Core Curriculum on
Childhood Trauma

The 12 Core Concepts

Concepts for Understanding Traumatic Stress Responses in Children and Families

NCTSN The National Child Traumatic Stress Network

The National Child Traumatic Stress Network

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) brings a singular and comprehensive focus to childhood trauma. NCTSN's collaboration of frontline providers, researchers, and families is committed to raising the standard of care while increasing access to services. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and dedication to evidence-based practices, the NCTSN changes the course of children's lives by changing the course of their care.

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12 Core Concepts for Understanding Traumatic Stress Responses in Childhood

1. Traumatic experiences are inherently complex.

Every traumatic event—even events that are relatively circumscribed—is made up of different traumatic moments. These moments may include varying degrees of objective life threat, physical violation, and witnessing of injury or death. Trauma-exposed children experience subjective reactions to these different moments that include changes in feelings, thoughts, and physiological responses; and concerns for the safety of others. Children may consider a range of possible protective actions during different moments, not all of which they can or do act on. Children's thoughts and actions (or inaction) during various moments may lead to feelings of conflict at the time, and to feelings of confusion, guilt, regret, and/or anger afterward. The nature of children's moment-to-moment reactions is strongly influenced by their prior experience and developmental level. Events (both beneficial and adverse) that occur in the aftermath of the traumatic event introduce additional layers of complexity. The degree of complexity often increases in cases of multiple or recurrent trauma exposure, and in situations where a primary caregiver is a perpetrator of the trauma.

2. Trauma occurs within a broad context that includes children's personal characteristics, life experiences, and current circumstances.

Childhood trauma occurs within the broad ecology of a child's life that is composed of both child-intrinsic and child-extrinsic factors. Child-*intrinsic* factors include temperament, prior exposure to trauma, and prior history of psychopathology. Child-*extrinsic* factors include the surrounding physical, familial, community, and cultural environments. Both child-intrinsic and child-extrinsic factors influence children's experience and appraisal of traumatic events; expectations regarding danger, protection, and safety; and course of posttrauma adjustment. For example, both child-intrinsic factors such as prior history of loss, and child-extrinsic factors such as poverty may act as vulnerability factors by exacerbating the adverse effects of trauma on children's adjustment.

3. Traumatic events often generate secondary adversities, life changes, and distressing reminders in children's daily lives.

Traumatic events often generate secondary adversities such as family separations, financial hardship, relocations to a new residence and school, social stigma, ongoing treatment for injuries and/or physical rehabilitation, and legal proceedings. The cascade of changes produced by trauma and loss can tax the coping resources of the child, family, and broader community. These adversities and life changes can be sources of distress in their own right and can create challenges to adjustment and recovery. Children's exposure to trauma reminders and loss reminders can serve as additional sources of distress. Secondary adversities, trauma reminders, and loss reminders may produce significant fluctuations in trauma survivors' posttrauma emotional and behavioral functioning.

4. Children can exhibit a wide range of reactions to trauma and loss.

Trauma-exposed children can exhibit a wide range of posttrauma reactions that vary in their nature, onset, intensity, frequency, and duration. The pattern and course of children's posttrauma reactions are influenced by the type of traumatic experience and its consequences, child-intrinsic factors including prior trauma or loss, and the posttrauma physical and social environments. Posttraumatic stress and grief reactions can develop over time into psychiatric disorders, including posttraumatic stress disorder (PTSD), separation anxiety, and depression. Posttraumatic stress and grief reactions can also disrupt major domains of child development, including attachment relationships, peer relationships, and emotional regulation, and can reduce children's level of functioning at home, at school, and in the community. Children's posttrauma distress reactions can also exacerbate preexisting mental health problems including depression and anxiety. Awareness of the broad range of children's potential reactions to trauma and loss is essential to competent assessment, accurate diagnosis, and effective intervention.

5. Danger and safety are core concerns in the lives of traumatized children.

Traumatic experiences can undermine children's sense of protection and safety, and can magnify their concerns about dangers to themselves and others. Ensuring children's physical safety is critically important to restoring the sense of a protective shield. However, even placing children in physically safe circumstances may not be sufficient to alleviate their fears or restore their disrupted sense of safety and security. Exposure to trauma can make it more difficult for children to distinguish between safe and unsafe situations, and may lead to significant changes in their own protective and risk-taking behavior. Children who continue to live in dangerous family and/or community circumstances may have greater difficulty recovering from a traumatic experience.

6. Traumatic experiences affect the family and broader caregiving systems.

Children are embedded within broader caregiving systems including their families, schools, and communities. Traumatic experiences, losses, and ongoing danger can significantly impact these caregiving systems, leading to serious disruptions in caregiver-child interactions and attachment relationships. Caregivers' own distress and concerns may impair their ability to support traumatized children. In turn, children's reduced sense of protection and security may interfere with their ability to respond positively to their parents' and other caregivers' efforts to provide support. Traumatic events—and their impact on children, parents, and other caregivers—also affect the overall functioning of schools and other community institutions. The ability of caregiving systems to provide the types of support that children and their families need is an important contributor to children's and families' posttrauma adjustment. Assessing and enhancing the level of functioning of caregivers and caregiving systems are essential to effective intervention with traumatized youths, families, and communities.

7. Protective and promotive factors can reduce the adverse impact of trauma.

Protective factors buffer the adverse effects of trauma and its stressful aftermath, whereas *promotive* factors generally enhance children's positive adjustment regardless of whether risk factors are present. Promotive and protective factors may include *child-intrinsic* factors such as high self-esteem, self-efficacy, and possessing a repertoire of adaptive coping skills. Promotive and protective factors may also include *child-extrinsic* factors such as positive attachment with a primary caregiver, possessing a strong social support network, the presence of reliable adult mentors, and a supportive school and community environment. The presence and strength of promotive and protective factors—both before and after traumatic events—can enhance children's ability to resist, or to quickly recover (by resiliently "bouncing back") from the harmful effects of trauma, loss, and other adversities.

8. Trauma and posttrauma adversities can strongly influence development.

Trauma and posttrauma adversities can profoundly influence children's acquisition of developmental competencies and their capacity to reach important developmental milestones in such domains as cognitive functioning, emotional regulation, and interpersonal relationships. Trauma exposure and its aftermath can lead to developmental disruptions in the form of regressive behavior, reluctance, or inability to participate in developmentally appropriate activities, and developmental accelerations such as leaving home at an early age and engagement in precocious sexual behavior. In turn, age, gender, and developmental period are linked to risk for exposure to specific types of trauma (e.g., sexual abuse, motor vehicle accidents, peer suicide).

9. Developmental neurobiology underlies children's reactions to traumatic experiences.

Children's capacities to appraise and respond to danger are linked to an evolving neurobiology that consists of brain structures, neurophysiological pathways, and neuroendocrine systems. This "danger apparatus" underlies appraisals of dangerous situations, emotional and physical reactions, and protective actions. Traumatic experiences evoke strong biological responses that can persist and that can alter the normal course of neurobiological maturation. The neurobiological impact of traumatic experiences depends in part on the developmental stage in which they occur. Exposure to multiple traumatic experiences carries a greater risk for significant neurobiological disturbances including impairments in memory, emotional regulation, and behavioral regulation. Conversely, ongoing neurobiological maturation and neural plasticity also create continuing opportunities for recovery and adaptive developmental progression.

10. Culture is closely interwoven with traumatic experiences, response, and recovery.

Culture can profoundly affect the meaning that a child or family attributes to specific types of traumatic events such as sexual abuse, physical abuse, and suicide. Culture may also powerfully influence the ways in which children and their families respond to traumatic events including the ways in which they experience and express distress, disclose personal information to others, exchange support, and seek help. A cultural group's experiences with historical or multigenerational trauma can also affect their responses to trauma and loss, their world view, and their expectations regarding the self, others, and social institutions. Culture also strongly influences the rituals and other ways through which children and families grieve over and mourn their losses.

11. Challenges to the social contract, including legal and ethical issues, affect trauma response and recovery.

Traumatic experiences often constitute a major violation of the expectations of the child, family, community, and society regarding the primary social roles and responsibilities of influential figures in the child's life. These life figures may include family members, teachers, peers, adult mentors, and agents of social institutions such as judges, police officers, and child welfare workers. Children and their caregivers frequently contend with issues involving justice, obtaining legal redress, and seeking protection against further harm. They are often acutely aware of whether justice is properly served and the social contract is upheld. The ways in which social institutions respond to breaches of the social contract may vary widely and often take months or years to carry out. The perceived success or failure of these institutional responses may exert a profound influence on the course of children's posttrauma adjustment, and on their evolving beliefs, attitudes, and values regarding family, work, and civic life.

12. Working with trauma-exposed children can evoke distress in providers that makes it more difficult for them to provide good care.

Mental healthcare providers must deal with many personal and professional challenges as they confront details of children's traumatic experiences and life adversities, witness children's and caregivers' distress, and attempt to strengthen children's and families' belief in the social contract. Engaging in clinical work may also evoke strong memories of personal trauma- and loss-related experiences. Proper self-care is an important part of providing quality care and of sustaining personal and professional resources and capacities over time.

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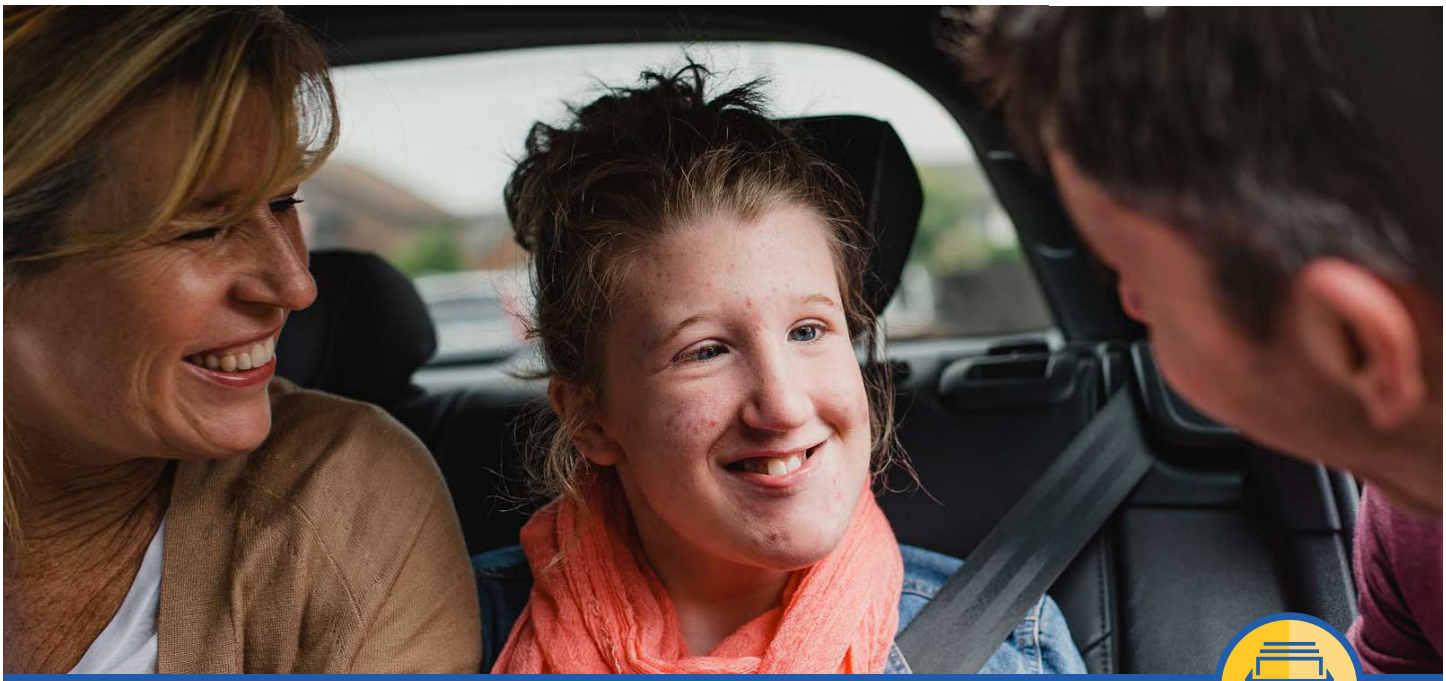

The Impact of Trauma on Youth with Intellectual and Developmental Disabilities: A Fact Sheet for Providers

Approximately one in six youth between the ages of 3 and 17 in the United States have an intellectual or developmental disability, as signified by major delays or difficulty in functioning in one or more key developmental areas. These areas may affect thinking and learning, language, motor skills, behavior, and adaptive functions such as self-care, communication, and social skills. Intellectual and developmental disabilities (IDD) affect functioning throughout a person's lifetime. They leave youth more vulnerable to a range of behavioral, social, and emotional difficulties, and to co-occurring medical and mental health disorders. In particular, youth with IDD are at risk for traumatic experiences in the home, school, and community and sometimes in conjunction with their frequent healthcare encounters.

Early intervention in childhood may reduce the impact of some types of disabilities. However, gaps in services for youth are leaving their mental health needs grossly underserved, especially with respect to trauma-informed care. There are many reasons for this, including provider misconceptions about IDD and trauma, siloed service systems, and specific challenges (e.g., deficits in speech, language, cognition, etc.) that may make it more difficult for youth with IDD to report traumatic experiences or internal distress. We developed this fact sheet for professionals across diverse practice settings (health, behavioral health, school, child welfare, juvenile justice) to increase understanding of trauma in youth with IDD. The overarching goal is to reduce service gaps and promote recovery and resilience.

Terms of IDD

Intellectual disabilities (ID) are conditions in which there is significant, persistent impairment in both thinking skills and everyday adaptive functioning such as self-care, communication, and social skills.

Developmental disabilities (DD) are disabilities with a pervasive impact, such as Autism Spectrum Disorder, cerebral palsy, Down syndrome, brain injury, and intellectual disabilities; DD may also be more focused in impact, such as a specific learning disability.

Youth with intellectual and developmental disabilities (IDD) are more vulnerable to a range of behavioral, social, and emotional difficulties throughout life, and many have co-occurring disorders, including those related to trauma exposure.

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1 IDD and Trauma

Youth with IDD are at increased risk for various types of traumatic experiences. These experiences include physical and emotional neglect, physical and sexual abuse, as well as trauma secondary to restrains and seclusion, and other interventions used to contain a youth who is presenting with behavior that is a danger to themselves or others. Youth with IDD are also more likely to experience changes in educational placements and school settings, out-of-home placements (at times accompanied by parental loss) and changes in residential placements if placed outside of the home. As a result, they are more likely to experience disruptions in social supports. They are also at heightened risk for teasing, bullying, rejection, and exploitation by peers and social media. This risk is further compounded for individuals vulnerable to discrimination due to their race, ethnicity, language, and socioeconomic status. Youth with more severe IDD are likely to experience a higher number of health-related procedures, as they often have chronic or comorbid conditions that necessitate surgeries, other invasive procedures, and frequent healthcare appointments. Such disruptions may put youth with IDD at risk for medical trauma. Nonetheless, trauma exposure and symptomatology are believed to be underreported for several reasons. As noted, some youth may be unable to communicate their experiences or distress to caregivers and professionals, who may themselves have limited understanding of trauma and trauma-related symptoms, and may attribute trauma-related behavior to the developmental condition alone. Such misattribution may delay or prevent needed services and contribute to or compound a youth's functional difficulties.

2 IDD, Communication, and Trauma-Related Behavior

Behavior is a form of communication for all youth. Youth with IDD may have difficulty with cognitive processing, reasoning, problem solving, and coping skills, as well as language and communication challenges, will often communicate their needs through their behavior. The more severe the IDD, the more likely they are to use behavioral indicators versus verbal expressions in the home, at school, in the medical examining room, or in the therapy office. Providers should be alert to behavioral indicators such as developmental regression, social withdrawal or isolation, reduced self-care, increase in disorganized and dysregulated behavior, aggression, and self-injury.

Crisis stabilization and management

For some youth with IDD, the first sign that a trauma has occurred may be a significant regression in skills or escalation of behavior difficulties. Youth experiencing these changes will often need stabilization interventions before more conventional trauma treatment can take place. However, it is critical that such interventions be trauma-informed as well, and implemented by trauma-informed providers.

3 IDD and Systems of Care

Mental health services and IDD-focused services have traditionally been provided through separate and parallel systems of care – a siloed approach, rather than collaborative service delivery involving shared recognition, accountability, and decision-making. The lack of intersystem planning and coordination has resulted in obstacles to mental health and trauma-informed care, within both the mental health and IDD sectors.

- In the mental health system, there may be reluctance to treat youth with IDD such as Intellectual Disability or Autism Spectrum Disorder; this likely stems from both the providers' lack of knowledge that youth with IDD can benefit from trauma treatment, and the providers' lack of expertise in implementing the appropriate care.

- In the IDD field, the tendency is to rely on behavior management instead of approaches that would better help youth process and recover from traumatic experiences.

- In the trauma field, providers often lack familiarity or experience working with youth with IDD.

Overcoming these obstacles within each sector requires greater understanding of the trauma-related needs of youth with IDD. Across sectors, there is equally pressing need for improved communication, collaboration, and sharing of resources by providers and systems.

The Trauma-Informed Agency

The Substance Abuse and Mental Health Services Administration (SAMHSA) has defined trauma-informed programs, organizations, and systems as those that:

Recognize the signs and symptoms of trauma in youth, families, staff, and others involved

Realize the widespread impact of trauma and understand potential paths for recovery

Respond by fully integrating knowledge about trauma into policies, procedures, and practices

Seek to actively resist re-traumatization

4 Screening and Assessment

The screening and assessment of trauma exposure is an essential component of a comprehensive mental health evaluation and plan for all youth with IDD. Providers should seek consultation when needed for interpreting prior cognitive or neuropsychological assessments in order to understand each youth's developmental status, cognitive readiness, communication level, and need for assistive communication. Due to intellectual, language, or communication deficits, assessment of trauma in youth with IDD is rarely considered in assessment or clinical care. Moreover, when trauma is considered, providers tend to rely on caregiver reports to the exclusion of the youth's input. There is a pressing need to incorporate trauma event and symptom checklists into screening and assessment protocols. Health care providers should strive to begin by just "asking the question." It is also important to include reports from multiple informants when possible, including the youth with IDD if possible, and, to the extent they are available, to use trauma measures that are adapted to self-report by youth with IDD.

5 Diagnostic Considerations

The differential diagnosis of trauma-related disorders in youth with IDD has been problematic because many trauma-related symptoms can mirror behavior seen with IDD. Diagnostic "overshadowing" refers to the process of over-attributing an individual's symptoms to a particular condition (in this case, IDD), resulting in key co-morbid conditions being undiagnosed and untreated. Due to this overshadowing, professionals fail to look beyond a youth's disability and overlook additional factors such as exposure to trauma. To overcome these biases, providers are encouraged to look carefully at behavior changes in particular, and should verify the changes with caregivers across multiple settings. If there is documented behavior change, providers should look at events surrounding the change and consider trauma as a possible contributing factor, particularly if evidence supports this view.

6 Treatment

Standard trauma-informed mental health treatments can be effective for most youth with IDD and trauma exposure (although more research is needed for those with severe difficulties). A growing number of providers with experience delivering evidence-based trauma interventions are already treating youth with IDD by making flexible adaptations with fidelity to the original trauma protocol. The degree of support that clinicians may need depends on their understanding of IDD issues and trauma care, as well as their comfort and confidence in tailoring treatment to this population. Some adjustments reported as helpful focus on:

- Session length and frequency (shorter sessions, more frequent sessions); length of treatment (more sessions), and slower pacing of content.
- Parent or caregiver involvement including increased time in youth sessions; increased time in parent/caregiver sessions; family sessions that include the youth, siblings, and parents; and between-session communications.
- Treatment content such as repetition and rehearsal of skills; use of sensory aids, use of individualized teaching materials; alternative modes of expression such as art; and measuring change in smaller and more gradual increments.
- Treatment structure including increased structure; more session (movement) breaks; use of enhanced engagement strategies (e.g., play rewards); more time on non-trauma-related issues; concrete presentations; plain language; simplified and reduced reliance on cognitive strategies as well as checks for understanding.

"We Needed Help as Much as Our Daughter Did"

Parenting a youth with IDD can be extraordinarily stressful. Against a background of day-to-day stressors, caregivers cope with social burdens such as stigma associated with IDD and mental health; emotional strain from worry about the future; excessive demands on the family unit and family members; strain on the marriage; and financial pressure. With the added element of traumatic stress, families will need support for increasing the youth's sense of safety, assuring family stability, and maintaining the health and well-being of each family member.

Caregivers and families need to be validated on their unique struggles, and to understand how essential they are to the youth's effective assessment and treatment. This is the case for all youth with traumatic stress but particularly for those with IDD. Providers rely heavily on parent or caregiver reports of the youth's experiences and functional changes. In support of caregivers, providers should offer them education on how they can help with the recovery process of their youth, themselves, and the family. Further, providers may need to educate families about the behavioral and emotional changes associated with trauma exposure, and connect them with sources for individual support or mental health care.

7 Resilience and Recovery

The recovery process is unique for each individual with IDD and trauma. The process is best reinforced by validation of the trauma, support of the youth and family, and reliance on youths' and families' existing strengths. Using a trauma-informed approach by trying to determine "what happened" to the youth instead of "what's wrong" with the youth is a helpful first step. Parents, teachers, and clinicians may need to work extra hard in building or rebuilding a trusting relationship; moreover, clinicians should advocate for the individual to have more time with caregivers who have established trusting relationships. Exploring special talents, interests, or activities of the youth or family, and ensuring increased time in these activities, may help to lessen the impact of trauma and hasten the recovery process. An emphasis on youth and family routines and rituals is another step toward validation and normalization. Helping the youth and family to gain meaning out of their shared experience and recovery is critical for the youth and family to heal.

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Children with Intellectual and Developmental Disabilities Can Experience Traumatic Stress

A Fact Sheet for Parents and Caregivers

The Intersection of IDD, Trauma, and Mental Wellness

Studies[1] indicate that children with intellectual and developmental disabilities (IDD) experience trauma and stressful circumstances or events at higher rates than children without these disabilities. For caregivers, including parents, family members, and others who support children with IDD, awareness of the impact of trauma on their children's mental health and wellness can greatly improve a child's opportunities for recovery from a traumatic or stressful experience. This fact sheet is designed to provide an overview of IDD and trauma and to:

- Help caregivers understand issues related to trauma and its impact on children with IDD and their families.
- Provide caregivers with information and resources that can help them improve the well-being of children with IDD who have experienced trauma.
- Help caregivers know the questions they should ask about traumatic stress and the treatments, services, and supports to expect for children and families.
- Promote awareness of the need to address the mental health and wellness of children with IDD.

With this guidance, we hope that caregivers will be able to better access services and advocate for their child.

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1 What Are Intellectual and Developmental Disabilities?

Intellectual and developmental disabilities is an umbrella term that refers to intellectual disabilities and also other disabilities that are apparent during childhood. Developmental disabilities appear before early adulthood and are likely to impact an individual across the life span. Some developmental disabilities are largely physical conditions, such as cerebral palsy or epilepsy. Some children may have co-occurring physical and intellectual disabilities, for example, Down syndrome or fetal alcohol syndrome.

An intellectual disability is one type of developmental disability that impacts intellectual functioning, often thought of as "intelligence," and adaptive behavior, or how a person functions in everyday life. Intellectual functioning generally refers to mental abilities such as learning, reasoning, and problem solving. Adaptive behavior relates to the social and life skills that we use in our everyday lives, such as language, time, money management, self-direction, the ability to follow rules, personal care, schedules and routines, safety, occupational skills, and much more.

2 How Does Trauma Impact Children with IDD?

Trauma is an upsetting, stressful event or series of events that causes a child to feel at risk for physical or emotional harm. Children respond to traumatic events differently depending on their personal sense of safety. Accordingly, children with IDD may be exposed to the same types of trauma as any other child but may experience and process the trauma differently and therefore may respond differently. Further, due to their dependence on others for assistance and security, children with IDD may also have an increased trauma response to any threat to the safety of caregivers.

Studies show that children with IDD experience childhood adversities and trauma at much higher rates than children without disabilities. In addition to major traumatic events such as physical or sexual abuse, neglect, natural disasters, or witnessing violence, children and youth with IDD are also exposed to everyday life traumatic events like bullying, name calling, social exclusion, lack of attention, abandonment or isolation, rejection, or even the embarrassment of "looking" or feeling different. Repeated exposure to these less visible traumatic events can have deep and lasting impacts.

> *"When I was in a bad car accident, I never imagined it would traumatize my son. When I returned from my hospitalization my son refused to leave my side, transitions to school and work were difficult, and he started having difficulty sleeping. I didn't connect the dots about the behavior and the trauma of my absence until I talked to another parent who had a similar experience."*
>
> – Parent of a child with IDD

3 Why are Children with IDD at Higher Risk for Trauma Exposure?

Children with IDD have characteristics and experiences that put them at higher risk for trauma. These risk factors include varied cognitive abilities, physical limitations, and reduced communication skills. Specifically,

- Communication and language barriers can make it harder for the child to tell others what is going on. Often, changes in behavior that may be symptoms of trauma can be mistakenly attributed to a child's disability.

- Children with IDD are more often exposed to repeated medical procedures and hospitalizations. These may entail pain, stress, and fear.
- Children with IDD often have multiple caregivers (home-care workers, residential staff, family members, and school staff, among others), some of whom may exploit them and cause repeated trauma with long-term consequences.
- Children with IDD are less likely to be believed due to their disability.
- Simply being viewed as different may increase the risk for trauma.

Some of these factors can also make it difficult for others to recognize that a child has experienced trauma, or that the child has not processed the trauma. The impacts of trauma on children with IDD can be significant and long-term if trauma is not recognized. The impact may include: changes in behavior (for example, increased irritability, loss of previously acquired skills, new fears, bed-wetting, and avoiding previously enjoyed activities or people) and trauma-related mental health conditions (for example, anxiety, PTSD, and depression). Unfortunately, children with IDD may not be believed when they tell others about traumatic events, may not know how to protect themselves, or may be easily influenced by others. Further, they may not be considered credible witnesses when reporting trauma.

> *"After my son experienced a traumatic event at school, he began displaying new behaviors with staff. The educators and behavioral specialists insisted that it was simply 'bad' and increased 'typical IDD' behavior. They missed the connections between the trauma my son experienced and the way he was behaving. They didn't recognize his need for safety and some control over his life."*
> – Foster parent of a child with IDD

4 Caregivers are Partners in Trauma Services

Caregivers know their children best and know when something seems "off." Caregivers can support their children in healing from trauma by listening to their child and partnering with trauma-informed providers. Caregivers are key in future safety and recovery from trauma. Partnership with trauma-informed providers should include a plan for caregiver wellness and safety.

> *"Parents and other caregivers need help in understanding the impact of trauma and the resulting mental health needs of our children with IDD. We need to know the right questions to ask and the appropriate treatment and services to expect. It is when our expectations for appropriate supports change, that appropriate mental health and trauma services will become available; the supply will begin to meet the demand."* – Parent of a child with IDD

References

1. Brendli, K.R., Broda, M.D., and Brown, R. (2021). Children with intellectual disability and victimization: A logistic regression analysis. Child Maltreatment. https://doi.org/10.1177/1077559521994177

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