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Effectiveness of Trauma Informed Parenting for Special Needs Children: A Case Study

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ABSTRACT
Trauma is any event actual or perceived that threatens the existence of a person physically, emotionally or mentally at any given age. Every child experiences stress, however, an event becomes traumatic for the child when their or their loved one's safety, security and bodily integrity are threatened. Trauma can be a single event, can be chronic with multiple instances, or it can be complex with a long history of experiencing or witnessing trauma. Children who suffer from traumatic stress are those who have been exposed to one or more traumas in their lives and have developed reactions that affect their daily lives even after the event has ended. Research shows that higher number of Adverse Childhood Experiences (ACE) impacts the development of the brain and the nervous system in children and increases health-risk behaviors like substance abuse. Children with special needs are more vulnerable to undergo ACE particularly childhood sexual abuse. However, it has been observed that trauma informed parenting helps children learn to manage traumatic experiences and lead meaningful lives. This paper supports the prior research work showing the effectiveness of trauma informed parenting using case studies.

KEYWORDS: *trauma, trauma informed parenting, adverse childhood experiences (ACE), special needs*

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I. INTRODUCTION:

Trauma is an emotional response to a distressing event, real or perceived. With increasing research in the field of trauma, the definition of trauma has shifted from focusing on the event to focusing on the emotional response of the person. American Psychological Association (APA) defines trauma as "an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives." Trauma can be a result of a single event, multiple events or can be a reaction to prolonged exposure (experienced or witnessed) to traumatic events. Trauma cuts across every segment of the society and culture at large. Research in the present times is shifting to incorporate the understanding of the effects of trauma with regards to health and disease across the human life span. The CDC (Centre for Disease Control) Kaiser Permanente ACE (adverse childhood experiences) study is one of the largest studies that investigated impact of early traumatic experiences on the health and well-being over a person's lifespan.

Adverse Childhood Experiences (ACEs) are traumatic events that occur in a child's life. These events threaten the physical, emotional and mental integrity of the child or a loved one. Some examples of ACEs are, abuse (physical, emotional and/or sexual), neglect (either physical or emotional or both), domestic violence, substance abuse by a member of the household, incarceration of a household member, divorce or separation of parents or caregivers, bullying, natural/manmade disasters, witnessing harm to loved one or a pet, unpredictable behaviour of caregivers due to their mental illness, homelessness etc. Some of the conditions that increase the risk for the child to undergo ACEs are living in a poor segregated neighbourhood, lack of basic resources, scarcity of food and proper nourishment, as well as frequently moving to new areas. The higher number of ACEs indicate that a person is at a higher risk of developing certain health conditions or behaviours in adulthood, however, it does not guarantee it (Leonard & Klein, 2020). Children who receive timely, proper, and adequate support for their emotional response to the traumatic event(s), grow on to live a fulfilling and meaningful life.

The early development of the brain is mainly affected by the genes; however, the lived experiences of the child and the environment constructs the brain (The Urban Child Institute, n.d.). Recent research has found that the prefrontal cortex, rational part of the human brain, does not fully develop until the age of 25 years (Health Encyclopedia, n.d.). Prefrontal cortex is used to assess situations, make judgements and process long

term consequences; it is the last part of the brain to mature. Therefore, higher number of ACEs at a young age becomes especially problematic since the child's brain and the capacity to rationally understand the circumstance is still developing.

Childhood trauma increases the risk of the effects of future traumas. Due to the impact of ACEs, people who have experienced them may contribute to ACEs for the future generations like substance abuse, domestic violence, mental illness, communal violence, racism etc (Leonard & Klein, 2020). Trauma that passes through generations is known as intergenerational trauma.

II. OUTCOMES OF TRAUMA:

The economic cost of ACEs to the society is enormous and runs into billions of dollars due to the long-lasting effects of trauma (Leonard & Klein, 2020). Children are resilient and some amount of stress like feeling nervous before a performance or leaving caregivers while at school helps them learn new and necessary skills to develop their brains (Factsheet for Families, 2014). However, when the traumatic event overwhelms the child's natural ability to cope, it triggers the 'fight-flight-freeze' response, which leads to various health consequences if the child is deprived of proper intervention and support. Potential consequences of ACEs include physical health issues, mental health issues, indulging in risky behaviours, developmental disruptions and increased use of the healthcare systems across their life span (Leonard & Klein, 2020; Factsheet for Families, 2014). Trauma increases the person's chances of developing cancer, diabetes, obesity, heart disease, injury, depression, anxiety, PTSD (post-traumatic stress disorder), substance abuse disorder, suicidal ideation, attempt and death by suicide, and early death in adulthood (Felitti et al., 1998). Developmentally, the person exhibits signs of lack of concentration, impaired memory, difficulty thinking and learning, difficulty switching from one task or activity to another, decreased IQ (intelligent quotient) (Gurwitch, n.d.). ACE(s) lead to feelings of low self-esteem, feeling unsafe, dissociation, trust issues, trouble forming attachments and relationships, difficulty regulating emotions, lack of impulse control, aggression, and hinders the person's ability to learn, graduate from school/college, and hold a job (Gurwitch, n.d.; Leonard & Klein, 2020). Separation anxiety especially in young children, sleep disturbances, nightmares, anger outbursts, somatic complaints, loss of interest in normal activities, development of new fears are also observed in children and adolescents as a reaction to trauma (APA, 2008).

Every child responds to trauma differently and the effects of trauma vary based on the child's temperament as well as the nature of the event experienced. Factors to be considered that determine the outcome and impact of trauma are the age of the child, developmental level of the child, frequency of the traumatic event, prior exposure to other traumatic events, relationship with the perpetrator, child's understanding and perception of the traumatic event, presence of supportive caregivers, coping skills, direct or indirect experience of the event, sensitivity of the child, socio-economic status as well as the cultural background of the child (Factsheet for Families, 2014; Gurwitch, n.d.).

III. TRAUMA AND MENTAL HEALTH:

Trauma symptoms that are long lasting, severe and disruptive to the child's ability to function on a day-to-day basis can have an overlap with certain mental illness diagnosis. Some common and frequently seen diagnoses in this context are ADHD (attention deficit hyperactivity disorder), ODD (oppositional defiant disorder), depression, and anxiety (Factsheet for Families 2014). Children who dissociate due to trauma triggers are seen as rebellious and defiant to authority figures, get diagnosed with ADHD and depression frequently and can be misdiagnosed as developmentally delayed (Factsheet for Families, 2014). Many adults who have been through traumatic pasts frequently get diagnosed with borderline personality disorder along with depression, anxiety, substance abuse disorders and eating disorders.

Incorporating the understanding of trauma in working with clients becomes imperative when making a diagnosis and collaborating with the caregivers in the child's life. Due to lack of awareness and understanding about trauma, frequent misdiagnosis happens, which leaves the healthcare providers, teachers, parents as well as the clients themselves wondering why their issues or symptoms do not improve. Some people who display trauma related anxiety will exhibit symptoms of hyperarousal like faster heart rate, changes in behaviour, anger outbursts, shallow rapid breathing, irritability, sleeping problems, hypervigilance, or make peculiar sounds in case of people with developmental or intellectual disabilities. On the other hand, others might become hypoaroused where they shutdown, dissociate, seem depressed, helpless or hopeless, talk about feeling "numb" or "dead inside" (Family Medicine e-learning, University of Colorado, 2018; Corrigan et al., 2011).

It is important to note that the maladaptive behaviours in the present were once developed as a response to cope with the trauma, however, when the fear becomes chronic or overwhelming those same responses become maladaptive.

Trauma and Special Needs Children:

Disability increases the risk of violence towards the disabled person. There is growing evidence that individuals with disabilities are particularly vulnerable to abusive experiences in their childhood as well as adulthood. Children with disabilities are three times more likely to have faced violence in their lives than non-disabled children. Specifically, children with mental and intellectual disability (ID) have increased risk of trauma as well as experience higher ACEs than children with other forms of impairments (Jones et al., 2012). Research has shown that children with disability, including ID, are 83% more likely to experience 2 or more ACEs and 73% more likely to experience 3 or more ACEs at age 5 (Vervoort-Schel et al., 2018). Even though there is evidence of a cause-and-effect relationship between ACEs and trauma symptoms in people with disability, there is still lack of research in understanding the intersection between the type of adverse experiences and the specific type of disability (Catani & Sossalla, 2015; Vervoort-Schel et al., 2018). The National Crime Victimization Survey showed that individuals with cognitive and physical impairments aged 12 years or older were two times more likely to face sexual assault than people without disability (Catanai & Sossalla, 2015).

The living circumstances of children with ID like poverty or parental trauma or mental illness impact their vulnerability to adverse experiences (Vervoort-Schel et al., 2018). Individuals with ID also face difficulty accessing resources such as adequate education, support and healthcare. It has also been suggested that people with disability often become victims due to their vulnerability, helplessness, and inability to report the crime within a biased system. Though this population is at an elevated risk of facing trauma it is unclear whether this risk is different from non-disabled individuals who have also faced adverse experiences.

Trauma Specific Care, Trauma Informed Care and Trauma Informed Parenting:

Trauma informed care and trauma specific care are sometimes used interchangeably, however, they differ in how the trauma is handled (DeCandia et al., 2014). Trauma specific care refers to clinical interventions that deal with prevention and treatment of trauma related symptoms and co-occurring disorders. On the other hand, trauma informed care is a strength based holistic framework that understands the complexities of trauma, which prevents re-traumatization of the individual (DeCandia et al., 2014; Gurwitch, n.d.). Trauma informed care sees the person as a whole rather than focusing only on the problematic parts. Trauma specific services can only be provided by qualified healthcare providers, whereas, trauma informed care expands the focus of intervention beyond the individual therapy and into the larger environment (DeCandia et al., 2014).

Trauma informed parenting is complete understanding of trauma while preventing their vicarious trauma to impact the child (Gurwitch, n.d.). It involves tuning into the child's trauma triggers and realizing that the symptoms of the trauma are the real problem and not the child (Factsheet for Families, 2014). Trauma triggers are aspects of a traumatic event that are felt in a completely different setting but reminds the individual of the original event (Factsheet for Families, 2014). Some examples of trauma triggers are smells, tone of voice, places, sounds, postures or even emotions. Individuals who have experienced traumatic events can re-enact old patterns that made them feel safe when they encounter a trigger (Factsheet for Families, 2014).

IV. METHODOLOGY:

In order to gain insight into the effectiveness of trauma informed parenting, semi-structured interview was conducted with two mothers of developmentally and intellectually differently abled children. The participants were asked ten open ended questions that gathered the data on their demographic background, ACEs, medical and psychiatric diagnosis, identifiable signs or symptoms of trauma, family/systemic support, traumatic history of the mother if any, the impact of their own trauma in parenting the child and the parents' efforts in building a safer environment for the child. The participants were selected from a special needs school in Mumbai, India. The interview was conducted over the telephone and lasted for approximately an hour. Answers were recorded by note taking and recording the calls with consent.

V. SUMMARY OF THE CASE STUDIES:

Two mothers who raised differently abled children were interviewed. Both these mothers' children graduated from the same school. The mother (A) who was interviewed first has a young adult daughter with Down's Syndrome, who post graduation from the special needs school went on to earn her BA (Bachelor of Arts), MA (Master of Arts) and B.Ed. (Bachelor of Education) degrees in Sanskrit. Contrary to the belief of the young woman's paediatrician that she wouldn't be able to achieve anything, she was awarded a gold medal for academic excellence in her BA (Bachelor of Arts) degree. This family hails from a middle-class socio-economic status and the family dynamics is functional, healthy and supportive. Parents have a healthy relationship where they were/are able to provide a safe and thriving environment for the child, as a team. The mother did not report any adverse experiences of her own that would have impacted her parenting skills.

The second participant (B) was a mother of four daughters from a low socio-economic background. She retired as a BMC (Brihanmumbai Municipal Corporation) school teacher and faced intimate partner violence (physical, verbal, emotional and financial) throughout her married life since she could not bear sons as a result the daughters faced neglect. Due to lack of support, financial burden and physical exhaustion, the mother fell down a flight of stairs while pregnant with her second daughter. This incident led to physical and developmental impairment in the child as well as premature birth and death in early adulthood. The mother's only support system were her parents and sister who lived far away from her. With the exception of the eldest daughter, the other daughters were diagnosed with developmental and intellectual disability. One of the two surviving special needs daughters is deaf and mute and was misdiagnosed with ID growing up. The other daughter is deaf, mute and autistic. With limited resources the mother has taught her children to survive on a day-to-day basis.

VI. DISCUSSION AND INTERVENTION:

There were stark differences observed between the children of both the mothers. B reported physically abusing her daughter who is deaf and mute due to her own trauma and resultant exhaustion. According to B, she was confused when her daughter did not exhibit any signs of intellectual disability as diagnosed by their healthcare provider. However, due to her physical disability, inability to express and misdiagnosis of ID, the child was rejected and suspended from multiple schools, which hampered her overall growth. She learned to become physically abusive to express herself as a result of her lived experiences. The daughter with autism was neglected, which hampered the neurological development of the child leading to her inability to care for self. The mother did not understand the effects of trauma and believed, "This is the way of life; mothers are not allowed to feel anything because they are equated to God." In one instance, to make her daughters self-reliant, the mother sent them on their own in a local bus to their school without considering the risk of sexual assault. Only when their teacher intervened did she realize her mistake. Nevertheless, she tried to gain awareness and using trial and error method gave her best to create a safe environment for her daughters. However, the effect of intergenerational trauma was evident in the parenting style and the development of the children.

Participant A understood the meaning of trauma and was also able to identify the vicarious trauma she faced. She was able to create a safer environment for her daughter through recognizing signs of distress in her child, giving the child the autonomy to make choices, and preventing retraumatizing the child. In one instance, A narrated an incident where during a Diwali visit to her in-laws place the daughter's cousin took the daughter to another room and sexually molested her. The daughter confided in A as soon as they reached home and though A was cognizant of her vicarious trauma, she chose to believe her daughter and confront her in-laws with her husband without victim blaming. The in-laws were supportive, understood the gravity of the situation and took immediate steps to rectify the damage caused. A's husband, parents and in-laws also played a big role in helping the daughter move beyond her disability and thrive. A said, "We are very proud of our daughter and when a child like her excels the joy is tenfold than what a normal child would bring."

Analysing both the cases, it is clear that trauma informed parenting creates a positive effect on the development of the child and assists them in establishing healthy coping mechanisms should they go through adverse experiences. It is imperative that parents learn to identify trauma triggers, listen, respond rather than react, be physically and emotionally available, avoid physical punishment, not take the behaviour personally, teach the child to relax, be patient, be consistent and predictable, and above all allow reasonable amount of age-appropriate control and autonomy to help them thrive (Factsheet for Families, 2014).

VII. CONCLUSION:

As observed from the case studies trauma informed care changes the life trajectory of the child and helps them cope with their ACEs more effectively. However, there is paucity of research in the long-lasting effects of trauma within the special needs population. Further research is also required to gain clarity on the intersection of trauma and special needs with regards to the cultural background, specific age groups, intergenerational trauma, community violence, marginalized section of the society, availability of resources, birth order, socio-economic status of the person with disability and effects of vicarious trauma of the caregivers. Without more research in the field of ACEs and differently abled community, trauma informed care for this section of the society will be based on trial and error.

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