

# National Association of Special Education Teachers (NASET)

## THE PRACTICAL TEACHER

***This Month's Topic:***

### Trauma Informed Teaching in Special Education

**By**

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TrIn any school, in any setting, the unfortunate possibly exists that educators have a student who has been impacted by trauma in some form. It is imperative that educators understand how trauma impacts learning and development and how students with learning disabilities and trauma often present in the field. There is much research about trauma informed care, and trauma informed schools, but what is lacking is specific real world illustrations of what a traumatized students with LD (learning disability) looks like and how to deal with this student. Trauma presents a set of learning issues as the student with LD presents a set of learning issues. This article is aimed at providing a very brief snapshot of what a student with this profile looks like and what techniques have actually worked in the field. Many of the techniques highlighted are researched based and considered on level or another to be best practice, however little if any specific research has been done to verify their efficacy on a wide sampling of the population. They are featured as they have worked in several settings, multiple times in the actual classroom, and are being shared her with the hope of providing teachers a little direction and insight into this quandary.

First let's take a look at what trauma is and what it means to us as educators in general. According to the American Psychological Association Trauma is "an emotional response to a terrible event. . ." <sup>1</sup> Reading this definition makes us think for a more immediate response but the APA says that there are longer lasting impacts of trauma such as flashbacks, unpredictable emotions and even physical symptoms. The National Institute of Trauma and Loss in Children provides information that further illustrates this emotional response. They Institute provided information on the impact of trauma in three domains: arousal and cognitive functioning, sensory functions, and behavior. Three domains we as special education teachers often get called upon by general education or administration to consult about when student deficits are noted in these domains.

When we look at the cognitive functioning of a student, we look at the brain's ability to process information and effectively interact with the world around it, as compared to others that are similarly situated. Special Education and Educational Psychology have instruments to measure cognitive functioning and often times they are also

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<sup>1</sup> <http://www.apa.org/topics/trauma/>

used to determine eligibility for special education. When using these tools and evaluating the cognitive functioning of a student we must look at signs, symptoms, and outcomes to determine if deficits are trauma related or of a more learning disability in nature. As mentioned earlier trauma is an emotional response to a terrible event that has long lasting impacts. Research tells us that when and if children or adults do not feel safe at the sensory level, cognitive processing is adversely impacted.<sup>2</sup> Research show that short-term and visual working memory processing ability decrease during the feeling or event. Students with learning disabilities often have organic or neurobiological deficits in these 2 areas already, without the impact of trauma.

So knowing and understanding that trauma limits these essential elements of cognition the implications for teaching students with learning disabilities are further complicated. Best practice in special education to mitigate the effects of these cognitive deficits are often to accommodate and even modify the instructional methodology pairing auditory with visual stimuli to support the internalization, providing opportunities for multi-sensory input and over-learning of the material. At best this often works over time, in my personal experience when a traumatized student is in a state of heightened arousal or panic though often temporary; their functional limitations in the cognitive domain can often be so limiting that even with all the special education interventions, the student is unable to cognitively function at a level allowing access to the information presented and will often present with a myriad of behavioral issues. These behavioral issues serve to even further complicate learning and cognition.

Trauma further complicates the issue of student cognition in that the students' behavior reaction to what they perceive is usually governed by the way they sense and identify what is going on the environment. This is where we as the special education teacher need to be even more tactful and know our students. We almost have to take off our teacher hat and put on our counselor hat and look analytically at what is going on. Having a relationship with our students, their families and understanding their history and background are essential at this point to further mitigate the cognitive deficits. Having at least a surface understanding of the trauma a student experienced, to the extent possible can help you identify triggers and situations that will cause cognition to be further stunted.

Behaviors such as aggression, anxiety, being extravagantly withdrawn from commonly engaging tasks or activities; loss of some small motor activities; such as being incapable of opening a door, making a telephone call, and even in some cases being unable to talk (stuttering), and even the inability to sleep, are not surprising behaviors in response to trauma.<sup>3</sup> These research based common behaviors are consistent with the actual real life behaviors often exhibited in some of my students. According to the National Institute for Trauma Loss in Children there was a study conducted on children's recall subsequent to a horrendous earthquake purported that 90% recollected the earthquake but found that that the recall was highly discerning and relevant mainly to events that had personal significance. The National Institute for Trauma Loss in Children further supports that if the internalized meaning of the event involves a sensory threat, be it real or perceive then their behavior will change based on this information. The Institute further goes on to share more evidence of the longer impact trauma has on children, in that though the actual peril may be over, the sense that is it not can lead to fear. Also specific sets of circumstances such as smells, sounds, vibrations, words, even mannerisms that cause that consciously or subconsciously remind the child of their experience, causing them to believe the peril exists yet again, in that moment cause their behaviors to change based on that perception.

Taking into account everything we have already talked about, with regard to cognition, learning disabilities, and trauma, now factor in LD behavior and you have a multi-faceted diagnostic impression. The behaviors cited as common behaviors in response to trauma can also be seen on some level in response to heightened frustration tolerance in students with learning disabilities.

Anxiety before being called upon, withdrawal from the activity because they perceive they can't process the information and even in some cases some aggression because they are upset or mad that you are pushing them to

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<sup>2</sup> <http://www.tlcinstitute.org/impact.html>

<sup>3</sup> <http://www.tlcinstitute.org/impact.html>

do something is hard. So the role of the special education teacher now becomes how to tease out with of the experiences is the student responding to and then address it in an individualized and developmentally appropriately manner which is narrowly tailored to meet the students' needs at that moment. So how do you do it? That is where knowing your student comes in again. Early identification of the traumatic triggers and rapid and effective mitigation and intervention prior to a full blow traumatic episode occurring is the key to effectively helping your student through their crisis. So as a special education teacher knowing your students and what triggers their trauma experience, and knowing how they respond to frustration and where they frustration tolerance is, becomes crucial.

As the special education teacher you must manage the environment to minimize the exposure to the traumatic trigger, unless you have a system in place where the proper supports are ready to help the student cope with their trauma. Some professionals may argue that removing the exposure will not help them learn to cope with the trauma. And on some level I agree. But if your goal is mitigate the learning disability, you need to mitigate the trauma, in order for the learning remediation to work. If you goal is to teach coping skills, and you have work with your administration to set up a comprehensive plan to respond to such a student reaction, then you would not remove the stimuli, but rather anticipate it, activate the steps that need to be activated and then support the student through it, providing concrete, tangible, successful techniques and tools for him or her to cope with the emotional upheaval they are feeling. Anticipation is key.

The excerpt below leads us into why it is important to know our students and identify the difference between trauma reactivity and learning disability behavior.

“Behavioral changes in addition to the alterations of cognitive processes discussed earlier are often misread for resistance, stubbornness, over reactivity, impulsiveness, confrontation or a having a learning disability or Attention Deficit Hyperactive Disorder (ADHD) (Levine, 2007; Weinstein, 2000).”<sup>4</sup>

Now we know about trauma, and LD and know why we have to know the difference in helping with the LD issues, but what about even before that. What about eligibility. What happens when we get called to look at a student or complete a diagnostic battery on a student and we observe these behaviors? We just read that they are often mislabeled. So what do we do? The best way to iron this out is to first get to know the student, get a detailed history, do a comprehensive home assessment, from birth until present if possible, conduct an FBA to identify specific triggers. If the triggers can be associated with the trauma, then diagnostically you manage the trauma, mitigate it in such a way that you minimize the impact of it on the cognitive process. There is no one specific way to do this, as every student is different. But if you know a student is triggered by sirens because they saw their house burn down and associate the sirens from the street with the fire trucks that couldn't save their house. You should follow the RTI model, tracking and monitoring progress in a manner specifically informed by the specific trauma. In the example provided above, take steps to provide the interventions in a room either in the middle of the building or away from the street where the possibility of hearing or seeing sirens is minimal. Document and track student behavior, while you provide intervention. If the behaviors are not an issue then the student is not triggered, and therefore tier 1 interventions should be adequate, perhaps tier 2 if they missed a lot of instruction due to trauma behavior. If over the course of set period of time the trauma mitigated Tier 1 or 2 instruction is not effective, then you move to tier 3, and possible consideration of Special Education Services.

Now clearly not all solutions to trauma are that simple. But the example serves to concretely indicate the method that should be followed. If you can mitigate the trauma reactivity, then if no learning disability exists, only gaps in instruction should in theory be present. If learning issues continue, re-evaluate if trauma is truly mitigated or minimized, if not, address it, if so, then learning issues are not related to trauma. The next challenge you will likely face is the one related to how they score on the assessments. If the gaps in learning are significant across the board due to trauma, then the question remains, will the discrepancy model work in this case. It may, and it may not. There may be low scores across the board that fall in the same range in all or many areas tested.

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<sup>4</sup> The National Institute of Trauma and Loss in Children <http://www.tlcinstitute.org/impact.html>

For example if Reading Comprehension falls in the high end of the low range, being only 1 point away from the low average range, and the Math falls in the low average range being on 3 points away from the low range, these scores are not far apart. And on face value it may seem like there is no learning disability, just lack to skills development, which will likely be blamed on the cognitive impact of the trauma and the behavior.

Blaming the relative consistency in low scores on all tests is not necessarily as simple as due to lack of instruction because of behavior or trauma. It could be because the student learned nothing due to cognitive impact of trauma, so the scores were relatively in the same range, but that if the student received intervention in all areas for a long period of time, progress would be seen in one specific area and not the other, though often the case, not enough progress to score high enough on the standardized tests. So if you have a student where you and your team believe that you effectively mitigated the trauma reactivity, who is receiving tier 2 and 3 respectively interventions with fidelity for a little over 3 months and slow but steady progress can be codified and documented in one area but little to none in the other area, when the team refers him or her to TEAM testing, depending upon how much progress was made and how large the gaps were in instruction you may not see the scores be all that different in each area but you see a significant difference in progress in each area, you should consider this when making your eligibility determination for special education.

If one area shows progress in Tier 2 interventions and the other shows little to none in tier 3, one can articulate a discrepancy. But you must, absolutely mitigate to the fullest extent possible the trauma reactivity; otherwise you are dealing with an exclusionary factor. Often trauma reactivity is looked at as an exclusionary factor and will be the reason for a student to found in eligible, but this should help people understand that learning disabilities can co-exist with trauma. So basically you are determining is a student's lack of progress primarily the result of an Exclusionary factor. If the trauma reactivity is mitigated and there is still lack of adequate progress or you see a discrepancy, then the answer to that question could be NO lack of progress is not due to trauma.

Now that we have heard about trauma and behavior how the heck to we actually intervene when a student is in a traumatic crisis? Well there is a lots of research on the topic but I have put enough research into this paper, when I promised you would hear practical applications. Here are a few that are research based but tweaked to make them my own. I have found that my work with students who have trauma histories that these work. The first technique I call 360 Processing with the kids. First I explain that 360 refers to 360 degrees, and that a circle is 360 degrees. 3<sup>rd</sup> graders usually understand it best. If I am working with a younger kid I might call it 2-way processing. This 360 processing accomplishes 2 goals. 1- it provides emotional support to students in a crisis, and 2- it provides an opportunity for the student and adult to both reflect critically on what they can both do differently in the future.

The first goal of 360 processing is accomplished by identifying when a student is in crisis. Usually it looks different for everyone, but each situation has some similarities. We talked about the behaviors earlier. This is the time when emotional support should be given. It is given by being a good listener and using active listening skills, attending to the student who is expressing what he/she feels in the moment, acknowledging the feelings (even if they are illogical and make no sense, do not accept them necessarily but acknowledge what you think they feel), summarizing what you heard the young person say, and bringing back a sense of normalcy. . This first part of process 360 is where the adult processes usually verbally at a level the student can understand what is going on and helps to attend to the students' emotional needs. According to the National Institute for Trauma and Loss in Children at time emotion supports such as the ones listed here is often all that one may need.<sup>5</sup>

Part 2 of Process 360 or 2way process is where the planning part comes in. In this phase the teacher should help the student, who is either coming down from their crisis cycle or is out of it already plan what to do next time this happens, meaning what behaviors to show, and plan what do next, meaning immediately after this processing is done. If you were able to intervene and have a healthy Process 360 with the student and no real behavior occurred, you could process part 2 about how well that process worked, what worked and who they could do it with if you were not there. The other part of this phase 2, is where you as the teacher facilitate a conversation with the student around how they felt just before the behavior, see if they understood why they felt that way, and then plan what to do instead for the next time.

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<sup>5</sup> <http://www.tlcinstitute.org/impact.html>

You also allow introspection and the student an opportunity to reflect on you, asking “what can I do differently”. They may say something like “ don’t make me do work” or “not make me pick my head up off the desk”. These are not realistic goals and you have a conversation around that with them, and say well the reason I asked you to do this was..... you fill in the blank, making sure you emphasize that expectations can’t change, but perhaps you can come up with a signal, or special sign to use so that you are not calling the student out in front of the class. I have found giving the student ownership of the reflection toward myself as the teacher has actually showed them that I am committed to helping them. This gives me leverage when I process with them.

While there are certainly other techniques that can be used to intervene, and help shape trauma behavior, there is lots of research out there. This paper is already forgiving in the length that it has taken to come to fruition, so exploration of other techniques will be reserved for other publications. In closing it is important to remember there is a difference in behavior of a trauma reactive student and an LD student with behaviors. There is also a difference in the origin of cognitive limitations when comparing students experiencing trauma reactivity and those with learning disabilities. The intervention strategies and remediation techniques are different. For a student who is experiencing trauma reactivity we must reframe and help renormalize, for a student who is experiencing an LD issue, we use our learning remediation strategies. Both different, but accomplish the same thing, effective cognitive function. It is imperative to not discount trauma reactive behaviors simply as an exclusionary factor on face value when determining eligibility; conversely it is equally imperative that you mitigate the trauma reactivity to pinpoint the existence of learning disability.

## References

American Psychological Association (n.d.). APA. Retrieved June 6, 2013, from <http://www.apa.org/topics/trauma/>

The National Institute for Trauma Loss in Children . (n.d.). Retrieved June 6, 2013, from The National Institute for Trauma Loss in Children : <http://www.tlcinstitute.org/impact.html>