The Weekly Word

ifapa a resource for families
Iowa Foster & Adoptive Parents Association

AUGUST 28, 2018

CREATING TRAUMA-INFORMED CLASSROOMS

Excerpts from the Adoption Advocate - A Publication of the National Council for Adoption

BY CASEY CALL, PH.D., KARYN PURVIS, PH.D., SHERI R. PARRIS, PH.D., & DAVID CROSS, PH.D.

Vulnerability in children from hard places can be attributed to six primary risk factors. Parents and educators are often stunned to realize the broad nature of these risks.

The first and most profound risk factor is prenatal stress. If the child's mother experiences hardship of any kind during pregnancy, her developing infant will bear neurochemical marks of her stress. Research documents the fact that anxious or depressed mothers give birth to infants who have higher levels of stress chemicals as well as alterations in brain activity. An additional prenatal risk is substance exposure, which is believed to be present in 80% of children in the foster care system (Dicker & Gordon, 2004). Prenatal substance exposure induces sweeping changes in brain development, and is associated with a plethora of cognitive and behavioral aberrations.

Another risk factor is birth trauma, which can, for example, cause minor brain hemorrhages that ultimately effect learning and behavior. A third risk factor is hospitalization in the early years of development. Medical procedures designed to save the life of a prematurely born infant, for example, comprise medical trauma. Surgeries, NICU care, and hospitalizations after accidents or during serious illnesses all impact development in ways similar to any other type of harm. In sum, "medical trauma" comprises trauma and bears a resemblance in impact and outcome to many other types of trauma.

The last three risk factors are more commonly recognized than the first three, and include abuse, neglect, and trauma. Abuse and neglect are common themes in the lives of children who are fostered or adopted. Physical abuse, sexual abuse, and emotional abuse are common among those removed from their biological families. Another major risk factor is neglect, which is the daily fare of children adopted from orphanages and from many domestic environments. While neglect may seem less impactful then abuse, in many ways it can be more damaging. The message of abuse is "I don't like you"; the message of neglect is "you do not exist."

Most teachers will never know the full backstory of vulnerable children in their classrooms. However, insightful teachers will bear in mind that these experiences might have been the daily standard for children from hard places, and these past experiences cast a shadow over their thoughts and actions in the classroom.

DID YOU KNOW?

Harkening back to the impact of trauma, trauma-informed environments will need to make proactive accommodations for children coming from hard places. For example, **glutamate, a neurotransmitter that is commonly elevated in children with histories of harm, is more active when children are dehydrated**. This creates significant issues behaviorally, because glutamate is associated with aggression, violence, and seizures. By simply making water bottles accessible to children during school hours, glutamate levels can be controlled (Boudaba, Linn, Halmos, & Tasker, 2003). Insulin receptors are altered by chronic stress and prenatal exposure to alcohol, resulting in variations in blood sugar that are associated with dips in learning and behavior. Having snacks at times of day when children's blood sugar may be low (e.g., mid-morning between breakfast and lunch; mid-afternoon between lunch and dismissal) can keep blood sugar from dropping too low and significantly improve behavior and learning (Benton, 2007; Benton & Stevens, 2008; Gailliot et al., 2007; Kaplan et al., 2004).

Finally, a majority of children with histories of harm are reactive to sensory input. Being prepared to meet these unique needs is critical. For example, in music class, if the sounds are too loud—or in art class, if the finger painting project is tactilely aversive—children can be permitted to choose an alternative activity, thereby disarming their fear and earning their trust. **READ FULL PUBLICATION**

Stop Fighting Your Child's Neurodiversity:

A Step-by-Step Plan for Parents in Diagnosis Denial

Your child is wired differently, and that means his life may not follow the path you envisioned. Before you can help him thrive, you must give yourself space and time to recognize the emotions that a neurodivergent diagnosis brings. Here's how to get started embracing your new "normal."

When your child was born, you imagined a future for him with no boundaries. His neurodivergent diagnosis – with attention deficit disorder (ADHD or ADD), autism spectrum disorder (ASD), learning disabilities, sensory processing disorder, or any other hallmark of neurodiversity – changed that, for you *and* your child.

Most literature about neurodiverse children tells parents how to help their kids thrive. What's missing: advice for how we, as parents, can thrive when raising a child who differs from the mental picture we painted before her birth. What's desperately needed: the time and space to move through the emotions that inevitably follow a diagnosis.

My personal transformation involved four tangible shifts in perspective. I call them "tilts" in my book, *Differently Wired: Raising an Exceptional Child in a Conventional World*.

Each phase requires this: notice your own thoughts and reflect on them. My reflection questions will guide you as you explore feelings of isolation and frustration – and suggest strategies for transforming your mindset and your parenting.

[Q: What Was Your Reaction to Your Child's Diagnosis?]

Phase 1: Process and accept your child's diagnosis.

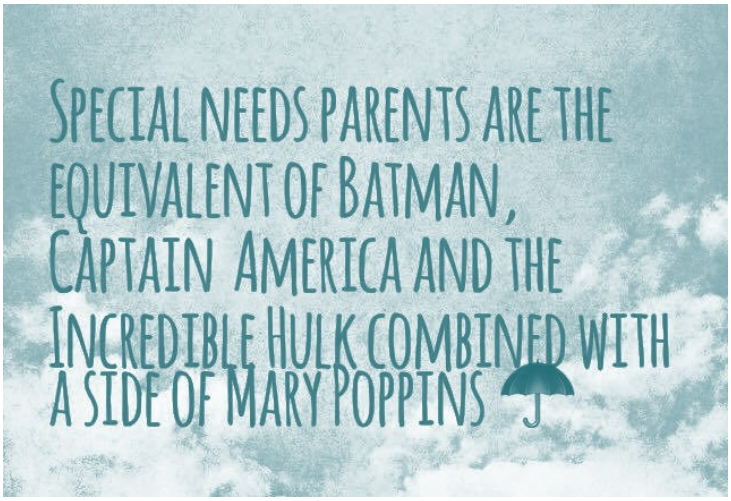
When you're fighting your child's true identity, you can't support him or nurture yourself. Your first step toward acceptance is to pause and grapple with your own complicated emotions about his or her diagnosis. Click here for a detailed plan.

Phase 2: Parent from a place of possibility, instead of fear.

Fear of the unknown will only hold back you and your child. But knowing that won't stop your brain's 3am parade of terrifying "what-ifs." Learn to recognize when anxiety is driving your decisions, and how to choose love and possibility instead. Click here for a detailed guide.

Phase 3: Help your child embrace self-discovery.

Give your child the self-esteem and skills to become a self-actualized adult. That is every parent's goal, but it is especially challenging — and important — when your child is atypical. Click here for a detailed plan.



Phase 4: Shift your mindset, thoughts, and actions.

Your child is "different," and that means you need to question everything you thought you knew about parenting. Click here for a detailed plan.

This advice came from "Accepting Your Child's Diagnosis: Transform Your Mindset, Thoughts, and Actions," an ADDitude webinar lead by Deborah Reber in June 2018 that is now available for free replay.