2-27-2023

Trauma-Informed Care in Native American Education: Compassion Satisfaction, Secondary Traumatic Stress, Burnout, and Resilience as Mediating Factors to Implementation

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Presented to the Faculty of the

Graduate School of Clinical Psychology

George Fox University

in partial fulfillment

of the requirements for the degree of

Doctor of Psychology

in Clinical Psychology

Newberg, Oregon

Approval Page

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by

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has been approved

at the

Graduate School of Clinical Psychology

George Fox University

as a Dissertation for the PsyD degree

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February 27, 2023

Abstract

With increased awareness and discussion of trauma-informed care, both within the educational setting and the Native-American community, this study went about developing a training series on trauma and resilience for educational and residential staff at a Native-American boarding school. This study sought to identify the effectiveness of this training series on improving participant's attitudes towards trauma-informed care, while also assessing individual characteristics including Resilience, Burnout, Secondary Traumatic Stress, and Compassion Satisfaction as possible predictors of trainees' attitudes. Results determined the training series did not significantly change trainees' attitudes on trauma-informed care. Additionally, while resilience and secondary traumatic stress proved to be significant predictors of trainee's attitudes, these effects did not persist over time. Therefore, implications for future trauma-informed care training and research are further discussed, with specific considerations for addressing resilience and burnout on a systematic level prior to implementing trauma-informed trainings or policies.

Keywords: trauma-informed care, Native-American, education, resilience, burnout

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Chapter 1

The Scope of Trauma

As its prominence both within research and public awareness grows, the topic of trauma is becoming increasingly more discussed and incorporated into the psychological discipline. According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), trauma is defined as an event or events that cause perceived threat to an individual's well-being, such that it has lasting adverse effects on one's physical, mental, social, emotional, and/or spiritual well-being, trauma constitutes a significant and impactful aspect of the human experience. A primary motivation to understand and research the nature and prevalence of trauma is due to the population most affected: children. Prior research estimates that two-thirds of children experience at least one traumatic event by the age of 16 years (Copeland et al., 2007). The most recent data from the United States Department of Health and Human Services (DHHS, 2022) reported 618,000 child victims of abuse and/or neglect in 2020, leading to a victim rate of 8.4 victims per 1,000 children. However, one of the most comprehensive and effective methods by which to define and track trauma began with the seminal study in 1998 by the Centers for Disease Control and Prevention regarding Adverse Childhood Experiences (ACEs; Felitti et al., 1998). Originally consisting of 10 distinct types of traumas, including forms of abuse, neglect, and household dysfunction, ACEs have now become a quantifiable means to evaluate the extent of childhood trauma. Subsequently, additional researchers have added to the original ACEs, recognizing that communal experiences, socio-economic factors, mortality, and other variables can result in traumatic childhood events (Burke-Harris, 2018). As a result, psychological

research and practice possesses a more comprehensive awareness of trauma within the pediatric population.

Native Americans and Trauma

While trauma exists across all demographics and communities, the trauma experienced by Native Americans is unique. First, as compared with non-Native groups, Native American children experience the highest rates of trauma, with childhood victimization rates at 15.5 per 1,000 children (DHHS, 2022). While the original Centers for Disease Control and Prevention study of ACEs did not include a representative sample of Native Americans, subsequent research has determined that 86% of Native Americans report at least one traumatic experience during their childhood (Koss et al., 2003). Additionally, Native Americans are more likely to report multiple ACEs (Kenney & Singh, 2016), as well as the highest average of overall ACEs of any ethnic group (Giano et al., 2021; Brockie et al., 2015).

Trauma Redefined

When referring to the experience of trauma, historically, this has been conceptualized more narrowly through the diagnostic label of posttraumatic stress disorder (PTSD), as defined by the American Psychiatric Association. While this diagnosis accurately captures the symptoms associated with a posttraumatic response, the PTSD label is limited in its ability to recognize trauma as not only a singular event (e.g., natural disaster, sexual assault, etc.), but also a chronic exposure (e.g., neglect, bullying, etc.) or a communal, as opposed to an individual, experience (Copeland et al., 2007). Perhaps the best example of this conundrum would be the experience of Native American peoples. Having survived colonization, genocide, forced relocation, and cultural assimilation, Native Americans have endured trauma that is intergenerational, communal, and ongoing. As a result, the term “historical trauma” was coined to describe the

cumulative and generational effects (e.g., emotional, physical, and psychological symptoms) experienced by Native Americans as a result of mass trauma exposure (Brave Heart & DeBruyn, 1998; Evans-Campbell, 2008). The effects of these historical traumas persist, both in the current individual and systemic experiences of racial prejudice, discrimination, and oppression (Carter, 2007), as well as in experiences of historical loss and unprocessed grief within the Native American community, including amongst present day adolescents (Whitbeck et al., 2004). Therefore, this unique form of trauma has also been described as a "soul wound," as the effects of historical traumas have become inherently intertwined into the Native experience, thus impacting both the identity and well-being of the entire Native American community (Duran, 2006, p. 16).

Effects of Trauma on Well-Being

Traumatic experiences in childhood have lifelong implications to an individual's health and functioning. The original ACEs study demonstrated that with four or more ACEs came a greater likelihood of physical health issues later in life (e.g., alcohol dependency, drug abuse, smoking, sexually transmitted illnesses, physical inactivity, and severe obesity; Felitti et al., 1998). Further research has confirmed numerous physical effects related to childhood trauma (Lopes et al., 2020; Suglia et al., 2015), including identifying chronic stress, brought on my complex and recurring trauma, as a predicator for premature death (Katz et al., 2012). Similarly, ACEs impact psychological functioning, both in childhood/adolescence, as well as into adulthood. Research has linked childhood trauma with increased likelihood of experiencing psychosis (Bremner, 2003) and being diagnosed with depression, anxiety, and/or posttraumatic stress disorder (Bremner, 2003; Chen et al., 2010; Nelson et al., 2017). Additionally, those who experience childhood trauma are more prone to experience suicidal ideation and/or attempts (Fry

et al., 2012), both as adolescents (Miller et al., 2013) and as adults (Ng et al., 2018). Socially, victims of ACEs (i.e., physical abuse) are more prone to experience intimate partner violence in adulthood (Fry et al., 2012). Also, trauma exposure in childhood results in both short-term and long-term neurobiological changes within the brain and body (van der Kolk, 2003). The immediate effects include a heightened sense of arousal (e.g., the fight/flight/freeze response), making one more reactive to their surroundings for fear of danger. Long-term effects of trauma include impairments to the prefrontal cortex, hippocampus, and amygdala, leading to deficits in executive functioning, memory, and affect regulation (Bremner, 2003; van der Kolk, 2003). Behaviorally, this results in slower processing speed, memory issues, dissociation, and issues with emotional reactivity, including aggression, poor impulse control, and emotional dysregulation (Mothes et al., 2015; van der Kolk, 2003; Vonderlin et al., 2018). Similarly, research demonstrates that higher ACEs within the Native American population also results in increased concerns, including elevated rates of mental health diagnoses, alcohol addiction, substance use, and academic difficulties (Kenney & Singh, 2016; Warne et al., 2017).

Trauma in Education

The effects of childhood trauma also impact survivors' education attainment. Behaviorally, students with a trauma history exhibit more behavioral concerns and have higher rates of absenteeism than non-traumatized students (Blodgett & Lanigan, 2018). Academically, childhood trauma has been associated with poor academic performance, higher grade retention and special education placement, and failure to meet grade-level standards (Blodgett & Lanigan, 2018; Hardner et al., 2018; Perfect et al., 2016; Porche et al., 2016;). As it relates to Native American students, additional effects ought to be considered due to the historical use of residential schools for Native Americans. This widespread practice has been shown to have been

a source of significant trauma within the Native American community (Brave Heart & DeBruyn, 1998; Duran, 2006), traumatizing not only those who attended, but also causing physiological changes and psychological distress on those students' children (Chief Moon-Riley et al., 2018; Evans-Campbell et al., 2012). All these byproducts of childhood trauma create significant barriers to academic achievement, such that there are negative impacts on survivors' educational, occupational, and economic trajectories (Blodgett & Lanigan, 2018).

The effects of trauma impact not only the survivors, but also pose an occupational and psychological challenge to educators. As frontline professionals, teachers respond to the emotional, behavioral, and psychological effects of trauma in their students every day. Their awareness of childhood trauma is evident, as teachers are second only to law enforcement personnel in reporting cases of child maltreatment in the United States (DHHS, 2022). This exposure to trauma takes its professional toll, as teachers consistently report elevated levels of occupational stress and varying levels of job satisfaction (Johnson et al., 2005; Borntrager et al., 2012). Psychologically, teachers are more at risk for secondary traumatic stress (STS), also known as vicarious trauma (Borntrager et al., 2012). With symptoms mirroring PTSD, STS develops in response to exposure to others' trauma (Caringi et al., 2015; Hydon et al., 2015). In hearing of childhood traumas and dealing with the effects of trauma in their students, teachers are subsequently also more inclined to report higher levels of burnout, particularly amongst younger educators (Fisher, 2011). As opposed to STS, which is an immediate psychological and physiological response to trauma exposure, burnout is the result of chronic stress, marked by feelings of hopelessness, exhaustion, low job satisfaction, and a sense of ineffectiveness in one's professional role (Stamm, 2010). Both STS and burnout have been previously found to be higher in educators working in low-income, high-minority schools (Abraham-Cook, 2012). Considering

these professional and psychological factors, it is understandable why approximately 50% of educators leave the profession within the first five years of teaching (Pas et al., 2012). Overall, in recognizing the effects of trauma, both on students and teachers, there is a significant need for the implementation of trauma-informed practices in educational settings.

Trauma-Informed Care in Education

With the increase in trauma awareness and research has come a rise in demand for efficacious practices for working with trauma survivors, including within the educational system. The basic tenets of trauma-informed care (TIC), as established by SAMHSA (2014), are rooted in attachment, trauma, and neurobiological research (van der Kolk, 2014), and outline the importance of safety, trustworthiness, peer support, collaboration, empowerment, and awareness of cultural, historical, and gender issues. However, due to differences in systems, resources, and populations, there is no one set method by which these TIC principles are implemented. In determining the methods of TIC, SAMHSA (2014) outlines four key assumptions for evaluating the effectiveness of TIC, known as the four Rs: realize, recognize, respond, and resist. By increasing education about trauma, learning to identify trauma symptoms, implementing trauma-informed intervention, and developing systems designed to not re-traumatize survivors, TIC can be successfully introduced in educational settings regardless of methodological differences.

The benefits of implementing TIC into the academic setting are clear. Students receiving TIC report experiencing an increase in emotional support and a reduction of psychological issues (Record-Lemon & Buchanan, 2017; Rishel et al., 2019). Teachers in TIC systems report an increase in classroom organization, confidence and competence in TIC practices, social engagement, and role clarity, as well as a reduction in stress (Record-Lemon & Buchanan, 2017; Rishel et al., 2019; Shamblin et al., 2016;). Also, TIC has been employed effectively in a

residential school setting, thus demonstrating that variations in academic settings do not preclude TIC principles from improving student and educator experiences (Day et al., 2015).

Barriers to Trauma-Informed Care

Previous research as has examined the individual factors of trainees (e.g., attitude, organization commitment, engagement, workplace perceptions, etc.) that facilitate both engagement in, and effectiveness of, implementing novel programs (Hales & Nochajski, 2020; Henggeler et al., 2008; Noe & Wilk, 1993; Schaufeli & Bakker, 2004). However, within education, minimal study has been completed to evaluate the individual characteristics of teachers that mediate the implementation, success, and sustainability of TIC programs (Yohannan & Carlson, 2019). Of the research that has been conducted, teacher perceptions of system fit (i.e., administrator and colleague support) and acceptability of trauma-informed practices (i.e., buy-in) mediate teacher engagement in TIC programs (McIntyre et al., 2019). Additionally, attitudes towards TIC have been associated with teacher self-reports of compassion satisfaction, secondary trauma stress, and burnout (Stamm, 2010; Christian-Brandt et al., 2020). Teachers with both high compassion satisfaction and high STS held more favorable views of TIC effectiveness, while teachers who reported high burnout reported more negative views of TIC effectiveness. Based on these findings, an educator's level of engagement in TIC processes (the key to successful TIC implementation) may be mediated by one’s levels of compassion satisfaction, STS, and burnout.

Lastly, research shows that resilience, the ability to bounce back despite challenging circumstances, is negatively correlated with burnout, including amongst educators (Polat & Iskender, 2018). This also indicates a potential contributing factor in determining educator characteristics that will impact the implementation of TIC training.

Purpose of This Study

In recognizing the prevalence of childhood trauma, especially within the Native American community, and the impact trauma has on students and teachers within the academic setting, this study developed and implemented a three-part, culturally sensitive, trauma-informed training for educators and residential staff at a Native American boarding school. Building upon the minimal research previously conducted around the effectiveness of TIC training in education, this study examined individual factors in trainees (i.e., Burnout, Compassion Satisfaction, Compassion Fatigue, and Resilience) in relation to reported attitudes towards TIC. In so doing, this study examined the relationship of these variables to further inform the development and implementation of TIC trainings and principles within academic settings, specifically residentially based Native American schools.

Hypotheses

H1: Participants' attitudes towards TIC will improve from Time 1 to Time 2, and from Time 2 to Time 3.

H2: Participants' reported levels of Compassion Satisfaction, Burnout, and Resilience will significantly predict attitudes towards TIC, with Compassion Satisfaction and Resilience as positive predictors and Burnout as a negative predictor.

Chapter 2

Methods

Participants

This study recruited individuals from the residential and academic departments of a Native American boarding school during the 2020–2021 academic year. The professional roles of these participants varied, with academic department participants consisting of high school

educators, school counselors, teaching assistants, and academic administrators. Trainees from the residential staff who participated in this study included general staff, social workers, and administrative personnel. While all academic and residential staff were invited to attend the trauma and resilience trainings, as well as complete three surveys, only a portion of individuals attended the trainings and completed at least one survey (N = 50). While attendance at the training sessions remained consistent, response rates on the surveys dissipated over time (Time 1: N = 43, Time 2: N = 24, Time 3: N = 26).

Demographically, identity markers for participants varied. First, an average 33 residential staff and 24 academic staff were present across all three trainings. Participants were not asked in the surveys to list their ethnic/racial identity, as this self-disclosure was considered by this research team as a potential concern for maintaining the anonymity of respondents. However, most academic staff identified as European-American and most residential staff identified as Native American, with other ethnicities also being represented. The age of research participants varied, with the majority identifying as middle age. Additionally, most research participants (Survey #1) identified as female (N = 23) with the remainder identifying as male (N = 19). Lastly, there was considerable variability in the number of years each participant had worked at this school (e.g., 1–20 years), with the average length of employment being just over 11 years.

Participation in this research study was voluntary, as all participants received an informed consent with the option to either join or abstain from this research process. For those that agreed to participate there were multiple incentives. For participation in Survey #2, trainees were entered into a raffle for one of four $25 gift cards. Similarly, to improve response rates amongst trainees, participants in training Session #3 were entered into a raffle for one of two $50 gift cards. Additionally, due to difficulties with contacting residential staff following the second

training, this research team also provided a $5 incentive in addition to the paper survey and mailing materials, which were distributed to the home residences of these staff members. Lastly, participation and engagement in this study, including the trauma and resilience training series may have been influenced by professional development/training requirements, as this training was used to count hours towards staff member's professional training obligations.

Materials

The materials for this study first included the trauma and resilience training information (see Appendix A). The initial curriculum for this training was developed by a licensed clinical psychologist and professional trainer with experience in trauma and resilience training with educators and Native American service agencies. While this curriculum is distinct to this psychologist/trainer, the topics and general information addressed within this curriculum are consistent with the research literature on trauma and resilience.

In considering the unique setting and trainee population, this research team made additions to the core curriculum including information specific to the Native American experience (i.e., defining historical trauma, discussing intergenerational impacts of mandatory boarding school attendance, resilience research specific to Native Americans, Native American specific TIC interventions—e.g., the use of storytelling). As a result, the curriculum for this training provided both accurate information and relevant TIC interventions for trainees to learn and employ in their various professional roles with Native American adolescents.

Survey Description

The survey for this research project was created to assess individual trainee factors over time. Therefore, this survey was distributed to participants at three different intervals, with minor changes in content between administrations. First, all three versions of the survey began with a

statement of informed consent to ensure that participants knew about and agreed to participate in this study (see Appendix B). Next, the survey requested demographic information (i.e., age, gender, years of employment at the school, department of employment, etc.; see Appendix C). Additionally, to accurately pair participants' responses between data collection periods, participants provided their employee email address. All three surveys consisted of multiple measures designed to assess participants' professional qualities of life (i.e., Burnout, Compassion Satisfaction, and Compassion Fatigue), attitudes towards TIC, and personal levels of resilience.

Professional Quality of Life Measure

The Professional Quality of Life Measure, as developed by Stamm (2010), is a 30-item, 5-point Likert scale self-report instrument that assesses three constructs: Compassion Satisfaction, Burnout, and STS (see Appendix D). In terms of validity, the The Professional Quality of Life Measure's three scales are proven to be distinct constructs with 2%–5% shared variance between scales. However, there is a 34% shared variance between Burnout and STS, as they are both elements of Compassion Fatigue. A critical distinction is found in that the STS scale assesses fear, while the Burnout scale does not. In terms of reliability, all three scales reported good or acceptable Cronbach alpha scores (Compassion Satisfaction: $\alpha = .88$; Burnout: $\alpha = .75$; STS: $\alpha = .81$).

Attitudes Related to Trauma-Informed Care

The Attitudes Related to Trauma-Informed Care (ARTIC), developed by the Traumatic Stress Institute, measures aspects of an individual's perspective on TIC (see Appendix E). This study utilized the ARTIC-10, which is an abbreviated 10-item, 7-point Likert scale form that assesses five domains related to TIC (i.e., underlying causes of problem behaviors and symptoms, responses to problem behavior and symptoms, on-the-job behavior, self-efficacy at

work, and reactions to the work). According to psychometric testing, the ARTIC-10 is a reliable measure, with a Cronbach's alpha score in the good range (α = .82), with good temporal consistency after 120 days (α = .82; Baker et al., 2016). For construct and criterion-related validity, the subscales on the ARTIC-10 are strongly correlated with scores of participants previously exposed to TIC and participants with higher levels of experience within TIC systems. Additionally, the educator-specific version of this measure was given to study participants, making it more precise to their profession.

Resilience Scale

To evaluate participants' resilience, this study incorporated the 25-item Resilience Scale (Wagnild & Young, 1993; see Appendix F). This measure's construct validity was determined through correlative comparisons to validated assessments for aspects related to the concept of resilience (i.e., morale, life satisfaction, depression, and somatic health). Initial psychometric analysis established Cronbach's alpha between .76 and .91 (Wagnild & Young, 1993), with follow-up analysis establishing similar levels of reliability (α=.72-.96; Wagnild, 2009).

Procedure

This study began with the development of a three-part training course on trauma and resilience. While this research team relied upon the pre-existing curriculum, the culturally specific information included in this training was identified and presented by clinical psychology graduate student trainees in partnership with the clinical psychologist overseeing the delivery of this training.

Because of the COVID-19 pandemic and social distancing requirements, trainees were prevented from congregating together in person. Therefore, a hybrid training model was developed using the online platform Zoom. Academic staff joined the training sessions via

Zoom, while residential staff socially distanced themselves in the school's auditorium and participated through Zoom via the projector system. Additionally, this research team was present via Zoom, presenting the training information via PowerPoint.

The trauma and resilience trainings were provided to participants across three different sessions of 2 hours each, over the course of approximately 3 months. The first training session highlighted the nature of stress, discussed the importance of self-care, and defined the various forms of trauma (including historical trauma of Native Americans), as well as provided an overview of ACEs and the long-term effects of childhood trauma. The second training session occurred 1 week later. This session discussed resilience, including research specific to Native American resilience. The final training session was intentionally staggered to provide a longer period between the first two sessions and the final training, thus allowing researchers to assess potential longitudinal effects of the training. During this final session, presenters briefly reviewed the previous key concepts related to trauma and resilience, then proceeded to teach specific TIC strategies (e.g., de-escalation, active listening, etc.) as well as discuss discipline and problem behaviors from a trauma-informed approach.

Data Collection & Storage

Data for this study was collected via online and paper surveys over three separate intervals. Time 1 data collection occurred prior to the start of the training series. Time 2 data collection occurred following the second training session. Time 3 data collection occurred following the third and final training session. Online surveys were disseminated via the online platform: Survey Monkey. Participant responses were also securely stored on Survey Monkey until all three surveys were completed, at which time they were downloaded and de-identified by this research team to ensure the anonymity of participant responses. Due to unforeseen

difficulties in communicating with trainees following the second training, paper copies of the survey were mailed to certain trainees' residences, with appropriate return postage provided. All returned paper surveys were transcribed into Survey Monkey for secure storage, with all paper copies being destroyed thereafter to ensure confidentiality of respondents. Additionally, prior to each data collection, potential participants were provided with an informed consent detailing the nature of the study, potential benefits and risks of participating, confidentiality safeguards, as well as contact information to reach this research team and a list of mental health resources (see Appendix B).

Prior to the facilitation of this training series and collection of research data, this research proposal was reviewed for ethical compliance by the Bureau of Indian Affairs and was approved to proceed. Additionally, administrators from the school's academic and residential departments granted permission for this research to occur.

Chapter 3

Results

Descriptives

The Statistical Package for the Social Sciences (version 28.0.1.1) was used for all analyses. In cases of missing data, linear interpolation was used (33% of total data). Normality of the test variables was explored using Kolmogorov-Smirnov Test of Normality, and results are displayed in Table 1.

Table 1

Kolmogorov-Smirnov Test of Normality

	M	*SD*	Kolmogorov-Smirnov *p*-value
Time 1			

	M	*SD*	Kolmogorov-Smirnov *p*-value
Compassion Satisfaction	41.688	1.293	.200*
Burnout	19.688	1.237	.200*
Secondary Traumatic Stress	21.313	1.551	.200*
Resilience	145.000	3.664	.200*
Attitudes towards Trauma-Informed Care	49.563	1.242	.200*
Time 2			
Compassion Satisfaction	40.813	1.119	.200*
Burnout	25.313	1.402	.200*
Secondary Traumatic Stress	20.500	1.414	.200*
Resilience	144.250	3.427	.200*
Attitudes towards Trauma-Informed Care	49.875	1.234	.200*
Time 3			
Compassion Satisfaction	41.188	.967	.066
Burnout	21.813	.797	.200*
Secondary Traumatic Stress	19.813	1.069	.055
Resilience	141.625	6.508	.008
Attitudes towards Trauma-Informed Care	48.875	1.224	.192

Hypothesis One

The primary question of this study was to explore the impact of a three-part intervention series on trainee attitudes toward TIC. Univariate Repeated-Measures Analysis of Variance was conducted to determine whether there were differences between Time 1, 2, and 3 on attitudes toward TIC. Results indicated that there were no significant differences between Time 1, 2, or 3.

Hypothesis Two

Stepwise linear regression was used to determine which trainee characteristics (i.e., STS, Burnout, Compassion Satisfaction, and Resiliency) were predictive of attitudes toward TIC. At Time 1, regression results indicated that only resilience was a significant predictor of attitudes toward TIC, positively predicting 30% of the variance, $R^2 = .30$, $R^2\text{Adj} = .29$, $F(1, 41) = 17.90$, $p < .001$. The strength of this relationship between Resilience and TIC attitudes was found to be moderate, Bivariate $r = .55$, Partial $r = .55$. At Time 2, regression results indicated that only STS was a significant predictor of attitudes toward TIC, negatively predicting 36% of the variance, $R^2 = .36$, $R^2\text{Adj} = .33$, $F(1, 22) = 12.38$, $p < .01$. The strength of relationship between STS and TIC attitudes was found to be moderate, Bivariate $r = -.60$, Partial $r = -.60$). Time 3, none of the predictors were significant. Model summaries for Time 1 and Time 2 can be found in Table 2 and 4, respectively. Coefficients for Resilience at Time 1 and STS at Time 2 can be found in Table 3 and 5, respectively.

Table 2

Time 1 Model Summary

	R	R^2	$R^2\text{Adj}$	ΔR^2	F_{chg}	p	df_1	df_2
Resilience	.55	.30	.29	.30	17.90	<.001	1	41

Table 3

Time 1 Coefficients

	B	β	t	Bivariate r	Partial r
Resilience	.16	.55	4.23	.55	.55

Table 4

Time 2 Model Summary

	R	R^2	R^2Adj	ΔR^2	F_{chg}	p	df_1	df_2
Secondary Traumatic Stress	.60	.36	.33	.36	12.38	.002	1	22

Table 5

Time 2 Coefficients

	B	β	t	Bivariate r	Partial r
Secondary Traumatic Stress	-.55	-.60	-3.52	-.60	-.60

Ancillary Analyses

Supplemental analyses were also conducted to explore whether any of the trainee characteristics measured change significantly between Time 1, 2, and 3. One-way repeated-measures multivariate analysis of variance (MANOVA) was used to explore change on four trainee characteristics (i.e., Compassion Satisfaction, Burnout, STS, and Resilience) over a sequence of three surveys (Time 1, 2, and 3). Mauchly's Test for Sphericity indicated equivalence of the hypothesized and the observed variance/covariance patterns for Compassion Satisfaction, Burnout, and STS. Greenhouse-Geisser corrections were run with the resilience scale.

MANOVA results indicated that there were significant differences between time periods on trainee characteristics, Wilks' $\Lambda = .141$, $F(2, 15) = 6.10$, $p = .01$, $\eta^2 = .86$, power = .93. Follow-up univariate analysis of variance tests were used to determine the measures on which significant differences were found between time periods. Results indicated that significant

differences occurred on the Burnout scale, $F(2, 15) = 12.55$, $p < .001$, $\eta^2 = .46$. No significant differences were found between time periods for the other trainee characteristics (see Table 6). Pairwise comparisons on the individual characteristic of Burnout indicated that there was a significant increase in Burnout from Time 1 ($M = 19.69$) to Time 2 ($M = 25.31$), and is a significant decrease in Burnout from Time 2 to Time 3 ($M = 21.81$).

Table 6

Mean Comparisons

		SS	*df*	*MS*	*F*	Sig.	Effect Size (η^2)
Compassion Satisfaction	Time	6.17	2	3.08	.46	.63	.03
	Error	199.83	30	6.66			
Burnout	Time	258.17	2	129.08	12.55	<.001	.46
	Error	308.5	30	10.28			
Secondary Traumatic Stress	Time	18.04	2	9.02	1.23	.31	.08
	Error	219.958	30	7.33			
Resilience	Time	100.50	2	50.25	.32	.73	.02
	Error	4682.83	30	156.09			

Chapter 4

Discussion

Within recent years, increased public awareness of trauma and its negative effects on well-being have led larger social systems (e.g., schools, hospitals, etc.) to develop initiatives and trainings on identifying and addressing posttraumatic symptoms as well as preventing re-traumatization amongst the populations they serve. This trend in research and practice coincides

with increased discussions regarding Native American peoples and their experiences of historical and intergenerational trauma experiences, which previous research has shown to have significant effects on Native American's psychological, physical, and academic functioning. However, only limited research has been conducted to identify and address the readiness of an individual to learn and develop new skills in TIC. Further still, no research to date has examined the concept of individual readiness for TIC training within a Native American boarding school, a setting wherein many of the students present with posttraumatic symptoms. Therefore, this study was initiated to further explore the individual characteristics of school-based professionals (e.g., teachers, counselors, administrators, residential staff, etc.) to determine if specific attributes (i.e., Resilience, Burnout, Compassion Satisfaction, and STS) predicted one's openness to learning about and engaging in trauma-informed approaches, specifically within the context of working with Native American adolescents.

Discussion of the Sample

The sample of individuals (N = 50) that participated in this study consisted of school-based professionals, ranging in ethnicity, age, gender, job title, and years of employment experience. While diverse in their roles, experiences, and attitudes, many of the individuals recruited for this research did not remain active participants throughout the full course of this study (e.g., only a portion of participants completed trainings and surveys at Time 1 and Time 2: N = 24). While the causes for this attrition in participant engagement may be numerous, the result leads this research team to consider how future research within Native-American settings can be altered to better engage and retain research participant.

Discussion of the Hypotheses

Hypothesis One

Contrary to this study's initial hypothesis, the three-part training series on trauma and resilience did not result in improved attitudes towards TIC approaches amongst its participants. This finding suggests that merely the presentation and discussion of TIC, including population-specific research (e.g., addressing trauma with Native Americans), was insufficient in altering the preconceived attitudes of participants in this study.

Hypothesis Two

This study hypothesized that individual characteristics of research participants would predict their attitudes towards TIC, with negative and positive predictors depending upon the characteristic.

At Time 1, trainee's reported levels of Resilience were found to be predictive of their attitudes towards TIC, such that more resilient respondents held more positive attitudes towards TIC. This trend is consistent with the previous literature, in that the characteristics of resilience and burnout have been determined to have a negative relationship, and burnout has been previously identified as a negative predictor of attitudes towards TIC. Additionally, this finding suggests that future TIC trainings and research may utilize self-reported levels of resilience a positive predictor of individual attitudes towards TIC. However, in this study, the predictive relationship between these two variables did not persist across Time 2 and Time 3, suggesting that Resilience ought to only be used as an initial measure of openness towards TIC and not a consistent positive predictor of one's TIC attitudes.

For Time 2, participants' report of STS was found to have a negative predictive relationship with TIC attitudes, such that those with higher levels of STS expressed lowered openness to learning and practicing TIC. This finding is contradictory to previous research findings, which suggested high levels of STS, combined with high Compassion Satisfaction,

were predictive of increased openness to TIC. Therefore, this study's finding suggests that without the presence of high Compassion Satisfaction as a mediating variable, the presence of STS results in decreased openness to TIC. However, this predictive negative relationship did not persist to Time 3, which indicates that perhaps environmental and circumstantial stressors (i.e., finals week, end of the trimester, information discussed in the first two training sessions, etc.) led to temporarily increased levels of STS that did not persist with time.

Results from data collected at Time 3 indicate that no individual characteristics had a predictive relationship, positive or negative, with trainees' attitudes towards TIC. This finding suggests that while individual characteristics may vary across time and due to various external factors, individual attitudes towards TIC remain consistent across time. Therefore, the individual characteristics evaluated within this research study may not prove to be sufficient predictors for determining if an individual is ready and prepared to engage in TIC training and practices.

Ancillary Analyses

In completing supplemental analyses, this study also found a significant increase in self-reported Burnout amongst the participants, with levels of personal Burnout peaking during Time 2. This finding demonstrates that participants were significantly more emotionally depleted and stressed by their job then prior to the start of the training series (Time 1). This trend may be understood as a function of the time of year, as participants' Time 2 responses were collected just prior to the end of the trimester and the start of the winter holiday break. In addition to the increased stress of completing the academic term, between Time 1 and Time 2, all participants attended the first two training session, which highlighted the traumas experienced by Native American people and the effects these traumas continue to have on the Native American community. Therefore, increased reports of Burnout may be a function of increased emotional

fatigue, as a byproduct of learning about or reliving the experiences of historical and intergenerational trauma experienced by Native American peoples.

Limitations

Numerous aspects of this study may have impacted the results of this research. First, study participants did not have equitable access to technological resources, both during the trauma and resilience trainings, as well as in completing the three surveys. Participants from the educational department each possessed school-issued devices and had individual access to the virtual training sessions via Zoom. In contrast, participants from the residential staff engaged with the training series via a singular video link projected in the school auditorium. Additionally, not all residential staff had access to school-issued devices, thus limiting some participants from completing the study's surveys via Survey Monkey. These disparities in resources impacted participants' abilities to engage in the training sessions, as well as provide their responses to the surveys. Due to these technological barriers, potential participants, specifically from the residential department, did not receive equal access to engage with this research study.

Participant attrition also likely limited the findings of this research study. While 43 individuals completed the survey at Time 1, participant totals decreased at Time 2 (N = 24) and Time 3 (N = 26). Although attrition amongst research participants is typical with longitudinal studies, due to the nature of this research and its evaluation of individual characteristics, such as Resilience and Burnout, the reduction in participant responses may be an indicator of an individual's level of Burnout and/or Resilience. However, without recurrent participant engagement across all three surveys, this study is limited in its findings in this regard.

Lastly, the timing of the training series and surveys may have impacted the participation, or lack thereof, from individuals who worked at this Native American boarding school. The first

two surveys and training sessions occurred in concurrent weeks, followed the next week by a month-long holiday break. Additionally, the second training session and follow-up survey coincided with the school's finals week schedule. Meanwhile, the final training session and last survey were provided to participants approximately 1 month after the conclusion of the school's holiday break. Considering the professional stressors present for those in academic settings during finals week and just prior to the end of a trimester, participant's reports of their individual characteristics (e.g., Resilience, Burnout, etc.) may have been unduly influenced.

Implications

Based on the results of this research study there are multiple takeaways for professional trainers, system's administrators, and mental health professionals. First, this study's finding that the training series on trauma and resilience did not result in significant changes in attitudes towards TIC suggests that attitudes of educators on TIC are well-established. Merely providing additional knowledge on trauma and trauma-based interventions is not sufficient to change an employee's beliefs or professional practices. Therefore, when considering the impact of a TIC training within a system, trainers and administrators should first establish if the target population is open to TIC principles and practices. This leads to the second implication, which is that resilience may serve as an initial predictor of openness to TIC. Trainers, administrators, and mental health professionals alike may then use resiliency measures to determine if a potential trainee population is ready to actively participate in TIC trainings and policy implementations. Lastly, this study identified that individual characteristics of trainees are susceptible to environmental and circumstantial factors (e.g., increased workload, time of the year, etc.). Therefore, when planning a TIC training or working to enact TIC principles within larger

systems, consider predictable stressors and variables that may increase burnout and STS, as these variables may impede the effectiveness of TIC interventions.

Future Directions

The results of this study determined that the trauma and resilience training series had no significant impact on trainee's attitudes towards TIC. Therefore, merely providing information on trauma, whether research, evidence-based practices, and/or culturally-specific information, does not appear to facilitate change in trainee's attitudes towards TIC. This affirms the need for increased research on factors that facilitate increased motivation to learn and practice trauma-informed approaches.

Considering the predictive relationship of individual resilience on trainee's attitudes towards TIC prior to the start of the training series, future research of TIC trainings may benefit from evaluating potential trainee's levels of personal resilience prior to initiating TIC trainings, thus ensuring increased openness to learning and practicing TIC within their professional roles. Additionally, considering the negative predictive relationship between STS and decreased openness to TIC, future research and training on TIC may benefit to consider environmental and circumstantial factors that may impact levels of acute stress in potential trainees and/or research participants.

Additionally, this study's findings that Burnout amongst participants increased from Time 1 to Time 2 is consistent with the literature on educators experiencing elevated levels of burnout. With additional stressors present during the COVID-19 pandemic, this study's findings reiterate the need for continued research and support for educators to better determine the factors that lead to high rates of burnout, as well as evidence-base methods of reducing and mitigating these symptoms. This suggests that prior to facilitating system-wide trainings on trauma-

informed principles and practices, systems would benefit from first establishing individual educator's levels of Resilience, Burnout, and STS, and find evidence-based practices to address these characteristics. In so doing, systems will increase the likelihood that trainees are individually and collectively more open to learning and enacting trauma-informed approaches.

Lastly, the study of the intersectionality of TIC, educational settings, and the Native-American community remains sparse. Considering the historical effects of residential boarding schools facilitating the forced assimilation of Native American youth, this setting is particularly relevant in understanding and enacting trauma-informed practices as a restorative step for Native American students and their communities. However, in order to begin this process of reconciliation, systems working with Native American youth (e.g., residential boarding schools, Indian Health Services etc.) would benefit from evaluating and supporting its staff, thus ensuring the professionals who teach and support Native American adolescents have the personal and professional capacity to be open and learn about effective and culturally-appropriate practices related to treating and preventing trauma.

Conclusions

In recognizing the increased demand for trauma-informed trainings within the academic setting as well as the historical and intergenerational aspects of trauma present within the Native American community, this research study sought to evaluate the impact of a TIC training series with employees at a Native American residential boarding school. From this study, it was determined that, despite its basis in evidence-based research and culturally-specific practices, this study's training series on trauma and resilience did not alter the attitudes of its participants. However, this study did identify that individual characteristics of participants may provide critical insight into whether trainees are open or resistant to learning and implementing TIC

within their professional duties. Identifying resilience as an initially positive predictor and STS as a temporarily negative predictor for a trainee's openness to TIC has applicability to trainers, administrators, and mental health professionals alike. It suggests that assessing potential trainees' levels of resilience can assist with identifying an individual's openness to learn about TIC. Additionally, TIC trainers should be aware of situational or environmental variables that may increase STS in trainees, as this negatively impacts trainees' receptiveness to TIC. Lastly, the results of this study only confirm the need for additional research and intervention within the education setting, recognizing that higher rates of burnout are present amongst educators. Therefore, in order for TIC trainings and policies to lead to both attitudinal shifts and sustainable TIC practices, the well-being of educators and those who work with survivors of trauma must first be addressed.

References

Abraham-Cook, S. (2012). *The prevalence and correlates of compassion fatigue, compassion satisfaction, and burnout among teachers working in high-poverty urban public schools* [Unpublished doctoral dissertation]. Seton Hall University.

Baker, C., Brown, S., Wilcox, P., Overstreet, S., & Arora, P. (2016). Development and psychometric evaluation of the Attitudes Related to Trauma-Informed Care (ARTIC) Scale. *School Mental Health*, *8*(1), 61–76.

Blodgett, C., & Lanigan, J. D. (2018). The association between adverse childhood experience (ACE) and school success in elementary school children. *School Psychology Quarterly*, *33*(1), 137–146.

Borntrager, C., Caringi, J. C., van den Pol, R., Crosby, L., O'Connell, K., Trautman, A., & McDonald, M. (2012). Secondary traumatic stress in school personnel. *Advances in School Mental Health Promotion*, *5*(1), 38–50.

Brave Heart, M. Y. H., & DeBruyn, L. M. (1998). The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research*, *8*(2), 60–82.

Bremner, J. D. (2003). Long-term effects of childhood abuse on brain and neurobiology. *Child and Adolescent Psychiatric Clinics of North America*, *12*(2), 271–292.

Brockie, T., Dana-Sacco, G., Wallen, G., Wilcox, H., & Campbell, J. (2015). The relationship of adverse childhood experiences to PTSD, depression, poly-drug use, and suicide attempt in reservation-based Native American adolescents and young adults. *American Journal of Community Psychology*, *55*(3), 411–421.

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

Caringi, J., Stanick, C., Trautman, A., Crosby, L., Devlin, M., & Adams, S. (2015). Secondary traumatic stress in public school teachers: Contributing and mitigating factors. *Advances in School Mental Health Promotion, 8*(4), 244-256.

Carter, R. T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist, 35*(1), 13-105.

Chen, L. P., Murad, M. H., Paras, M. L., Colbenson, K. M., Sattler, A. L., Goranson, E. N., Zirakzadeh, A. (2010). Sexual abuse and lifetime diagnosis of psychiatric disorders: Systematic review and meta-analysis. *Mayo Clinic Proceedings, 85*, 618–629.

Chief Moon-Riley, K., Copeland, J. L., Metz, G. A. S., & Currie, C. L. (2018). The biological impacts of Indigenous residential school attendance on the next generation. *SSM - Population Health, 7*, 100343.

Christian-Brandt, A., Santacrose, D., & Barnett, M. (2020). In the trauma-informed care trenches: Teacher compassion satisfaction, secondary traumatic stress, burnout, and intent to leave education within underserved elementary schools. *Child Abuse & Neglect (110,* Part 3), 104437.

Copeland, W. E., Keeler, G., Angold, A., & Costello, E. J. (2007). Traumatic events and posttraumatic stress in childhood. *Archives of General Psychiatry, 64*(5), 577–584.

Day, A. G., Somers, C. L., Baroni, B. A., West, S. D., Sanders, L., & Peterson, C. D. (2015). Evaluation of a trauma-informed school intervention with girls in a residential facility school: Student perceptions of school environment. *Journal of Aggression, Maltreatment & Trauma, 24*(10), 1086–1105.

Duran, E. (2006). *Healing the soul wound: Counseling with American Indians and other native peoples*. Teachers College Press.

Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence, 23*(3), 316-338.

Evans-Campbell, T., Walters, K. L., Pearson, C. R., & Campbell, C. D. (2012). Indian boarding school experience, substance use, and mental health among urban two-spirit American Indian/Alaska natives. *The American Journal of Drug and Alcohol Abuse, 38*(5), 421–427.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245–258.

Fry, D., McCoy, A., & Swales, D. (2012). The consequences of maltreatment on children's lives: A systematic review of data from the East Asia and Pacific region. *Trauma, Violence, & Abuse, 13*(4), 209–233.

Fisher, M. H. (2011). Factors influencing stress, burnout, and retention of secondary teachers. *Current Issues in Education, 14*(1), 1–36.

Giano, Z., Camplain, R., Camplain, C., Pro, G., Haberstroh, S., Baldwin, J., Wheeler, D., & Hubach, R. (2021). Adverse childhood events in American Indian/Alaska Native populations. *American Journal of Preventive Medicine, 60*(2), 213–221.

Hales, T., & Nochajski, T. (2020). A structural regression analysis of trauma-informed climate factors, organizational commitment, and burnout among behavioral healthcare providers in a large public hospital. *Journal of Community Psychology, 48*(3), 777-792.

Hardner, K., Wolf, M. R., & Rinfrette, E. S. (2018). Examining the relationship between higher educational attainment, trauma symptoms, and internalizing behaviors in child sexual abuse survivors. *Child Abuse & Neglect, 86*, 375–383.

Henggeler, S.W., Chapman, J.E., Rowland, M.D., Halliday-Boykins, C.A., Randall, J., Shackelford, J., et al. (2008). Statewide adoption and initial implementation of contingency management for substance-abusing adolescents. *Journal of Consulting and Clinical Psychology, 76*(4), 556–567.

Hydon, S., Wong, M., Langley, A., Stein, B., & Kataoka, S. (2015). Preventing secondary traumatic stress in educators. *Child and Adolescent Psychiatric Clinics of North America, 24*(2), 319-333.

Johnson, S., Cooper, C., Cartwright, S., Donald, I., Taylor, P., & Millet, C. (2005). The experience of work-related stress across occupations. (Author Abstract). *Journal of Managerial Psychology, 20*(2), 178-187.

Katz, D. A., Sprang, G., & Cooke, C. (2012). The cost of chronic stress in childhood: Understanding and applying the concept of allostatic load. *Psychodynamic Psychiatry, 40*(3), 469–480.

Kenney, M. K., & Singh, G. K. (2016). Adverse childhood experiences among American Indian/Alaska Native Children: The 2011-2012 National Survey of Children's Health. *Scientifica (Cairo), 2016*, 7424239–14.

Koss, M. P., Yuan, N. P., Dightman, D., Prince, R. J., Polacca, M., Sanderson, B., & Goldman, D. (2003). Adverse childhood exposures and alcohol dependence among seven Native American tribes. *American Journal of Preventive Medicine, 25*(3), 238–244.

Lopes, S., Hallak, J. E. C., Machado de Sousa, J. P., & Osório, F. de L. (2020). Adverse childhood experiences and chronic lung diseases in adulthood: A systematic review and meta-analysis. *European Journal of Psychotraumatology, 11*(1).

McIntyre, E. M., Baker, C. N., & Overstreet, S. (2019). Evaluating foundational professional development training for trauma-informed approaches in schools. *Psychological Services, 16*(1), 95–102

Miller, A. B., Esposito-Smythers, C., Weismoore, J. T., & Renshaw, K. D. (2013). The relation between child maltreatment and adolescent suicidal behavior: A systematic review and critical examination of the literature. *Clinical Child and Family Psychology Review, 16*(2), 146–172.

Mothes, L., Kristensen, C. H., Grassi, O. R., Fonseca, R. P., de Lima Argimon, I. I., & Irigaray, T. Q. (2015). Childhood maltreatment and executive functions in adolescents. *Child and Adolescent Mental Health, 20*(1), 56–62.

Nelson, J., Klumparendt, A., Doebler, P., & Ehring, T. (2017). Childhood maltreatment and characteristics of adult depression: Meta-analysis. *The British Journal of Psychiatry, 210*(2), 96–104.

Ng, Q. X., Yong, B. Z. J., Ho, C. Y. X., Lim, D. Y., & Yeo, W.-S. (2018). Early life sexual abuse is associated with increased suicide attempts: An update meta-analysis. *Journal of Psychiatric Research, 99*, 129–141.

Noe, R. A., & Wilk, S. L. (1993). Investigation of the factors that influence employee's participation in development activities. *Journal of Applied Psychology, 78,* 291– 302

Pas, E. T., Bradshaw, C. P., & Hershfeldt, P. A. (2012). Teacher-and school-level predictors of teacher efficacy and burnout: identifying potential areas for support. *Journal of School Psychology, 50*(1), 129–145.

Perfect, M. M., Turley, M. R., Carlson, J. S., Yohanna, J., & Saint Gilles, M. P. (2016). School-related outcomes of traumatic event exposure and traumatic stress symptoms in students: A systematic review of research from 1990 to 2015. *School Mental Health: A Multidisciplinary Research and Practice Journal*, *8*(1), 7–43.

Polat, D. D., & Iskender, M. (2018). Exploring teachers' resilience in relation to job satisfaction, burnout, organizational commitment and perception of organizational climate. *International Journal of Psychology and Educational Studies, 5*(3), 1–13.

Porche, M.V., Costello, D.M. & Rosen-Reynoso, M. (2016). Adverse family experiences, child mental health, and educational outcomes for a national sample of students. *School Mental Health* 8, 44–60.

Record-Lemon, R., & Buchanan, M. (2017). Trauma-informed practices in schools: A narrative literature review. *Canadian Journal of Counselling and Psychotherapy, 51*(4), 286.

Rishel, C. W., Tabone, J. K., Hartnett, H. P., & Szafran, K. F. (2019). Trauma-informed elementary schools: Evaluation of school-based early intervention for young children. *Children & Schools, 41*(4), 239–248.

Schaufeli, W., & Bakker, A. (2004). Job demands, job resources, and their relationship with burnout and engagement: A multi-sample study. *Journal of Organizational Behavior., 25,* 293-315.

Shamblin, S., Graham, D., & Bianco, J. A. (2016). Creating trauma-informed schools for rural Appalachia: The partnerships program for enhancing resiliency, confidence and workforce development in early childhood education. *School Mental Health: A Multidisciplinary Research and Practice Journal, 8*(1), 189–200.

Stamm, B. H. (2010). *The concise ProQOL manual*. Pocatello, ID: ProQOL.org.

Substance Abuse and Mental Health Services Administration (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach.* Retrieved from https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

Suglia, S. F., Sapra, K. J., & Koenen, K. C. (2015). Violence and cardiovascular health: A systematic review. *American Journal of Preventive Medicine, 48*(2), 205–212.

United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). *Child maltreatment 2020*. Retrieved from https://www.acf.hhs.gov/cb/data-research/child-maltreatment

van der Kolk, B. (2003). The neurobiology of childhood trauma and abuse. *Child and Adolescent Psychiatric Clinics of North America, 12*(2), 293–317.

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

Vonderlin, R., Kleindienst, N., Alpers, G. W., Bohus, M., Lyssenko, L., & Schmahl, C. (2018). Dissociation in victims of childhood abuse or neglect: A meta-analytic review. *Psychological Medicine, 48*(15), 2467–2476.

Wagnild, G. M., & Young, H. M. (1993). Development and psychometric evaluation of the Resilience Scale. *Journal of Nursing Measurement, 1*(2), 165–178.

Wagnild, G. (2009). A review of the Resilience Scale. *Journal of Nursing Measurement*, *17*(2), 105–113.

Warne, D., Dulacki, K., Spurlock, M., Meath, T., Davis, M., Wright, B., & McConnell, K. (2017). Adverse childhood experiences (ACE) among American Indians in South Dakota and associations with mental health conditions, alcohol use, and smoking. *Journal of Health Care for the Poor and Underserved*, *28*(4), 1559–1577.

Whitbeck, L., Adams, G., Hoyt, D., & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology*, *33*(3), 119–130.

Yohannan, J., & Carlson, J. S. (2019). A systematic review of school-based interventions and their outcomes for youth exposed to traumatic events. *Psychology in the Schools, 56*(3), 447-464.

Appendix A

"Transforming Education by Targeting Childhood Adversity through Resilience Building & Compassionate Connection" - Training Curriculum Outline

Session 1:

- Introduction
- Land Acknowledgement
- Trauma-Informed Disclosure
- Learning Objectives
- Empathy and Listening
    - Exercise: The Importance of Perspective-Taking (Video and Discussion)
- Patterns of Stress (Bruce Perry)
- Secondary Stress (i.e., Compassion Fatigue)
    - Burnout and Self-Care
- Effects of Staff Secondary Stress and Burnout on Students
- Discussion: How does stress affect your job and where can you find support?
- Student Stress
    - Residential environments
- Trauma Defined
    - Acute vs Complex
    - Historical Trauma
        - Native Americans historical trauma
        - [school name] and historical trauma
    - Intergenerational trauma
        - Boarding school effects on Native Americans
- Adverse Childhood Experiences (Felitti, 1998)
    - Additional ACEs (Burke-Harris, 2018)
    - Native Americans and ACEs
        - Boarding schools and ACEs
    - Health effects of ACEs
- Discussion: Learning about ACEs and impact on student behavior

Session 2:

- Trauma-Informed Disclosure
- Compassion-Informed Care (CIC)
- CIC Goals
    - SAMHSAs 4 Rs: Realize, Recognize, Response, Resist
- Resilience
    - Defined
    - Benefits of resilience
    - Ginsberg's 7 Cs of resilience
- Native American Resilience
    - Cultural knowledge and practice as a source of resilience
        - The use of story
        - Identifying values

- Map of Safety (Bessel van der Kolk)
- Blowing Your Lid (Dan Siegel)
- Interventions
    - Active listening
    - Non-verbal communication
- Discussion: The use of story and the power of listening

Session 3:

- Review of Trauma
    - Types of traumas
        - Native American experience
- ACEs
    - Long-term effects
- Resilience
    - Native American resilience
- Compassion-Informed Care
    - Interventions
- Discipline
    - Skills-deficit vs behavioral problem
    - Four approaches to discipline
- Circle of Support (intervention)
- De-escalation
    - HALT acronym
- Repair
    - Maintain connection with students
- Secondary Stress on Staff
    - Need for self-care
- Conclusion: Mindfulness activity

Appendix B

Informed Consent for Participation in Training and Research

Description of Study and Your Involvement

This is a follow-up questionnaire to assess staff member's experiences of the trauma-informed training conducted by George Fox University Interns and Dr. Amy Stoeber, in partnership with [redacted]. Involvement in this process includes attending the training session and completeing Questionnaires 3. Both the training and this questionnaire are designed to understand and support [redacted] employees in their work with students and in caring for their own well-being. By agreeing to participate, you are allowing your questionnaire scores, responses, and demographic information to be made accessible to this research team of George Fox Doctoral Students. This information will be de-identified following its collection, to ensure that no one participant can be identified. Additionally, *this information is NOT accessible to [redacted] administrators, to ensure that all participants' responses are kept confidential.* Again, involvement in this research is voluntary, and participants can ask to have their data removed from the study at any point up until it undergoes statistical analysis.

Possible Risk and Benefits of this Study

Risks involved in this research include potential emotional discomfort and/or re-traumatization, due to the discussion of challenging and personal topics, such as trauma and adverse childhood experiences. If you have concerns for your well-being as a result of this research, please see the resources available at the conclusion of this survey. Also, feel free to connect with the primary researcher and/or supervisor of this project.

Due to the sensitive nature of trauma, there will be no negative repercussions if you choose to not complete the following survey. Benefits of participating in this study include personal awareness, learning, and skill acquisition, as it relates to understanding and working with students with trauma. Again, there are no consequences for withdrawing from this research, including no professional repercussions for [redacted] if you decide to not participate.

Compensation

If you attend the final training on February 22nd and complete this questionnaire you will be entered into a raffle for *1 of 2 $50 Target gift cards*. Also, connect with your [redacted] administrators ([redacted]) about counting these training hours towards professional development hours or professional training credits.

Confidentiality

All participant data collected will be de-identified to maintain the anonymity of respondents. Data will be stored in a password-protected manner, such that *ONLY* this researcher will have access to participant responses. Additionally, the results of this research will be reported in a way that no one participant can be identified.

* 1. By checking the box below, I agree to the terms of the research above and am voluntarily choosing to participate. I understand that my information will be de-identified and kept confidential throughout the research process and will be made accessible for future group analysis research (your information will remain confidential through this process as well).

- [ ] I agree to part c pate
- [ ] I do **NOT** agree to part c pate

Appendix C

Demographics

* 2. Select your age:

* 3. Please list your [redacted] employee email:

* 4. Select your gender:

- ◯ Female
- ◯ Male
- ◯ Other (please specify)

* 5. How many years have you worked at [redacted]?

* 6. Select your department:

* 7. Select your role(s) at [redacted]

- ☐ Teacher
- ☐ Ed Tech
- ☐ Case Manager
- ☐ Social Worker
- ☐ Other (please specify)
- ☐ Counselor
- ☐ Administration / Management
- ☐ Staffer

Appendix D

Professional Quality of Life Measure (ProQOL; Stamm, B. H., 2010) – Version 5

Instructions: When you [teach] people you have direct contact with their lives. As you may have found, your compassion for those you [teach] can affect you in positive and negative ways. Below are some questions about your experience, both positive and negative as a [teacher]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflect how frequently you experienced these things in the ***last 30 days*.**

1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Very Often

1. _____ I am happy.
2. _____ I am preoccupied with more than one person I [teach].
3. _____ I get satisfaction from being able to [teach] people.
4. _____ I feel connected to others.
5. _____ I jump or am startled by unexpected sounds.
6. _____ I feel invigorated after working with those I [teach].
7. _____ I find it difficult to separate my personal life from my life as a [teacher].
8. _____ I am not as productive at work because I am losing sleep over traumatic experiences of a person I [teach].
9. _____ I think that I might have been affected by the traumatic stress of those I [teach].
10. _____ I feel trapped by my job as a [teacher].
11. _____ Because of my [teaching], I have felt “on edge” about various things.

12. _____ I like my work as a [teacher].
13. _____ I feel depressed because of the traumatic experiences of the people I [teach].
14. _____ I feel as though I am experiencing the trauma of someone I have [taught].
15. _____ I have beliefs that sustain me.
16. _____ I am pleased with how I am able to keep up with [teaching] techniques and protocols.
17. _____ I am the person I always wanted to be.
18. _____ My work makes me feel satisfied.
19. _____ I feel worn out because of my work as a [teacher].
20. _____ I have happy thoughts and feeling about those I [teach] and how I could help them.
21. _____ I feel overwhelmed because my [work]load seems endless.
22. _____ I believe I can make a difference through my work.
23. _____ I avoid certain activities or situations because they remind me of frightening experience of the people I [teach].
24. _____ I am proud of what I can do to [teach].
25. _____ As a result of my [teaching], I have intrusive, frightening thoughts.
26. _____ I feel “bogged down” by the system.
27. _____ I have thoughts that I am a “success” as a [teacher].
28. _____ I can’t recall important parts of my work with trauma victims.
29. _____ I am a very caring person.
30. _____ I am happy that I chose to do this work.

Scoring: Total your score from items 3, 6, 12, 16, 18, 20, 22, 24, 27, and 30; this is your Compassion Satisfaction Score. Total your scores on items 8, 10, 19, 21, and 26, then reverse score items 1, 4, 15, 17, and 29 (1=5, 2=4, 3=3, 4=2, 1=5) and add the reverse scored items to the five aforementioned items; this is your Burnout Scale Score. Total your score from items 2, 5, 7, 9, 11, 13, 14, 23, 25, and 28; this is your Secondary Traumatic Stress Score. Scores of 22 or less indicate a *Low* score. Scores between 23 and 41 indicate an *Average* score. Scores 42 or more indicates a *High* score.

Appendix E

Attitudes Related to Trauma-Informed Care Scale (ARTIC) – Version: ARTIC-10 Education

(10-item version)

Developed by the Traumatic Stress Institute

Instructions: For each item, select the circle along the dimension between the two options that best represents your personal beliefs during the past two months of your job.

I believe that…	**1 2 3 4 5 6 7**	
1. [Students] could act better if they really wanted to.	O O O O O O O	[Students] are doing the best they can with the skills they have.
2. Focusing on developing healthy, healing relationships is the best approach when working with people with trauma histories.	O O O O O O O	Rules and consequences are the best approach when working with people with trauma histories.
3. If [students] say or do disrespectful things to me, it makes me look like a fool in front of others	O O O O O O O	If [students] say or do disrespectful things to me, it doesn't reflect badly on me.
4. The ups and down are part of the work so I don't take it personally.	O O O O O O O	The unpredictability and intensity of work makes me think I'm not fit for this job.
5. It's best not to tell others if I have strong feelings about the work because they will think I am not cut out for this job.	O O O O O O O	It's best if I talk with others about my strong feelings about the work so I don't have to hold it alone.
6. [Students] do the right thing one day but not the next. This shows that they are doing the best they can at any particular time.	O O O O O O O	[Students] do the right thing one day but not the next. This shows that they could control their behavior if they really wanted to.
7. [Students] need to experience real life consequences in order to function in the real world.	O O O O O O O	[Students] need to experience healing relationships in order to function in the real world.
8. I realize that [students] may not be able to apologize to me after they act out.	O O O O O O O	If [students] don't apologize to me after they act out, I look like a fool in front of others.
9. I feel able to do my best each day to help my [students].	O O O O O O O	I'm just not up to helping my [students] anymore.
10. The most effective helps find ways to toughen up – to screen out the pain – and not care so much about the work.	O O O O O O O	The most effective helps allow themselves to be affected by the work – to feel and manage the pain – and to keep caring about the work.

Scoring: Items 1-10 are scored on a 1-7 Likert scale. Reverse score items 2, 4, 6, 8, and 9 (1=7, 2=6, 3=5, 4=4, 5=3, 6=2, 7=1). Total the sum of all 10 items and compute the average of all items. This is your ARTIC-10 score.

Appendix F

The Resilience Scale

(Wagnild & Young, 1993)

Instructions: Circle the answer that shows how much you agree or disagree with each statement.

	Disagree						Agree
1. When I make plans I follow through with them.	1	2	3	4	5	6	7
2. I usually manage one way or another.	1	2	3	4	5	6	7
3. I am able to depend on myself more than anyone else.	1	2	3	4	5	6	7
4. Keeping interested in things is important to me.	1	2	3	4	5	6	7
5. I can be on my own if I have to.	1	2	3	4	5	6	7
6. I feel proud that I have accomplished things in life.	1	2	3	4	5	6	7
7. I usually take things in stride.	1	2	3	4	5	6	7
8. I am friends with myself.	1	2	3	4	5	6	7
9. I feel that I can handle many things at a time.	1	2	3	4	5	6	7
10. I am determined.	1	2	3	4	5	6	7
11. I seldom wonder what the point of it all is.	1	2	3	4	5	6	7
12. I take things one day at a time.	1	2	3	4	5	6	7
13. I can get through difficult times because I've experienced difficulty before.	1	2	3	4	5	6	7
14. I have self-discipline.	1	2	3	4	5	6	7
15. I keep interested in things.	1	2	3	4	5	6	7
16. I can usually find something to laugh about.	1	2	3	4	5	6	7
17. My belief in myself gets me through hard times.	1	2	3	4	5	6	7
18. In an emergency, I'm someone people can generally rely on.	1	2	3	4	5	6	7
19. I can usually look at a situation in a number of ways.	1	2	3	4	5	6	7
20. Sometimes I make myself do things whether I want to or not.	1	2	3	4	5	6	7
21. My life has meaning.	1	2	3	4	5	6	7
22. I do not dwell on things that I can't do anything about.	1	2	3	4	5	6	7
23. When I'm in a difficult situation, I can usually find my way out of it.	1	2	3	4	5	6	7
24. I have enough energy to do what I have to do.	1	2	3	4	5	6	7
25. It's okay if there are people who don't like me.	1	2	3	4	5	6	7

Scoring: Total all 25 items. This is your Resilience score. Scores below 65 indicate *low* resilience; between 65 and 81 indicate *moderate* resilience; above 81 indicate *high* levels of resilience.

Appendix G

Curriculum Vitae

Peter Daniel Tissell, MA

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8001 S Interstate 35 Frontage Rd #131
Austin, TX 78744
(206) 696 - 9330
ptissell13@georgefox.edu
Pronouns: he/him

EDUCATION

Doctor of Psychology in Clinical Psychology *(APA accredited)* August 2018 – Present
George Fox University, Newberg, OR *(Class of 2023)*
4th year student, 3.87 GPA
Academic Advisor: Celeste Jones, PsyD.

Master of Arts in Clinical Psychology *(APA accredited)* 2020
George Fox University, Newberg, OR
Academic Advisor: Kathleen Gathercoal, PhD.

Bachelors of Arts in Psychology, Sociology 2017
George Fox University, Newberg, OR
Graduated Summa Cum Laude, 3.95 GPA
Academic Advisor: Kristina Kays, PsyD.

SUPERVISED CLINICAL EXPERIENCE

Doctoral Internship: Psychological Intern July 2022 - Present
Travis County Juvenile Probation Department - Health Services Division
Austin, TX
Individual, Family, and Group Therapies
Psychological Assessment

Clinical Supervisors: Casey O'Neal, PhD., Daniel Hoard, PhD, Jasmine Jenkins, PhD
Duties:

- Conducting individual and family therapy with youth in a secure, residential facility for justice-involved youth.
- Facilitating DBT skills groups with youth in a secure, residential facility for justice-involved youth.
- Completing clinical interviews, administering, and scoring psycho-diagnostic assessments, and providing diagnoses and treatment recommendations for detained and

community-based justice-involved youth referred for mental health evaluations through Travis County Juvenile Probation Department.
- Participating on a multi-disciplinary team providing consultation in a diversionary court setting for youth presenting with mental health issues.
- Participating on a multi-disciplinary team of community-based professionals providing mental health consultation to complex care youth and their families.

Pre-Internship: Psychological Evaluator August 2021 - May 2022
Providence Willamette Falls Hospital - Child and Adolescent Psychiatric Unit
Oregon City, OR
In-Patient Psychological Assessment
Clinical Supervisor: Tyson Payne, PsyD.
Duties:
- Administered and scored psycho-diagnostic and neuropsychological assessments for child and adolescent psychiatric patients.
- Interpreted test results and authored integrated psychological reports to provide diagnostic clarity and inform patient treatment.
- Worked on an interprofessional care team (psychiatrist, family therapist, nursing staff, and teachers) to provide consultation and evidence-based recommendations and resources for ongoing treatment.
- Called the caregiver(s) of patients to collect collateral information, provide psychoeducation, and refer patients and their family members to appropriate outpatient resources.
- Provided milieu therapy, psychoeducation, and coping-skills strategies to support patients' mental health and functioning while remaining on an in-patient psychiatric unit.

Supplemental Practicum: Psychological Report Writer October 2021 - May 2022
360 Pediatric Psychology
Lake Oswego, OR
Private Practice Psychological Assessment
Supervisor: Erika Doty, PsyD.
Duties:
- Interpreted and authored integrated psychological reports for pediatric clients within an out-patient psychological setting.
- Provided feedback to clients and their families, including information and resources related to the presenting diagnosis.

Practicum 1 & 2: Psychological Evaluator & Psychotherapist August 2019 – May 2021
Chemawa Indian School
Keizer, OR
School-Based Assessment and Therapy
Supervisor: Kristie Knows His Gun, PsyD, ABPP
Duties:
- Administered and scored psychological assessments, interpreted outcomes, and authored integrated psychological reports for students' individualized education plans (IEP).
- Developed, administered, and scored assessment batteries assessing cognition, academic achievement, and behavior of high school students referred for initial or re-evaluation for IEPs through the Special Education Department (SPED).
- Composed comprehensive reports, providing consultation to school faculty, SPED staff, students, and their families.

- Provided individual, school-based psychotherapy services on a weekly basis to SPED students, both in-person and via telehealth. Psychotherapy services provided from a person-centered therapeutic orientation with the use of cognitive-behavioral interventions.
- Developed telehealth protocols to establish telepsychological services (psychotherapy and psycho-educational assessment) for students. This included developing systems to identify and document ethical and professional considerations for inter-jurisdictional telehealth services, providing services to students out-of-state and on tribal reservations.
- Developed and presented a multi-session training on adverse childhood experiences (ACEs), trauma, and resiliency for academic and dormitory staff in partnership with Dr. Amy Stoeber, PhD.

Supplemental Practicum: Psychological Evaluator & Psychotherapist October 2020 - March 2021
George Fox University Behavioral Health Center
Newberg, OR
Community Mental Health - Psychological Assessment and Psychotherapy

Supervisors: Kristie Knows His Gun, PsyD, ABPP
Duties:

- Administered and scored psychodiagnostic and neuropsychological assessments for individuals ranging from 11 - 14 years of age.
- Interpreted psychological tests and authored integrated reports to provide diagnostic clarity, academic support eligibility, and treatment recommendations.
- Provided feedback and resources to individuals and their parents, as well as consulted with other providers (primary care providers, county mental health therapists, etc.).
- Provided psychotherapy services to a justice-involved adolescent male, operating from a humanistic perspective with cognitive-behavioral interventions.
- Provided suicidal risk assessment and safety planning with client and family.

Supplemental Practicum: Behavioral Health Intern May 2020 – May 2022
Willamette Valley Medical Center / Providence Newberg Medical Center
McMinnville, OR / Newberg, OR
Behavioral Health - Crisis Intervention

Supervisors: Mary Peterson, PhD, ABPP/CL, Luann Foster, PsyD., Bill Buhrow, PsyD.
Duties:

- Providing behavioral health and crisis intervention services to patients presenting with suicidal, homicidal, psychotic, and/or cognitively impaired symptoms.
- Administering the Columbia-Suicide Severity Rating Scale (C-SSRS) and the Montreal Cognitive Assessment (MoCA) in evaluating suicidality and cognitive functioning, respectively.
- Consulting with attending physicians and hospital staff regarding patient care.
- Coordinating community resources for patients, including referrals to acute and sub-acute psychiatric hospitals, outpatient services, and community mental health resources.
- Completing safety plans and coordinated care with patients and their social supports.

Pre-Practicum: Student Therapist February 2019 – May 2019
George Fox University
Newberg, OR
University Mental Health - Psychotherapy

Supervisors: Sylvia Ramirez, M.A., Dr. Glena Andrews, PhD, MSCP, ABPP
Duties:

- Provided psychotherapy for undergraduate students, employing person-centered therapeutic techniques.
- Developed skills in electronic record-keeping and case management.

Pre-Practicum Supplemental: Student Therapist September 2018 – November 2018
George Fox University
Newberg, OR
University Mental Health - Psychotherapy
Supervisors: Lori Napier, M.A., Dr. Glena Andrews, PhD, MSCP, ABPP
Duties:

- Provided psychotherapy for undergraduate student-athletes, using brief solution-focused therapeutic strategies.
- Developed skills in electronic record-keeping and case management.

RELATED WORK EXPERIENCE

Youth Care Counselor June 2017 – August 2018
Boys and Girls Aid
Portland, OR
Residential Youth Facility
Duties:

- Supervised male youth, 11-18 years of age, who were referred into our organization's care from the Department of Human Services or Department of Community Justice.
- Reinforcing behavioral management systems in accordance with program policy.
- Developed and implemented skills training curriculum for group counseling utilizing trauma-informed, strengths-based treatment models.

TEACHING AND ACADEMIC APPOINTMENTS

PSYD: 526 - Child and Adolescent Assessment: Teaching Assistant June 2021
George Fox University - Graduate School of Clinical Psychology
Professor: Christabel Leonce, PsyD.
Duties:

- Aided in the organization and structuring of the course material.
- Aided in teaching and modelling individualized assessments, specifically related to cognitive functioning (WJ-Cog, WNV), academic achievement (WJ-Ach), and adaptive functioning (Roberts-2).
- Provided instruction in the scoring and interpretation of psychological assessment measures.
- Provided instruction and feedback on psychological report writing.
- Attended regular meetings with the professor and other teaching assistants to confer regarding grading concerns, student needs, and course progression.

RESEARCH EXPERIENCE & PARTICIPATION

2018 - Present **Dissertation Research**
George Fox University, Graduate School of Clinical Psychology
Newberg, OR
Committee Chair: Celeste Jones, PsyD
Other Committee Members: Kristie Knows His Gun, PsyD, ABPP,.
Title: "Trauma-Informed Care in Native American Education: Compassion Satisfaction, Secondary Traumatic Stress, Burnout, and Resilience as Mediating Factors to Implementation"
Topic: Developing and implementing a culturally responsive training on trauma and resilience with staff at a Native American boarding school, with specific consideration to the individual factors that promote "readiness" to learn and engage in trauma-informed approaches.
Preliminary Proposal Defense: Completed July 21, 2021
Final Defense: Estimated completion March 2023

2018 - Present **Research Vertical Team Member**
George Fox University, Graduate School of Clinical Psychology
Newberg, OR
Chair: Kathleen Gathercoal, PhD
Research: Meet bi-monthly to discuss and collaborate on research, including the progress, methodology, and design of group and individual research projects, including dissertation research.
Personal Interests: trauma informed care, trauma informed education, historical and intergenerational trauma, resilience, evidence-based treatment and assessment of diverse populations, juvenile justice

August 2020 Young, D., Flores M., **Tissell, P.**, Hamilton, E., & Gathercoal, K. (2020) *Culturally Relevant Intelligence Assessment in Rural, Latinx Youth.* Poster presented at the 128th annual meeting of the American Psychological Association, Washington, DC.

PROFESSIONAL PRESENTATIONS

December 7 & 14, 2020 and February 22, 2021 **Transforming Education by Targeting Childhood Adversity through Resilience Building & Compassionate Connection**
Presented with Dr. Amy Stoeber, PhD - *Chemawa Indian School*

September 25, 2020 **Telehealth: The Future is Now**
Presented with Lindsay Price, MA - *George Fox University*

ASSESSMENT COMPETENCY, EXPERIENCE & EXPOSURE

(*Trained-in, but without formal administration for clinical use)

Cognitive Assessment:
- Comprehensive Test of Nonverbal Intelligence - 2nd Edition
- Wechsler Adult Intelligence Scale - 4th Edition
- Wechsler Abbreviated Scale of Intelligence *
- Wechsler Memory Scale - 4th Edition
- Wechsler Nonverbal Scale of Ability *
- Wechsler Intelligence Scale for Children - 5th Edition
- Wide Range Intelligence Test *
- Woodcock-Johnson Tests of Cognitive Abilities - 4th Edition

Achievement and Academic Assessment:
- Wechsler Individual Achievement Test - 4th Edition
- Wide Range Achievement Test - 3rd Edition *
- Woodcock-Johnson Test of Achievement

Behavioral and Diagnostic Assessment:
- Achenbach System of Empirically Based Assessment
- Adaptive Behavioral Assessment System - 3rd Edition
- Beck Depression Inventory *
- Behavioral Assessment System of Children - 3rd Edition
- Behavior Rating Inventory of Executive Functioning - 2nd Edition
- Behavior Rating Inventory of Executive Functioning for Adults *
- Children's Depression Inventory - 2nd Edition *
- Conners - 3rd Edition
- Generalized Anxiety Disorder 7-Item Scale
- House-Tree-Person Test
- Patient Health Questionnaire-9
- Patient Health Questionnaire - modified for adolescents
- Roberts Apperception Test for Children - 2nd Edition
- Screen for Child Anxiety Related Disorders

Neuropsychological Assessment:
- Booklet Categories *
- California Verbal Learning Test - Children's Version
- Children's Memory Scale
- Delis-Kaplan Executive Function System
- FAS Behavioral Screening Tool
- Grooved Pegboard *
- NEPSY - 2nd Edition
- Test of Memory Malingering *
- Wide Range of Memory and Learning - 2nd Edition

Personality Assessment:
- Jesness Inventory - Revised
- Millon Adolescent Clinical Inventory *

- Millon Clinical Multiaxial Inventory—Fourth Edition *
- Millon Pre-Adolescent Clinical Inventory *
- Minnesota Multiphasic Personality Inventory—2 *
- Minnesota Multiphasic Personality Inventory—2–Restructured Form *
- Minnesota Multiphasic Personality Inventory—Adolescent *
- Personality Assessment Inventory—Adolescent
- Sixteen Personality Factor Questionnaire*

Visual-Motor Assessment:
- Beery-Buktenica Developmental Test of Visual-Motor Integration

Risk Assessment:
- Columbia-Suicide Severity Rating Scale

CERTIFICATIONS

2019 - 2022 **Qualified Mental Health Professional**
Yamhill County, OR

January 17, 2021 **AED/CPR Certification - Healthcare Provider BLS**
International CPR Institute

PROFESSIONAL AFFILIATIONS

American Psychological Association (Student Affiliate) 2018 – Present

American Psychology – Law Society (Division 41) 2019 – Present

NOTABLE AWARDS

Presidential Scholar Award August 2013 – May 2017
George Fox University
Awarded to students with a GPA of 3.8 or greater.

REFERENCES

Kristie Knows His Gun, PsyD, ABPP
Chemawa Indian Health Center
Indian Health Service
3750 Chemawa Rd NE
Salem, OR 97305
(503) 304-7600 (general clinic phone number)
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