NCTSN The National Child Traumatic Stress Network

# Facts on Traumatic Stress and Children with Developmental Disabilities

National Child Traumatic Stress Network
Adapted Trauma Treatment Standards Work Group

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From the

National Child Traumatic Stress Network
Adapted Trauma Treatment Standards Work Group
Subgroup on Developmental Disability

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# Facts on Trauma and Children with Developmental Disabilities

## Federal Definition of Developmental Disability

*General*
The term *developmental disability* means a severe, chronic disability of an individual that

1. is attributable to a mental or physical impairment or combination of mental and physical impairments;

2. is manifested before the individual attains age 22;

3. is likely to continue indefinitely;

4. results in substantial functional limitations in three or more of the following areas of major life activity:

    a. self-care,
    b. receptive and expressive language,
    c. learning,
    d. mobility,
    e. self-direction,
    f. capacity for independent living,
    g. economic self-sufficiency; and

5. reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

*Infants and Young Children*
An individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (a) through (g) of subparagraph (4) if the individual, without services and supports, has a high probability of meeting those criteria later in life.

Reference: *Developmental Disabilities Assistance and Bill of Rights Act of 2000*, Public Law 106-402.

## Incidence of Disability in the General Population

- The national prevalence rate for developmental disabilities in the U.S. is 1.8 percent, based on an estimate conducted by Golay & Associates and used by the Federal Administration on Developmental Disabilities to extrapolate state level prevalence rates.

- About 3 percent of the population has an IQ of less than 70. The standard Wechsler IQ tests are based on a normal curve, so that 13 percent of the population has an IQ between 70 and 85, 68 percent between 85 and 115, 13 percent between 115 and 130, and 3 percent above 130.

- The exact prevelance of autism is not known, but estimates range from 1-in-250 to 1-in-1,000 in the United States (National Institutes of Mental Health, 2003).

## Statistical Information Regarding the Incidence of Trauma for this Population

The following statistics should be interpreted with caution. Most reports regarding the incidence of trauma for people with developmental disabilities indicate it is likely the statistics reported under-represent the prevalence of trauma. A variety of factors interfere with the ability to report, such as difficulty communicating that abuse has occurred, difficulty in being believed, and problems related to communication in general.

- Individuals with developmental disabilities are at increased risk for abuse as compared to the general population (Gil, 1970; Mahoney & Camilo, 1998; Ryan, 1994).

- Goldson, 2002 reports maltreatment among children with disabilities:

**Incidents per 1,000**

| | Children without Disabilities | Children with Disabilities |
|---|---|---|
| Physical Abuse | 4.5 | 9.4 |
| Sexual Abuse | 2.0 | 3.5 |
| Emotional Abuse | 2.9 | 3.5 |

- Individuals with disabilities are over four times as likely to be victims of crime as the non-disabled population (Sobsey, 1996).

- Sixty-four percent of the children who were maltreated had a disability. The most common disabilities were behavior disorders, speech/language, learning disability, and mental retardation. The most common type of maltreatment was neglect. Children with mental retardation were the most severely abused. Children with communication disorders were more likely to be physically and sexually abused (Sullivan & Knutson, 1998).

- Five million crimes are committed against individuals with disabilities each year in the United States (Petersillia, 1998).

- Individuals with disabilities are 2-to-10 times more likely to be sexually abused than those without disabilities (Westat Ind., 1993).

- Maltreatment of children with disabilities is 1.5-to-10 times higher than of children without disabilities (Baladerian, 1991; Sobsey & Doe 1991; Sobsey & Vamhagen, 1989; Sullivan & Knutson, 2000; Westat, 1991).

- One of 30 cases of sexual abuse or assault of persons with developmental disabilities is reported as opposed to one of five in the nondisabled population (James, 1988).

- Even when the abuse is reported, the charges are rarely investigated when the victim is disabled (Senn, 1988).

- Victims typically have difficulty accessing appropriate services (Sobsey & Doe, 1991).

- Risk of abuse increases by 78 percent due to exposure to the "disabilities service system" alone (Sobsey & Doe, 1991).

- Immediate family members perpetrate the majority of neglect, physical abuse, and emotional abuse. Extrafamilial perpetrators account for the majority of sexual abuse (Sullivan & Knutson, 2000).

- Sexual abuse incidents are almost four times as common in institutional settings as in the community (Blatt & Brown, 1986).

- Ninety-nine percent of those who commit abuse are well known to, and trusted by, both the child and the child's care providers (Baladerian, 1991).

## Special Characteristics of the Population that May Influence the Incidence of Trauma

Abuse and neglect have profound influences on brain development. The more prolonged the abuse or neglect, the more likely it is that permanent brain damage will occur. Not only are people with developmental disabilities more likely to be exposed to trauma, but exposure to trauma makes developmental delays more likely.

- “The developing brain is exquisitely sensitive to stress.” Persistent states of fear in children impair their capacity to benefit from cognitive, social, and emotional experiences (Perry, 2001).

- Exposure to trauma can modify the child’s ability to access different levels of brain functioning, resulting in changes in their perception of time, cognitive style, affective tone, ability to develop solutions to problems, and ability to respond to and understand rules, regulations, and laws (Perry, 2001).

- Severe neglect can result in reduced brain size, density of neurons, and head circumference (Perry and Pollard, 1997).

*People with developmental disabilities are*

- trained to be compliant to authority figures;
- dependent on caregivers for a longer period of time for more types of assistance than a nondisabled child, and they are dependent on a larger number of caretakers;
- often unable to meet parental expectations;
- isolated from resources to whom a report of abuse could be made;
- sometimes impaired in their ability to communicate;
- sometimes impaired in their mobility;
- more likely than other children to be placed in residential care facilities;
- sometimes more credulous and less prone to critical thinking than others, which may result in it being easier for others to manipulate them;
- often not provided with general sex education, and caregivers may feel that people with developmental disabilities are asexual, although
    - for people with mild to moderate mental retardation sexual development and sexual interest occur at approximately the same age as the normal population (Tharinger, 1990), and
    - precocious puberty is 20 times more likely to occur in persons with developmental disabilities than in the normal population (Siddigi, 1999); and
- viewed negatively by society, which may label them as "bad" because they are different or may view them as less than human.

*People with developmental disabilities may also experience*

- cognitive and processing delays that interfere with understanding of what is happening in abusive situations, and
- feelings of isolation and withdrawal due to their differences, which may make them more vulnerable to manipulation because of their increased responsiveness to attention and affection.

*In addition, the effect of trauma is increased for people with developmental disabilities due to*

- a predisposition toward emotional problems and impaired resiliency before the abuse occurs (Burrows & Kochurka, 1995);

- reduced protective factors that could lessen the effects of sexual abuse (Mansell et al., 1998);

- a long-standing belief that people with developmental disabilities cannot benefit from traditional verbally oriented therapies (Mansell, et al., 1998); and

- a lack of trained professionals who are comfortable in working with people who have developmental disabilities to help them in processing traumatic incidents.

## Possible Reasons for a Higher Incidence of Mental Illness for Clients with Developmental Disabilities Than the General Population

(Avrin, Charlton, Tallant, 1998)

- It is more difficult to cope with normal life stressors given the limited resources the client has available.

- There is increased vulnerability to abuse in the home, since these children are often very difficult to raise and place a high level of strain on the family.

- These children are more vulnerable to abuse in the community because of their poor judgment and lack of self-protective skills.

- An additional stressor for the higher functioning clients is awareness of their intellectual deficits. They have many grief and loss issues associated with their functioning problems.

- People with developmental disabilities experience greater difficulty in getting help for mental illness due to communication and processing problems.

## Suggestions for Modifying Evaluation and Therapy to Meet the Needs of this Population

- Because of the high likelihood that the ability to communicate will be severely impaired, it is extremely important that a wide range of caregivers be involved in both the assessment and treatment process. These should include parents/guardians and school and daycare personnel.

- Since reporting of trauma by this population is unlikely, it is important that caregivers receive training on the type of behavioral changes that may be associated with trauma exposure so they may assist in reporting and obtaining services.

- All children with developmental disabilities tend to behave like much younger children, so when working with very young children with developmental disabilities, it is extremely important to slow down speech, use simple language, present one concept at a time, supplement therapy with drawing and play materials, and make related adaptations.

## Special Diagnostic Considerations with Clients Who Have Developmental Disabilities

(Avrin, Charlton, Tallant, 1998)

1. Their thought process are usually very concrete. Responses to common mental status questions may sound very bizarre because of the client's concrete interpretations.

2. Their concrete thought processes make the use of projective assessment techniques such as the Rorschach and TAT ineffective in identifying pathology.

3. If the client has sufficiently high verbal skills, sometimes the MMPI-2 or A can be helpful, if interpreted conservatively. Use of audio tapes is recommended, even if the reading level seems sufficient, as the multisensory input often improves comprehension of the questions.

4. People with developmental disabilities often share the following thought processes:

    a. difficulty with fluidity and flexibility of thinking,
    b. a dislike of ambiguity (black and white thinkers),
    c. a tendency to concentrate on one aspect of a situation while neglecting other aspects,
    d. difficulty prioritizing and breaking down tasks into manageable projects,
    e. a tendency to have highly focused areas of expertise and interests, e.g., beets, weather, sports, statistics, phone numbers, dates, and so on,
    f. a tendency for poor generalization skills—a person belongs in one and only one environment—and utilization of a skill in one situation but not others.

5. People with developmental disabilities often share the following communication problems and social issues:

    a. idiosyncratic speech,
    b. inability to perceive social cues,
    c. difficulty utilizing or understanding nonverbal communication well,
    d. frequent miscommunications and misunderstandings,
    e. a tendency toward one-sided conversations,
    f. a tendency to ask many questions, especially when uncomfortable with a conversation,
    g. a tendency to return to familiar, rote questions, or subjects of personal interest when anxious,
    h. intrusive behavior,
    i. an ability to pretend to be normal,
    j. a poor understanding of the impact of behavior on others, and
    k. difficulty making and keeping friends.

6. People with developmental disabilities may also have the following miscellaneous issues:

    a. special talents, including memory for facts, artistic talents, and unique insights (Albert Einstein, Temple Grandin);
    b. difficulty with change, especially unexpected changes, including
        i. anticipatory anxiety and
        ii. continued use of a familiar plan even if it doesn't work;

c. significant anxiety in many situations, which may present as agitation, acting out, worry, perseveration, or obsessive-compulsive behaviors, often with the following characteristics:
    i. responses when anxious tend to be highly predictable,
    ii. even though the pattern is predictable, it may be hard to see when the anxiety is high, and
    iii. the acting out may be chaotic;
d. difficulty with Impulse control, particularly when frustration, anxiety, or tension builds until behavioral acting out occurs.

Be aware that all types of psychiatric treatment are useful if properly selected and executed (Szymanski et al., 1994). Behavioral and cognitive behavioral strategies are particularly effective and easy to adapt for this population.

## Suggestions for Therapy

(Avrin, Charlton, Tallant, 1998)

1. Slow down your speech.

2. Use visuals whenever possible to reinforce your verbal messages:
    a. draw pictures, and
    b. write down suggestions for change in brief, outline form.

3. Present information one item at a time.

4. Ask for feedback after each item to ensure clear comprehension.

5. Be specific in making suggestions for change.

6. Practice different ways of handling tough situations the client is likely to encounter.

7. Format your therapy session so that several repeats of key information occur. For example

    a. review information covered in the previous meeting,
    b. discuss how week has gone,
    c. work on specific ways of handling various troublesome events that occurred,
    d. review the key things you want the client to work on during the week, and
    e. write the homework assignment out and review it with the client to be sure it is clear.

8. Work on building coping skills rather than insight.

9. Remember that with these clients change will occur more slowly than with others. Be content to measure change with a micrometer rather than a yardstick.

10. Remmber that effective treatment for people with developmental disabilities must also include a variety of support and education services for families and caregivers.

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