behavior Scores, as measured by the SAEBRS, based on attendance. Table 11 displays the results of this analysis.

Table 11

One-Way ANOVA by Attendance – Academic Behavior Scores

Source of variation	***Sum of squares***	***df***	***Mean square***	***F***	***P-value***	***F critical***
Between Groups	70.42	2	35.21	1.89	.156	3.086
Within Groups	1877.43	101	18.59			
Total	1947.85	103				

Null Hypothesis 6d: There is no difference between the Emotional Behavior scores of students who did not attend Study District ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.

To determine if there were differences in Emotional Behavior scores, as measured by the SAEBRS, between students who attended an early childhood program intentionally teaching skills for resiliency and those who did not, the researcher conducted an ANOVA. The descriptive statistics associated with this analysis are displayed in Table 12.

Table 12

Students by Attendance – Emotional Behavior Scores

Attendance	***N***	***Mean***	***Std. Deviation***
More than one year	35	18.57	3.58
One Year	34	19.24	2.86
None	35	17.83	3.54

The results of the analysis revealed there were no significant differences between the means of the three groups. The researcher failed to reject the null hypothesis and concluded there were no differences in Emotional Behavior Scores, as measured by the SAEBRS, based on attendance. Table 13 displays the results of this analysis.

Table 13

One-Way ANOVA by Attendance – Emotional Behavior Scores

Source of variation	***Sum of squares***	***df***	***Mean square***	***F***	***P-value***	***F critical***
Between Groups	34.19	2	17.09	1.53	.222	3.086
Within Groups	1131.66	101	11.20			
Total	1165.85	103				

Null Hypothesis 7: There is no difference between subtest scores (Cooperation: Adaptability to Change; Ability to Rebound) of students who did not attend Study District ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.

Null Hypothesis 7a: There is no difference between the Cooperation Subtest scores of students who did not attend Study District ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.

To determine if there were differences in the Cooperation Subtest scores, as measured by the SAEBRS, between students who attended an early childhood program intentionally teaching skills for resiliency and those who did not, the researcher conducted an ANOVA. The descriptive statistics associated with this analysis are displayed in Table 14.

Table 14

Students by Attendance – Cooperation Subtest

Attendance	***N***	***Mean***	***Std. Deviation***
More than one year	35	2.43	.92
One Year	34	2.38	.92
None	35	2.26	.98

The results of the analysis revealed there were no significant differences between the means of the three groups. The researcher failed to reject the null hypothesis and concluded there were no differences in the Cooperation Subtest scores, as measured by the SAEBRS, based on attendance. Table 15 displays the results of this analysis.

Table 15

One-Way ANOVA by Attendance – Cooperation Subtest

Source of variation	***Sum of squares***	***df***	***Mean square***	***F***	***P-value***	***F critical***
Between Groups	.55	2	.27	.31	.733	3.086
Within Groups	89.29	101	.88			
Total	89.84	103				

Null Hypothesis 7b: There is no difference between the Adaptable to Change Subtest scores of students who did not attend study District ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.

To determine if there were differences Adaptable to Change Subtest scores, as measured by the SAEBRS, between students who attended an early childhood program intentionally teaching skills for resiliency and those who did not, the researcher conducted an ANOVA. The descriptive statistics associated with this analysis are displayed in Table 16.

Table 16

Students by Attendance – Adaptable to Change Subtest

Attendance	***N***	***Mean***	***Std. Deviation***
More than one year	35	2.49	.78
One Year	34	2.74	.45
None	35	2.26	.88

The analysis results revealed there was a significant difference between the means of at least two groups. The researcher rejected the null hypothesis and concluded there were differences in Adaptable to Change Subtest scores, as measured by the SAEBRS, based on number of years in attendance. In a post hoc analysis, the Scheffe Test revealed a difference in Adaptable to Change Subtest scores between Group 2 and Group 3, indicating scores were higher for those students who attended the early childhood program one year versus those who had not attended. Table 17 displays the results of this analysis.

Table 17

One-Way ANOVA by Attendance – Adaptable to Change Subtest

Source of variation	***Sum of squares***	***df***	***Mean square***	***F***	***P-value***	***F critical***
Between Groups	3.94	2	1.97	3.69	.029	3.086
Within Groups	54.05	101	.54			
Total	57.99	103				

Null Hypothesis 7c: There is no difference between the Ability to Rebound Subtest scores of students who did not attend Study District ECC, those who attended for one year, and those who attended for more than one year, as measured by the SAEBRS.

To determine if there were differences in Ability to Rebound Subtest scores, as measured by the SAEBRS, between students who attended an early childhood program intentionally teaching skills for resiliency and those who did not, the researcher conducted an ANOVA. The descriptive statistics associated with this analysis are displayed in Table 18.

Table 18

Students by Attendance – Ability to Rebound Subtest

Attendance	***N***	***Mean***	***Std. Deviation***
More than one year	35	2.57	.88
One Year	34	2.68	.59
None	35	2.37	.91

The results of the analysis revealed there were no significant differences between the means of the three groups. The researcher failed to reject the null hypothesis and concluded there were no differences in Ability to Rebound Subtest scores, as measured by the SAEBRS, based on attendance. Table 19 displays the results of this analysis.

Table 19

One-Way ANOVA by Attendance – Ability to Rebound Subtest

Source of variation	***Sum of squares***	***df***	***Mean square***	***F***	***P-value***	***F critical***
Between Groups	1.66	2	.83	1.27	.286	3.086
Within Groups	66.18	101	.66			
Total	67.85	103				

Summary of Quantitative Analysis

The analysis exploring potential differences in Social, Academic, Emotional Behavior Rating Scale (SAEBRS) scores based on attendance time, more than one year, just one year, or no attendance, at an early childhood center intentionally teaching social skills and skills for resiliency to preschoolers returned varied results between *t*-tests and one-way ANOVA analyses. The following table, Table 20, is a compilation of all *t*-tests and ANOVA analyses with concise description of the result of each hypothesis investigated.

Table 20

Summary of Quantitative Analyses

	Test	p-Value	Conclusion
Null Hypothesis 1			
Total Scores	*T*-test	.035	Neurotypical students who have been intentionally taught social/emotional skills received higher scores than those who were not
Social Behavior	*T*-test	.069	Moderate evidence supports neurotypical students who have been intentionally taught social/emotional skills received higher scores than those who were not
Academic Behavior	*T*-test	.033	Neurotypical students who have been intentionally taught social/emotional skills received higher scores than those who were not

Emotional Behavior	*T*-test	.104	No evidence of differences of means between groups
Null Hypothesis 2			
Total Scores	*T*-test	< .001	Students with IEPs received lower scores than other students who have had same instruction
Social Behavior	*T*-test	< .001	Students with IEPs received lower scores than other students who have had same instruction
Academic Behavior	*T*-test	< .001	Students with IEPs received lower scores than other students who have had same instruction
Emotional Behavior	*T*-test	< .001	Students with IEPs received lower scores than other students who have had same instruction
Null Hypothesis 3			
Cooperation Subtest	*T*-test	< .001	Students with IEPs received lower scores than other students who have had same instruction
Cooperation Subtest	*T*-test	.002	Students with IEPs received lower scores than students who were not given same instruction
Cooperation Subtest	*T*-test	.269	No evidence of differences of means between groups
Null Hypothesis 4			
Adaptable to Change	*T*-test	< .001	Students with IEPs received lower scores than other students who have had same instruction
Adaptable to Change	*T*-test	.024	Students with IEPs received lower scores than students who were not given same instruction

Adaptable to Change	*T*-test	.008	Neurotypical students who have been intentionally taught social/emotional skills received higher scores than those who were not
Null Hypothesis 5			
Ability to Rebound	*T*-test	< .001	Students with IEPs received lower scores than other students who have had same instruction
Ability to Rebound	*T*-test	.002	Students with IEPs received lower scores than students who were not given same instruction
Ability to Rebound	*T*-test	.315	No evidence of differences of means between groups
Null Hypothesis 6			
Total Score	ANOVA	.101	No evidence of differences of means between groups
Social Behavior	ANOVA	.123	No evidence of differences of means between groups
Academic Behavior	ANOVA	.156	No evidence of differences of means between groups
Emotional Behavior	ANOVA	.222	No evidence of differences of means between groups
Null Hypothesis 7			
Cooperation Subtest	ANOVA	.733	No evidence of differences of means between groups

Adaptable to Change	ANOVA	.029	Scores were higher for those students who were intentionally taught social/emotional skills for one year versus those who had not attended
Ability to Rebound	ANOVA	.286	No evidence of differences of means between groups

Chapter Five: Discussion

The purpose of this study was to examine the relationship between intentionally teaching positive social/emotional strategies to young children and their ability to exhibit less risk for social, emotional, and behavior challenges as they enter elementary school. Contribution to the knowledge base of the literature within the fields of early intervention, screening for a variety of mental health issues, identification of adverse childhood experiences, and the importance of helping young children develop strategies needed for resilience was also important. Trauma-informed, research-backed practices, such as strategies used in Conscious Discipline are thought to increase skills in young children when teachers use evidenced-based methodology to intentionally teach students appropriate social/emotional skills, discipline and self-regulation; skills needed for resiliency and mental wellness far beyond early childhood. To this end, the researcher set out to show that social, emotional, and behavioral risk screening in early childhood is important to determine which students need support in mental health because significant adversity impairs growth in the first three years of life, in all areas of development.

Results and Analyses

This study addressed one research question and seven hypothesis statements, which addressed whether students had been intentionally taught social/emotional skills, were identified with any developmental delays, and how long they attended a center where targeted skills were taught by highly trained staff (i.e.: more than one year, one year, or none). *T*-test and One Way ANOVA statistical analyses were used. Skills were measured based on the Social, Academic, Emotional Behavior Risk Screener (SAEBRS). Null Hypotheses 1 measured the Overall scores; Total Scores, Social Behavior,

Academic Behavior, and Emotional Behavior. Neurotypical students who had been intentionally taught social/emotional skills received significantly higher scores than students who had not had the same opportunity in Total SAEBRS score (p=.035) and Academic Behavior (p=.033). There was moderate evidence to support the same statement in Social Behavior (p=.069) scores. There was no evidence of differences in means between the two groups, being intentionally taught social/emotional skills or not, in Emotional Behavior scores (p=.104). One-way ANOVA analyses investigating whether student scores were better when instructed over time were not significant in overall scores, Total, Academic Behavior, Social Behavior, or Emotional Behavior. However, one subtest, Adaptable to Change (p=.029) did show positive correlation for those students who had the benefit of specific teaching in social/emotional skills for one year compared to those students without the same experience. No statistical significance was noted for the other subtest areas, cooperation and the ability to rebound after difficult situations.

After analyzing the ANOVA data and *t*-test statistical analyses, conclusions appear to indicate children who have an opportunity to attend an early childhood program with teachers trained to implement science-backed and research-based curriculum designed to teach children strategies for improving self-regulation, resiliency, and peer interaction skills may not score statistically higher in all areas than their peer counterparts who have not attended such a program. However, there is enough evidence to indicate benefit of attendance in such a program, as overall scores generally reflect positive outcomes. Lower scores on the SAEBRS indicate lower risk of social problems. The information concluded that children who are intentionally taught how to deal with stress,

whether that be traumatic stress caused by abuse or family dysfunction, or other typical day to day stressors, will exhibit, to a lesser degree, maladaptive behaviors. Children who are unable to adapt to change may struggle with flexible thinking, causing challenges with later academics such as math facts and vocabulary skills. The child may experience anxiety, mood swings, and difficulty coping with big emotions.

The information gained in this study added to the literature in contradicting Psychiatrist, Amariah Brigham, as he stated early life stimulation caused insanity (Brigham, 1833). The current literature shows us the opposite. Children become traumatized because they are left alone with hurt after adverse experiences, not because they got hurt. In the documentary, *The Wisdom of Trauma*, Mate discusses the two fundamental needs of children are attachment and authenticity (as cited in Benazzo & Benazzo, 2021). Additionally, science-based and research-backed Conscious Discipline shows infants require parents help them regulate their brain and internal states and is based on "internal resources of safety, connection and problem solving instead of external rewards and punishments" (Bailey, 2015, p. 12). Parents continue to need support of early educators, physicians, and community stakeholders. As the pendulum has moved back and forth over the last century, ultimately early education and family support programs have proven to impact childrens' healthy brain development (A Brief History, Part 2, 2017b; Benazzo & Benazzo, 2021; Koshuk, 1947; Shonkoff & Meisels, 1990). Parent support should ultimately be a priority as strategies are needed in the home to help adults recognize their adaptive behavior and dysregulation to subsequently be able to help their children learn to regulate their own emotions in healthy ways. When a parent is unable to promote positive relationships, children fall behind (Sharkins et al., 2016).

Limitations

Because behaviors were rated based on what can be observed externally, other behaviors may have occurred, but missed when teachers rated students. Also, the Likert scale ranging from never to almost always can be somewhat personal opinion/subjective causing some discrepancy in scoring, even though it is easy to understand. Additional limitations of the study may include teacher implicit bias/attitudes toward students from different social groups. Teachers rate a child they like to have less negative or maladaptive behaviors just based on their preference, and vice versa, in cases of implicit bias. Cate and Glock (2019) reviewed literature considering implicit teacher attitudes toward students finding moderate favor of groups not considered marginalized. Follow-up interviews to investigate teacher attitudes toward student responses to adversity, misfortune, and setbacks may be beneficial if a longer study is desired by district and community stakeholders.

Briggs-Gowan et al. (2010) discussed how researchers have begun to study outcomes for young children, based on environmental, demographics, and parent-child relationships. Buss et al. (2015) stated "these factors may either insulate a child from adverse effects of trauma or increase the child's risk for developing psychological distress" (p. 229, para. 4). The Study District offers parent Conscious Discipline nights. Because secondary data were used, it was unknown whether scores reflected parent knowledge of strategies used in the classroom and whether parents used them in the home. Hypothetically, if a parent also used Conscious Discipline strategies, training provided Study District, to help their child with emotional regulation and resiliency, scores may have been influenced positively. Conversely, if parents use fear-based

discipline strategies in the home, scores may have been influenced in a negative manner, as these students may take longer to exhibit the tools for resiliency modeled by adults who understand brain states and that our internal state dictates our external behavior (Bailey, 2015). Another limitation may involve the teacher's ability to recognize emotions in students. Some teachers may prioritize connecting with each student daily, strengthening relationships, and better able to meet children where they are at any given time, using each of these moments as a teaching opportunity. Lastly, although data was compiled from several elementary schools with multiple kindergarten teachers, ultimately the study collected data from a single Midwestern, public school district. Fundamentally, future research should include samples from other geographic regions as well.

Discussion and implications

Interest in and awareness of adverse childhood experiences, beginning with the landmark Felitti et al. (1998) study, and toxic stress in the early years has resulted in more discussion in the recent past. Scientists are making progress in their knowledge about how the brain grows during the early years of life and how different types of stress interfere with that growth and development. At this time, children's emotional needs are extremely underserved.

Information gathered during this study does indicate there are some differences in social/emotional skills between those children who have benefitted from attendance at a school with teachers highly trained in understanding brain states, how to make healthy relationship connections with students, and how to intentionally teach skills needed for resiliency (Bailey, 2015). Children identified as students requiring special education services and have an Individualized Education Program (IEP) received lower scores in all

categories (Total and subtest scores). It would be ideal to continue using the Conscious Discipline strategies with these students beyond the preschool years. It is well known, students with special needs often require repeated exposure, repeated drill and practice to learn new skills and to generalize skills to new environments and they require frequent prompts to participate in age-appropriate tasks and activities (Temple et al., 2014). Additionally, research has shown young children learn best through play (Sutherland & Friedman, 2012; Featherstone, 2014). However, students with developmental delays often demonstrate deficits in play skills compared to same age peers. These deficits in play repertoire may impact the child's ability to interact in socially appropriate ways with others (Temple et al., 2014). Another suggestion for future research is a longevity study including continued social emotional learning instruction, and other forms of intervention, such as counseling, use of Cognitive Behavior Therapy (CBT), or Acceptance and Commitment Therapy (ACT) to investigate additional supports and benefits to improve skills.

After analyzing results of subtest scores, cooperation, adaptability to change, and the ability to rebound, no evidence of differences of means between groups was realized, with one exception, the Adaptable to Change subtest. Results of the ANOVA test (p=.029) indicated scores were statistically higher in the area of being able to adapt to change for those students who were intentionally taught social/emotional skills for one year versus those who had not attended an early childhood with the same social/emotional learning instruction. Due to lack of statistical significance in analyses of aforementioned hypotheses relating to cooperation (p=.733) and the ability to rebound after a setback (p=.286), the researcher completed postliminary t-tests to consider other

SAEBRS subtests not chosen initially. The subtests indicative of behaviors, such as arguing (p=.145), worry (p=.684), withdrawal (p=.549), fearfulness (p=.548), sadness (p=.651), and temper tantrums (p=.314), in comparing students who attended an early childhood center where skills needed for resiliency have been intentionally taught and modeled by highly trained teachers, compared to those students who were not afforded the same opportunity, did not reveal statistical significance, as outlined by the parameters of this study.

In reflecting on results and possible impacts of the study, the year 2020 may likely be categorized as an anomalous year, due to the COVID-19 pandemic and closures of businesses and schools. Families stayed at home, children learned via online platforms, and restrictions for shopping and travel were imposed. Many students have not experienced a “normal” school year in three years and children currently in grades kindergarten through second have never yet participated in a school setting without masks, quarantines, or fear of illness. They also have not had the freedom to navigate close physical distances with peers in the classroom or on the playground, due to reminders to stay socially distanced impacting healthy personal touches and hugs. Cognitive abilities may be stable, yet the ability to understand a more complex social setting is lacking. Moreover, children already living in dysfunctional homes, subjected to traumatic events including parental drug use, abuse, lack of food, among other potential adverse situations, have been unable to escape to the safety of the school day. This may have potentially impacted scores showing less of a difference between groups as expected. Wholly, these study groups were not subjected to the teaching described in earlier chapters for a normal amount of time as in previous years. A continuation of this

study is recommended for this reason, with the additional qualitative component of teacher interviews to investigate educator perception of student social/emotional skill development and ability to process inimical experiences.

Implications include needing more programs like this Midwestern school district's early childhood program where teachers are highly trained and qualified using a research-based curriculum to actively and intentionally teach preschool age students these skills needed for resiliency in adulthood. Additionally, stress and trauma have been called a hidden epidemic in the United States. Teachers dealing with students who exhibit behavior problems in their classrooms often become stressed themselves. Having the data to show programs, such as Conscious Discipline positively affect student outcomes, encourages administrators and stakeholders to provide this type of training to teachers resulting in physically and mentally healthy students. Because the programs help adults focus on their own difficulties and self-regulation, teachers also gain ability to build capacity to create a classroom climate valuing relationships and resiliency (Bailey, 2015). At this time in our country's history, providing our youth with the ability to overcome trauma is of utmost importance.

Many children have experienced ACEs. Knowing what makes children resilient and actively teaching these skills will give them tools to use as they grow. When children are resilient, they are more likely to reach their full potential in adulthood. The more researchers learn, it seems there is opportunity for individuals to overcome early adversity. Gershon and High (2015) wrote, "It takes less time, intensity, and repetition to organize developing neurosystems [sic], than to reorganize them later in development" (p. 359, para. 2). In Gershon and High's (2015) exploration of previous studies completed

on the ability of the human genome to adapt, it was indicated many changes in gene expression might be able to be reversed. The emerging field of epigenetics is helping scientists to understand how the human body and brain has learned to adapt to its environment (Gershon & High, 2015). Gershon and High (2015) defined epigenetics in the following way: "the study of heritable, but modifiable, changes in gene expression that do not involve changes to the underlying DNA sequence" (p. 353, para. 3). Based on what is known about early life adversity and toxic stress, this is good news. Early intervention is most effective when implemented as early as possible in a child's life. A writing by the Foundations of Lifelong Health at Harvard University stated, "It is imperative educational and medical communities prioritize a variety of supports, such as therapies and education, for families burdened with toxic stress" (Harvard University, p. 19, para. 2). In his book, *The Body Keeps Score*, Van der Kolk (2014) discussed how physical problems, such as headaches, pain, and oversensitivity are experienced when our body makes stress hormones, such as cortisol. Additionally, Jack Shonkoff, Founding Director, Center of the Developing Child at Harvard University indicated stress hormones undermine a child's ability to attend and get along with others. He stated it is "a biological problem that becomes a behavior problem" (Wooward, 2019, 44:13).

Educators do an upstanding job identifying early childhood students who require special education services based on language, motor, self-help, adaptive behavior, and social/emotional deficits when parents are told by physicians, friends, community stakeholders and others such services exist. However, based on current trauma informed educational practices, special education appears to be lacking in this area as there are no identification areas of delay formally recognized specifically targeting delayed skills due

to adverse childhood experiences, significant early life trauma and/or current detrimental home life and parental issue, especially for those children who experience internalizing problems rather than primarily externalizing problems. Many of these children are left to struggle through their school day without the resources to help them with mental health, emotional, social, and behavioral struggles. For example, eligibility criteria in the state of Missouri for identification of Emotional Disturbances states "children who experience and demonstrate problems of everyday living and/or those who develop transient symptoms due to a specific crisis or stressful experience are not considered to have an emotional disturbance" (Strange, 2021a, p. 2, para. 4). Therefore, there appears to be limited availability of adequate, and of equal importance, age-appropriate supports for young children and families dealing with toxic stress in our communities.

Future research may include comparing other similar programs to Conscious Discipline and investigating strengths and weaknesses according to teacher interviews and other qualitative measures. A longevity study to determine if children maintain the skills learned early but without continued teaching or skills become stronger with instruction into higher grade levels would be beneficial, especially to district decision-makers. Information from such a study may help with financial decisions. Additionally, exploration of strategies for use in conjunction with Conscious Discipline and identifying students with lagging skills, such as decreased attention, negative emotionality, decreased persistence, sensory-motor concerns, cognitive inflexibility (Lives in the balance, n.d.). Not many empirical studies currently exist on the prevalence of psychiatric disorders in the early childhood years; therefore, more studies regarding mental illness in early

childhood and strategies needed to help change the course of biological gene sequences are needed.

Recommendations

Study District Board of Education and administrators will have evidence-based information regarding the effective use of strategies based in Conscious Discipline and its effects on students' social/emotional skills which aligns with their commitment to positive peer influences and for all students to reach their full potential (Study District, n.d.) as indicated by significance found in this study for overall scores for district kindergarten students as rated by district kindergarten teachers.

Based on study results, including quantitative outcomes and the review of literature, training for teachers beyond preschool may be warranted, in addition to adscititious therapeutic treatments such as those able to be implemented by school counselors and/or behavior specialists. Additionally, trauma-informed systems of understanding should be developed by school districts, beginning in early childhood education. This system should include annual screening for trauma and toxic stress exposure through interview with parents, childcare providers, and/or other caregivers. Information gained in such interviews may be used to develop intervention plans targeting strategies for emotional healing and family education where needed. Resources should be made available to school staff and families regarding exposure to trauma, its impact, along with effective, research-based treatments. It is also recommended that school staff participate in continuing education opportunities to recognize parent and caregiver trauma and its impact on family systems. By being mindful of these patterns, educators can begin to build capacity in families, strengthening resilience and protective

factors of children and adults (Harden et al., 2019). A school-based trauma system should also include care for staff members who interact with, address and treat families experiencing significant toxic stress. Support for staff members is needed to minimize their stress and build resilience as they persist in the daunting task of caring for families enfeebled by affliction and significant hardship. Furthermore, when needed, a clear process should be developed for referring and reporting children and families to other organizations, such as Child Protective Services or Department of Mental Health, including more training and guidance with mandated reporting and signs or symptoms of mistreatment of a child or an adult.

Furthermore, because adults increasingly use cell phones, computers, laptops for work and leisure such as social media instead of attending to and being fully present with their children, ramifications of parental/caregiver excessive use of technology and effects on young children and parental relationships should be explored. This technological neglect, per se, may likely be hindering a child's ability to learn to be resilient due to adult inability to recognize negative internal states, emotions, and behaviors as they are not fully attending to their child, subsequently missing out on opportunities to teach needed skills. More research is needed to develop parent education regarding parent-child relationships and brain development in early childhood. Genes and environment converge throughout a child's development. The brain is responsible for basic wiring and environment/experiences impact connections and how the brain interprets events and situations (Center of the Developing Child, 2010). When parents start to realize how neglect and trauma effect brain development and growth, they are likely to begin to understand how their child thinks, feels, and behaves.

Conclusion

In conclusion, based on this research, review of literature, and current data, it is important for teachers and other stakeholders to understand the value in teaching the whole child. Understanding emotional regulation and resiliency in children is important in combatting a continued cycle of traumatic and toxic stress and its consequences into adulthood and future generations. Schools should put a policy in place to screen children not only for behavior and academic concerns, yet also for mental illness symptoms as early as possible and monitor those children, and their families, who are experiencing or have experienced toxic stress and adverse experiences. Treatment should be multidisciplinary and teams should include parents, educators, counselors, behavior specialists, and medical personnel. National Alliance on Mental Health, NAMI (n.d.), Mental Health Care Matters poster, reports an 11-year delay between onset of symptoms to treatment (para. 4). Based on current research, this is unacceptable. If teachers, medical personnel, social workers, mental health care providers and other helping community members ultimately get this right for children and families, as early as possible, those devastated and battered by significant adversity and toxic stress could have tools to overcome those obstacles and begin to pursue life, liberty, and happiness to its fullest. By getting this right for children and families, our country could potentially be positively different.

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Appendix A

Letter to Dr. DuBray, Superintendent, and Response

Dear Dr. DuBray,

Let me first begin by saying how thankful I am for this district and its leadership during this unprecedented time. I am very grateful for the extensive planning, and thoughts for students and staff by administration and the Board of Education. I am an alumna who graduated from Fort Zumwalt North High in 1988. The way Fort Zumwalt leads in general, and especially in challenging times, make me proud as a former student and current employee.

I currently am working as a School Psychological Examiner at the Early Childhood Center. I started working in this role in 2002; continuing my graduate education for most of this journey. The growth and changes in this program I have witnessed and participated in over the years has been nothing short of amazing. The genuine school family culture Dr. Ellerbrook has created is beyond measure. I sincerely hope you feel that when you walk into the Early Childhood Center.

At this time, I am nearing the end of my doctoral program at Lindenwood University and I am requesting your permission to use data the district already collects. I plan to complete a quantitative study related to the intentional teaching of social/emotional skills at an early age. The title of my study is "A Quantitative Study Examining Intentional Teaching of Social Emotional Skills".

The data I am requesting permission to use is information from the SAEBRS (Social, Academic, Emotional, and Behavior Rating Scale). I would like to know if there are any differences in the scores between students who have attended the Early Childhood Center and been taught by well trained teachers using Conscious Discipline and those who have not attended our center.

My hope is results show the use of conscious discipline (intentional teaching of social/emotional skills) is setting our young students up to be resilient as they grow. I have heard many success stories of our young students coaching their peers through tough times and moving themselves through times of dysregulation. I appreciate those stories; however, I am a person who leans toward numbers and data to show statistical significance one way or the other.

I plan to submit my prospectus to the IRB in the near future and request your permission to use this data, already collected by Fort Zumwalt, once I have approval for my study. Dr. Ellerbrook has access to the data and has stated she would be willing to pass that on to me once it is de-identified and I have your permission to gain the information.

I know you are exceptionally busy during this time and appreciate your time and consideration for my request. Please do not hesitate to let me know if you have any questions or concerns. Additionally, if you would like to meet with me in person to discuss my dissertation plans further, I am very happy to do that as well.

Again, thank you very much for your consideration.

Sincerely,

Christy Huse

Sun, Sep 20, 10:48 AM

DuBray, Bernard <bdubray@fz.k12.mo.us>

to Sharon, Jennifer, me, Laura

Dear Christy,

I have received your request to use District data in your Doctoral research for your degree completion at Lindenwood University. I have reviewed your premise for your study and I will approve your request. Please be advised that any use of District data must be anonymous and any time you devote to your research must be outside your regular school hours. With these two caveats I approve of your request. Best of luck with your research and please share the results with me when they are available. Take care.

Bernard DuBray

Superintendent of Schools

--

Dr. Bernard J. DuBray

Superintendent

Fort Zumwalt School District

O: 636.240-2072

fz.k12.mo.us

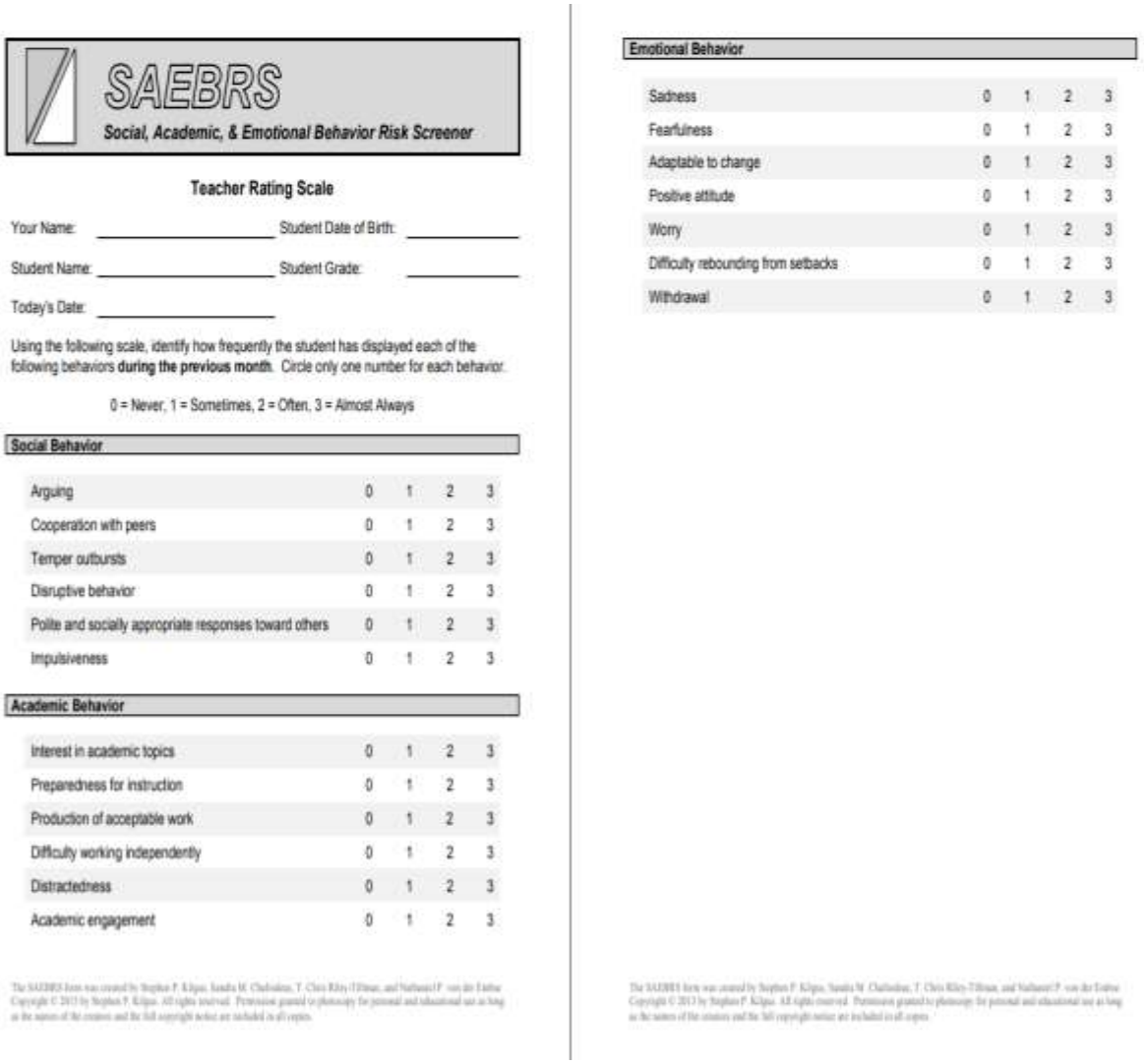
PUSHING FOR POSITIVE PEER INFLUENCE

FZ West, FZ East, FZ South, FZ North

among America's Best High Schools two consecutive years

Appendix B

SAEBRS rating scale



SAEBRS

Social, Academic, & Emotional Behavior Risk Screener

Teacher Rating Scale

Your Name: _____ Student Date of Birth: _____

Student Name: _____ Student Grade: _____

Today's Date: _____

Using the following scale, identify how frequently the student has displayed each of the following behaviors **during the previous month**. Circle only one number for each behavior.

0 = Never, 1 = Sometimes, 2 = Often, 3 = Almost Always

Social Behavior

Arguing	0	1	2	3
Cooperation with peers	0	1	2	3
Temper outbursts	0	1	2	3
Disruptive behavior	0	1	2	3
Polite and socially appropriate responses toward others	0	1	2	3
Impulsiveness	0	1	2	3

Academic Behavior

Interest in academic topics	0	1	2	3
Preparedness for instruction	0	1	2	3
Production of acceptable work	0	1	2	3
Difficulty working independently	0	1	2	3
Distractedness	0	1	2	3
Academic engagement	0	1	2	3

Emotional Behavior

Sadness	0	1	2	3
Fearfulness	0	1	2	3
Adaptable to change	0	1	2	3
Positive attitude	0	1	2	3
Worry	0	1	2	3
Difficulty rebounding from setbacks	0	1	2	3
Withdrawal	0	1	2	3

The SAEBRS form was created by Stephen P. Kilgus, Sandra M. Chafouleas, T. Chris Riley-Tillman, and Nathaniel P. von der Embse
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Vitae

Christina Scrivner-Huse

10287 Plantation Manor, Foristell, MO 63348 | 636-384-9540 |

Christina.s.huse@gmail.com

ACADEMIC DEGREES

Lindenwood University, St. Charles, MO

Doctor of Education (ABD) **Expected 2022**

Educational Leadership with emphasis in behavior analysis

Dissertation Title: A Quantitative Study Examining Intentional Teaching of Social Emotional Skills.

Educational Specialist **August 2017**

Behavior Analysis with emphasis in Instructional Leadership

Master of Arts in Education **1998**

Emphasis in Counseling and diagnostic assessment

Bachelor of Arts in Elementary Education –Cum Laude **1993**

Emphasis in early childhood and early childhood special education

PROFESSIONAL EXPERIENCE

Fort Zumwalt School District, O'Fallon MO **2002 –Present**

Early Childhood Special Education School Psychological Examiner

Francis Howell School District, St. Charles MO **1994 - 2002**

Early Childhood Special Education Teacher

United Services, St. Charles MO **1992 – 1993**

Paraprofessional, Early Childhood Special Education

Classroom

CERTIFICATIONS

Early Childhood Special Education

Career Continuous Professional Certification

School Psychological Examiner

Career Student Services

PROFESSIONAL ORGANIZATION MEMBERSHIP

ACBS – Association for Contextual Behavior Science (RENEW)

Heartland ACBS – Missouri Chapter

CEC - Council for Exceptional Children

MASP – Missouri Association of School Psychologists

CURRENT COMMITTEE PARTICIPATION

Fort Zumwalt Early Childhood Center TLC (Trauma Informed Leadership Committee)

PROFESSIONAL DEVELOPMENT

Adverse Childhood Experiences: Lifelong

Consequences and How to Overcome Them

Autism and Aspergers Syndrome

Attention, Language Processing and Sensorimotor

Disorders in Children

Behavior Economics: Fundamentals and Implications

for Behavioral Intervention in Autism (ABA)- Iser

DeLeon

Brief Solution-Focused Interventions for School Problems

Bringing Missouri Special Education Law into Focus

Conscious Discipline

Creative Curriculum

Driving Missouri to Results: Assessment Based Intervention

Early Childhood Special Education Diagnostic Coalition

Early Childhood Special Education Environments

Ethics in Behavior Analysis: Translating the Code into Conduct in our Work

Evaluating and Progress Monitoring Students with Complex Communication Needs

Evidence-Based Practice: Steps for Staff working with English Language Learners

Executive Functions in the Classroom

Focus on Assessment: No Psych Left Behind

Lindenwood University Early Intervention Conference

Fort Zumwalt Early Childhood Diagnostic Meetings (weekly)

Hardwiring Happiness

Helpful Entry Level Skills Checklist – Revised Edition

I Can't Make You: Attitude Shift and Derailments for Resistance

Introduction to Interactive Metronome – History and Research

Medications in Autism: What Works, What Doesn't

Missouri Department of Elementary & Secondary Education webinars

Missouri First Steps Modules

New Regs, New Roles, New Tools: IDEA and Neuropsychology of Reading Disorders

Non-Violent Crisis Prevention and Intervention

Picture Exchange Communication System

Project STEPS

Section 504: Updates and Overview

Supporting Communication in Verbal and Nonverbal Individuals with Interfering Behavior: Functional Communication Training

Thompson Center Autism Conference

Transdisciplinary Play-Based Assessment

Vowel Therapy – Linguisystems

AWARDS AND HONORS

Dean's List – multiple semesters

Who's Who Among Students

COMMUNITY SERVICE

Faith Christian Family Church Prayer Against Human Trafficking

Wentzville Civil Air Patrol Composite Squadron Booster Club – Treasurer (previous)