

## Discussion Paper 16

### Disability and Trauma in the classroom setting

It is important to begin this discussion paper with the acknowledgment that children with disability have the same 'child' needs as any other child and the impact of trauma on the developing brain and attachment patterns are as relevant for children with disability as it is for those without disability. The purpose of this paper is to take into consideration the additional complexity of disability and explore the use of the framework principles of the SMART practice for working with children with disability who have experienced trauma. It is hoped that this paper gives staff working with children with disability who have experienced trauma an opportunity to reflect on how we might incorporate SMART practices into their Educational environment.

#### Children with Disability and Trauma

There are approximately 39,058 children on care and protection orders and 37,648 children living in out-of-home care. Research in the area of disability and trauma highlights that children and young people with disability are especially vulnerable to abuse or neglect. While statistics vary it is thought that children with disability may be 3.4 times more likely to be a victim of some type of abuse compared to children without disabilities, the maltreatment may start when they are very young and continue throughout childhood and the level of abuse is likely to be more severe and of longer duration.<sup>1</sup> The commission for Children and Young People and Child Guardian (2006) found that the rate of disability reported by children and young people in care was 22.5% for 5-8 year olds and 20.8% in 9-18 year olds.

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<sup>1</sup> Sullivan, P., & Knutson, J. (1998). The association between child maltreatment and disabilities in a hospital-based epidemiological study. *Child Abuse & Neglect*, 22 (4), 271-288. And Howlin, P & Clements, J. (1995) Is it possible to assess the impact of abuse on Children with pervasive developmental disorders? *Journal of Autism and Developmental Disorders*, Vol. 25, No. 4, 1995

Children are not born knowing how to manage their emotions; they rely on others to interpret their emotions and to respond accordingly. This adult-infant/child attunement supports the development of the child's self regulation skills.<sup>2</sup> Children with disability, in particular those with developmental challenges (cognitive, communication, social), generally rely on others to interpret their emotions until they are much older than their non-disabled peers.

For all children whose parents/carers have been the cause of their fearful states, and whose parents/carers have not responded to their needs sensitively when they have been distressed are left in a chronic state of extreme dysregulation. Their brain is overwhelmed and in response copes defensively. Over time these defensive coping strategies lead to a distorted reality and lays down partial and incomplete memories and dysfunctional behavioural patterns that are reactivated when the child experiences similar situations.

***'the neural connections that result in defenses shape our lives by selecting what we approach and avoid, where our attention is drawn and the assumptions we use to organize our experiences'*** [Cozolino 2001].<sup>3</sup>

As the child has not been supported while distressed they are unable to find or explore his/her own emotional self within relationship with the carer. Hence the child cannot manage emotional arousal in him/herself or in others. When maltreated children need parents to help them contain and regulate their escalating arousal they actually experience danger and emotional abandonment.

When the child has experienced trauma, their understanding of the world is that it is unsafe place. This impacts on their ability to explore their environment due to their need to focus on keeping safe from danger. This also impacts on the development of play skills which in turn leads to relationship and problem solving difficulties. Once the child is in a safe environment they can be encouraged to explore their environment safely and they can begin to further develop these important skills. For children with disability engaging and exploring their environment often has additional challenges due to the nature of their disability and they need adults to support them to adequately access and experience developmental opportunities e.g., body positioning, developing narratives, sensory opportunities.

The trauma related symptomology for children with \*pervasive developmental disorder is vast and may include increased fear, anxiety and clingy or withdrawing behaviour; irritability, rigidity to change, self-injurious, aggressive and destructive behaviour's; poor compliance, mood disturbances, over activity and 'tantrums'; decreased interest in daily activities, disturb sleeping and eating disorders.<sup>4</sup>

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<sup>2</sup> Kostelnik Stein & Whiren Soderman. (1998). Guiding Children's Social Development 3<sup>rd</sup> Ed.

\* Definition of pervasive developmental disorder: Any of several disorders, such as autism and Asperger's syndrome, characterized by severe deficits in many areas of development, including social interaction and communication, or by the presence of repetitive, stereotyped behaviours. Such disorders are usually evident in the first years of life and are often associated with some degree of mental retardation.

<sup>3</sup> David Howe. (2005), Child Abuse and Neglect. Attachment, Development and Intervention. P46

<sup>4</sup>Howlin, P & Clements, J. (1995) Is it possible to assess the impact of abuse on Children with pervasive developmental disorders? Journal of Autism and Developmental Disorders, Vol. 25, No. 4, 1995.

### Case Study:

Tara is an 11 year old child with Pervasive Developmental Disorder and mild intellectual disability. In first 5 years of her life Tara had witnessed significant domestic violence and she had experienced homelessness, physical abuse, sexual abuse and neglect. When placed into care Tara was hyper-active and required constant supervision. She had multiple placements before finally being placed into a long-term placement two years ago. Tara is highly anxious; she has poor sleep patterns and frequently wakes the house with night terrors. At school Tara is not be able to sit for long periods she has approximately 7 out of seat behaviours (stand-sit, move-sit, lean-sit) within each 15 minute time period. She is hyper-vigilant of any movement or sounds in the environment and is unable to concentrate to complete most tasks. Tara has no friend. She wants and seeks friendships is unable to initiate the appropriate social contact, or maintain interactions. She will quickly begin to argue with the other children, can't wait her turn, grabs at things and always wants the equipment the other children are using. Tara regularly takes food from their bags, and says mean things to them. Tara finds any changes in the class difficult, and when a relief teacher is allocated there is a significant increase in the out of seat behaviour and she becomes enraged over minor things.

## **Section 2 SMART PRACTICE and Children with Disability**

SMART PRACTICE is a framework of intervention tailored for use in the school environment. The intervention provides school staff with a range of strategies that aim to support the transformation of trauma impacts for children.

This paper provides an adapted SMART PRACTICE framework, specifically designed to support traumatized children with disability in an Education environment.

### **Predictable**

As with their non-disabled peers, traumatised children with disability perceive any change as a potential threat.

Everyday patterns are often unpredictable for a child with disability. Many children with disability have additional service providers or staff who are involved in their lives e.g., taxi/bus drivers, health workers, SSOs, therapists etc. hence there is a greater likelihood of predicted or unpredicted changes occurring.

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They may be surprised or caught off guard by others innocently moving around them, leading to anxiety and hyper-vigilance. This further reduces their capacity to attend to tasks and increases the likelihood of them using their behaviour to express their fear and frustration.

### Specific Strategies

- When approaching the child, ensure they see or hear you approach.
- Use symbols that are meaningful to the child e.g., objects, photographs or line drawings targeted to the child's developmental level
- Use a visual schedule for the day, week, month. Include a change or cancelled because ....



'Swimming is cancelled because it is raining, we will do Art and Craft' (NOTE: C can be placed on clear laminate so it can be overlaid on swimming)

- Have work stations and items clearly labeled
- Provide a visual story about the class and its expectations
- Explain changes within the environment using visual prompts e.g.,



'Tara is sick, so John will work with Tommy today'

### Responsive

As with their non-disabled peers traumatized children with disability have not experienced adults who respond consistently to their needs leading to confusion, mixed messages and inconsistent responses. Many children with disability have cognitive limitations, communication difficulties and immature social skills. Due to their developmental challenges they may use behaviours in an attempt to communicate their needs when they become distressed and/or frustrated. These communicative

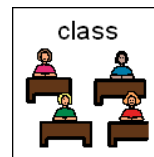
attempts can present as internalized or externalized behaviour's. e.g., head banging, screaming, hitting out, withdrawing into a world of their own.

Children with disability who have experienced trauma need adults who are responsive, who are able consider the communicative purpose of the behaviour and look beyond the behaviour to see the child in need.

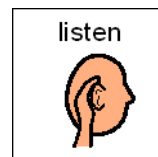
### ***Specific Strategies***

- Consider the child's developmental stage rather than chronological age.
- Remain calm and matter-of- fact should you be presented with an emotional outburst.
- Look for the meaning of the behaviour e.g., anxiety due to changes in staff, trauma memory, any underlying health issues or fears.
- Be empathic and consistent in your expectations and responses. Keeping your explanations clear, simple, and brief. The child may only be able to hear or understand the key words, the additional information or connecting words may be confusing.
- Stay present with the child, especially if they are or have been upset, so they know that an adult is there to support them.
- Be willing to approach the child following an outburst of emotion/behaviour rather than expecting the child to approach you.
- Depict the class expectations visually e.g.

In Ms. Jones' class we:



✓ Listen



✓ Speak quietly



- Make a visual story book about who the child can go to when they need help, make a supporting cue card for the desk/tray top of wheel chair.

- Find ‘magic moments’ to reassure the child of their innate value, take photos/ video and make esteem lifting stories/videos.
- Be animated when showing gestures of pleasure and care for the child.
- Provide opportunities for acknowledgement for participation in a task rather than completion of tasks.

**Attuned**

Due to the unique challenges of the child’s disability (e.g., cognition, vision, hearing, communication, sensory) the child may find it difficult to understand what is being communicated and misread gestures and cues. As with their non-disabled peers, children with disability who have complex trauma have also not experienced sensitive attunement to their needs from significant caregivers. These children need adults who sensitively read their cues and respond accordingly in understanding the child’s needs and providing an experience of relationship that meets those needs.

**Specific Strategies**

- Work collaboratively to map what the child finds difficult, and ways of responding. E.g. using the stress model to map out signs, triggers, and responses at various stages of escalation
- Imbed emotion language within the daily activities for the child to develop a affect identification.
- Label what you perceive is the message of the child’s emotion e.g., you look upset, sad etc for the child to develop affect expression skills
- Be aware of your own messages e.g., matching your emotion to your words
- Make emotions lists with the child
- Using the emotions list, role play the facial and body gestures, take photos and make emotions cards to use in games (ensuring that the child has the opportunity to ‘shake off’ the emotion at the end)
- For children who are non-verbal or have severe/profound disability you could develop a Personal Communication Dictionary to assist new staff to understand the child’s specific needs. This is best done with a few people who know the child well.

What John Does	What it might mean	What you can do
Wiggles in his chair and bangs the table while frowning	The room is too noisy and John is becoming anxious	1. Reassure him and ask ‘is it too noisy?’ and help him to move to a quiet space or go for a walk in the courtyard
Moves back and forth near the cupboard	John may be telling you he is hungry	1. Reassure him break time is coming 2. Offer a piece of fruit

**Connecting** Like their non-disabled peers, children with disability who have experienced trauma have difficulties trusting that adults will meet their needs. This results in the child having difficulties in developing an understanding of emotions, emotional responses and relationship boundaries.

System responses/expectations can at times also add to confusing double messages about trust and healthy relationship boundaries, e.g., don't go with strangers, but today you have to go in the taxi with a different driver. In the case of children with intellectual disability difficulties with problem solving and information processing adds a further layer of complexity and it may take considerably more time for them to develop these skills than their non-disabled peers.

For some children who have Autism Spectrum Disorder, Fragile X and/or severe to profound intellectual disability engaging or connecting with another person can be anxiety provoking. This does not mean they do not need relationships, it is just they may become overwhelmed by the stimuli around them which results in them withdrawing further into their own world.

### ***Specific Strategies***

- Have consistent calm staff
- Have soft furnishings that dampen noise in the room
- Positive engagement with adults
- Emotions activities that include a range of mediums, painting, drawing, movement,
- If the child is non-verbal with severe or profound disability and/or Autism Spectrum Disorder, engage the child in his/her communication world e.g., sit near the child, mimic his actions ( tapping shoe, flicking a string); once you have entered his/her world and his/her attention slightly change the rhythm/action; once he/she engages you comfortably introduce a similar activity/action; build on the repertoire by introducing other activities<sup>5</sup>

**Translating** Traumatized children with disability have limited capacity to tell others about their experiences, they are at risk of being over looked or dismissed due to their limited or repetitive repertoire of social conversation. They often need help to share their experiences with others. There are many simple ways to support them to share stories and to develop their social communication skills. These tools include the use of chat

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<sup>5</sup> Pheobe Calwell. Intensive Interactions

books, routine stories, visual story books, personal profiles, and personal communication dictionaries. These visual tools can also be adapted into a other medium such as audio books, personalized DVDs, and electronic tablets.

### ***Specific Strategies***

- Chat books which provide area for the child to collect items while out for other to use as a prompt or cue for social interactions e.g., a shell from the beach with a message 'I went to the beach on the weekend'
- Routine boards or stories which a help the child and others to know what activities they have scheduled for the day e.g., get home, play with....., go to nana's, have a bath, have dinner, go to bed.
- Personal profiles to assist the child to tell others about their likes and dislikes, strengths, fears, how best to support them.
- Personal Communication Dictionaries to assist those who support children who are non-verbal to know how the child communicates the likes and dislikes etc.

### **Involving**

Children with disability often find it difficult to explore their world due to the challenges of their disability hence they often have immature or are developmentally delayed in the area of play. They may also misread the social cues and norms for forming friendships. This is compounded further if the child has also experienced trauma. This confirms to them that 'the world is very unsafe'. They need support to develop the building blocks of play e.g., turn taking, sharing, waiting and sportsmanship and to relate appropriately with other children. Some children may also need modified or adapted equipment to ensure they have the same physical opportunities as their peers.

### ***Specific Strategies***

- Activities that allow for with turn taking opportunities
- Modeling sharing and promoting the benefits of sharing

### **Calming**

As with their non-disabled peers children with disability who have experienced trauma live in a constant state of elevated stress, without the capacity to regulate their levels of arousal. These children need to be supported by adults who are able to maintain a calm state themselves, and who can provide repeated experiences of activities which are rhythmical and bring their arousal levels in line with others.

### ***Specific Strategies***



- Repetitive activities such as shredding paper or photocopying
- Sensory related activities imbedded into the patterns and rhythm of the day e.g., digging for objects in a box of lupens/ dried peas/beach sand, bubble blowing, listening to music or for outside bird sounds while wearing eye shades, squeezing though foam tunnels, rocking in hammocks exercise with theraband.
- A calm area that has minimal distractions and sensory input e.g., a reading corner at the back of the library.
- 'calming bag' with relaxing objects and readers for the child to access when feeling anxious or hyperaroused.
- Relaxation training/session for the whole of class to identify tense Vs relaxed states e.g., adapted versions of progressive muscle relaxation utilizing music and visual pictures to initially teach the skills

### **Engaging**

Children who experience trauma have not experienced appropriate modeling of social relationships leading to difficulties in social engagement activities. For children with disability this can be further complicated as their disability may make it difficult for them to read and understand the subtle nuances in what may be classified as ideal situations. To understand appropriate proximity, communication turn taking, and to be able to control impulsive statements that others find offensive is difficult for those with social immaturity. This impacts on their development of friendships through out their life span but can make them exceptionally vulnerable to being manipulated into unhealthy and/or dangerous situations when they are teenagers or young adults e.g., being used as a look out, or being pressured into unhealthy sexual practices. As such they need repeated experiences of one-one interactions with others, with clear modeling, and support to develop healthy and safe ways of engaging.

Some children with disability will require additional adult supervision until they are chronologically much older than their non-disabled peers.

### ***Specific Strategies***

- Role play and video self modeling to support the child to learn social boundaries and to practice social interactions
- Visual stories, pictures to explain appropriate relationship boundaries
- Provide empathic but clear feedback
- Mentoring opportunities
- Encourage strong healthy relationships
- Always ensure the individual(s) providing care are introduced and the child has an opportunity to get to know the person prior to activities, especially with regard to personal hygiene activities.

### Section 3 Reflection

- In your current class or school environment how are everyday changes being explained to traumatised children with disability?
- How have you been able to maintain your relationship and to respond to a child with disability and trauma history when they have communicated their distress or frustration using their behaviour?
- In what way are you or your school currently sharing information that is supportive of meeting a child's with disability's needs.
- What practices does your educational setting have that may be either supportive or confusing to a child's understanding of relationships and their social boundaries?
- Are there some sensory based activities that you are able to incorporate into the curriculum? e.g., digging for treasure in the sandpit, finding the objects in a box of lupines, drumming etc
- Does your school environment have allocated calm places for students? If not how might your school provide these types of spaces?
- Does your school environment have routines or rituals that support transitioning times for these children?

For children with disability and trauma navigating everyday events can be exhausting. As children spend a large portion of their day within the school environment, there is a wonderful opportunity for all education staff to promote positive relationships and be actively engaged in the healing process. When the whole school is able to be trauma informed both the child and those who are directly supporting the child, can rest assure they can seek the help and support they require. Consistency in trauma responses across the school will ensure that the efforts made in the class and the home are upheld and respected and will support the healing and the education of the child.

We should never underestimate how each person's interaction and relationship can and will have a contribution to a child's healing.

## References

Howe.D., (2005), Child Abuse and Neglect. Attachment, Development and Intervention. P46

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