Trauma and Developmental Disabilities

"People with DD are more likely to be exposed to trauma AND exposure to trauma makes DD more likely"

While there has been an explosion of information about the impact of traumatic life events and trauma-informed care in the fields of mental health, education, homelessness, and criminal justice, comparatively little has written about these topics related to people with developmental disabilities. Many in the DD field have received little training in psychological trauma. For this reason, the Traumatic Stress Institute is working on an adaption of *Risking Connection* for people who treat and support people with DD.

Developmental disability is a very broad term encompassing people with intellectual disabilities to autism spectrum to medically-related impairments. However, research, not surprisingly, has found that people with developmental disabilities have alarmingly high rates of trauma -- Individuals with disabilities are four times more likely to be victims of crimes as non-disabled (Sobsey, 1996); prevalence of sexual abuse for children with autism spectrum disorder (ASD) is 16.6 percent compared to 8 percent for general population; the risk of abuse increases 78 percent due to exposure to the disability service system (Sobsey & Doe, 1991).

People with disabilities are more vulnerable at every point in the "lifecycle of a traumatic event." Because of limited knowledge, social skills, and verbal skills, they are more vulnerable to being exposed to abuse. They are less likely to tell someone about the abuse. If exposed, they may be limited in their ability to make sense of the experience. They are likely to display more trauma-related symptoms and behaviors. Their capacity to heal may be limited by their disability. They face immense stigma and marginalization by society at large which may be traumatic in itself or make traumatic experiences worse.

But, how do you tell if a particular symptom or behavior is evidence of the disability or related to trauma exposure. Many trauma-related symptoms can mirror behavior typical of DD. For example, severe self-injury is often assumed to be related to more primitive developmental level when, in fact, it may be a way to manage intolerable feelings or memories stemming from cues of past trauma.

There are also important "chicken and egg" questions. Were traumatic events at least a partial cause of the developmental delay and disability? Or, did the traumatic event occur with a client who already had developmental disabilities making those disabilities more profound and problematic. Research on the neurobiology of trauma has made great advances about trauma's serious impact on the brain and nervous system. It has also found that the brain has more

capacity than previously thought for regeneration and healthy adaptation when the environment is healthy.

How can a trauma lens enhance traditional approaches to work with client with DD? Traditional approaches have often assumed that DD clients have limited capacity to engage in or benefit from relationships. Treatment providers working with DD clients raise concern that functional analyses are being used without attention to the relationship between the treater/support person and the client. Frequently, treatment recommendations growing out of the functional analysis are view as mechanistic technologies that can be implemented successfully regardless of the relationship.

Whereas a trauma lens stresses that treatment techniques like behavioral interventions are much less effective or don't work at all without a therapeutic relationship. In addition, the therapeutic relationship heals attachment wounds so common with traumatized clients, repairs damaged neural pathways in the brain, and teaches self-regulation skills. Clients with DD and histories of trauma often have profound mistrust and feelings of betrayal about caretakers, treatment providers, and the social service system in general. Many suffered abuse by those who cared for them either in their homes or in the social service system. They enter relationships expecting to be hurt, neglected, and abandoned. Healthy, healing relationships challenge those expectations.

A trauma lens contributes an additional perspective to understanding problem behavior. The stimulus or trigger for a problem behavior can often be connected to trauma cues such as how a staff person looks or a staff's new aftershave that reminds the client of past traumatic events. Problem behavior can also be a re-enactment of past traumatic events. When clients and treatment providers make these connections, both feel empowered ("there's a reason I act this way"), staff take the behavior less personally ("It's not about me"), and this awareness leads to more compassionate and targeted interventions.

Finally, a trauma framework instructs up to pay attention to the unique impact of the work on those who treat and support DD clients, the impact of vicarious traumatization (VT). Treaters of DD clients can feel hopeless that clients can change ingrained behavior; they witness clients abandoned by families; they see first-hand how clients are stigmatized and viewed as "other." If we believe relationships are important and healing, BOTH the treater and client side of the relationship matter --hence, the importance of self-care, promoting agency cultures that are aware of VT, and attending the success and resilience we witness in the work.