



Center for Child and Family Traumatic Stress
at Kennedy Krieger Institute

TRAUMATIC STRESS CHRONICLES

GROWTH THROUGH TREATMENT, TRAINING, AND RESEARCH

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TRAUMA-INFORMED CARE FOR A VULNERABLE POPULATION: CHILDREN WITH IDD

Intellectual and developmental disabilities (IDD) affect about 2% of children and adolescents in the United States and internationally. Defined as an early onset, severe, and chronic set of disabilities resulting from mental or physical impairment, or both, IDD affects a range of functional and adaptive skills. They present as intellectual disabilities and learning disorders, autism spectrum disorder, chromosomal disorders such as Down



syndrome, disorders due to in-utero exposure to toxins such as fetal alcohol syndrome, and other conditions (see **Table** page 8). Perhaps most importantly, having an IDD influences the child's ability to function in the world in simple ways that others take for granted, like talking to a friend, ordering in a restaurant, climbing stairs, or mastering a reading assignment.

Children with IDD face a number of daunting, potentially traumatic challenges. Among them is increased vulnerability to maltreatment and violence: These children are the

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TRAINING FRONT

8TH BIENNIAL TRAUMA CONFERENCE SET TO STRATEGIZE AMIDST CONCURRENT PANDEMICS

On September 30 and October 1, 2021, the Center for Child and Family Traumatic Stress will sponsor its 8th Biennial Trauma Conference: *Addressing Trauma Across the Lifespan*. Having endured 2020, we realized it was simply not possible to discuss trauma and traumatic stress outside the context of three concurrent pandemics: COVID-19, structural racism, and escalating mental health challenges. Alone and together the three pandemics have had massive adverse impacts on the United States population, particularly Communities of Color. Our conference, *Strategies for Managing Concurrent Pandemics*, acknowledges these impacts and faces them head-on.

Development and implementation of strategies to effectively address traumatic stress arising from our concurrent public health crises is rooted in the theory of syndemics.

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DIRECTOR'S CORNER



We are pleased to announce that The Center for Child and Family Traumatic Stress has been awarded a 5-year grant, totaling nearly \$3 million, from the Substance Abuse and Mental Health Services Administration. As a Category II site in the National Child Traumatic Stress Network, we will partner with the Social Work Community Outreach Service of the University of Maryland School of Social Work (UMSSW), and with consultants Dr. Hector Adames and Dr. Nayeli Chavez-Dueñas of the Chicago School of Professional Psychology, to

form the *Collective for Anti-Racist Child and Family Systems*. I will serve as Principal Investigator and Program Director. My colleague Dr. Wendy Shaia, Executive Director of the Social Work Community Outreach Service, is the Co-Principal Investigator.

The overall goal of the project is to transform child- and family-serving systems by supporting their adoption of anti-racist, anti-oppressive practices in the provision of care to members of Communities of Color with trauma exposures. In an effort to remedy the persistent lack of intervention strategies that are designed by, created for, and tested among Black and Indigenous People of Color (BIPOC), the collective will advance two frameworks – SHARP and radical healing – and one intervention – HEART – that were developed specifically for Blacks/African Americans or Latinx populations. What these culturally responsive and race conscious approaches have in common is that they acknowledge the social, political, historical, and environmental contexts of children and families of color. Their adoption and successful implementation will prepare providers and systems to implement strategies that promote healing and equity, by addressing such issues as structural and systemic barriers, obstacles stemming from power imbalances, and biases within the provider-client relationship.

An Advisory Board comprised of parents, family members, and youth from past or current programs at UMSSW and the Traumatic Stress Center will be established to help ensure that our project plans are responsive to the needs of families as intended. Additionally, the collective will collaborate with a host of community partners to develop, implement, and disseminate approaches and products. We expect to serve 40 agencies and 2000 providers over the life of the project.

■ Elizabeth A. Thompson, PhD

For further reading, see:

Chavez-Dueñas, N., Adames, H., Perez-Chavez, J., Salas, S. (2019). Healing ethno-racial trauma in Latinx immigrant communities: Cultivating hope, resistance, and action. *American Psychologist*, 74, 49-62.

French, B., Lewis, J., Mosely, D., Adames, H., Chavez-Dueñas, N., Chen, G., and Neville, H. (2020). Toward a psychological framework of radical healing in communities of color. *The Counseling Psychologist*, 48, 14-46.

Shaia, W. (2019). SHARP: A framework for addressing the contexts of poverty and oppression during service provision in the United States. *Journal of Social Work Values and Ethics*, 16, 16-26.



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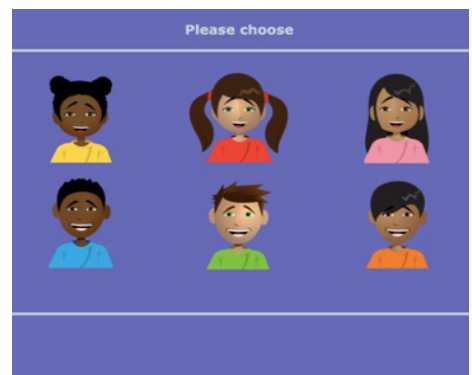


RESEARCH UPDATE

THE INTERACTIVE TRAUMA SCALE

A NEW APPROACH TO TRAUMA ASSESSMENT FOR CHILDREN WITH IDD

The question comes up repeatedly as we treat children with comprehension and language difficulties: How do you assess the child's experiences of trauma when he or she can't report verbally? The answer: tablets and electronic devices. Since almost all children readily use touchscreen devices such as tablets and smartphones, they seem like a natural platform for asking direct questions about trauma. As a clinical psychologist at the Center for Child and Family Traumatic Stress, I was puzzling over the best way to obtain self-report information from children who have endured trauma and abuse. I came up with the idea for what is now called the Interactive Trauma Scale, or ITS. In the past, researchers have relied mainly on adult caregivers' reports to assess mental health symptoms of children with intellectual and developmental disorders (IDD). But this process leaves out much important data. Studies have shown that adults' reports of their children's trauma give only a narrow and possibly inaccurate view of the children's mental health. This has been a major gap in the field, one we are trying to address with this new means of achieving a more accurate trauma assessment.



The ITS is a Web-based measure, currently used for children ages 6 to 14, that asks direct questions about various kinds of trauma and their effects through the use

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...INTERACTIVE TRAUMA SCALE

of an “avatar” character, selected by the child before starting the assessment items. The avatars come in different genders, hairstyles, and skin tones, and they populate the scenes throughout the measure’s interactions.

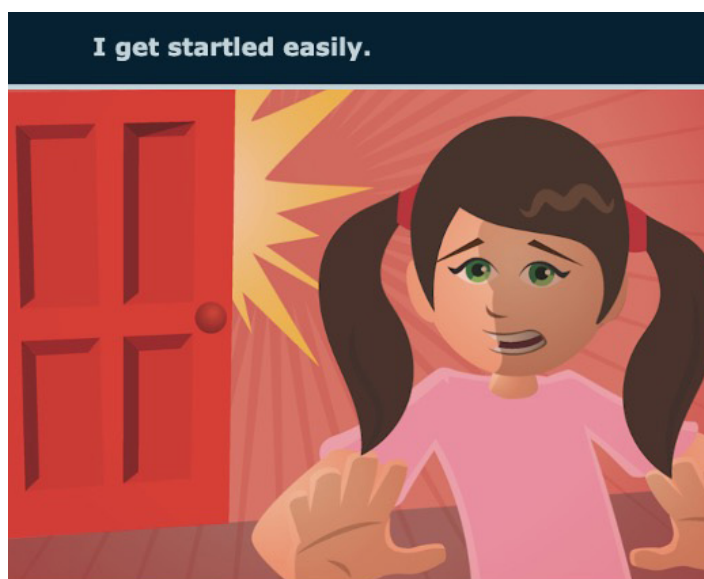
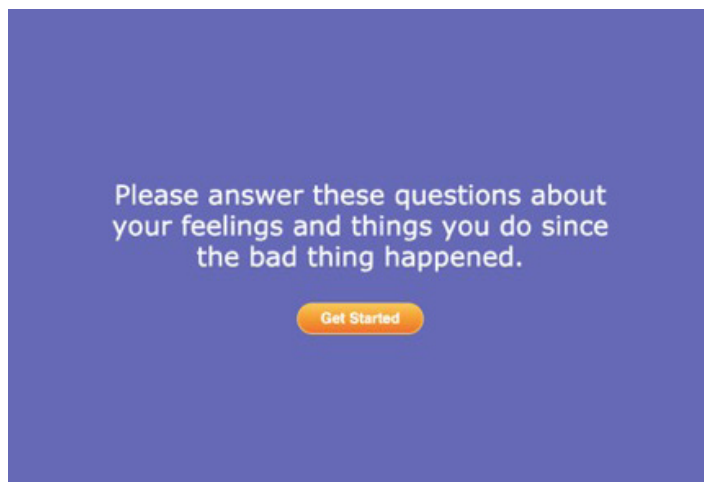
The graphic presentation first illustrates “yes-no” questions about trauma that the child might have experienced. These questions include: “Did you see bad or scary things like someone getting hurt?” and “Did someone touch your private parts or get you to touch their private parts?” Unlike most other trauma measures, the ITS also asks questions about bullying and teasing, something that is especially prevalent among children with IDD. After assessing for exposure to trauma, the scale asks about trauma symptoms or effects. The child is asked to rate the frequency of experiences or symptoms from “never” to “always” on statements such as “I have bad dreams,” “When I’m sad or scared I go somewhere else in my mind,” and “It is hard to remember much about the thing that happened.” The questions and statements were written to be easy to understand and read aloud to the child.

In response to each question, the child simply touches the screen. The nature of the graphic interface makes it natural to administer the measure on-screen during telehealth sessions. A therapist is always present to administer it and to support the child through potentially upsetting topics. Scoring of responses is based on the *DSM-5* diagnostic criteria for posttraumatic stress disorder.

**WE FOUND THAT THE ITS
PRODUCED VALID RESULTS BASED
ON A COMPARISON WITH THE
UCLA PTSD REACTION INDEX.**

During development of the ITS, we asked clinicians who are well-versed in autism, IDD, and trauma to review the content and language accessibility of the questions. The measure was then pilot-tested with a group of 20 children and youth with autism spectrum disorder and known trauma histories. We found that the ITS produced valid results based on a comparison with another standard trauma scale, the UCLA PTSD Reaction Index. Children rated the ITS as easy and comfortable to use, and effective in giving them a platform for discussing their trauma experiences. A new multisite study, currently underway, will use the ITS to compare groups of typically developing children, younger children ages 5 to 7, children with autism, and children with mild intellectual disability. We plan to make the measure available to clinicians in the United States and internationally as our evidence base expands. We expect that it will improve the diagnosis and treatment planning for this vulnerable group of children.

■ **Daniel Hoover, PhD**



HORIZONS CLINIC: TREATMENT AT THE INTERSECTION OF TRAUMA AND DISABILITY

Traumatized children with intellectual and developmental disorders (IDD) require specialized care that is adapted for their comprehension, language, and other behavioral differences. The Horizons Clinic at the Center for Child and Family Traumatic Stress comprises a dedicated, multidisciplinary group of clinicians working at the intersection of trauma and disability, one of only a handful of such clinics operating in the United States. As this specialty area is in its infancy in terms of research-guided practice, therapists are finding new ways of adapting established treatments that were originally developed for nondisabled children.

The Horizons clinic began in 2014, growing naturally out of practical necessity. Clinicians at the Trauma Center had been seeing children and families in the local community for many years but had referred treatment of children with IDD to other departments at Kennedy Krieger Institute that possessed greater expertise with this population. When it became clear that there was a need for trauma-specific therapy that wasn't being consistently met elsewhere, the idea for Horizons took hold. Traditionally, IDD therapists and trauma therapists have had very different approaches to treatment and the two groups have rarely interacted with each other, resulting in what has been termed "silos" of care. For example, a child with autism who has been sexually abused and who has repetitive thoughts, hyperactivity, and sleep problems might be treated in a behavioral IDD clinic with less focus on the trauma and more on behavior management – whereas a typically developing child with sexual abuse history and the same types of symptoms would be seen by trauma-informed therapists, diagnosed with posttraumatic stress, and treated with trauma-focused therapy to reduce emotional discomfort and intrusive memories and to learn steps for preventing further trauma. Ideally, the therapist would combine aspects of both IDD and trauma work to achieve the best outcomes. Until providers gain a sense of how trauma and developmental disorders interact with each other and should be addressed together, missteps in care will happen. Clinicians at Horizons, seeing the rationale for such a "dual-diagnosis" approach, opened the door to serving clients who have these overlapping clinical presentations.

ADAPTING TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a good example of a treatment model that is being adapted to help children with IDD. It is perhaps the most widely used and best researched method for treating trauma in children and families. The model is highly flexible and has been successfully used to help children with traumas ranging from early sexual abuse to combat exposure. Although TF-CBT was originally designed for non-disabled children, we at Horizons have found it to be a good fit for children with IDD who have at least minimal verbal skills and a supportive caregiver. The clinician uses a "matrix" table that acts as a guide for tailoring the usual steps of TF-CBT for children with verbal comprehension

difficulties, language differences, and difficulty applying newfound strategies to life outside of the therapy office.

As illustrated on the following page, we placed these areas of difference for a child with a developmental disorder across the top of the matrix, with the standard TF-CBT steps along the side. Each cell shows effective methods, tools, and adaptations. The clinician first assesses the level of comprehension of the child with IDD. Then, in addition to teaching skills verbally, as might be done with a typically-developing child, the clinician uses techniques derived from IDD behavioral therapists or speech/language pathologists to make learning more understandable and relevant to the child, and thus more usable. The matrix suggests, for example, that the Zones of Regulation model and materials for teaching emotion regulation be used for children who have limited verbal skills. The model offers ready solutions and strategies that families can practice ahead of time, with visual prompts to facilitate memory in times of crisis or upset.

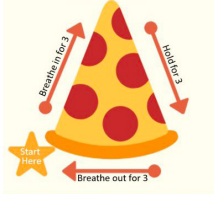


THE CASE OF LUIS

Luis is a nine-year-old boy with autism who became increasingly fearful and regressed after a group of boys beat him up at school. His teacher and parents noticed that he was afraid of going to school, and now he has been refusing to go, a new behavior for him. Since the bullying, Luis has resumed some of the repetitive behaviors (spinning, rocking, repeating favorite TV show scripts) that he had previously reduced. He seemed to be using these behaviors as a means of self-comfort.

Luis was taught to relax his body through mindful breathing, supported by his parents at home. After this practice, his therapist guided him through emoji feelings charts to zero in on his emotions, and then helped him come up with skills for coping with them. As an example of his coping skills, when Luis felt anxious, he would play a game of Uno with his mother or a sibling. Soon he was ready to tell his story. While he did not have words for his experience at the hands of bullies, he worked with his therapist to draw pictures of what happened, and then to label the events and his related feelings. After sharing the story of his bullying with his parents, he began to feel better almost immediately. He slept better and was able to let go of the repetitive behaviors and return to school comfortably.

■ **Daniel Hoover, PhD**

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		IDD DIFFERENCES AND ADAPTATIONS			
		VERBAL LANGUAGE COMPREHENSION	VISUAL-SPATIAL COMPETENCE	WILLINGNESS/ MOTIVATION	GENERALIZATION OF SKILLS
TF-CBT SKILLS	PSYCHO-EDUCATION/ PARENTING SKILLS	Use in-range books and stories; share flash cards	Use behavior charts; offer trauma picture cards (“What Do You Know” game)	Follow visual schedule, routine; move slowly at first	Provide psychoeducation to other systems (schools, social services)
	RELAXATION	<p>“Pizza” breathing; “noodle” practice</p> 	Movement-based yoga practice; videos and apps	Interest-based alternatives; substitute distraction	<p>Video modeling; yoga practice at home; charts of progress with reinforcers</p> 
	AFFECT REGULATION	Emotion game apps, emoji charts; Zones of Regulation	“Check your engine” Alert Program; Parking Space game; feelings thermometers	M&M emotions game; Power Cards	Practice in school and community settings
	COGNITIVE COPING	Thought bubbles, “worry bugs;” “true-false” game	Thought bubbles; Comic Strip Conversations	Triangle of Life app; CBT game	Stop sign at home/ school: “Stop and Think;” “When” reminders
	TRAUMA NARRATIVE	Have parent or caregiver in session as “interpreter”	Draw cartoon narrative, use pictures and collages	Keep narrative session short followed by special interest play	Consider “safe space” or clinician’s office for narrative sessions
	IN-VIVO DESENSITIZATION	Use roller coaster or child-specific analogies	Develop habituation chart	Reinforce small “ladder rungs”	Hierarchies for home, school, community
	SAFETY SKILLS	Use in-range books and stories; use Circles Curriculum/ app	Use pictures, tables, charts; Circles app	Address parents’ concerns about topics; reinforce practices	Use Circles colors for door, bathroom; wear reminder bracelet; engage school personnel
					

A MATRIX FOR ADAPTING TF-CBT FOR CHILDREN WITH IDD

PARTNERING FOR THE BENEFIT OF THE AUTISM SPECTRUM DISORDER COMMUNITY

The Center for Child and Family Traumatic Stress is proud to partner with the Center for Autism and Related Disorders at Kennedy Krieger Institute to provide mental health treatment, through our Horizons Clinic, for children in the autism spectrum disorder community who have also experienced trauma.

IN CONVERSATION

with *Emily Driscoll-Roe, LCSW-C*



ERICKA WODKA, PhD
Clinical Director at the Center for Autism and Related Disorders



MELANIE PINKETT-DAVIS, MSW
Assistant Vice President of Clinical Services at Kennedy Krieger Institute

Since 1995, the Center for Autism and Related Disorders (CARD) at Kennedy Krieger has provided interdisciplinary assessment and treatment services to children and teens with ASD. CARD offers a variety of services to enhance children's functioning, including speech and language services, occupational therapy, mental and behavioral health services, and social and life skills groups. CARD is a nationally recognized leader in the development and implementation of services for children with ASD and their families, and as a provider of training to professionals who work with them.

Ericka Wodka, PhD, Clinical Director at CARD, said that more than 5,000 children and teens each year receive evaluations or ongoing services through CARD. The children served come from the Baltimore area, neighboring states, and even outside the United States. CARD providers offer extensive diagnostic evaluation services

with a multidisciplinary team. As part of the evaluation, providers consider trauma history to determine if an adverse experience is having an impact on the child's functioning. Dr. Wodka explained the importance of inquiring about trauma history, noting that "the symptoms of ASD and trauma can be so similar that the effects of trauma might be missed if a family is not specifically asked about possible exposures." Some of these similar symptoms are regressed development, tantrums, anxiety, emotional dysregulation, irritability, avoidance, and repetitive play.

Assessing for trauma during the diagnostic evaluation at CARD is also important because children with ASD are more likely to be victimized due to deficits in their language skills, physical functioning, and ability to interpret social cues. The most commonly reported traumas experienced by children and teens with ASD are

school violence; physical, sexual, or emotional abuse; witnessing domestic violence; and bullying.

Sometimes family members are not aware of a trauma that their child has experienced and do not endorse trauma in the initial assessment, Dr. Wodka said. "So it is also important to ask a family about the timing of the child's symptoms and whether there has been a change in symptomatology that might suggest a trauma may have occurred." She went on to say that at first, children may not have the language skills to disclose trauma to their parents or to a CARD clinician. But as the child's language skills improve through treatment, a disclosure may be made.

A specific area of concern is the potential for victimization that begins with strangers through online contact. Melanie Pinkett-Davis, MSW, Assistant Vice President of Clinical Services at Kennedy Krieger Institute, said that children on the autism spectrum are more vulnerable to online predators due to their difficulties reading social cues and their desire for acceptance. Dr. Wodka agreed, saying that many children and teens with ASD use technology for a variety of appropriate and beneficial reasons, but without close monitoring, they are vulnerable to victimization.

Ms. Pinkett-Davis shared a story about a teenage boy with whom she worked who was groomed by a predator while playing an online video game. The teen was led to believe that the predator was a peer when he was, in fact, an adult, she said. "The teen's feelings of isolation and desire for friendship made him particularly vulnerable to being groomed online."

Ms. Pinkett-Davis said she appreciates that there are mental health services available to this young man and others like him through our Horizons clinic. (Learn more about Horizons in this issue's **Intervention Insights**, page 4.) She especially appreciates the evidence-based services the Center provides; how its interventions are adapted with the child's strengths and abilities in mind; and the level of training and experience of the clinical staff – CARD refers many children to the Center each year for this particular reason. "I also appreciate the Center for its adult services," Ms. Pinkett-Davis said. "Parents with children on the spectrum can experience loneliness, isolation, and intense stress, so being able to process their experiences with a provider who has an understanding of their unique circumstances is extremely beneficial." Parents already trust the quality of services their children receive at Kennedy Krieger Institute, and so may be more willing to engage in their own mental health care there.

We look forward to continuing to collaborate with CARD to develop and implement effective trauma-informed treatments for children and families in the ASD community.

■ **Emily Driscoll-Roe, LCSW-C**

...8TH BIENNIAL TRAUMA CONFERENCE

The term syndemic was coined by Merrill Singer in the mid-1990s* and has been defined as two or more afflictions interacting synergistically and contributing to excess burden of disease in a population; to prevent a syndemic, the theory holds, we must control not only each affliction but also the forces (e.g., social factors) that tie the afflictions together. It was clear to us at the Training Academy that our trauma conference was a perfect platform for collective discussions among experts in public policy, racial justice, and mental health on the complexity of the concurrent pandemics, their influences on each other, and strategies for bringing healing and recovery to our children and families. The conference will provide 10 workshops dedicated to evidence- and practice-based solutions for dealing with, and recovering from, the repercussions of the current syndemic.

Among the offerings addressing interventions for traumatized Communities of Color, Day 1 will hold a 3-hour pre-conference workshop entitled *Healing Interpersonal and Racial Trauma: Cultural Considerations for Integrating Racial Socialization into Trauma Focused Cognitive Behavioral Therapy with Black Youth*; and a 4-hour pre-conference workshop, *Syndemic "Strains:" Real Struggles and Rap Songs Toward Transformative Youth Violence Prevention*, featuring a trauma-informed youth violence prevention program that uses rap music and hip-hop culture.

Day 2 presents three plenary sessions on the identified areas for collaboration and solution-focused discussions. The morning plenary is entitled *Promoting the Needs of Underserved Communities Through Trauma-Informed Public Policy: Milestones, Best Practices, and the Road Ahead*. Keynote speaker Stephen B. Thomas, PhD, will lay the groundwork for Day 2 with his talk, *The Traumatic Colors of COVID-19: Translating the Science of Pandemic Mitigation into Culturally Tailored Community Based Interventions Designed to Achieve Health Equity*.

Dr. Thomas is a tenured Professor in the Department of Health Policy and Management in the School of Public Health, and Director of the Maryland Center for Health Equity, at the University of Maryland in College Park. One of the nation's leading scholars in



We invite you to join us virtually for the
**8th Biennial Trauma Conference on
September 30-October 1, 2021.**

For more information on workshops, registration, virtual participation, and opportunities as sponsors or exhibitors, visit www.kennedykrieger.org/TraumaConference2021 or call us at 443-923-5971.

the field of racial and ethnic health disparities, he has been a lead investigator of multiple studies examining racial differences in health outcomes. Over the decades, he has developed a significant network of relationships and leadership roles across multiple health disparity-influencing sectors, including academic researchers; healthcare providers and service organizations; community leaders; national foundations; and local, state, and federal policymakers. Dr. Thomas has specific expertise in the development, implementation, and evaluation of community engaged, minority health care, and health disparity interventions. He also has extensive experience in overcoming barriers associated with the legacy of the Tuskegee Syphilis Study (carried out at Tuskegee from 1932 to 1972 by the US government); and conducting scientifically sound and culturally tailored community-based interventions aimed at eliminating racial and ethnic disparities to achieve health equity. Nationally, he serves on the Institutional Review Board of the *All of US* Research Program, a major longitudinal study (National Institutes of Health) that seeks to enroll one million Americans. Dr. Thomas also currently serves on the Advisory Board of the Health Equity Research Initiative of the Robert Wood Johnson Foundation.

This year we are very excited to offer virtual participation in the trauma conference, so that you will be able to join us from the comfort of your own home or office. And best of all, you will still have opportunities to connect with a variety of child and family serving professionals nationally. Networking opportunities such as virtual exhibitor booths and virtual appointments between attendees and other attendees or exhibitors will be available with a click of a mouse or touch of a button on your electronic device. There are sponsorship options available for all budgets: scholarship sponsors can support a conference attendee, for example, while major sponsors receive a virtual exhibitor booth, promotion on our conference Website, and social media recognition. After you register for the conference, you will receive information on accessing and planning all aspects of your virtual conference experience.

■ Danielle Gregg, MA

*Singer, M. (1996). A dose of drugs, a touch of violence, a case of AIDS: Conceptualizing the SAVA syndemic. *Free Inquiry in Creative Sociology*, 24, 99-110.

The Traumatic Colors of COVID-19

Keynote speaker
Stephen B. Thomas, PhD



Stephen B. Thomas, PhD, is slated as keynote speaker at the upcoming 8th Biennial Trauma Conference, Center for Child and Family Traumatic Stress.

...CHILDREN WITH IDD AND TRAUMA

victims of abuse and neglect and bullying at a rate that is about two to three times that of their typically developing peers. They have more scary and painful medical procedures due to associated physical conditions. They also are more likely to be subject to physical management or restraints in educational or treatment settings, which may cause more trauma.

Adding to the concern, children with IDD are overlooked by systems that should be protecting them. They often cannot tell their stories in a coherent and clear way due to language delays. They are at higher risk of removal from their parents' homes, spend longer time on average in foster care, and end up in non-family, group-living placements for longer periods than children without disabilities. IDD typically come with other complications – mental health and behavioral problems, increased family stress, and income insufficiency due to the costs of raising a child with a disability.

With all of their issues, what can we do to help these children and families? The Center for Child and Family Traumatic Stress is at the leading edge of developing trauma-informed treatment to help children with IDD move past traumatic experiences with less fear and threat of further trauma. The therapy has two main components: increasing the family's recognition and understanding of traumatic stress and IDD, and how the conditions intersect; and providing evidence-based therapy that is carefully tailored to the needs of this population of children.

Details about this customized intervention at the Center can be found in our article about Horizons Clinic, the site of our trauma-informed care delivery for the IDD community (see page 4, **Intervention Insights**). It is worth noting here that a major part of treatment is to help caregivers better understand the impact of trauma hidden by an overemphasis on the child's IDD and the belief that the child's difficult behaviors are related to disabilities. Sometimes called "diagnostic overshadowing," this focus may lead

JORDYN'S STORY

The steps of adapted intervention are illustrated in the case of Jordyn*, an eight-year-old girl with autism who nearly drowned in a swimming pool and required resuscitation. After the incident Jordyn returned to wetting the bed, could not sleep at night, avoided pools and other social activities, and engaged in hitting her head when she was reminded of the drowning incident. However, with help from her mother during TF-CBT, Jordyn was able to learn how to relax her body by deep breathing and cuddling her stuffed animals when the memories of trauma upset her. She told her trauma story aloud while the therapist transcribed it, and then the therapist and Jordyn together shared the story with her mother in detail; it included her words, "I lost my goggles and couldn't breathe and I died." Although it was scary for Jordyn to approach narration, she did it a little at a time and experienced considerable relief from her traumatic memories as a result.

(*Names and other personal details are changed in all case descriptions.)

caregivers, medical professionals, and educators to miss a child's emotional needs related to trauma. They may medicate children and manage them physically, failing to assess or recognize the influence of traumatic experience in their behaviors. All of us in the field need to get better at recognizing that children with IDD have feelings and thoughts separate from their disability, and can benefit from help that is adapted to their special needs.

■ **Daniel Hoover, PhD**

TYPES, FEATURES, AND COURSE OF SOME DEVELOPMENTAL DISORDERS

TYPE OF DISABILITY/ CAUSE	EXAMPLE	COMMON FEATURES	COURSE
Chromosomal disorder	Down syndrome	Predisposed to medical conditions. Intellectual delays	May gain increasing independence in adulthood
Exposure to toxins	Fetal alcohol spectrum disorder	Physical and facial differences; intellectual delays; behavioral and learning difficulties	Lifetime course, but early intervention may improve outcomes
Neurodevelopmental disability	Autism spectrum disorder	Social comprehension difficulties; repetitive, rigid behavior	Lifetime course, but functioning may improve over time with intervention
Traumatic brain injury	Frontal lobe injury	Changes in mood, memory, behavior; physical symptoms	Varies by injury; may seem "fine" at first with impacts observable over time