5-2020

Self-Regulation Rooms within the School: The Impact on Behavioral Referrals and Self-Regulating Emotions

Leah L. Taylor
St. Cloud State University, tale03011@gmail.com

Self-Regulation Rooms within the School: The Impact on Behavioral Referrals and Self-Regulating Emotions

by

Leah L. Taylor

A Starred Paper

Submitted to the Graduate Faculty of

St. Cloud State University

in Partial Fulfillment of the Requirements

for the Degree

Master of Science in

Curriculum and Instruction

May, 2020

Starred Paper Committee:
Huseh-I Lo, Chairperson
Mary Jo Froemming
Marc Markell

Table of Contents

Chapter Page

List of Tables

List of Figures

Chapter 1: Introduction

This is my 11th year teaching special education. I have a dual license in Emotional Behavioral Disorders (EBD) and Specific Learning Disabilities (SLD). At the end of the school year in 2018, I was involved in a schoolwide MTSS (Multi-Tiered Systems of Support) Social/Behavioral Audit. I was the only teacher representative on the committee, and I found myself feeling overwhelmed with the new standards and terminology that came out with this audit.

The MTSS Social/Behavior Rubric that was used was created by the St. Croix River Education District (SCRED) in 2018, using new guidance from the Minnesota Department of Education (MDE) in 2017, and research-based practices. The rubric reflected five domains they found as essential to implementing a comprehensive MTSS Social/Behavior framework. The domains were: Positive Behavior Interventions & Supports (PBIS), Trauma-Informed Practices, Restorative Practices (RP), Social Emotional Learning (SEL), and Vision, Resource Allocation & Communication. Each domain looked at 12-26 sub-items within the school and as a team we determined how well the framework was implemented on a scale of 1-4; 1 (not implemented) to 4 (fully implemented).

As a school, we determined that we have a very well established PBIS program. We were also making good headway in the domain of Trauma-Informed Practices, overall, though we have some room for improvement averaging a 2.069 out of 4 on implementing all aspects of our MTSS throughout the school. As a special educator I felt our department had many of these things in place, but wanted to do more, especially in the area of Trauma-Informed Practices.

The hardest piece for me as a special educator (besides paperwork) is knowing the trauma our kids have been through. It is heart-breaking, and at times seems so unfair, knowing what these kids have seen or experienced. We see the trauma expressed in their acting out and their breaking down within classroom settings. Two of the sub-items under Trauma-Informed Practices that I could help to impact were:

- Regular opportunities exist for students to learn and practice regulation of emotions and modulation of behaviors.
- School contains predictable and safe environments (including classrooms, hallways, playgrounds, and school bus) that are attentive to transitions and sensory needs.

As a school we scored ourselves as a two (Partially in Place) in providing regular opportunities for students to learn and practice self-regulation of emotions and modulation of behaviors. These skills are being explicitly taught in the special education Personal Enrichment classes and in small group behavior and social skills groups that I teach but are not being explicitly taught anywhere else in the building. In Personal Enrichment and within the small groups we teach students to recognize their triggers and teach them skills to self-regulate. One of the skills that we teach is asking for a break. In fact, 30% of our students have it written in their IEP's or 504 Plans that they can take breaks. The only problem is that this accommodation does not provide a safe place for them to go. Students are taught a variety of skills. Listening to music and practicing breathing are the most socially acceptable to be done within the classroom. However, most students find that they need to leave the classroom for their break to be effective. This could mean that at any given time our school could have up to 54 students walking around potentially unregulated, angry, sad, and unaccounted for.

Teachers and support staff reported that students get up to leave for a break and may not return for the rest of the class period. The hall monitor reported that students are meeting up in the hallways and hanging out. Students are found in areas of the school where they are not permitted. This has the potential of being unsafe and, in our high school, is a serious problem. There is no way for the breaks to be monitored and/or regulated, unless they are supported 1:1 with a para, which is very restrictive. The other option is having teachers report and monitor breaks, but teachers are often so busy that they are unaware of what time a student leaves and then comes back to their room.

This brings me to the next sub-item: School contains predictable and safe environments (including classrooms, hallways, playgrounds, and school buses) that are attentive to transitions and sensory needs. As a school, we ranked ourselves as a 4 (fully implemented). However, after the meeting, we discussed how we could do better because allowing students to just roam the halls as they please is not providing a safe environment for anyone.

With this research, I would like to look into the history of MTSS as this is a new acronym to me. I would also like to help my school move forward in helping to implement Trauma-Informed Practices within the school, especially within the two areas that are identified above by researching self-regulation and the techniques used to build-up this skill within the schools.

The research questions I address in this paper are:

1. Does providing a safe place for students to take breaks effectively help regulate emotions?
2. What is the frequency and duration that the break room is being used?

3. Does providing a safe place for students to take breaks reduce the number of referrals that they are earning?

Chapter 2: Literature Review

The purpose of this literature review was to examine the effectiveness of regulation breaks within the schools. Since there is not a lot of research specifically around students taking breaks when they are dysregulated, this chapter reviews best practices and history of the following practices that are becoming the standard in most public schools: MTSS, Trauma-Informed Schools, and Self-Regulation Skills.

History of MTSS

Multi-Tiered Systems of Support (MTSS) are a byproduct of two very effective systems in the schools today: Response to Intervention (RTI) and Positive Behavioral Interventions and Supports (PBIS). RTI was introduced in 2004 with the reauthorization of the Individuals with Disabilities Act (IDEA; 2004) which required schools to use research-based interventions when determining eligibility for special education. MTSS was a much more proactive approach than the previous discrepancy model. In the discrepancy model, students did not qualify for special education until there was a gap between a student's intellectual ability and their performance in school. This is also referred to as the "Wait to Fail" model, because the gap typically continued to grow without support and eventually students qualified. The academic RTI model is a preventive systems approach to improving schoolwide and individual achievement through high-quality universal instruction and additional tiered supports provided in response to student need. It includes collaborative teaming across general and special education. Decisions in academic RTI are based on data from validated screening and progress monitoring tools. This data may be used as part of the special education eligibility determination process, but academic RTI includes

all academic instruction systems, including core classroom instruction (McIntosh & Goodman, 2016).

PBIS has been used in schools since the late 1980s and is defined as a framework for implementing evidence-based practices, providing a three-tiered continuum of support to students using systems to support staff in implementation and emotional behavior. PBIS emphasizes an instructional approach to behavior support, prevention through environmental change, adaptation to the local context, and using the science of applied behavior analysis to achieve outcomes that are valued by staff, students, and families (McIntosh & Goodman, 2016).

In 2011, 51% of elementary schools reported full implementation of RTI for reading and 20% reported full implementation of PBIS for behavior. In the secondary schools, 13% reported full implementation in reading and 8% reported full implementation for behavior (McIntosh & Goodman, 2016). This number has only continued to grow over time, despite the fact that nearly 70% of change initiatives fail (Leonard & Coltea, 2013). RTI and PBIS continue to be successfully implemented across the country and are making a drastic impact on students and staff within these districts.

So why are RTI and PBIS initiatives working while so many other initiatives fail? To start answering that question, neither initiative is a 'one and done add-on' for staff to implement. They are a core change to a district's philosophy and how they service students by meeting them where they are. They are a framework that is fully integrated into a district's core that help all students by gathering data and collaboratively using research and the problem-solving model to determine what is best for individual students. Though these two programs have differences, they are fundamentally the same. MTSS is a melding of these two practices and is defined as a

model that provides all students the best opportunities to succeed both academically and behaviorally in school. MTSS focuses on providing high quality instruction and interventions matched to student need across domains and monitoring progress frequently to make decisions about changes in instruction or goals. It is not simply the implementation of both academic RTI and PBIS systems. There is a systematic and careful integration of these systems to enhance the efficiency and effectiveness of all school systems (McIntosh & Goodman, 2016).

Before MTSS were in place, RTI and PBIS systems that were running concurrently often caused confusion and were overwhelming for families, students, and staff alike. MTSS reduced the jargon associated with each system and allows everybody to focus on the concepts the framework is built on. By integrating them into one program, MTSS, it may reduce the anxiety the multiple initiatives bring staff. It also eliminates competition between the two for funding and provides more sustainability for both. One of the most important reasons to integrate these two programs is the seamless support it provides all students. (Freeman, Miller, & Newcomer, 2015). Academic and behavior are not islands, the two go hand-in-hand when predicting student success.

Trauma-Informed Schools

One of the key components to MTSS is Trauma-Informed Schools. Trauma-Informed Schools are aware of trauma and its prevalence in schools and respond to trauma systematically using the principles of trauma-informed care. The *International Journal of Child, Youth and Family Studies* defined trauma as "an overwhelming experience that undermines the individual's belief that the world is good and safe" (Brunzell, Stokes, & Waters, 2016). A substantial and useful piece of information is the Adverse Childhood Experiences (ACEs) study which explores

trauma and the effects that take place because of it. This initial study started in 1995 and went through 1997. The study was conducted by Felitti et al. (1998) through the Centers for Disease Control (CDC), and continues to be used at the local and state level impacting many agencies including social services, public health, education, juvenile justice, mental health, pediatrics, criminal justice, and even business. The ACEs (2007) study asked trauma-oriented questions about abuse (sexual, physical, and emotional), family dysfunction (a parent who is mentally ill or an alcoholic, a mother who is a domestic abuse victim, a family member who has been incarcerated, a loss of a parent through divorce or abandonment), and also asked about emotional and physical neglect, for a total of 10 ACEs. Stevens's (2015) research found the correlation between childhood trauma and adult onset of chronic disease, mental illness, incarceration, and employment issues is very strong. They also found that ACEs often did not occur in isolation, and the more ACEs an individual identifies with, the more at risk they are. Nearly two-thirds of the adults in the study had at least one or more types of adverse childhood experiences. Of those, 87% had two or more types. One point nine million cases of heart disease and 21 million cases of depression could have been potentially avoided by preventing ACEs (CDC, 2019).

Looking specifically at schools, ACEs are associated with social, emotional, and cognitive impairment, engaging in high-risk behaviors, disabilities, and social problems, all of which are common, but not limited to students with Emotional Behavioral Disorder in special education (Cavanaugh, 2016). The brains of students who have experienced trauma have responded similarly to brains of students diagnosed with ADHD. In fMRI models, these two populations have shown a decreased activation of the frontal cortex from the control group (Carrion, Garrett, Menon, Weems, & Reiss, 2008). The frontal cortex is responsible for specific

skills such as planning for the future, judgment, decision-making skills, attention span, and inhibition. Other parts of the brain that are affected with trauma are the hippocampus and amygdala. The hippocampus and amygdala work together to bring back or create emotional memories. Cortisol and norepinephrine are two neurochemical systems that are critical in the stress response. Cortisol has a number of effects which facilitate survival and norepinephrine perceives stress (Bremner, 2006). A child with trauma is likely to respond with a fight or flight response to very basic directions or expectations within the classroom setting, even a smell or sound may trigger a response. This can affect social, emotional, physical, and academic health. Trauma can also lead to "being too scared to learn" (Terrasi, & Galarce, 2017). Students' response to trauma can cause school staff to see those children as 'problem children' and this label may amplify students' trauma within the classroom. Trauma-Informed teachers are able to see that behavior is a manifestation of trauma (Terrasi, & Galarce, 2017).

Knowing that trauma is very prevalent and the effects that it causes is the first step to combatting this global health problem. Raising awareness can help change the way people deal with behaviors, reduce stigma around seeking help, and help shift the focus from the individual to a community solution. The CDC (2019) recommended the following prevention strategies to help prevent ACEs: strengthen economic support to families, promote social norms that protect against violence and adversity, ensure a strong start for children, teach skills, connect youth to caring adults and activities, and intervene to lessen immediate and long-term harms. These practices lean to trauma-informed educational practices in the schools.

In the SCRED (2018) MTSS Social/Behavioral Rubric (SCRED), the writers acknowledged that Trauma-Informed Practices are not a model that can simply be implemented

with a fidelity checklist. "Rather it is a systematic paradigm shift in knowledge, perspective, attitudes, and skills that continues to deepen and unfold over time." The steps that they describe are on a continuum moving from: Trauma-Aware to Trauma-Sensitive to Trauma-Responsive to being fully Trauma-Informed.

SCRED's (2018) definition for Trauma-Aware organizations is: organizations have become aware of how prevalent trauma is and have begun to consider that it might impact their clientele and staff. This can start with reading and presenting national and local ACEs surveys and the results. Also, organizations can have staff take an intrinsic look at themselves by allowing them to take the ACEs survey and then reflect and discuss their own experiences. It is important to also look at resilience factors or strength factors as well (Leitch, 2017). The Substance Abuse and Mental Health Services Administration have a "four R approach. the four "R's" include Realization, Recognize, Respond, Resist. The first two "R's" in this approach are the following:

- Realization: all people at all levels of the organization or system have a basic realization about trauma and understand how trauma can affect families, groups, organizations, and communities as well as individuals.
- Recognize: people in the organization or system are also able to recognize the signs of trauma. These signs may be gender, age, or setting-specific and may be manifest by individuals seeking or providing services in these settings. (Huang, 2014)

SCRED's (2018) definition for Trauma-Sensitive organizations is: organizations have begun to explore the principles of Trauma-Informed care within their daily work, have built a

consensus around the principles and consider adopting the principles and prepare for change. The National Center for Trauma-Informed Care has identified six core principles of what it means to be Trauma-Informed: (1) safety; (2) trustworthiness and transparency; (3) peer support; (4) collaboration and mutuality; (5) empowerment, voice, and choice; and (6) being responsive to cultural, historical, and gender issues (Huang, 2014).

SCRED's (2018) definition for Trauma-Responsive organizations is: organizations have begun to change their organizational culture to highlight the role of trauma. At all levels of the organization, staff begins re-thinking the routines and infrastructure of the organization. This is where the last two "R's" comes in from The Substance Abuse and Mental Health Services Administration.

- Responds: the program, organization, or system responds by applying the principles of a trauma-informed approach to all areas of functioning. This means that all people in the organization may start to rethink their behavior, language and policies with the consideration of trauma. Leadership finds ways to systematically incorporate the six key principles into the culture of the building through sustainable training, manuals, staff handbooks, policies, and mission statements.

The fourth "R" is:

- Resist Re-Traumatization: a trauma-informed approach seeks to resist re-traumatization of clients as well as staff. This is where staff seeks to recognize and eliminate potential triggers within the organizational setting (Huang, 2014).

SCRED's (2018) definition for Trauma-Informed organizations is: organizations have made trauma responsive practices the organizational norm. The trauma model has become so accepted and so thoroughly embedded that it no longer depends on a few leaders. The organization works with other partners to strengthen the collaboration around being Trauma-Informed. Not all systems that are fully functioning can call themselves Trauma-Informed. It is a process that will fluctuate on the continuum.

Building Self-Regulation Skills

The study of self-regulation changes as you look across the different fields: psychology, medical science, sociology, and economics all look at self-regulation differently. Psychology studies want to know how self-regulation influences an individual's behavior. The medical sciences study how self-regulation contributes to pathology. In sociology, self-regulation is associated with deviance or criminality. Economics interprets self-regulatory behaviors on how individuals choose and use resources. In the last several years, interdisciplinary research has been far more prevalent having a far greater impact that it could have on its own (Booth, Hennessy, & Doyle, 2018). Many students with trauma and with Individualized Education Plans (IEP) have difficulties with self-regulation skills and have a chance of having it affect them in several aspects of their lives as they grow into adulthood.

Self-regulation can be defined as the act of managing thoughts and feelings to enable goal-directed actions (Rosanbalm, 2017). Self-regulation skills began to be researched abundantly after Mischel and Ebbesen's marshmallow test in 1970. The marshmallow test was conducted with individuals ages 3-5, who were given a choice between a small, but immediate reward of one marshmallow, or double the award if they could wait. Mischel and Ebbesen

(1970) would put the marshmallow on the table and tell the child they could eat the marshmallow while they were out of the room, but if they could wait until they returned, they would receive double. Then he would leave for about 15 minutes while the youth were tempted by the marshmallow. The follow-up of this original research and the duplicated research after, found that the children who were able to delay gratification or self-regulate were more successful later in life. This research continued to be duplicated over and over, but once researchers started to include control factors such as the child's socioeconomic status, intelligence, personality, and behavior problems, there was no longer a correlation between the two (Payne & Sheeran, 2018). Indicating that self-regulation skills are both hereditary and learned within your environment. This test highlighted the importance of self-regulation skills and future success and the need to develop self-regulation skills in all children.

All people are born with a biological predisposition of self-regulation skills, but then skills and motivation, both internal and external, are developed from caregiver support and environmental context (Rosanbalm, 2017). Not all children have parents who are supportive; thankfully, caregivers can be any person who spends a significant time with a particular child and can make an impact on their life. This can include family, extended family, friends, childcare, and school staff. When caregivers help support children to build self-regulation skills, the US. Department of Health and Human Services calls that Co-Regulation. Co-Regulation is a tripod of support. The first is providing children with a warm, responsive relationship where they feel cared for no matter what. The second is structuring the environment to be consistent, predictable and safe. Finally, the third is teaching self-regulation skills to children by modeling, teaching, and practicing skills (Rosanbalm, 2017). These skills are developed quickly within the

first years of life and then are built-up throughout young adulthood. Co-Regulation looks different as children learn and grow.

The first leg of the tripod of Co-Regulation is support; making sure a child feels supported and has a positive relationship. In a review of educational research (Sparks, 2019) found that strong teacher-student relationships were associated with higher student academic engagement, attendance, grades, fewer disruptive behaviors and suspensions, and lower school dropout rates.

The second leg of Co-Regulation is structuring the environment to be consistent, predictable, and safe. Students with trauma can be hypervigilant and can perceive everyone in their space as a potential threat (Terrasi, & Galarce, 2017). Building relationships and allowing students an escape can provide students time to reset. The break should not be tied to behavior and should not have to be earned, rather just asked for. A break for 10 minutes is a common starting point (Minahan, & Rappaport, 2012). Research from the Council for Exceptional Children recommended sensory breaks to help children relieve stress and improve their focus. These can be built into the classroom environment, by providing brain breaks during lessons, purchasing seating that provides movement, or it can also be provided in an alternative place if it is going to be distracting to other students within the space. Breaks can be built into the regular class schedule or used as needed for individual students. Alternative spaces and classrooms to the best extent possible, should provide natural lighting or a less harsh lighting. A calming space should have access to calming imaging and sounds (Brunzell et al., 2016).

The third leg of Co-Regulation is teaching self-regulation skills to children by modeling, teaching, and practicing skills. Teaching self-regulation techniques seem to come from one of

two areas: psychology and education. Psychology practices that promote self-regulation can be seen in Cognitive Behavior Therapy (CBT) and Mindfulness techniques. Education practices that promote self-regulation can be seen in the Minnesota State Social Emotional Learning (SEL) standards adopted from the Collaborative for Academic, Social, and Emotional Learning (CASEL). Finding a combination of these two practices will empower and enable teachers to promote both healing and growth in their classrooms (Brunzell, Waters, & Stokes, 2015).

CBT is goal oriented and problem-focused, with the goal of teaching the student/client to recognize their own dysfunctional thoughts and reframing them to change their thinking, mood, and behavior more positively. Allowing the student/client to be in control of themselves. Sessions of CBT help students/clients develop ways to achieve and maintain relaxation (Gentry, Baranowsky, & Rhoton, 2017). This type of therapy is typically done by a therapist. Mindfulness can be a large component of CBT but can be adapted to the classroom.

Mindfulness is a mental state achieved by focusing one's awareness on the present moment, while calmly acknowledging and accepting one's feelings, thoughts, and bodily sensations. Practicing mindfulness can actually change both the structure and functioning of the brain (Riner & Tanase, 2014). To practice mindfulness, it is important to stay in the present, return when thoughts drift away, be non-judgmental, open your heart, and let go. Some mindfulness activities that can be implemented into the classroom are breathing, labeling and tracking thoughts and attitudes, meditation, attending to everyday activities, redirecting attention with activity, and confined motion (Riner & Tanase, 2014). Having a student being present in a daily activity for example, giving them a task of eating a slice of bread in 10 bites, chewing each

bit 10 times, allowing 10 seconds between swallowing and taking the next bite. This practice involves extreme focus and allows them to push out thoughts that are not relevant in the moment (Riner & Tanase, 2014).

The Minnesota State SEL standards (2017) adopted from CASEL do not use the term self-regulation. They instead use the word self-management, which they describe as the ability to successfully regulate one's emotions, thoughts, and behaviors in different situations—effectively managing stress, controlling impulses, and motivating oneself. The ability to set and work toward personal and academic goals. This is a more specific definition. When breaking down the skill within self-management using CASEL's guide and Transition Assessments in Ten Sigma, 55 specific skills can be broken down within this category and taught. Everything from ignoring distractions by others, to using relaxation strategies, both of which can be broken down to specific skill steps. These educational terms provide a concrete base for learning skills but combining the psychology can begin to promote the growth and healing within the classroom.

Teachers are not psychologists, but many students who have experienced trauma do not have access to those types of services. School may be the only consistent environment that they have in their day, that is why Brunzell et al. (2016) considered teachers "front-line trauma healers" since nearly 40% of the student population has been affected by some sort of trauma. Teaching as a front-line trauma healer, Brunzell et al. (2016) suggested using both a physical and emotional approach to self-regulation. With the physical approach teachers will engage the body's sensory and nervous systems. Mindful breathing, visualizing, music, and yoga can help regulate the body. Introducing biofeedback lessons and heart rate information with short exercise bursts on treadmills or bikes can help students understand strategies that can potentially

combat the stress response. Lessons about neurodevelopment and how the brain responds with stress and trauma can be very effective when encouraging people to take control of their own body and responses. To regulate emotions, Brunzell et al. (2015) suggested identifying and linking feelings to experiences. This can be in literary texts, TV shows, and comics. Expressing gratitude daily and recognizing hope, optimism, resilience, mindfulness, and other character strengths within daily practice (Brunzell et al., 2015).

Chapter 3: Action Research

The purpose of this study was to investigate the impact the use of break rooms has in a 9-12 high school setting. The research shows that breaks can be effective in calming the body. The research questions are the following:

1. Does providing a safe place for students to take breaks help effectively regulate emotions?
2. What is the frequency and duration that the break room is being used?
3. Does providing a safe place for students to take breaks reduce the number of referrals that they are earning?

Methodology

This study took place in a rural high school which serves 1,089 students grades 9-12. The participants in this study were students with Individual Education Plans (IEP's) or 504 plans. There are currently 114 students receiving special education services, about 10% of the school's population. The school also has 44 students on 504 plans, about 4% of the school's population. Break accommodations were written in the plans of 34 of the 114 students with IEP's, or 30%, and 14 of the 44, students with 504's, or 32%, for a total of 48 students with a break accommodation written in their plan. Of the 48 students, 19 were identified as students who struggled regulating their behavior in the classroom and also were receiving direct social skill or behavior skill instruction. These students are the intervention group in this study that have access to the Reset Room. The building administrator granted approval for the Reset Room to help monitor effectiveness, duration, and frequency of the breaks. The students' identities

remain confidential and are referenced as Student A and Student B or are broken down by category.

This study was designed so that the three research questions would be evaluated separately.

1. Does providing a safe place (Reset Room) for students to take breaks help effectively regulate emotions? This will be monitored using a 5-Point Scale for behavior on the check-in and check-out form on the computer. Students are also required to check-in prior to their break, and check-out after their break to monitor this data. During the check-in and check-out process students also chose a calming strategy to implement. The 5-Point Scale is identified below:
    - 5- Angry, Mad, Out of Control
    - 4- Disgusted, Irritated, Annoyed, Frustrated
    - 3- Anxious, Scared, Nervous, Slightly Frustrated
    - 2- Sad, Tired, Anxious, Not Myself
    - 1- Calm, Happy
2. What is the frequency and duration that the break room is being used? This data is being monitored via the check-in/check-out process.
3. Does providing a safe place (Reset Room) for students to take breaks reduce the number of behavior referrals that they are earning? Behavior referral information for the intervention students were gathered from terms 3 and 4 during the 2018-2019 school year. This data was used as the control data. Referral data collected for terms

1 and 2 of the 2019-2020 school year was also gathered to monitor the effectiveness of the intervention.

Check-In/Check-Out Procedure

The Reset Room is located on the east end of the building and is in close proximity to the Resource Room, Behavior Room, and Special Education offices and staff. The fluorescent lights in the room have been covered with light diffusers and the room is equipped with multiple options for self-calming and regulation. This room is not directly supervised by staff, so students must check-in and out on the computer in the Resource Room. Resource Room staff are indirectly supervising the Reset Room by monitoring the number of students in and out. Only one student is allowed in the Reset Room at a time. If the space is being occupied, students should wait or walk until the other student has vacated the room.

When signing into the Reset Room, students first choose their name, case manager, and classroom teacher. This sends an email alerting them that the student is starting their break once the student submits the form. Students then rank their emotions using the 5-Point Scale and choose the strategy they feel may help. The student has an option to add comments on the bottom of the form if they wish. Once the student has signed in, they take the handheld timer and set-it for the time that they need. Students were pre-taught individually to use the Reset Room. During this time, we tried to help the students identify the amount of time that they may need. When we first started, most students already had a 5-minute break written into their IEP accommodations, some accommodation pages did not specify the lengths of the breaks. All students were told to set a timer for 5 minutes; if they were not calm, take 5 more minutes. If they were not calm after a total of 10 minutes, they were directed to connect with a trusted adult

to process. There were two students with the initial direction to take up to 15 minutes to process before checking in with an adult because that was an identified need for them.

When the timer goes off, the student should go back to the Resource Room, return the timer, fill-out the check-out form, and head back to class. Once the check-out form is filled out, another email is sent to the classroom teacher and case manager alerting them that the student is heading back to class.

The 5-Point Scale

- 5-Angry, Mad, Out of Control
- 4-Disgusted, Irritated, Annoyed, Frustrated
- 3-Anxious, Scared, Nervous, Slightly Frustrated
- 2-Sad, Tired, Anxious, Not Myself
- 1-Calm, Happy

Calming Strategies Available

- Aromatherapy
- Balance Board
- Bean Bag Chairs
- Breathing Strategies
- Calming Lights
- Calming Sounds
- Coloring
- Fidgets
- Pin Art
- Puzzles
- Stair Stepper
- Thera-Putty
- Weighted Blanket
- Yoga

Participants

There are 19 students piloting the Reset Room intervention. All of the students identified for the pilot program had either an IEP or 504 Plan with breaks written into it. Of the 19 students trained and allowed to use it, one had a 504 Plan. The rest of the students qualified for special education; four under Autism Spectrum Disorder (ASD), six under Emotional/Behavioral Disorders (EBD), four under Other Health Disabilities (OHD), three under Specific Learning Disabilities (SLD), and one under the category of Traumatic Brain Injury (TBI). Of the 19, six were female and 13 were male; seven freshmen, four sophomores, five juniors, and three seniors. There were three students who were trained and allowed to use the Reset Room who chose not to use it during the study period.

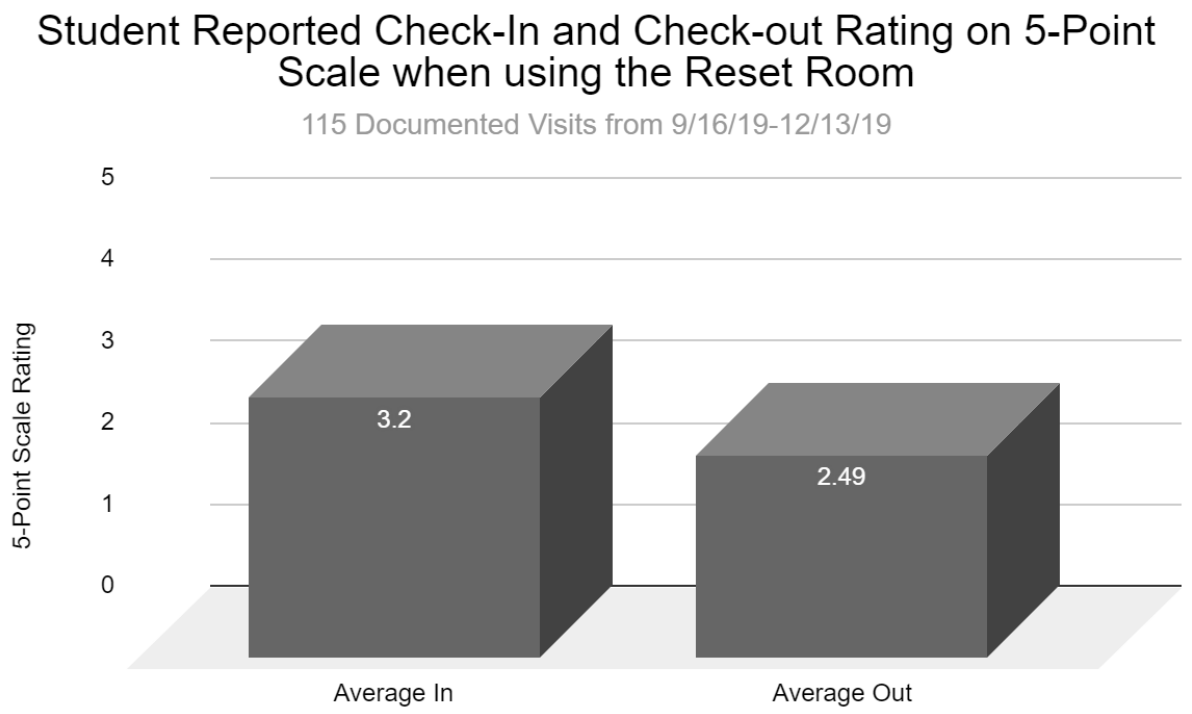
Results

Question 1: Does providing a safe place (Reset Room) for students to take breaks help effectively regulate emotions?

When taking overall data of the 16 students who used the reset room, nine of the students reported a reduction, four showed no change, and two increased on the 5-Point scale. Student O's data could not be calculated; on the three occasions that he used it, he either did not check in or check out. Overall students checked-in at an average of 3.20 (3- Anxious, Scared, Nervous, Slightly Frustrated) and checked out at an average of 2.49 (2- Sad, Tired, Anxious, Not Myself), a decrease of .71 (see Figure 1).

Figure 1

Student Reported Check-in and Check-out Rating on a 5-point Scale when Using the Reset Room



When reviewing individual data, 94% of the visits come from 61% of the students, students D, F, G, H, I, J, M, N, P, Q, and S. Only 25% of the students with ASD used the Reset Room three or more times; 83% of students with EBD, 50% with OHD, and 66% of the students with SLD used the Reset Room three or more times. All students had a negative change, indicating a positive mood shift, except for two students, I and M.

Student I checked in a total of five times with an average check-in of 2.75 (Sad, Tired, Anxious, Not Myself) and an average check-out of 3 (3-Anxious, Scared, Nervous, Slightly

Frustrated), showing a positive change, indicating a negative mood shift. Student I indicated using the following calming techniques: Walk, Fidget, Bean Bag Chair, and Being Alone.

Student M's data should be taken with caution due to his lack of checking-in or checking out. Of the 18 times Student M used the Reset Room, he failed to check-in or check-out 17 times, or 94%. Of his total check-ins and check-outs, Student M averaged a 4.2 at check-in, and a 4.75 at check-out, both indicating that he was Disgusted, Irritated, Annoyed, or Frustrated. On the one occasion where Student M both checked-in and checked-out, he indicated that he was at a 5 (Angry, Mad, Out of Control) both at check-in and check-out, showing no change when he left. Student M indicated using the following calming techniques: Bean Bag Chair, Calming Music, and/or Walk (see Table 1).

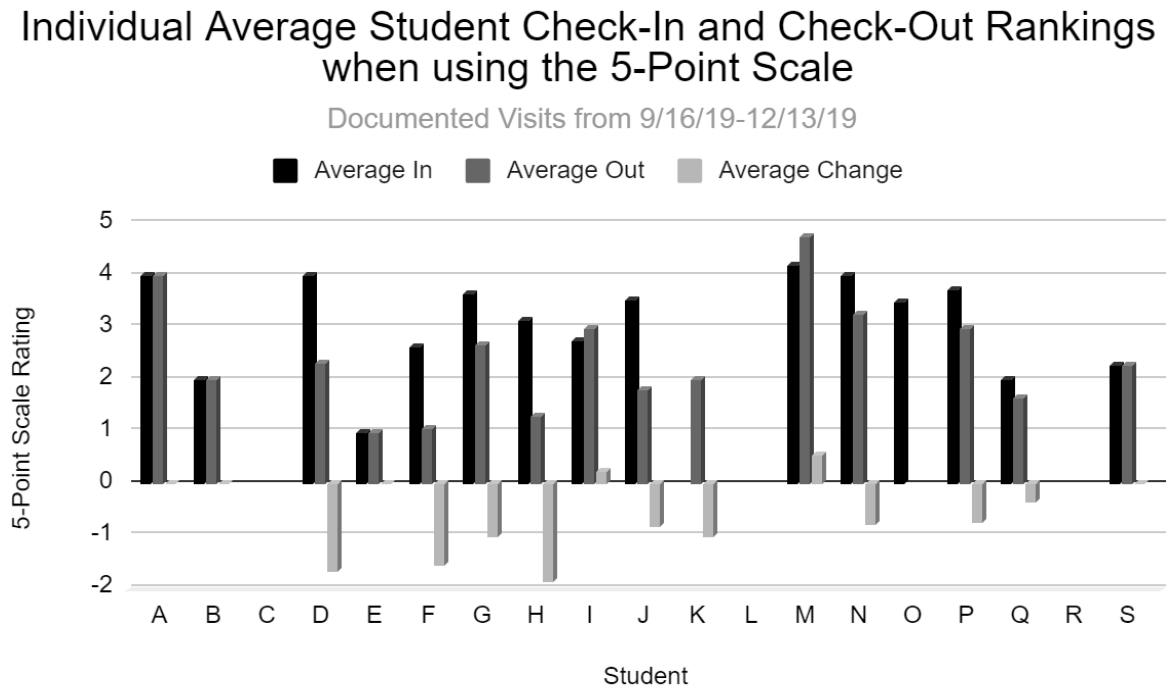
Table 1

Individual Students Trained in Using the Reset Room

Student	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
Disability	504	ASD	ASD	ASD	ASD	EBD	EBD	EBD	EBD	EBD	EBD	OHD	OHD	OHD	OHD	SLD	SLD	SLD	TBI
Grade	9	9	9	10	11	9	10	10	11	11	11	10	12	12	12	9	9	11	9
Sex	F	M	M	F	M	M	F	M	M	M	M	M	M	F	M	F	F	M	F
Visits	1	1	0	4	2	12	6	12	5	28	1	0	18	4	2	11	4	0	4

Figure 2

Individual Average Student Check-In and Check-Out Rankings when Using the 5-Point Scale

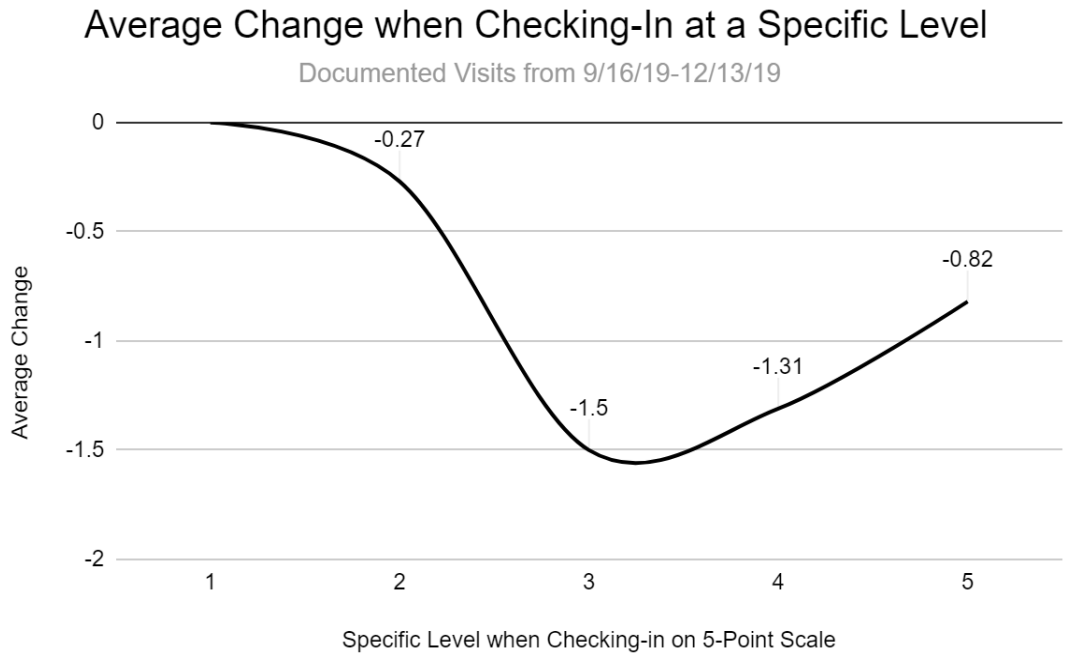


The data showed that the Reset Room is the most effective when students check-in at a 3 (Anxious, Scared, Nervous, Slightly Frustrated). Students are able to self-regulate their emotions and reduce their levels an average of 1.5, indicating they went from being Anxious, Scared, Nervous, or Slightly Frustrated to being Calm or Happy. If escalated higher than a 3 on the 5-Point Scale, the Reset Room becomes less effective. When checking in at a 4, students are able to self-regulate their emotions and reduce their levels an average of 1.31, indicating they went from being Disgusted, Irritated, Annoyed or Frustrated to being Sad, Tired, Anxious, or Not Myself. When checking in at a 5, students are able to self-regulate their emotions and

reduce their levels an average of .82, indicating they went from being Angry, Mad, or Out of Control to being Disgusted, Irritated, Annoyed or Frustrated (see Figure 3).

Figure 3

Average Change when Checking-in at a Specific Level



Discussion

Question 1: Does providing a safe place (Reset Room) for students to take breaks help effectively regulate emotions?

Based on the data gathered, allowing students to take a break and use the Reset Room has been successful in regulating emotions and allows them to return to class calmer and in a better

state of mind. It is important to help students to identify their emotions or triggers that may cause them to get upset early and encourage them to take breaks preventively. If they take breaks when they are anxious, scared, nervous, or only slightly frustrated students are able to regulate their emotions a lot better than if they get to a point where they are disgusted, irritated, annoyed, or frustrated. This confirms the current research and practice currently done with CBT therapy and aligns with the Minnesota State SEL standards.

A limitation to this research is the number of students who failed to check-in or check-out at the beginning of this study. The most common factor was the student not understanding the check-in and check-out process. This was remedied throughout the duration of the study by teaching and reteaching the skill of using the Reset Room within the Personal Enrichment class or during small group sessions. We also had two students who told their teachers that they needed a break with a half hour left in the day. The two students met up and left the building together. Staff did not find out until this happened a second time. Students earned a referral and a lunch detention for skipping and were also retaught the skills of asking for a break appropriately. When it happened a third time, both students lost access to breaks for 2 weeks. Staff did not believe self-regulation was the function of their behavior, but rather social interaction. When students earned their breaks back, they were able to retain them by following the process. The practice of removing breaks tied to behavior was not recommended within the research (Minahan, & Rappaport, 2012), but the function of their particular behavior did not seem to match the purpose of the Reset Room, so that is why removing breaks was justified in that situation.

The other factor that led to difficulties with the check-in and check-out process was computer and internet issues. Students were requesting breaks and leaving in a slightly agitated state came to a computer to check-in that was not always working; this did not help their agitation. Often students, rather than asking for help, would just skip the process altogether. The computer and internet received upgrades during the study. The interventions of teaching and reteaching skills, implementing consequences for not following protocol, and upgrading technology drastically improved the percentage of students following the check-in and check-out process, improving the validity of the study.

Results

Question 2: What is the frequency and duration that the Reset Room is being used?

In total there were 115 visits to the Reset Room in 57 school days, averaging just over two visits per day. The initial direction for students was to check-in and use a 5-minute timer once in the Reset Room, if they were not calm after 5 minutes, reset the timer. If students needed more than 10 minutes total they were to check in with a trusted adult. Students I and M were the students told initially they could have up to 15 minutes in the Reset Room on their own, before they checked in with a trusted adult. Overall, from check-in to check-out students are averaging 10.48 minutes. Fifteen out of the 19 students, 79%, stayed within the 10-minute timeline; 0% stayed within the 5-minute timeline. Students A, G, M, and N exceeded the 10-minute timeline; students A and N only exceeded it marginally. Removing the outliers, students G and M, the average break was 8 minutes long.

Student G used the Reset Room six times, on three of the occasions, 50%, she forgot to check-out. The other three times she averaged 20.67 minutes. The first time she checked in, she

checked-in at a 4 (Disgusted, Irritated, Annoyed, Frustrated), was there for 27 minutes and checked out at a 2 (Sad, Tired, Anxious, Not Myself). The second time she was there she checked-in at a 2 (Sad, Tired, Anxious, Not Myself) was there for 8 minutes and left at a 1 (Calm, Happy). The third time she checked-in and out, she was there for 27 minutes and she started at a 5 and left at a 5 indicating that she was Angry, Mad, or Out of Control.

Again, Student M's data should be taken with caution due to his lack of checking-in or checking out. Of the 18 times Student M used the Reset Room, he failed to check-in or check-out 17 times, or 94%. Of his total check-ins and check-outs, Student M averaged a 4.2 at check-in, and a 4.75 at check-out, both indicating that he was Disgusted, Irritated, Annoyed, or Frustrated. On the one occasion where Student M both checked-in and checked-out, he was there for 26 minutes and indicated that he was at a 5 (Angry, Mad, Out of Control) both at check-in and check-out, showing no change when he left (see Table 2).

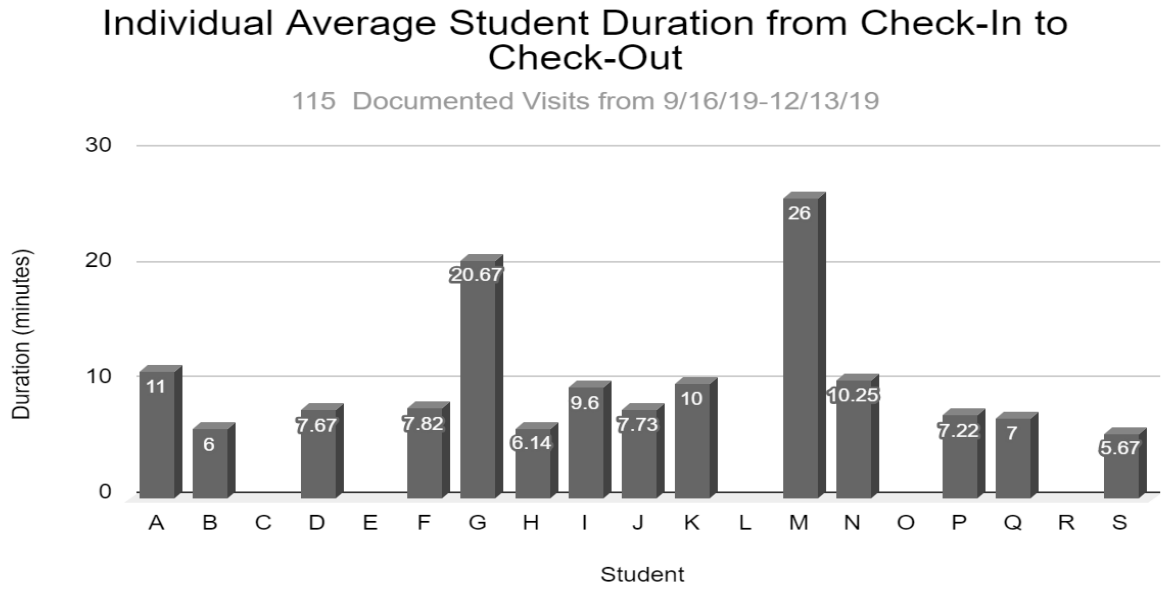
Table 2

Individual Students Trained in Using the Reset Room

Student	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
Disability	504	ASD	ASD	ASD	ASD	EBD	EBD	EBD	EBD	EBD	EBD	OHD	OHD	OHD	OHD	SLD	SLD	SLD	TBI
Grade	9	9	9	10	11	9	10	10	11	11	11	10	12	12	12	9	9	11	9
Sex	F	M	M	F	M	M	F	M	M	M	M	M	M	F	M	F	F	M	F
Visits	1	1	0	4	2	12	6	12	5	28	1	0	18	4	2	11	4	0	4

Figure 4

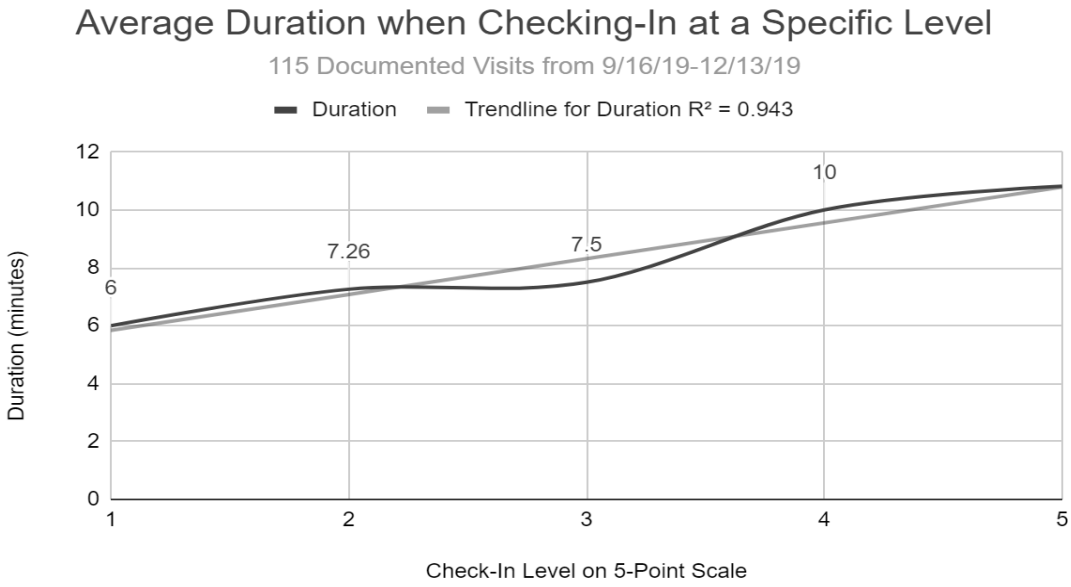
Individual Average Student Duration from Check-in to Check-out



There was a direct correlation found with the level students are checking-in at and the duration that they are staying, r = .943. On average if students checked-in at a 3 or lower they were able to meet the 10-minute timeline. If checking-in at a 4-5, students exceeded the timeline.

Figure 5

Average Duration when Checking-in at a Specific Level



Discussion

Question 2: What is the frequency and duration that the Reset Room is being used?

Students are using the Reset Room, but they are not using it within the original timelines that were set by looking at the accommodations within their IEPs. Many students had it written that they are allowed a break, some even specify that students can take a 5-minute break when they need to calm down or self-regulate. The research showed that a 10-minute break may be a better place to start. (Minahan & Rappaport, 2012). The majority of the students showed that the 10-minute time limit was much more suitable, after removing the outliers, the average break was 8 minutes long. The recommendation for case managers of students with IEP's was to change

the verbiage from “students may take a 5-minute break,” to “XXX needs access to the Reset Room to self-regulate their emotions,” if they are struggling to calm down on their own they will access special education staff to process. Any mention of time was recommended to be removed, except for students who have shown they are not able to self-regulate after so long. Then their additional needs should be documented in a statement similar to: “if XXX is not able to calm down after 15 minutes, a special education staff member will check in on them to help them process.”

The expectation of a 5-minute break from class while accessing the Reset Room does not seem possible. The Reset Room and the Resource Room are located on the far east end of the building. It can take students as much as 3 minutes to walk to the Reset Room from various locations in the building. The check-in and check-out each take 1 minute. Without officially taking a break, students can be out for 8 minutes. Teachers that have students in class who are allowed breaks should expect that the student may miss up to 18 minutes of class, assuming that the break was effective, and students are able to go back to class without getting additional assistance from a teacher.

Physically not being present in class for that amount of time, can be frustrating to teachers who are not Trauma-Informed. The Reset Room helps to bring down cortisol levels in the brain and allows students to get out of the flight or fight response that trauma can cause (Terrasi, & Galarce, 2017). This response may be more effective than allowing escalated students to sit in class that are mentally and emotionally not there or have the potential to escalate.

A fear that the study team had was that the Reset Room was going to be abused and become a “hang out” for students. The research shows that the Reset Room is only being accessed two times daily, students seem to be using periodically, as needed. Using as needed and practicing the calming strategies and skills within the Reset Room was an emphasis in training students to use the space. Students were told as part of the training that if the space was not being used appropriately, access may be lost. Since it is currently being accessed twice daily by the pilot group, it seems plausible that as training is expanded to all students with identified needs that the current space may be able to accommodate.

As discussed under Question 1, helping students to identify triggers and emotions early is essential. Not only will they be able to more effectively deescalate themselves, they will also decrease the duration that they are out of class, since there is a direct correlation between the level checking in to the Reset Room and the amount time needed to calm down.

Results

Question 3: Does providing a safe place (Reset Room) for students to take breaks reduce the number of behavior referrals that they are earning?

The average number of referrals were down from the end of the 2018-2019 school year compared to the beginning of the 2019-2020 school year. There was a 60% decrease in referrals overall; students averaged 11.8 referrals last year to averaging 4.8125 this year. The overall number of referrals issued last year for the pilot group was 222. This year the pilot group earned 96.

In reviewing the individual referral data, all but one of the students showed a decrease or maintained the same number of referrals from last year. Student E did not receive any referrals

last year but has earned two this year. Student M was not enrolled in the district last year as a junior, but information for Terms 3 and 4 as a sophomore were gathered as comparable data. Student K was an outlier last year earning 45 referrals during Terms 3 and 4. If his data was removed, the school average of referrals still showed a decrease in referrals averaging from 9.8 last year to 4.8 this year.

Figure 6

Average Number of Referrals for Students Trained in Reset Room

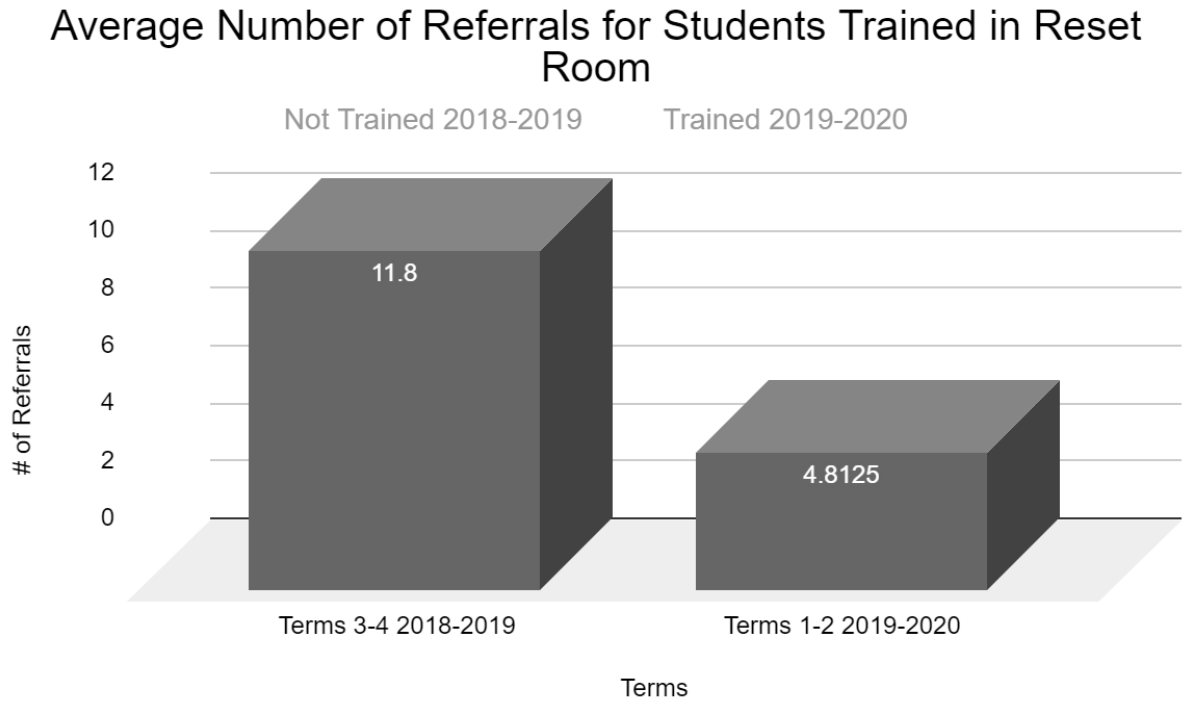
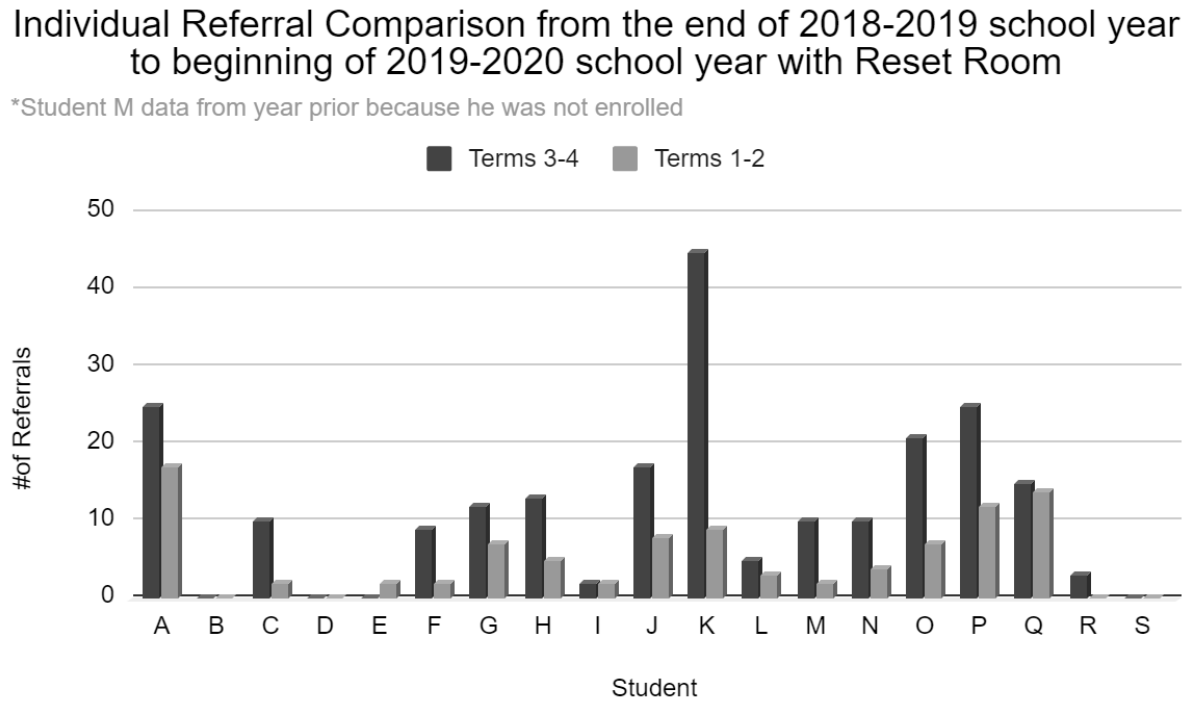


Figure 7

Individual Referral Comparison from the End of the 2018-2019 School Year to the Beginning of the 2019-2020 School Year with Reset Room



Discussion

Question 3: Does providing a safe place (Reset Room) for students to take breaks reduce the number of behavior referrals that they are earning?

There was a 60% reduction in referrals from 2018-2019 Terms 3-4 to 2019-2020 Terms 1-2. Numerous factors could explain the drastic reduction of referrals including the students maturing over time and the typical increase in behavioral referrals later in the school year. The Reset Room seems to play a big role. The Reset Room meets the needs of at least two of the

National Center for Trauma-Informed Care's six core principles: safety and empowerment. When students are feeling the flight or fight response, they know they have a consistent safe place to go where they can work on self-regulation skills and calm their bodies. They are also empowered to make the choice and recognize that I can stay in this situation and escalate, or I can choose to calm myself. When they get to the Reset Room, after being pre taught all of the strategies, they can choose the strategy that works best for them.

Conclusion

Self-regulation is such an important skill throughout one's life, it can affect your physical, mental, and financial health throughout adulthood. Trauma can impede this skill from progressing and nearly 40% of our students are coming to us with some form of trauma. Trauma and other disabilities, such as ADHD, can affect the brain and can hinder decision-making skills and push students to a point of flight or fight.

MTSS are beginning to be implemented in schools to support all students academically, socially, and emotionally. By researching Trauma-Informed practices and different ways to teach students to self-regulate, our rural school was further able to implement these practices into our building by creating a Reset Room. One of the keys to implementing the Reset Room successfully was pre-teaching the skills to the students beforehand and then reteaching throughout.

The Reset Room provided a safe, empowering option for 19 of our highest need students in the school. The option is not only safe for those 19 students, but also for the rest of the student population by making sure all students are accounted for and not just roaming the school unregulated.

The space is being accessed almost two times daily and has been effective at positively regulating emotions. Students are seeing a .71 decrease on the 5-point scale, indicating a positive mood change after choosing a relaxation activity in the reset room. Referrals over the first two terms of the 2019-2020 school year have reduced 60% from terms 3-4 the year prior. Although other factors may have contributed to the success of this program, the results from this study are promising.

Limitations

This study has a limited sample with only 19 students being trained and able to use the Reset Room. Findings should not be generalized to the larger population. This study is limited to the time frame of 57 school days. The outcome may have been impacted by student maturation and natural skill development progression. Referral data were compared from the 2018-2019 Terms 3-4 to the 2019-2020 Terms 1-2. Typically, Terms 3-4 see an increase of behavioral referrals as the school year comes to an end.

Future Recommendations

This study was limited to the 19 students of a potential of 48 students who have a documented need for breaks either in their 504 plan or IEP. The results and conclusions of this study suggest that there is a need for further research, and the following studies are suggested:

1. A larger sample size to add more validity to the findings.
2. A longer-term study to show the effects over time.
3. Implementing multiple Reset Rooms that can be accessed quickly as to limit the time students are out of class.
4. Surveys that gather student and staff perceptions of the data.

5. Implementation of a Reset Room in a variety of settings such as: high school, middle school, elementary school, and kindergarten to add more validity to the findings.

The action research findings demonstrated the benefits of having a Reset Room available in the school for students who have difficulty self-regulating their emotions. Although the benefits of breaks have been documented by the Council for Exceptional Children (Brunzell et al., 2016), not much research was found directly correlating mood and feelings to the breaks. This research should be continued.

References

Booth, A., Hennessy, E., & Doyle, O. (2018). Self-regulation: Learning across disciplines. *Journal of Child and Family Studies, 27*(12). 3767-3781. doi:10.1007/s10826-018-1202-5

Bremner, J. D., MD. (2006). Traumatic stress and the brain. *Dialogues in Clinical Neuroscience, 8*(4), 445-461.

Brunzell, T., Stokes, H., & Waters, L. (2016). Trauma-informed flexible learning: Classrooms that strengthen regulatory abilities. *International Journal of Child, Youth and Family Studies, 7*(2), 218. doi:10.18357/ijcyfs72201615719

Brunzell, T., Waters, L., & Stokes, H. (2015). Teaching with strengths in trauma-affected students: A new approach to healing and growth in the classroom. *American Journal of Orthopsychiatry, 85*(1), 3-9. doi:10.1037/ort0000048

Carrion G., Garrett, A., Menon, V., Weems, C. F., & Reiss, A. L. (2008). Posttraumatic stress symptoms and brain function during a response-inhibition task: An fmri study in youth. *Depression and Anxiety, 25*(6), 514-526. doi:10.1002/da.20346

Cavanaugh, B. (2016). Trauma-informed classrooms and schools. *Beyond Behavior, 25*(2), 41-46. doi:10.1177/107429561602500206

Center for Disease Control. (2019, December 31). *Preventing adverse childhood experiences* Retrieved January 25, 2020, from https://www.cdc.gov/violenceprevention/childabuseandneglect/aces/fastfact.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fchildabuseandneglect%2Facestudy%2Faboutace.html.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards,…& Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine, 14*(4), 245-258. doi:10.1016/s0749-3797(98)00017-8

Freeman, R., Miller, D., & Newcomer, L. (2015). Integration of academic and behavioral MTSS at the district level using implementation science. *Learning Disabilities: A Contemporary Journal, 13*(1), 59-72.

Gentry, E., Baranowsky, A. B., & Rhoton, R. (2017). Trauma competency: An active ingredients approach to treating posttraumatic stress disorder. *Journal of Counseling & Development, 95*(3), 279-287. doi:10.1002/jcad.12142

Huang, L. N. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach* (United States, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services). Rockville, MD: HHS Publication No. (SMA) 14-4884. Retrieved January 25, 2020.

IDEA (2004). Pub. L. No. 108th Congress-Public Law, §§ Public Law-108-446. US Department of Education. Retrieved from: https://www.govinfo.gov/content/pkg/PLAW-108publ446/pdf/PLAW-108publ446.pdf 2004).

Leitch, L. (2017). Action steps using aces and trauma-informed care: A resilience model. *Health & Justice, 5*(1). doi:10.1186/s40352-017-0050-5

Leonard, D., & Coltea, C. (2013). *Most change initiatives fail—but they don't have to.* Retrieved from: https://news.gallup.com/businessjournal/162707/change-initiatives-fail-don.aspx.

McIntosh, K., & Goodman, S. (2016). *Integrated multi-tiered systems of Support: Blending RTI and PBIS*. New York, NY: The Guilford Press.

Minahan, J., & Rappaport, N. (2012). Anxiety in students a hidden culprit in behavior issues. *Phi Delta Kappan, 94*(4), 34-39. doi:10.1177/003172171209400410

Minnesota Department of Education. (2017). *Social emotional standards*. St. Paul, MN: Minnesota Department of Education.

Mischel, W., & Ebbesen, E. B. (1970). Attention in delay of gratification. *Journal of Personality and Social Psychology, 16*(2), 329-337.

Payne, K., & Sheeran, P. (2018). Try to resist misinterpreting the marshmallow test. Retrieved February 1, 2020, from: https://behavioralscientist.org/try-to-resist-misinterpreting-the-marshmallow-test//.

Riner, P. S., & Tanase, M. (2014). Inviting calm within: ADD, neurology, and mindfulness. *Journal of Invitational Theory and Practice, 20*, 11-25.

Rosanbalm, K. D. (2017). *Promoting self-regulation in early childhood: A practice brief* (*2017-2079,* pp. 1-9). Washington DC: US. Department of Health and Human Services, Office of Planning, Research, and Evaluation, Administration for Children and Families).

St. Croix River Education District (SCRED) (2018). *MTSS social/behavior audit rubric*, pp. 1-19.). Rush City, MN: St. Croix River Education District.

Sparks, S. D. (2019). Why teacher-student relationships matter. Retrieved February 1, 2020, from: https://www.edweek.org/ew/articles/2019/03/13/why-teacher-student-relationships-matter.html.

Stevens, J. E. (2015). The adverse childhood experiences study—the largest, most important public health study you never heard of—began in an obesity clinic. Retrieved January 25, 2020, from: https://acestoohigh.com/2012/10/03/the-adverse-childhood-experiences-study-the-largest-most-important-public-health-study-you-never-heard-of-began-in-an-obesity-clinic/.

Terrasi, S., & Galarce, P. C. (2017). Trauma and learning in America's classrooms. *Phi Delta Kappan*, *98*(6), 35-41. doi:10.1177/0031721717696476