



# Bullying, Trauma and Children with Developmental Disabilities

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Trauma is a devastating problem for many children, no leEmotional trauma is a byproduct of feeling intense distress or fear. When a person is faced with danger, pain or the threat of pain, is overwhelmed and out of the control of the situation, trauma can result. Trauma and its effects can be devastating for children, including those with developmental disabilities. Unfortunately, the symptoms of children with developmental disabilities (DD) are likely to be dismissed as part of their disability rather than the effects of trauma due to a phenomenon known as diagnostic overshadowing (Reiss, Levitan, & Szyszko, 1982). Yet, experiencing the daily stress, confusion, and powerlessness that often accompany a developmental disability may be traumatic in itself.

Bullying is a potential source of traumatic stress for children with physical or developmental disabilities. According to the U.S. Department of Education, bullying can contribute to lowered academic performance and goals, mood and anxiety disorders, health problems, suicide and self-harm, among other problems (Young, Ne'eman, & Gelser, 2011).

As current bullying rates suggest, having a DD means children are more likely to be targeted for maltreatment. There are several reasons for this. Children with DD are often gullible, making it easier to convince them that victimization is OK or "what friends do" (Greenspan, 2008). The same gullibility also makes it easier to threaten children that they will be in trouble or appear foolish if they report the bullying or abuse. Further, if they do tell, they may not be believed, again due to their DD. And even if they are believed, the incident(s) may not be reported and/or communicated back to the rest of the people working with them on a daily basis.

The problem doesn't end there. Even when incidents of maltreatment or abuse are reported to the appropriate persons, (a) they may not know what to do, including the need to obtain trauma-focused psychotherapy; and (b) the necessary services may not be available. When it comes to traumatic stressors, like bullying, responding immediately and appropriately is essential.

## Bullying Is Stressful and Can Impact the Brain

It's impossible to determine exactly how a child will react to potentially traumatic events or stress such as bullying. Individual risk and resilience factors, as well as the nature of the situation itself, combine to create a unique profile of the bullying and its effects. We do know, however, that given enough repetition or severity of the stressor, anyone can be vulnerable to lasting effects from traumatic stress. Further, the younger the child is when exposed to traumatic stress and fear, the more devastating, pervasive, and long-lasting are the potential neurological effects (DeBellis, 2011).

What are the possible results of being bullied or frightened? When threatened, physiologically, we are flooded with adrenaline and cortisol, preparing us to survive by fighting, fleeing, or freezing. Our cortex, giving us the context of what is happening and allowing us to think rationally, is relatively inactive. Usually, our brain returns to baseline arousal when the danger is over, with little or no neurological change. However, if the fear is intense, and especially if it recurs, neurons start to "wire together" for a more efficient response, and the cycle gets faster and stronger. Soon, just a reminder of the trauma starts the fear cycle, and over time the cycle can start itself with little provocation. Each time, the brain learns the sequence better, making fear responses quicker and more powerful. Repeated exposure to the caustic chemicals of fear can cause actual injury to brain cells (Schore, 2003), and the cortex, with the situational information to override the system, is slower to respond.

Traumatic stress can occur even if you are never victimized. We think of trauma as being caused by dramatic events such as abuse, exposure to violence, warfare, or disasters. However small stressful events can accumulate over time with the same effect as one single, large traumatic event (Sobsey, 1994). Social Pain Overlap Theory suggests that the same nerves convey both physical and emotional pain (Eisenberger & Lieberman, 2011). Individuals who are teased or feel "other" experience that pain as they would the pain of being slapped. Being ostracized or yelled at regularly

would register on the brain the same way as having one's face slapped regularly. Bullying, whether physical or emotional, can have the same effect.

One of the hallmarks of traumatic stress is that it can be reactivated days, months, years, and even decades after a traumatic event. Such recurrences can be extraordinarily upsetting and confusing. Significant traumatic stress means that in moments of being triggered, the brain is "hijacked" by fear, making it hard to evaluate the consequences or control one's actions, which, in the case of DD, may already be difficult.

For example, a child may be reminded of a situation in which he was bullied, abused, or traumatized, and respond as if it were happening now, and shut down, act out or hurt others in panic or anger. Clearly, this can be confusing to parents, teachers, and others who can't see what is triggering the child – after all, nothing appears to be a threat at the moment – and mistakenly interpret the behavior as being willfully disruptive or manipulative. As a result, the child may be trap in a vicious circle of emotional distress, reaction, and possible punishment.

Thus, it is important that traumatic stress in children with DD be recognized as early as possible. Trauma-focused psychotherapy and supportive interventions at home and school, as discussed below, will help children learn that emotions come and go and that they will be nurtured and safe even when triggered by fear. Experiencing safety and self-control despite triggers will build new neural pathways, allow the amygdala to calm down, and trust to be built, helping to prevent panic, aggression, and withdrawal. Engaging their cortexes more quickly, children will be better able to evaluate choices, predict consequences, and manage themselves and their feelings. These experiences will reinforce themselves over time in the brain, just as re-experiencing trauma reinforces anxiety.

Because traumatic stress is so pervasive in large and small ways for children with disabilities, and because trauma-informed care is so simple in its central concepts, it makes sense to use trauma-informed care as a universal precaution for everyone with a developmental disability.

### Trauma-Informed Care

Trauma-informed care is based on the understanding that individual who have experienced trauma may be vulnerable to triggers that traditional service delivery approaches may exacerbate. There are many trauma-informed care models but they all rest on two basic principles: ensuring people feel safe and in control.

When a traumatized individual feels safe and in control the amygdala is calm and higher brain functions such as reasoning are possible. When a traumatized person does not feel safe and in control, the amygdala signals a flood of stress chemicals in the brain, and rational thinking like problem-solving may be impossible in the moment.

All children with DD, but especially those who have experienced bullying, should be treated proactively with the principles of trauma-informed care: feeling safe and feeling in control. The minority who do not have significant traumatic stress will not be harmed by being made to feel safe and in control—all humans want those things. Trauma-informed care should be a priority in IEPs, classroom strategies, and behavior plans. Aversive interventions should be phased out completely. Teachers, school staff, and administrators should be trained in basic approaches and attitudes of trauma-focused mental health.

We should also take advantage of every opportunity to bolster resilience as a means of protecting and strengthening children to prevent bullying, as well as helping to build them back up if bullying has occurred. Some important resilience-building factors include:

- **Autonomy** (knowing what I have control over and how I make things happen)
- **Self-Esteem**
  - Sense of self: likes and dislikes, values, qualities
  - Sense of self-worth: when I feel loved and valued
  - Sense of self-efficacy: how do I affect change?
- **External Support** (people, a pet, a fantasy)
- **Affiliation** (connection to and identification with a cohesive supportive group: church, volunteering, scouts)
- **Positive experiences** with people outside a stressful environment, especially people in authority (Rintoul, 2005)

Offering children basic literacy in emotional health, such as being able to name feelings accurately, understand and describe healthy interpersonal boundaries, and identify the things that provide happiness and meaning for them are building blocks that can be worked in to school curricula as well as the lives of families.

Understanding the impact of bullying and implementing the basic principles of trauma-informed care, as a universal precaution requires a shift in priorities, an emphasis on training, and system collaboration. When this happens, parents, teachers, and administrators will see better outcomes, and most important, children with developmental disabilities can attend school and live life without debilitating stress and fear.

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