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BEHAVIOR ASSESSMENT TRAINING

TOOLKIT TOPIC 6

Understanding and Addressing the Impact of Childhood Trauma and Other Adverse Circumstances on Behavior

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TOPIC 6

Understanding and Addressing the Impact of Childhood Trauma and Other Adverse Circumstances on Behavior

EXECUTIVE SUMMARY

Childhood trauma, whether from single incidents or sustained stress, has lasting effects on physical and mental health in that it impacts behavior and learning. Trauma-sensitive practices in schools are crucial for supporting affected students. Understanding trauma's origins and its manifestation in behavior can enable the use of empathetic, skill-building approaches to mitigate its impact, fostering academic success and emotional well-being.

INTRODUCTION

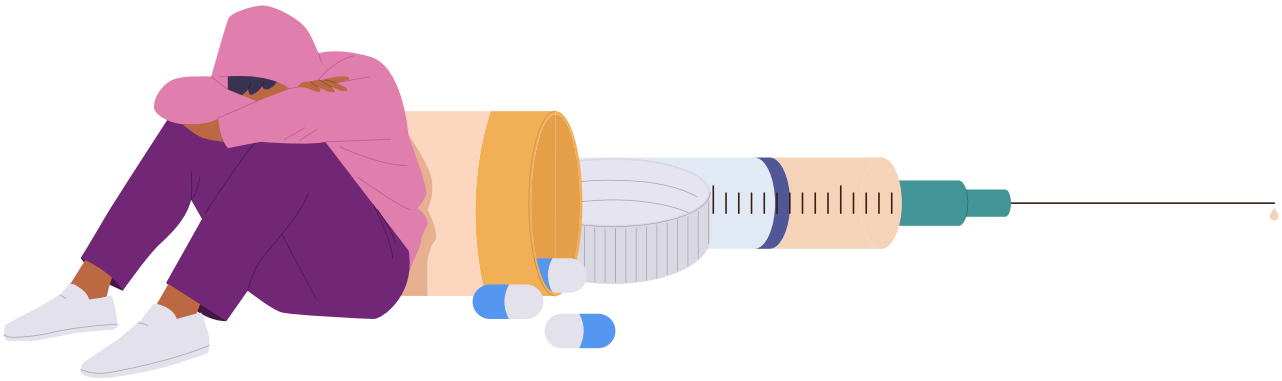
Chronic stress and trauma cause children to view the world as an unsafe place where nobody will protect them. Additionally, the Adverse Childhood Experiences Survey reported that elevated levels of childhood trauma have lasting impacts into adulthood, including higher rates of heart disease, liver disease, lung disease, human immunodeficiency virus *(*HIV), and sexually transmitted diseases.[i] Lasting impacts include an increased risk of drug abuse, alcohol abuse, and self-mutilation behaviors. Schools can mitigate the effects of chronic stress and trauma by using trauma-sensitive practices. This requires a shift in how schools perceive and react to student behavior.

Elevated levels of childhood trauma have lasting impacts into adulthood.

TRAUMA DEFINED

There is no simple definition of trauma, which is somewhat fitting given that traumatic events are often nuanced and complicated. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma as "an event, series of events, or set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being."[ii](SAMHSA, 2012, p. 2).

Traumatic events can be classified as Type 1, meaning a single incident, or Type 2, meaning a complex developmental trauma sustained over time. Type 2 traumas usually occur



in childhood, involving someone with whom the child is in a close relationship and where escape is perceived as difficult or impossible.

Traumatic events are also categorized as “Big T” events, which are life-threatening events like war, rape, and torture, and “Little T” events, which are stressful events like bullying, neglect, and exposure to violence.

All these traumatic events can affect our physiology and neurology. It also is important to note that “it is not the objective facts that determine whether an event is traumatic, but the person’s subjective emotional experience. The more frightened and helpless one feels, the more likely they have been traumatized”[iii] (The Arc, 2011, p. 1).

IMPACTS ON BRAIN DEVELOPMENT

Trauma to developing brains alters brain development, creating physical alterations in the brains and bodies of those who have experienced it. Many children carry the traumatic experience into all other life experiences. It becomes a lens through which all sensory data is filtered, a framework for understanding the reality that the individual cannot simply turn off, outgrow, or otherwise “get over.” A student who has experienced significant trauma continues to experience and reenact that trauma until they are provided with the support and tools required to address it. Trauma-based behaviors often can mimic mental health disorders, like obsessive behavior, paranoia, or schizophrenia. In reality, students may be dealing with a form of post-traumatic stress disorder (PTSD) and should be treated by educators

as such. For those experiencing PTSD, the initial trauma is still going on. However, they are experiencing "reality" differently than those around them.

PTSD can look like the following:

- Distortion of their perceptions of people and events.
- Their body is on the lookout for danger (triggers).
- Stimuli response levels are engrained (too much or too little).
- Limited capacity for flexible thinking and creative problem-solving.
- Physical discomfort symptoms.

In the classroom, traumatized children may appear defiant, overprotective, overly reliant on adults, or distant from peers and adults.[iv] In addition, individuals who have experienced trauma can exhibit behaviors that can be disruptive in school settings and can include property destruction, noncompliance, aggression, or escape behaviors.

In school, trauma can look like the following:

- Attention problems
- Executive functioning problems
- Diminished language competency
- Behavioral dysregulation
- Anxiety, depression, self-injurious behaviors
- Learning issues
- Social skills difficulties
- Non- or over-compliance
- Dissociation

TRAUMA AND YOUNG CHILDREN

Children have less power and control over their lives than adults; young children perceive different events as life-threatening. Early childhood trauma occurs between birth and 6 years of age.[v] In the past, the assumption was that young children were somewhat protected from the full impact of trauma because of their age, but research has shown that this is

not the case.[vi] Young children are aware of frightening visual stimuli, noises, and movements often experienced during unpleasant events. They are highly reliant on their caregivers for survival and protection. When this protection is not provided during traumatic events, they cannot anticipate danger and keep themselves safe.

When educators can focus on their own self-regulation, as opposed to the student's, it can have a big impact. A calm demeanor, soft voice, and postural and proximal cues (lowering one's body, providing space for a dysregulated student, deliberately assuming non-confrontational poses, etc.) can provide a sense of security that enables to student to articulate their sensations and emotions rather than acting upon them.

Young children respond to trauma differently than older children and adults. Young children do not have a fully developed understanding of reality or cause and effect. They may "believe their thoughts, wishes, and fears have the power to become real and can make bad things happen" (National Childhood Trauma Stress Network (NCTS), n.d., p. 1). These factors, combined with their developing language skills, mean they cannot often clearly explain a traumatic event. Also, the ongoing nature of some traumatic events may result in the child believing abuse or neglect is normal. Young children's rapidly developing brains are highly vulnerable to trauma and chronic stress caused by repeated abuse and neglect. These children's brains present with a smaller cortex, the area of the brain responsible for "memory, attention, perceptual awareness, thinking, language, and consciousness" (NCTS, n.d., p. 1).

Deficits in these areas may impact the child's IQ and create difficulty with emotional regulation. Chronic stress also alters the brain's chemistry, increasing cortisol and adrenaline. Cortisol can be protective in true life-or-death situations, according to the Attachment and Trauma Network.[vii] In situations of chronic stress, where it is continuously released, it has corrosive effects and can damage or kill neurons in critical regions of the brain.[viii] This then leads to overuse of the child's fight, flight, freeze, and fawn responses. When trauma occurs in early childhood, the child may be unable to describe their experiences accurately. Caregivers may not be aware of a child's trauma and thus do not realize these behaviors are trauma responses; instead, they are categorized as "challenging behaviors" to be managed or eliminated. This belief dramatically changes how caregivers respond to the child. Caregivers who do not recognize behaviors as trauma responses will try to eliminate the undesired behavior instead of focusing on providing comfort and support to the child.

IMPORTANCE OF ATTACHMENT

Healthy attachment to a caregiver is crucial for early childhood development. In the attachment cycle, an infant feels a need and then expresses the need. The caregiver responds in a loving, supportive manner and meets that need. When this occurs repeatedly, the infant develops a healthy emotional attachment to the caregiver. This attachment plays a considerable role in a child's emotional/mental health.[ix] When this cycle does not consistently occur, an infant becomes distressed and helpless; the more chronically an infant's needs are unmet, the more stress hormones are released, impacting brain development. Infants with unmet needs develop disordered attachment, which causes them to be viewed as overly independent, withdrawn, or clingy. The child also may present with prominent levels of anger or rage. When a caregiver attempts to soothe the infant through "typical" strategies, such as holding or feeding them, the infant rejects the efforts, further damaging the attachment relationship. As the child grows, their attempts to survive result in them attempting to control every aspect of their life. They also may have strong trauma triggers to certain stimuli or situations. Because these traumas occur so early in life, they are considered "state memories" or "memories that reside in the child's mid-brain and impact the way they react to the world with little or no understanding of why they react the way they do" (Attachment and Trauma Network (ATN), 2020, p. 2.).

PREVALENCE AND DISABILITY

Children and youth with disabilities are more likely to experience traumatic events than their non-disabled peers. For example, McDonnell et al.[x] found that children with autism spectrum disorder and learning disabilities have higher risks for maltreatment than their peers without disabilities, and children with autism are three or four times more likely to be bullied (40-90% of children with autism, compared to 40% of neurotypical children). In addition, youth with autism have more than double the risk of youth protective services referrals – but reports are less likely to be investigated.[xi] Furthermore, the Spectrum Institute[xii] (move endnote to end of sentence?) found that 70% of respondents with disabilities reported being victims of abuse; of those, 90% had experienced abuse multiple times.

Trauma is often expressed behaviorally and emotionally rather than cognitively.

Trauma is often expressed behaviorally and emotionally rather than cognitively. Trauma can result in significantly increased aggression rates, self-injurious behaviors, and psychological stress. For those with severe/profound intellectual disability, the key signs of abuse included

a “deterioration of adaptive skills and behavior immediately following the abuse.”[xiii] Beyond traumatic events, the experience of living with a significant disability can lead to experiences perceived as traumatic. Some leading causes of this are:

- Limited self-determination skills
- Limited emotional regulation skills
- Not able to predict harm as easily
- Needing support from others
- Feeling different

SIGNS OF TRAUMA

Children and youth with disabilities may struggle to verbalize their experiences, so caregivers should watch for nightmares, new fears, and reenactments of traumatic events in play.[xiv] In addition, signs of trauma may vary by the child's age at the time of exposure. According to the ATN and National Child Traumatic Stress Network, n. d.,[xv] common symptoms of trauma in young children may include the following:

Infants and Toddlers (birth–age 2)

- Poor verbal skills for age
- Memory difficulties
- Excessive screaming and crying
- Appetite issues (poor appetite)
- Low weight

Preschool-Age Children (ages 3–6)

- Difficulties focusing or learning
- Poor or delayed skill development
- "Acting out" in social situations
- Reenactment or imitation of traumatic events
- Verbal abuse of others
- Physical abuse of others
- Difficulty forming and maintaining friendships with peers
- Unable to trust others
- Feel they are to blame for a traumatic event
- Display a lack of self-confidence
- Struggle to focus on tasks
- Hyperfocus (excessive focus) on traumatic events
- Hypervigilance and hyperarousal (may be mistaken for ADHD symptoms)
- Somatic symptoms (headache, stomachache)

Elementary School-Age Children[xvi]

- Withdrawal from activities, peers, and adults
- An increase in nightmare frequency
- Somatic symptoms (headache, stomachache)
- Discussing traumatic events
- Mood swings
- Increased levels of fear, like being more easily startled
- Learning delays
- Immature or regressive behavior
- Aggressive play
- Exploring or reenacting a traumatic event through art
- Verbal abuse of others
- Physical abuse of others
- Difficulty forming and maintaining friendships with peers
- Inability to trust others

Middle School-Age Children[xvii]

Changes in behavior

Withdrawal from activities, peers, and adults

Outbursts of anger and irritability with others

Emotional numbness

Somatic symptoms (headache, stomachache)

Expresses fear and anxiety for themselves and others

Extreme responses to loud noises and other sensory experiences

Less able to concentrate

Verbal abuse of others

Physical abuse of others

Difficulty forming and maintaining friendships with peers

Unable to trust others

High School-Age Children[xviii]

Refusals to participate in discussions or raise their hand

Struggles to recall information

Somatic symptoms (headache, stomachache)

Withdrawing from peers and adults

Lack of engagement

Submits assignments that are incomplete

Does not turn in assignments at all

Difficulty focusing

Verbal abuse of others

Physical abuse of others

Difficulty forming and maintaining friendships with peers

Unable to trust others

DISCIPLINE RESPONSES AS TRAUMATIC EVENTS

Sometimes schools' responses to student behavior can themselves be traumatic events. Examples of this can include:

- Negative interactions with trusted adults
- Contact with law enforcement
- Seclusion
- Restraint
- Suspension and expulsion
- Incarceration
- Isolation

TRAUMA-INFORMED PRACTICES

Trauma-informed practices are not a specific set of actions but rather a set of services, supports, and principles rooted in empathy.[xix] Trauma-informed practices shift the focus of interventions from "What's wrong with you?" to "What happened to you?"

- Consider the youth's learning profile
- Be sensitive to the youth's stress-response style (fight, flight, freeze)
- A direct approach to stress response — validation and modification, not "don't worry"
- Remember, when youth go into survival mode, they cannot access higher-level skills like language
- Avoid isolated time out and physical restraint
- Teach Skills
- Academic
- Executive functioning
- Social behaviors
- Emotional behaviors
- Ability to identify their emotional state
- Self-advocacy
- Self-regulations skills
- Build resiliency
- Modify the environment and provide support rather than expecting the student to change
- View challenges as problems to be solved
- Help students identify sensory processing/soothing techniques
- Have spaces without "visual noise"
- Present information visually
- Provide options for individual or group work
- Provide explicit expectations for all tasks
- Encourage respect and understanding from peers
- Honor multiple ways to demonstrate understanding
- Have patience for slow processing

NOTES FROM THE FIELD

Mr. Verte on trauma and behavior

The single most reliable constant in three decades of working with students throughout Illinois has been the sheer pervasiveness of trauma across every horizon of my students' experience. Trauma is a force, a gravitational field with the power to twist and buckle the students' perceptions of and reactions to their environment. It is the individual heartbreak and despair of countless untold biographies and the air that marginalized kids breathe from the moment they first draw breath. It is cultural, familial, historical, political, environmental, spiritual, emotional, and profoundly personal. Trauma is the power of suffering to persist regardless of circumstance, so that every encounter and reaction becomes a re-enactment of the original wound.

Because the experience of trauma effectively "freezes" the individual in the moment of the trauma, it has profound effects on the individual's emotional growth and ability to learn. People are often "stuck" in the emotional stage they occupied when the trauma occurred. This mismatch between the apparent stimuli and what may look like a wildly inappropriate or exaggerated response that is often an indication that we are dealing with someone with a post-traumatic stress disorder. That reaction will in turn shape the perceptions of those around them and may result in the application of various psychiatric and behavioral labels that, while they may accurately describe the symptoms the student experiences, utterly fail to analyze or even acknowledge the root of the issue.

This has profound implications for the ability to incorporate and utilize new information, which is the essence of education. It is difficult, if not impossible, to learn or engage in creativity while one's entire body is shrieking out chemical and neurological alarms that trigger perpetual fight/flight/freeze/fawn responses.

The fact that many of our students who have been most impacted by traumatic events have found important levels of social and academic success is a testimony to the effectiveness of trauma-informed pedagogy. This is an approach to working with students with challenging behaviors that assumes a significant likelihood of trauma in the students' experience that may be contributing to their current behavioral profile. It assumes that the student has a valid reason for their response or behavior, even if the reason is not immediately evident to observers or may occur under conditions that do not make rational sense to anyone else.

This does not mean abandoning consequences or boundaries for student behavior that may pose a threat to the student or to others. It does not mean tolerating or ignoring injurious action. It means that, however unacceptable the student's behavior may be, there is a reason (if not a justification) for the student's behavior and emotional state that we are obligated to try and understand, if we are to be an effective ally to the student in addressing and healing the issues that lead to the behavior we're attempting to address. In doing so, we avoid making unwarranted assumptions about the student's mental state or intention (that the student is stubborn, or malicious, or perverse or lazy or manipulative or mentally ill). We can afford them the dignity of both understanding and accountability.

KEY TERMS

Isolation

Involuntary confinement of a student alone in a time out room or other enclosure outside the classroom without a supervising adult in the time out room or enclosure.

Restraint

The restriction by mechanical means, physical holding, or otherwise restricting the movement of a student's limbs, head, or body.

Seclusion

To isolate a student in a room or space that they are physically prevented from leaving. Seclusion spaces and rooms vary between schools and districts. Some schools have makeshift spaces that operate like time out corners.

Self-Management

A collection of strategies designed to increase a student's management and control of their own behavior. These strategies include training the student in self-monitoring, self-evaluation, and self-reinforcement.

Self-Regulation

1. The cognitive component, which is the degree to which children can regulate their own behaviors, are reflective and can plan and think aloud…controlling and remembering on purpose.

2. Social-emotional component is the ability to inhibit and delay gratification.

Trauma-Informed Practices

Set of services, supports, and principles rooted in empathy and recognition that most individuals have experienced some form of trauma in their lives and will show symptoms of their trauma in different ways.

BEHAVIOR INTERVENTION EXAMPLES

ENVIRONMENTAL/ ACTIVITY MODIFICATION

Changing or manipulating the environment in order to promote the use of a desirable behavior or reduce unwanted or challenging behaviors. The teacher sets up the environment for the student to utilize a skill that has been recently taught. Changing the setting to set up the learner for success.

Examples of Environmental Modification:

A student is going to start a writing activity, the teacher purposefully removed the pencil from the student's desk to facilitate communication. The student's need of the pencil and its removal by the teacher promotes the student to ask for a pencil.

BEHAVIOR INTERVENTION EXAMPLES

SENSORY REGULATION

The ability to effectively manage and regulate one's sensory experiences in order to maintain an optimal level of arousal and well-being. It involves the processing and integration of sensory information from the environment and one's own body to respond appropriately and adaptively. When sensory regulation is functioning well, individuals can maintain an optimal level of arousal, attention, and emotional regulation. Some individuals may experience sensory dysregulation, which refers to difficulties in effectively processing and responding to sensory input, leading to challenges in daily functioning and emotional well-being. When sensory regulation is functioning well, individuals can maintain an optimal level of arousal, attention, and emotional regulation. Teaching sensory regulation skills often begins with co-regulation, which involves an adult helping individuals to regulate their sensory experiences. As individuals develop co-regulation skills and become more comfortable with sensory experiences, the focus can shift towards teaching self-regulation techniques and empowering them to independently manage their sensory needs.

Examples of Sensory Regulation:

- **Sensory Breaks:** Providing designated areas or opportunities for students to take sensory breaks when they need to regulate their sensory input. This can include a sensory corner with calming sensory tools like weighted blankets, fidget toys, or sensory bins.

- **Quiet Spaces:** Creating quiet spaces in the classroom where students can retreat when they feel overwhelmed or overstimulated. These spaces can be equipped with soft lighting, comfortable seating, and calming sensory materials.

- **Visual Supports:** Using visual supports such as visual schedules, visual timers, or choice boards to help students anticipate and navigate sensory experiences throughout the day. Visual supports provide a visual structure and support self-regulation.

- **Flexible Seating:** Offering a variety of seating options in the classroom, such as bean bags, wiggle cushions, or standing desks, to accommodate individual sensory preferences and needs. This allows students to choose seating that helps them regulate their sensory input.

- **Sensory Tools:** Providing access to sensory tools and aids that can assist students in regulating their sensory experiences. This may include noise-canceling headphones, stress balls, or sensory-friendly manipulatives.

Non-examples of Sensory Regulation:

Dismissing or disregarding students' sensory needs and not providing appropriate supports or accommodations. Creating an environment with excessive sensory stimuli, such as bright lights, loud noises, or strong smells, without considering the impact it may have on students' sensory regulation. Using punitive measures or disciplinary actions in response to students' sensory reactions or behaviors related to sensory dysregulation. Failing to provide designated spaces or areas where students can go to regulate their sensory input when needed. Maintaining rigid seating arrangements without considering individual students' sensory preferences or needs. This may limit students' ability to regulate their sensory experiences effectively.

BEHAVIOR INTERVENTION EXAMPLES

MUSIC-MEDIATED INTERVENTION (MMI)

Music-Mediated Intervention (MMI) is an approach that utilizes music as a therapeutic tool to address a variety of cognitive, emotional, social, and behavioral goals. It involves the intentional use of music to support and facilitate positive changes in individuals' functioning and well-being. The intervention incorporates songs, melodic intonation, and/or rhythm to support learning or performance of skills/behaviors. It includes music therapy, as well as other interventions that incorporate music to address target skills. MMI should be done in collaboration with a trained music therapist.

Examples of MMI:

- **Emotional Regulation:** Undesirable behaviors often stem from difficulties in emotional regulation. MMI can help learners develop emotional awareness and learn healthy coping strategies. For example, calming music can be used to create a soothing environment, promoting relaxation, and reducing anxiety or agitation that may contribute to undesirable behaviors.

- **Behavior Replacement:** MMI can provide alternative, more appropriate outlets for individuals to express themselves. Engaging in musical activities like drumming or singing can serve as a constructive and expressive means of channeling energy and emotions, redirecting them away from problematic behaviors.

- **Social Skill Development:** Undesirable behaviors can be linked to challenges in social interactions. MMI can be used to enhance social skills by incorporating group music-making activities. These activities foster communication, cooperation, turn-taking, and listening skills. By engaging in collaborative music experiences, individuals can learn appropriate social behaviors and build positive relationships.

- **Sensory Integration:** Some undesirable behaviors may be related to sensory processing difficulties. MMI can provide sensory input and help individuals regulate their sensory systems. For example, rhythmic activities or using different musical instruments can provide sensory stimulation, which can be calming or alerting depending on the individual's needs.

- **Self-expression and Communication:** Undesirable behaviors may arise from difficulties in expressing needs, wants, or emotions. MMI offers a nonverbal and creative platform for self-expression and communication. Songwriting, improvisation, or using lyrics of meaningful songs can help individuals express their thoughts, feelings, and experiences, reducing frustration and the need for challenging behaviors.

- **Reinforcement and Reward Systems:** Music can serve as a powerful reinforcer. In behavior management, MMI can be integrated into reinforcement and reward systems. For example, individuals can earn access to preferred music or engaging in a musical activity after demonstrating appropriate behavior, thereby reinforcing, and promoting positive alternatives to undesirable behaviors.

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Impact of Trauma video:

RESOURCE LINKS

- ISBE Trauma
- ISBE Social and Emotional Learning
- Illinois Child Trauma Coalition
- Prevent Child Abuse Illinois
- Illinois Early Learning Project - Childhood Stress and Trauma

This is not an endorsement nor an exhaustive list of possible resources. Please consult with your individual district, Regional Office of Education, and the Illinois State Board of Education for additional resources. Illinois State Board of Education

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