Capturing the experience of disability in Queensland primary schools: The case of PTSD

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Abstract

There is little known about the experiences of children with disabilities in primary schools. There is even less known about the experiences of children with emotional disabilities. Contemporary policy frameworks such as Education Queensland's Ascertainment Policy attempt to support assertions of full inclusiveness of all children with disabilities and learning impairments. However, they neglect to account for how these children "experience" this system and how that experience informs policy development. This information is crucial for assessing the effectiveness of policy implementation. This paper presents a framework for investigating and reporting those informative experiences to direct future policy evolution.

Introduction

(Throughout this paper the terms Post Traumatic Stress Disorder (PTSD), traumatic stress and emotional disabilities are used interchangeably as each is inexorably associated with the other).

The politics of "inclusion" are very complex, as is the discourse of disability. The issues concerning how these two entities are defined and interact have raised much debate and discussion over the past few decades (Dempsey, 2004; Guetzloe, 2003). There have been large amounts of resources invested into establishing and maintaining an interactive, proactive evolution of the learning environment towards a notion of "full inclusion" by Australian education systems where the plan is to ensure children with disabilities and impairments remain in mainstream classrooms. Thus far, most Australian states with their own independent education systems have successfully followed this plan. However, a significant and perhaps most detrimental oversight (if one can refer to it as such) is the absence of acknowledgement by these Education systems to recognise the experiences of their disabled students.

The current problem spotlighted by this paper is that the Queensland Education system (EQ) does not utilise a mechanism that systematically collects and optimally utilises data on the experiences of its students with disabilities to inform policy amendments and evolution. The principle document used to identify and categorise disability in EQ students is its Ascertainment policy. This is where the symptom of the problem lies: in its lack of capacity to collect information regarding its impact on its target audience. This creates a paradox of intention. On the one hand, EQ aims to account for the full inclusion of all its students with disabilities, yet cannot do so as it does not employ a system that reports to the principles and guidelines driving that intention towards full inclusion. EQ's behaviour management principles endorse a practice of 'self-governance' in managing problematic behaviour in students; leaving it up to the individual student to assume responsibility for, and effectively control their behaviour

(Manning, 2005). This creates many issues and fosters many default assumptions in policies relating to disability management to "fill in the gaps" and may be why there is no specific information on how the system interacts with the specific vulnerability of emotional disabilities caused by traumatic stress. Therefore, this thesis presents a research strategy designed to fill in these gaps through the deliberate selection of a specific example of the neglect and denial of the student's experiences of disability by EQ.

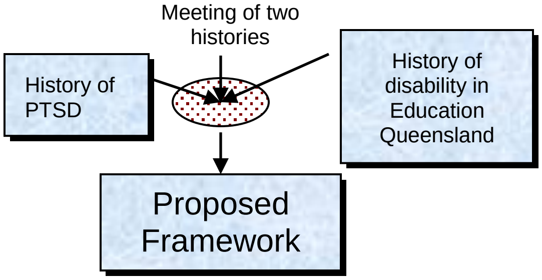
Gaps in knowledge.

To date, there appears to be little research conducted that either collects or critiques data on the experiences of students with a disability, particularly within EQ. There is even less on the experiences of children with familial histories of trauma and emotional disabilities. The bulk of the limited available literature originates from overseas. This may be due to the numerous gaps that appear in this issue, perhaps not in the knowledge of familial transmission of trauma itself, but in connecting this knowledge with its impact and ability to know how to manage the progression, evolution and outcomes of these situations in the school environment. This may be indicative of the lack of support services in existence for these children in EQ schools, even though they are known to be at increased risk of psychosocial and academic (Cuthbertson & Silovsky, 1996a). It is equally well known that all students with a disability are devalued by society and their peers (Lyons, 1991).

A recently published article that edifies and validates the investigation of an Australian perspective of this evolving issue is presented by E. Brown (2005), who states that children and families dealing with traumatic stress also might benefit from research on community-based interventions and preventive programs (designed to prevent the development of PTSD following traumatic events).

Therefore, this paper will be invested in presenting a proposed framework for study into the experiences of PTSD, traumatic stress, emotional disabilities and their associated conditions and how they impact on the learning and social capacities of young primary-school aged children in Queensland. PTSD is used merely as an example of one of many disabilities and impairments that has detrimental impacts on a child's potential, yet is concurrently "brushed over" by EQ. The data collected can then be used to provide feedback to the policy decision-makers to assist them in creating relevant, appropriate and applicable amendments. It aims to do this by presenting the framework as a means of drawing together the history of disability in EQ and the history of PTSD to demonstrate how they meet to produce the vulnerable child in the Queensland primary school environment. These histories will be brought together to outline some of the specific concepts and strategies for capturing this experience to inform future policy development. Figure #1 illustrates this concept.

Figure #1
The structure of a proposed informative framework.



The focus of the framework.

If any future research into this issue is going to have value and influence it must focus on the child's perspective of disability and their environment. Deering (2000) supports and further enhances this view by asserting that researchers and clinicians need to understand the experience from a child's point of view and account for the individual child's particular development level and sensitivity of perception. Historically, clinical investigation and analysis of childhood disabilities have been diagnosed from an adult-observational medical perspective. Only recently have studies been interested in the experience of disability from the child's perspective in a social or community environment (Burger & Lang, 1998; Nicholson, Sanson, Rempel, Smart, & Patton, 2002). The findings of such research has made controversially radical moves to challenge traditional methods of diagnosis and management, and to propose a consideration of the child's and immediate family's experience of the issue.

This paper will attempt to raise some very pertinent questions and (hopefully) generate discussion that may result in further investigations and policy reviews for the education systems that have maintained a disabling environment for children with disabilities.

Overview.

The first chapter will discuss how the current problem is reflected in many academic approaches to disability as they relate to EQ's management of the experience. It will explore the reasons why PTSD was selected for research and why a framework should be created in retrospect of shifting trends in research and criticisms of current practice.

Chapter II will explore the difficulty in defining disability and the history of EQ's management and conceptualization of disability to recent times. How EQ constructs policy and supports its own mechanisms of design will be discussed in light of recent research.

Chapter III will explain the condition of PTSD and how it evolved to its current status. Its unique impact on children and adults will be presented including its influence on the individual's ability to self-manage stress. Central and peripheral effects of PTSD will be discussed including memory impairments, neurobiology and genetics behind its perpetuation.

Chapter IV will draw the two previous chapters together by demonstrating how they meet to produce the vulnerable child. It will discuss the reasons behind EQ's management style and why this issue needs research. It will look at the issues that need to be addressed before an adequate management style can be created and implemented.

Finally, Chapter V will reflect upon main assertions and how the framework contributes to our understanding of the experiences of disability in EQ. it questions the need for the target group of students to be identified and segregated from mainstream pupils and concludes by discussing the need for EQ to re-conceptualise its definition and management of disability.

CHAPTER 1: Academic approaches to disability

This chapter will discuss three main models of disability and contrast them with EQ's current system of disability management. Two prominent perspectives of disability, with a focus on the role of PTSD and traumatic stress in disability theory will be discussed din light of a shifting trend in research towards a sociological bend and the benefits behind inclusion.

The role of PTSD in disability theory.

PTSD has a significant role in disability theory. Michailakis (2003) outlines three principal models of describing disability (medical, social and contextual) each accounting for the impairment/s facilitated by traumatic stress. The traditional medical perspective views it as impacting heavily on an individual's ability to adequately and appropriately function in society. This model asserts that the functional impairments associated with PTSD, once labelled with a clinical diagnosis, could be treated with therapy to compensate the individual back into society through rehabilitation. The focus here is on the individual as the source of impairment or abnormality. This is the primary model used by EQ; to view disability as a medical condition residing within the individual and therefore to manage and treat it medically with responsibility for management being owned by that individual.

The Social Model describes disability emerging as an effect of the obstacles raised by that society in which the individual lives (Michailakis, 2003). The focus is on the interactions between the individual and their society and the societal demands that establish whether impairment becomes a disability or not (B. Adkins, Smith, Barnett, & Grant, 2007). This model also asserts that it is society that must be adapted to include disabled people and absorb individuals with a difference to minimize the adverse social effects of that difference. As discussed elsewhere in this paper, this perspective asserts a situational relevance to disability. In a society where all children have the same disability, it will be the able child who is impaired.

The third model claims no causality between impairment and disability. The Contextual Model asserts that disability is culturally, socially, economically and politically constructed and is driven by discrimination. As stated, "*Disability becomes equivalent with oppression by social and institutional structures within which certain physical, emotional and intellectual differences are identified and treated in a certain way"* (Michailakis, 2003, p.: pg 211). 211). This model views disability as belonging to an excluding and oppressive society and is popular with disability support organisations. B. Adkins et al. (2007) describes a critique of traditional perspectives of disability that illustrates how the assumptions of the medical model of disability significantly contribute to the social exclusion model. Applying these models to EQ's management of disability allows for dedicated research to be conducted that further investigates the impact of disability on EQ.

Resistance to full inclusion.

Some social sectors perpetuate a resistance to the full inclusion of disabled students into mainstream classrooms. Some argue for social reasons, some for economic reasons. From the social perspective, (Slee, 2001b) comments that full inclusion of disabled children might have an effect on the education of others by confusing academic standards with school discipline. This portrays a view that, although schools try to minimise any segregation by peers and teachers of children with a disability, some level of prejudice will always persist. Schools have a social and moral obligation in setting the stage for the development of community ideologies and attitudes. Schools need to assure their communities that children with difficulties will not have any negative impact on the learning potential of other children at that school. Slee further states that schools compete with one another for high quality students who add value to their academic structures. Disabled students are seen to decrease value and invite risk. Those schools that do extend invitations to disabled children require additional programs in their curriculum and changes to physical structure. This tends to result in conflict with State education boards when one school is seen to be challenging government-enforced standards. That school may then be pressured by tightening of education budgets and restriction of resources to adapt to a preferred mode of management. Slee (2001b) questions the educational agendas of local and state governments, claiming schools are marketised for producing social contributors, not liabilities, to supports the status quo.

Those who support the financial reasons for excluding disabled students from mainstream classrooms argue that full inclusion as a whole, drains valuable resources away from those who could utilise them more appropriately and efficiently (Slee, 1999). Although there is some confusion surrounding this argument, Slee claims that Australia has supported long term exploitation of disabled people in sheltered workshops where they are paid disproportionately low wages for the ‘privilege of work’ and that the unfair wages are compensatory for giving disabled people ‘something to do’. Disabled people have historically been forcibly sterilized, educated separately and represented by the law disproportionately to non-disabled people (Slee, 1999).This is supported by Michailakis (2003) who claims a profit-driven rationale for the social exclusion of people with disabilities in that they do not contribute to social progress. Regardless of the reason for excluding children with “differences”, their perpetual segregation may be costing society more than including them. Unfortunately, the limitations imposed on this research do not allow for a deeper investigation of this point. That may be taken up in subsequent investigation.

Why choose PTSD?

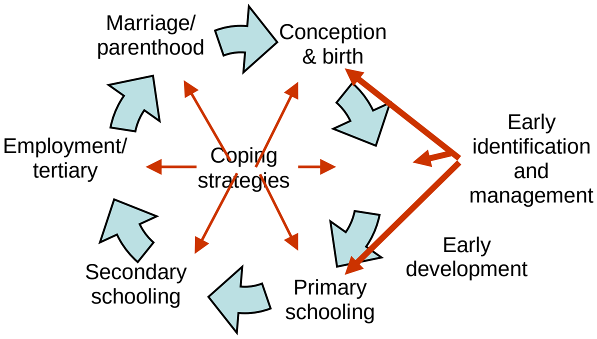
PTSD (and its disabling effects) has been selected for this paper for a couple of reasons. On the one hand PTSD is just one example of disability, selected to extract and explore EQ’s methods of conceptualisation and management of disability as a whole. This is done to demonstrate the need to design approaches to make the experience of disability more visible. At another level PTSD is a case of a disability that has quite unique characteristics manifesting in a wide variety of specific impairments that are way less recognised and understood than other more obvious ones. Therefore, these specific barriers to learning are less catered for, even implicitly, at the policy level. This, in turn, intensifies some of the problems associated with the neglect of the experience of disability in the educational context.

Current and recent research in this field is beginning to reveal a sub-culture of children who are at risk of developing severe emotional disorders, such as anxiety and depression, as a result of either direct traumatic experience, or from an inherited predisposition (O'Brien, 2004). It is suggested in this paper that PTSD has an intergenerational transference affect which results in the next generation being born with a lower Stress Management Threshold (SMT) than children with no familial history of PTSD. This means that a son or daughter of a parent with PTSD may be unable to adequately process emotionally stressful information as effectively and efficiently as their counterpart whose parents do not have a history of PTSD. The consequences have been found to lead to socially unacceptable behaviours such as violence and aggression, substance-related behaviours, eating disorders, conduct disorders and suicide (Johns & Guetzloe, 2004; Weingarten, 2004). When a child with these inherent vulnerabilities presents at an EQ primary school, it creates many problems that EQ is not adequately prepared for to manage suitable outcomes for these children. Hence the purpose of this paper.

As the increasing incidents of natural disasters, conflicts, war, and terrorism is thrust into our family lounge rooms on an almost daily basis, it becomes more of a challenge to protect our children from the effects who are more often the most susceptible, and they frequently transfer the effects from the domestic environment to their school environment. We are beginning to witness the distressing effects of trauma on the learning potential of our children. The principal effect of trauma in children is emotional disabilities: the “invisible” disabilities (Gable, 1999). They are not obvious to adults and peers and therefore do not attract the same attention from researchers and health professionals as the “visible” disabilities do.

Additionally, the early school years are the most impressionable and vulnerable for any child, (Peterson, 2004) regardless of their “abilities”. Figure #2 illustrates this assertion by presenting the Cycle of Intergenerational Trauma (O'Brien, 2004) which highlights the crucial developmental stages where the implementation of an effective management strategy can greatly influence the production of social contributors, or liabilities. If identified early and managed appropriately, the burdens on finance, infrastructure and resources to both society and the individual can be minimised.

Figure #2: Cycle of Trauma Transference.

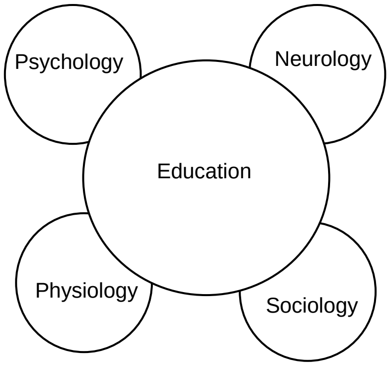


With informed management, EQ can significantly reverse the damaging impact of many classes of disability and impairment, including PTSD and its associated conditions. This model can be applied to almost any disability or impairment.

Why create a framework?

This framework needs to be created for two principle reasons. Firstly, to bring together the disciplines that co-ordinate research into specific disabilities and to effectively implement the findings into the education system. Unfortunately, the doctrines that conduct this research cannot extend the influence of their findings beyond the philosophical boundaries assigned to that discipline. Therefore they stop short of having any real impact on the most vulnerable, and most needy: children. As illustrated in figure #3, this framework will have the purpose of bringing those disciplines together to complete the picture.

Figure #3: Bringing it together. Joining doctrines to form the framework.



Secondly, the framework will be essential in moderating and managing future research into the experience of disability in Queensland primary schools. The appropriate coordination and regulation of research and investigation will need to be established early to avoid confusion, misrepresentation and mismanagement. Failure to do so may result in further impairments for the students, families and communities concerned and the economic and social costs to Queensland.

Shifting trends.

The way EQ is changing to manage its disabled students more effectively may be driven by a shifting trend in academic research. More literature identifies the benefits of including these children with physical and/or behavioural difficulties in the mainstream classroom. These benefits are not only for the child with the learning difficulty, but for their peers as well (Noble & Munnings, 1999; Priestley, 1998).

If a child has a condition that risks the learning and development of other students, then that child may be separated from those other students and placed in an environment where their specific needs can be managed. This is classic intervention and special education can suggest exclusive education. It may also suggest the child with a learning difficulty remains in the classroom, but is provided with a variety of support services to assist their learning providing their particular disability is not disruptive to the learning of their peers.

However, as (Slee, 2001a) comments, the notion of disruption is socially, economically and geographically relative. In a community with a high proportion of students with a particular learning impairment, local schools will be well-equipped to manage their needs and these students will be perceived as mainstream and not as disruptive. The policy and process of ascertainment is standardized across all societies, economies and locations in Queensland and, as has been previously mentioned, each individual disability is different. Standardization of ascertainment is optimized only if students are standard. Slee (2001a) questions whether the social construction of “disability” is actually a product of a “disabling environment”. If schools are not equipped (environment and attitude) to manage children with differences, these differences become a disability to the child, not the school. Such is the case with PTSD. Communities exist in Queensland that present higher proportions of families with clinical accounts of PTSD and other traumatic stress conditions. The schools that provide education to children in these areas need to be aware of and equipped to manage the effects of these conditions.

Criticism of the DSM-IV-TR

As previously mentioned, the medical model of disability asserts the reference of the DSM for diagnosis and prognosis of psychological conditions. The DSM is one of two of the most widely used resources, yet some prominent researchers assert it is not an accurate tool of diagnosis and assessment at all. They claim that it is essentially a classification system that places individuals in categories without systematically delineating the underlying causes of their disorders, and that the etiology and nosology of many disorders are still intensely disputed among mental health professionals (F. Kaslow, 1996). Understanding its causes may assist in understanding how it is experienced. This may help to understand how best to manage it. Additionally, some researchers assert the system of empirical research that underpins the DSM is in itself, flawed. To support this assertion, F. Kaslow (1996) draws on events in history that have challenged the scientific evidence for the classification of a condition. One such event involves the reluctant inclusion of PTSD into the DSM-IV following several years of pressure both from within the DSM’s internal research community and the general public. Now PTSD is attracting far more clinical research than ever before. The doubt surrounding the effectiveness of the DSM may be contributing to the confusion, frustration and uncertainty of how to manage and treat many psychiatric and emotional disabilities in EQ schools, since EQ relies heavily on it. As the DSM constructs the medical model of disability, and may be, in itself, flawed, perhaps EQ could benefit in its management of disability by adopting a different model based on a different resource.

Although these academic theories, models and approaches to disability do much to describe how disability is culturally and socially conceptualized, they do little towards collecting information concerning the experiences of children with disability that inform policies built on these dominant models. Consequently, an academically driven acknowledgement has evolved for the need for the creation of a framework that does just that. This may not have previously been provided in the history of disability management in EQ.

CHAPTER II: The history of disability management in Education Queensland.

This chapter will review the history and evolution of the management of disability in Australia, discussing current conceptualizations, definitions and recent reforms embraced by EQ. A discussion concerning the current limitations of the school environment and its impact on disabled children is presented. This approach is necessary to formulate the first half of the meeting of two histories.

The management of disability in Australia has had a disturbing history that has only recently changed to be more understanding and accepting. This has been reflected in the history of how Australia's education systems have managed the issue. The Queensland education system has recently implemented innovative strategies on classroom management and centralized responsibility for student progress to the school and its community (New Basics Report). This has provided many benefits to the quality of education through the reconstruction of the curriculum and core management procedures. However, many disabilities have remained unacknowledged and unrepresented and therefore will continue to be mismanaged.

Defining disability.

One of the possible causes for the continued confusion over disability management may come from the confusion over its definition. This topic has been discussed and debated in local, national and international settings in an attempt to find a universal definition that meets the needs of those who deal with this human condition (Dempsey, 2004). No suitable definition has been agreed upon as yet. As a consequence individual organisations are able to adapt a flexible definition to serve their needs, depending on their desired outcomes and tools of policy delivery. The variety of organisations that provide supportive services to EQ and its students all have varying definitions of disability that may affect the quality and focus of service delivery. This can create further administrative confusion that unnecessarily contributes to the already dense quagmire of processes and procedures that health professionals, support agencies, parents and students must endure to gain recognition and support for their disability. Farran and Shonkoff (1994) claim that categorization of disabilities are a function of discernible differences and more related to contemporary societal definitions rather than a national or global agreed definition.

To fully understand the logic behind the construction of EQ's definition of disability that governs this policy it is necessary to delve a little into how it has evolved in recent times, how it is currently defined and constructed. This will assist in identifying what is required from the framework.

To define disability and impairment, in 2002 EQ adopted a medical definition which is currently enforced throughout its operations. Disability is thus defined as "*any* *restriction or lack of ability (resulting from impairment) to perform an activity in the manner or within the range considered normal for a human being."* (Education Queensland, 2000, p. 47). Impairment is defined as "*the loss or abnormality of psychological, physiological, or anatomical structure or functions"* (Education Queensland, 2000, p. 47). These definitions neatly and comfortably account or a variety of impairments and disabilities that negatively influence a child's learning potential. The classes of disability that EQ recognize in their Disability Ascertainment Policy are limited to:

- Autistic Spectrum Disorders (ASD)
- Speech Language Impairment (SLI)
- Intellectual Impairment (II)
- Hearing Impairment (HI)
- Physical Impairment (PI), and
- Vision Impairment (VI).

EQ's limitation of Ascertainment to these six classes excludes many conditions that have severe detrimental impacts on a student's learning abilities. Further elaboration on the limited scope of the Ascertainment policy is discussed later in this chapter.

Recent history of disability and exclusion.

To grasp an appreciation of the recent reforms made by EQ in the provision of quality educational service, it is essential to briefly explore a history of how the management of disability has evolved to what it is today, and of some elements of the policy decision-making process.

Compulsory inclusion for disabled children has been a recent event. The first schools that practiced the belief in the educability of disabled children began in 1913 in Victoria within the Kew Cottages Asylum. They exercised the right to segregate disabled children until 1984 when policy changes required more specialized forms of support for students with disabilities (Slee, 2001a). However, this did not result in inclusion. Rather, it resulted in a more specialized form of exclusion where the policies reinforced the reasons to segregate to avoid disadvantaging the non-disabled students and teachers, an attitude perpetuated by many even today. In 1992 the Commonwealth Government passed the Disability Discrimination Act (DDA) which requires educational institutions to adapt their processes so that students with disabilities achieve substantive equality. The DDA implies a broad definition of disability that is difficult for health professionals, teachers and staff to use to clarify clearly what constitutes a disability or impairment and is therefore considered for ascertainment. The DDA definition of disability refers to "*a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour"* (Shaddock, 2004, p. 53). EQ chooses not to adopt this definition, yet the behaviours manifested by traumatic stress can affect the thought processes, perceptions of reality, emotions and judgments of the individual. Indeed many conditions that significantly impact on a child's learning potential are not accepted for ascertainment by EQ. this may suggest that the demand from parents and the community needs to be asserted enough to force EQ to consider the condition for ascertainment. If the need is great enough, and there is enough supportive research and literature, then the odds are greater that the condition will be accepted for ascertainment.

The World Health Assembly endorsed the International Classification of Functioning, Disability and Health (ICF) in May 2001 (World Health Organisation, 2001). The ICF has been widely accepted as a framework for conceptualizing impairment and disability and has been adopted by a variety of organisations and applied in a variety of capacities (Australian Institute of Health and Welfare (AIHW), 2003). The AIHW state that, as a multi-dimensional concept, disability relates to the body functions and structures of individuals, their activities, the life areas in which they participate, and the influencing factors in their environment (World Health Organisation, 2001). The ICF recognizes environmental impacts and personal factors as representing an important and vital influence on individual functioning and disability (Australian Institute of Health and Welfare (AIHW), 2003).

The ICF adopts the broader definitions of disability as asserted by the ICD-10 (International Statistical Classification of Diseases and Related Health Problems, 10th revision). However, when defining and classifying intellectual disabilities most Australian statutory organisations use and enforce the definition of "mental retardation" as used by the American Association on Mental Retardation (AAMR) who draw on the Diagnostic and Statistical Manual for Mental Disorders (DSM) which is the alternative diagnostic tool for the ICD-10 (Australian Institute of Health and Welfare (AIHW), 2003). (Australia does not support the term "mental retardation" as the United States does. Australia prefers "intellectual disability or impairment").

In 2002 the Minister for Education, Anna Bligh, established a Taskforce on Inclusive Education for students with disabilities whose purpose it was to investigate and advise on how to adapt the schooling system to be more inclusive of students with disabilities or learning difficulties or differences. This taskforce collected data from several sources involved in the appropriate education of students with disabilities and impairments. This information was collated and presented in the Education Adjustment Program (Education Queensland, 2005a). A significant limitation of this effort is that it only considers the issue from the adult perspective, not through the eyes of the child experiencing disability. Therefore many crucial elements may have been 'brushed over'. This serves to validate and perpetuate core designs in the original policy on disability. If there appears to be no problem, nothing will be changed. To continue to neglect to account for the experiences of the child with the disability or impairment, simply perpetuates ignorance and deepens their barrier to appropriate education.

The recent expansion of the DDA to include the Disability Standards or Education in 2003 indicates a growing acceptance for the inclusion of students with disabilities in regular schools (Gentle, 2004). This desegregation of students with differences has led to a deeper understanding of the value to the individual and community of full inclusion for all students. However, does the recent expansion serve to further blur the boundaries of definition? Will this result in less clarity for those experiencing a disabling condition and will it be increasingly difficult for mental and health professionals to accurately diagnose those conditions? Consequently, those students excluded from mainstream classrooms may experience institutionalization that is likely to perpetuate into adulthood. The ramifications of this are complex, costly and extensive.

Current management practices for traumatic stress and emotional disabilities.

Currently EQ's management practices for emotional disabilities and associated impairments caused through traumatic stress are ineffective and dysfunctional in themselves and contribute to the severity of the condition by perpetuating and environment that enables life-long suffering of its symptoms. Under its Duty of Care policy, children who either directly or indirectly experience a traumatic event are attended to immediately by EQ (Manning, 2005). The current management procedure requires an assessment by the school principal who must inform EQ of the situation and the requirement of EQ's Critical Incident Response Team (CIRT). This request is assessed by the receiving officer and the manager of the CIRT and is prioritized according to severity, impact and potentiality. The CIRT then attends the school and provides intensive counselling and therapy to any child or adult affected by the event (McGrath, 2005). However, evidence suggests that EQ falls short in providing effective long-term management of the damaging effects of trauma on the developing child. Current studies reveal EQ allows only a short time frame for addressing trauma and its side effects in school children under their care. The current maximum time frame for the CIRT can remain in any one school is two weeks (McGrath, 2005). PTSD can take weeks, months or even years before it manifests as destructive and detrimental behaviours and impairments in children (American Psychiatric Association, 2000). This opens doorways for approaches to effectively managing this phenomenon that will be touched on briefly later in the paper.

Establishing a policy.

Before a disability or class of impairment is accepted for recognition in EQ's policy guidelines, it must be subjected to many tests. One of these involves general agreement and acceptance by a majority of health professionals (Education Queensland, 2000). EQ asserts a multi-faceted management approach to disability in primary schools. This requires the involvement of teaching staff, medical and mental health professionals and parents and families of the child. Once a student is identified as requiring support for learning, data concerning the nature and impact of their impairment or disability is collected from a variety of sources. This data is collected from mental and medical health professionals, teachers and family (but not directly from the children). Evidence for this is included with EQ's Ascertainment Policy guidelines. Templates are provided to medical and mental health representatives to complete and forward to EQ when a child is referred to them for assessment (Education Queensland, 2000).

Endorsing database of medical authorities.

These representatives are part of a strict database EQ uses to endorse and enforce its provision of ascertainment. They are trained by EQ on how to complete the required template documents. Those medical and mental health professionals who challenge EQ's guidelines do not receive referrals from EQ. This further restricts the boundaries of definition of disability and allows optimum control of variables by EQ. Conditions change with time and the qualifying criteria change also. The APA has amended criteria for various mental conditions over time and intends in the next version of the Diagnostic and Statistical Manual (DSM-V) to have a category specifically for Posttraumatic Stress Disorder (American Psychiatric Association, 2000). Currently this condition is listed as an anxiety disorder, yet many symptoms are depressive. There is a growing pool of literature that supports a review of this condition and the way it is categorized by the APA (Lichtenthal, Cruess, & Prigerson, 2004).

Documents of current interventions and supports are reviewed by a panel of EQ representatives. In the case of emotional disabilities and other traumatic-stress related conditions, there is not likely to be any formal documents to support a claim of learning impairment. Additionally, as EQ does not recognize these as having any impact on a child's learning potential, they do not provide the relevant templates for the mental and medical health professionals. As a double-edged sword, any such professional who does consider a child's learning to be threatened by a traumatic stress condition will not be recognized by EQ. this makes it very difficult for parents and children suffering these conditions to have their experiences heard, recorded and acted upon in school.

There are three possible outcomes from the document review. (1) the student's requirements are met by resources available at the school, (2) appraisement is initiated formally, and/or (3) ascertainment is initiated formally. Outcome (1) is managed in-house by the school and the resources available immediately to them. This involves a documented Strengths and Needs Analysis, data collection and discussion using school-based and EQ regulated procedures, and a review and documentation of current interventions and supports (if any are in place). Appraisement in Primary Schools in outcome (2) involves an in-house process consisting of the identification of a student who may have learning difficulties or impairments, data collection and the choice of a Program Type and Support Plan. These are implemented and managed by the student's teacher and support teacher. Outcome (3) involves the initiation of the formal ascertainment process, incorporating documented investigation and assessment by duly authorized and qualified medical and mental health representatives. Outcomes (1) and (2) require the school to utilize to its optimum, the services and supports it has access to. Schools and families work cooperatively and collaboratively to identify the child's strengths and weaknesses and construct an appropriate plan of learning and instruction to meet that student's specific needs. To date, this is the inevitable choice in the management of emotional disabilities and other traumatic stress conditions.

EQ states it is committed to providing an inclusive curriculum that meets the needs of all students and society and it can only be inclusive when all participants in the learning process

"(a) identify and address barriers that limit students' opportunities, participation and benefits from schooling;

(b) include, value, and use as a basis for learning, the perspectives, contributions and experiences of the full range of social and cultural groups, by acknowledging diversity both within and among these groups;

(c) develop the knowledge, skills, attitudes and processes necessary to:

- (i) question how disadvantage has developed and exists within social structures;
- (ii) challenge rather than accept social injustice;
- (iii) empower people to participate as equals."

(Education Queensland, 2005a).

The policy further states that these principles must be applied by all educators in planning and reviewing the teaching practices and learning experiences of all social, cultural and ability groups. With respect to students with traumatic stress-related conditions, this statement is *not* applied on the coal-face, where it is most needed, making it almost hypocritical. It appears that the EQ system does not yet recognize, and therefore is not aware of the full impact of the effects of traumatic stress on the learning potentials of our children, and it may be the policies themselves that create this ignorance; the way they are designed and implemented may be self-impeding.

EQ recent reforms.

The recent reforms adopted by EQ's New Basics Project are presented in the New Basics Research Report which claims to have resulted in improving learning environments for all out children (Education Queensland, 2004). The new curriculum is "on trial" to provide more fulfilling educational outcomes for its students, based on answering the four core questions:

- Who am I and where am I going?
- How do I make sense of and communicate with the world?
- What are my rights and responsibilities in communities, cultures and economies? And
- How do I describe, analyse and shape the world around me?

(Education Queensland, 2000). These reforms intend to improve the quality of content and structure of education in Queensland to provide children with better outcomes. Additionally, the reviewed Ascertainment Policies and Guidelines also set new precedents for educational reform (Manning, 2005). However many gaps still exist and need addressing. The current ascertainment policies do not account for nor recognize children with emotional disabilities or other conditions relating to PTSD. This may be due to the way EQ conceptualises disability.

How is disability conceptualised in EQ?

In conjunction with Michailakis (2003) and others, Slee (2001a) provides insight into how EQ conceptualises disability and its effect on the education system. EQ appears to utilize two main approaches. The first involves the Medical Model. In this approach disability is seen as an individualised medical condition that is scientifically categorised into various classes of impact and impairment that affects a student's participation and performance in the mainstream classroom. This is reflected in EQ's definition of disability as described in its Ascertainment Policy (described earlier in this Chapter).

These definitions neatly and comfortably account for a variety of impairments and disabilities that negatively influence a child's learning potential. Institutions may choose to implement any one from a variety of definitions of disability that will meet their needs. EQ is no different. The limited scope of six classes of disability and impairment leaves a range of disabilities and impairments unaccounted for that also have negative influences on a child's academic and social development. Those idiomatic with traumatic stress are extensive and detrimental in their course and prognosis. They can have quite disastrous implications on a child's social and academic learning potential and produce many other related conditions that impair them as well. It may be claimed these are frequently misdiagnosed and their source is often overlooked or neglected(Scott, 2004; Strand, Sarmiento, & Pasquale, 2005). Therefore the child does not receive appropriate treatment and management for their situation and, as commented by Slee (2002) continue to be mistreated by the education system that establishes the boundaries for the rest of that child's life.

The second approach EQ appears to use to conceptualise disability (but to a lesser influence on policy) involves the Social Model where disability is seen as a socially constructed condition that reflects local and national societal attitude and opinion on "differences" that affects a student's participation and performance in the mainstream classroom. These “differences” are subject to public scrutiny and pressure to be either accepted or rejected by the status quo and the systems that perpetuate the order. This approach may best be summarized by (Slee, 2001a, 2001b) when claimed there are no disabilities, only disabling environments. In an earlier work, Slee (1999)asserts that the Australian education system fails to recognize educational disablement as an issue of human rights and rather as a technical issue that is bureaucratized through the medical model of diagnosis to further self-validation. Impairment has been established by politics as an individual defect and disabled people as objects of treatment and research. Slee continues to claim that schools are a location of political struggle for disabled students and Australian education systems fail to recognize this. Under EQ’s current philosophy, a disability or impairment must attract enough research to agree on a definition and course of management before it is considered as a condition requiring support. If societal pressure builds, schools may be forced into accepting the condition.

Michailakis (2003) further outlines the systems in society that contribute to the disabling of individuals. The three principal systems he identified are the medical, education and labour market systems. Michailakis describes these systems as communication hubs and suggests they may be where identifying factors such as language (terminology/labelling), attitude (acceptance/rejection) and perception (self/others/disabled) are formed in young social individuals.

These explanations of how disability is constructed and conceptualised are both salient and do not assist in the collection or explanation of the student’s *experience* of disability. The missing requirement is the meeting of the two histories of traumatic stress and the EQ system that identifies and categorises disability and impairment.

CHAPTER III: PTSD – History and impacts.

Posttraumatic Stress Disorder is a psychological condition that is becoming more a common household term every year. The comorbid conditions that manifest from it are complex and detrimental to the individual. Many result in impairments in the individual's ability to manage their emotions while under stress. PTSD is having severe negative impacts on an increasing plethora of disorders that demands further investigation. Where it was once only whispered in the hallways of psychiatric facilities for the mentally disturbed, it is now far more commonplace and mentioned freely in pubs, on television and in schools. This is perhaps due to the public exposure given to the condition since the Vietnam War finished in 1974.

Chapter 3 very briefly presents a history of PTSD as a mental illness, with emphasis of traumatic stress as a learning and emotional disorder. The neurological impact of trauma will be briefly overviewed with the symptoms of traumatic stress illustrated and compared in adults and children. The recent research surrounding the genetic predisposition hypothesis of traumatic stress-related mood/emotional and behavioural disorders will be presented. Finally, there will be a brief discussion on the effect and responsibility of media on the transmission of trauma.

What is Posttraumatic Stress Disorder?

PTSD, or Post Traumatic Stress Disorder, has plagued humans for centuries, if not millennia. It has appeared throughout clinical history in a variety of forms and mostly attached to the psychological symptoms associated with war service. These include "Post Combat Disorder", "Soldiers' Heart", "shell shock", "war neuroses", "combat fatigue", "combat stress reaction", and most recently "Gulf War Syndrome" (National Centre for Postraumatic Stress Disorder, 2003). Some of the earliest known records emerged from the Egyptian and Roman practitioners who treated their army soldiers after battle, however, today, PTSD pertains to an overwhelming majority of survivors of all traumatic events in all countries around the world (O'Brien, 2004). These include sexual assault, automotive accidents, terrorism, armed holdup, holocaust, war, and even workplace harassment.

The latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), the most widely used and preferred diagnostic tool for mental health professionals in Australia (Rosenman, 2002) defines PTSD as an individual's symptomatic reactions following direct exposure, or witnessing or learning about an extreme traumatic stressor involving actual or threatened death or serious injury (American Psychiatric Association, 2000). This leaves a lot of scope for children to acquire this condition and the associated emotional disabilities.

With the increase in recent terrorist activity and conflict situations world-wide, the risk that individuals may experience a severe or life-threatening trauma is also likely to increase. Those who directly experience such an event often develop dysfunctional behaviours and somatic symptoms that negatively affect their daily functioning in many ways. Similar symptoms are reported in individuals who witnessed the event, or heard about it, or saw it on television or in the paper. Perhaps the most susceptible individuals to this secondary form of trauma are the children and grandchildren of those who directly experienced the event. The transmission of trauma to these young people can occur on many levels.

History of Mental Illness.

PTSD is considered a mental illness that is commonly treated by psychologists, psychiatrists and other mental health professionals. It has a comparatively recent history that has attracted debate and analysis across all cultures and societies. The earliest accounts of PTSD stem from Greek psychiatrists. Although individual doctors of Ancient Greece occupied themselves with the care of the insane, psychiatry as a discipline did not emerge until the eighteenth century. Yet mental illness is as old as humanity itself as much of it is caused by biological, environmental and genetic disturbances. The majority of beggars, idiots and fools that wandered the streets were mentally disturbed individuals. Most were kept in the family home where, if quiet they were permitted to run free. If not, they were often chained or tied down and food brought daily. If hospitalized, these individuals frequently faced persecution, torture and even death at the mercy of archaic treatment beliefs and principles (Scheerenberger, 1987; Shorter, 1997).

Rise of the Asylum.

The emerging thirteenth century witnessed the rise of the asylum. All had solely custodial functions to keep the mentally disturbed out of normative society. It was considered inappropriate to domestically house the mentally afflicted and many authentic and pseudo mental health professionals advocated the forced housing of these individuals claiming they were “insane” or “possessed”. Most mental disorders were originally considered demonic possession and the mentally ill were exposed to extreme physical hardship in an attempt to drive the evil spirits out. National statistics became available in England in 1826 and revealed startling revelations concerning mental confinement. Asylums had evolved to provide a therapeutic treatment of mental disorders, not just incarceration, turning their attention to the nerves of the body as causing mental illness. They were close, yet far from the source and utilized hydrotherapy to attempt to ease the nervousness of patients. The first therapeutic approach to behaviour management came from psychoanalysis. Its founder, Sigmund Freud, provoked a tremendous struggle within psychiatry, a discipline oriented towards biological foundations for behaviour, not psychological. This struggle would see the privatization of therapy into the community (Matthews, 2005).

Before the turn of the 1900s intellectually disabled people could remain at home or be placed in a lunatic asylum, where they would be given care for their condition. There was no schooling, no interesting activity and no respect, merely the means of survival. This was the only service provided by the Government until the 1960s (Crawford, 2002). Previously the intellectually disabled were cared or by their families (by means fair of foul) or by benevolent organisations at great cost to the families. Many suffered abuse and neglect.

Some countries did not accept responsibility for their mentally ill until the turn of the nineteenth century. Germany did not have any form of psychiatry until this time due to its statist attitude. It may have feared world opinion and perspectives, as did many other countries, some which continue to deny responsibility. By the mid nineteenth century study was encouraged and supported in these closed environments where positive outcomes were aimed for (Shorter, 1997).

The First World War saw a rapid rise in the influence of psychoanalysis and the emergence of less radical forms of psychotherapy. Although severe invasive procedures such as lobotomies were still widely practiced, a shift in trend was starting to emerge that focused more on interactions between the client and therapist based on expressive techniques. The English contribution to psychiatry was the notion that all mental illness is caused by poisoned human relationships. It was concluded that all dysfunctions could be treated by restoring healthy relationships, principally in group therapy. This was the first step towards the reintegration of the mentally ill back into society after treatment (Matthews, 2005).

The principality of biological psychiatry focuses on the genetics behind mental illness. Studies in the early nineteenth century found some familial history of mental illnesses. This perspective gave birth to twin studies and adoption studies to separate genetic influences from environmental influences. The principal behind twin studies is that identical or monozygotic twins develop from a single fertilized ovum and have a common set of genes. Therefore both individuals should express the same set of behaviours (Shorter, 1997). This approach gained in popularity and was applied to many studies.

History of PTSD as a mental diagnosis.

The Vietnam War provided one of the biggest challenges and periods of recognition for psychiatry and psychology alike. The First National Conference in the Emotional Needs of Vietnam-Era Veterans was organized by the National Council of Churches in early 1973. This initiated a nation-wide push to have a condition known as “Post-Combat Disorder” officially recognised by mental health professionals. The inclusion of the diagnosis “Post-Traumatic Stress

Disorder" (PTSD) into the Diagnostic and Statistical Manual was not made until 1978. Since then, the field of mental health has witnessed several amendments to the description of the disorder, and to an increasing level of awareness in the community (Shorter, 1997).

PTSD has been officially recognised by the American Psychiatric Association (APA) since 1978. Since then it has maintained the classification of an anxiety disorder even though it is often expressed in depressive symptoms. The current version of the DSM (IV-TR) describes PTSD in more detail than previously and discusses the clinical significance of its high degree of comorbidity with other psychiatric and somatic conditions.

PTSD is not a new disorder. It has existed in different forms for centuries. It has been referred to as "Soldier's Heart", "Shell Shock", "War Neuroses", "Combat Fatigue", "Combat Stress Reaction", and most recently "Gulf War Syndrome" (National Centre for Posttraumatic Stress Disorder, 2003a). Documented accounts can be found as early as the American Civil War when a PTSD-like disorder was identified as "Da-Costa's Syndrome". World War II and Jewish Holocaust survivors provided accurate descriptions of PTSD symptoms in medical literature. Even the early Egyptian and Roman practitioners have documented an unstable mental condition following battle trauma in their soldiers. However, it was the Vietnam War that insisted the careful and deliberate study of this condition. PTSD pertains to an overwhelming majority of survivors of traumatic stress in all countries around the world (O'Brien, 2004). Since this, there have been numerous studies and research conducted on PTSD and its effects on the individual, families, communities and society as a whole (Yehuda, 2002).

Effects in Adults.

Individuals with PTSD often suffer from symptoms that reinforce the traumatic stress such as nightmares, hypervigilance, flashbacks or even emotional numbing (Yehuda, 2004). The individual re-experiences intrusive distressing recollections of the event, experiences illusions or hallucinations, intense psychological or physiological distress to stimuli that resembles an aspect of the traumatic event. The individual also persistently avoids thoughts, feelings, activities, places or people that arouse memories of the trauma, and they may have lapses in memory for periods before and after the trauma and of the trauma itself. They may describe feelings of detachment and diminished interest and participation in social events, they may even have difficulty sleeping, be irritable, have difficulty concentrating and have and exaggerated startle response. These symptoms must not have been present before the traumatic event occurred (American Psychiatric Association, 2000). There are numerous ways an individual can experience a life-threatening trauma. Such experiences include road traumas, rape, sexual and physical abuse, armed hold-ups, hostage situations, unexpected medical procedures, natural disasters, holocaust, war or witnessing or being distressed by any of these. Quite often the onlooker to a trauma can experience higher levels of post trauma issues than the individual who experienced it directly. This form of Secondary Trauma is frequently overlooked and can be a primary source of trauma for a child (Fullerton et al., 2001).

Effects in Children.

Much of the following information has been collected over the years through observations of children by adults. There is alarmingly little research available on the experience of traumatic stress from the child's perspective. It is a combination of the information presented in this section, and that collected by the proposed framework, that is intended to assist in the provision of optimal learning environment and outcomes for children with this class of disability.

The longitudinal effect in children is of concern to this thesis. Adults can both consciously and unconsciously transfer their experience and reaction to that trauma to their children in many ways. This occurs through the many channels of verbal and non-verbal communication that children are highly susceptible to and aware of. Due to the disturbing nature of the memory of trauma, many parents aim to protect their children by not discussing the trauma with them. Consequently, children do not question the behaviours of their parents because they accept this as normal and others as different. It is only after maturation or their parents' death that the child may account for these behaviours and the effects it may have had on their own emotional programming (Weingarten, 2004). What differences will this retrospective awareness have on the child? How might their behaviour change as a result of understanding their parent's trauma? Parents can program their child's emotions and ability to manage emotions from an early age. Children model their behaviour from their parents and use their responses as templates for perceived appropriate behaviours.

Younger children who have neither awareness nor empowerment may react adversely with retrospective awareness. Possibly the most concerning situation, however, is where the child is aware of the meaning and significance of the trauma, but is powerless to do anything about it. These children have the potential to carry the burden of guilt for many years to come. The resulting symptoms and behaviours typify those of traumatic stress.

The effects of trauma on a child can often be more socially and developmentally detrimental than to an adult. Children frequently do not possess the complex coping mechanisms that take time and experience to develop. They cannot defend or protect themselves from the psychological damage of the effects of severe trauma. Due to this, children frequently experience both adult symptoms and unique responses pertinent to their age group. Children who have experienced a traumatic stressor may display serious acting-out behaviours causing disruption. These have been stated as being responsible for up to half of all clinical referrals of children and adolescents in the school system (Alexander & Pugh, 1996). Oppositional, defiant and conduct disorders in childhood may be attributed to violent or antisocial acts, neglect or abuse. They can be extremely costly to society. Children who are left to progress unmanaged in their disability may become involved in crime, alcoholism, drug abuse chronic unemployment, physical disorders and persistent psychiatric and social disorders.

The DSM-IV-TR states that in children, repetitive play may occur where the trauma is acted out and frightening dreams may be experienced that have no recognizable content (American Psychiatric Association, 2000). Young children may report separation anxiety or avoidance behaviours, a preoccupation with an object or words that may or may not be related to the trauma and even loose a developmental skill such as toilet training. School-aged children often experience a “time-skew” where recall of the trauma looses consecutiveness in sequence. This is not typically seen in adults. Elements of the trauma may be exhibited through play, art or verbal expression. Adolescent behaviours begin to resemble adult symptoms including the strong desire to “rescue” a potential victim of trauma that is younger than themselves and viewed as helpless (National Centre for Postraumatic Stress Disorder, 2003).

Often, children with trauma related emotional impairments will present to clinicians with comorbid symptoms and be treated for those, rather than dealing with the trauma itself (Rosenbaum, 2004). This results in the true cause of the problem being overlooked. The clinician will unknowingly apply a bandaid measure, rather than addressing the root cause. This can cause negative consequences for the child and society. Clinicians need to be aware of the likelihood of traumatic stress in a child’s presentation.

N. Kaslow, Deering, and Ash (1996) assert that a child who frequently experiences depression will likely develop into an adult with depression or anxiety issues. In their paper, they review several familial and non-familial features that promote and maintain depression in children, including the school environment. They state that depression in children is frequently comorbid with other psychiatric problems, notably anxiety, attention deficit and conduct/ oppositional defiant disorders. This is supported by other researchers (Barry, Dunlap, Cotten, Lochman, & Wells, 2005; Gartstein & Sheeber, 2004; Kim-Cohen, Moffitt, Taylor, Pawlby, & Caspi, 2005) and strongly suggests that parental depression and/or anxiety is a major influence on the child’s state of mood.

Kidd and Ford (1998) summarise some of the characteristics and behaviours reported in children with emotional disturbances that indicate an exposure to severe trauma as:

- Hyperactivity – short attention span and impulsiveness,

- Aggression and self-harming behaviour – acting out and fighting on self and others,
- Withdrawal – failure to initiate interaction with peers and retreat from social exchanges,
- Immaturity – age inappropriate responses and behaviours.
- Learning difficulties – academic performance below normal grade level.

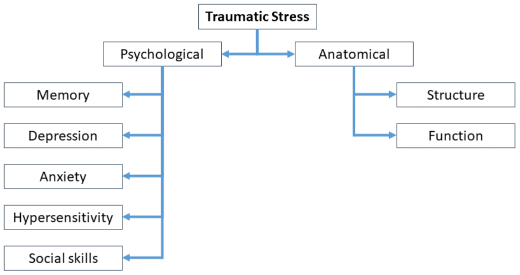
Severe cases may exhibit distorted thinking, expressive anxiety, bizarre motor acts and abnormal mood swings. Adolescent PTSD begins to resemble the adult condition in many ways, but still retains unique age-respective characteristics (Kidd & Ford, 1998). Weingarten (2004) claims that awareness of the meaning, significance and impact of the event, and whether that child feels ability to intervene or control any element of the event and empowerment are crucial to the initial effect of trauma. An effect of social avoidance is dubbed by a prominent neuropsychologist as the “You go” syndrome (Ewing, 2005) in which the individual prefers to sit at home or in a secure environment than to participate in public and social activities. This may be a more easily observable trait in adolescents and adult survivors of trauma, but may be more difficult to recognise in children.

PTSD as a disability in EQ.

As mentioned previously, PTSD and traumatic stress meet the requirements for consideration as a disability and/or impairment as stipulated in EQ’s Ascertainment Policy yet is neglected or ignored as such. This section will illustrate how a significant learning impairment can be let past the curtain of ascertainment, by using traumatic stress as an example. It will demonstrate the apparent contradiction in definition that sparked initial interest in this topic.

Most disabilities accepted for ascertainment by EQ require only one criterion to be met in one category (psychological/anatomical). Figure #4 illustrates how PTSD meets several criteria in both categories for a disability as set by EQ. the effects of extreme traumatic stress manifest both psychological and anatomic abnormalities, each with sub-categories of impairment.

Figure #4: How PTSD fits EQ disability criteria



The anatomical alterations involve changes in both the structure and function of specific components of the brain. Several of these brain components are responsible for managing and regulating vital bodily functions such as metabolism, weight management, appetite, body temperature, and skin condition. The psychological alterations involve changes in memory, mood, sensitivity, concentration, attention, arousal and awareness, emotional input and responses, threat perception and social skills that impair daily functioning (J. Pinel, 2002).

Once developed, the effects of traumatic stress often become disabling and unremitting, being accompanied by a high incidence of comorbid depression as well as somatization, both of which may impede recognition of the condition. As with other anxiety disorders, PTSD is associated with substantial impairment (Davidson, Stein, Shalev, & Yehuda, 2004). Yehuda (2002) claims severe stress can create significant structural and functional alterations in the amygdala (a complex cluster of neural structures that regulates emotions, motivation and memory). Yehuda, Halligan, and Grossman (2001) have also found that the children of clinical PTSD sufferers more frequently report emotional distress.

There may be no directly observable physical impairments that result from traumatic stress, (making it an “invisible” disability) but on neurological and behavioural levels the transformations caused by severe trauma can be catastrophic. Brain components that are responsible for regulating a wide variety of whole-of-body functions are altered both in structure and function. This, subsequently, results in a variety of changes in the individual form mild anxiety and depression to paranoia, weight issues and self-harm. Stein, Jang, and Livesley (1999) found that the amygdala and hippocampus shrink following trauma. These structures regulate emotional processing. McKinney (2002) found that they are intimately involved in the management of emotion and motivation and, hence, in learning and, interestingly, some recent research implicates the formation in the establishment of long-term memory. Joseph (1998) found that trauma affects not only memory, but causes deterioration in areas of the physical brain. Additionally, with the onslaught of corticotropic steroids involved in the stress-response, the hippocampal pyramid cells, temporal lobe and amygdala regions actually decrease in physical size (Joseph, 1998). These regions are largely responsible for emotional control and reactions to stress. The physical impairment may be present from birth (congenital – this supports the genetic theory of transmission of PTSD and associated conditions) or acquired later (which supports the environmental theory).

The conditions immediately associated with traumatic stress are often treated, but as the emotional and psychological effects of the trauma may not manifest for days, weeks, months or even years, they are frequently overlooked, misdiagnosed or ignored (Doyle & Mitchell, 2003).

Traumatic stress experienced at early points in psychological development may severely compromise the survivor’s core sense of self and capacity for secure attachment as well as fundamental self and relational schemata (Kidd & Ford, 1998). These factors significantly impact on the functional development of any child, and can negatively influence their journey through their early school years. A poor self-image, attachment issues and inability to affectively and functionally relate to others will lead to emotional disturbances that can challenge them throughout their lives. The effects may manifest as impairments in memory (Davidson et al., 2004; Yehuda, 2002; Yehuda, Halligan, & Grossman, 2001), emotional numbing (Ruscio, Weathers, King, & King, 2002) and violent behaviour (Glenn et al., 2002).

Some individuals are highly resilient to extreme or high levels of stress and do not manifest dysfunctional or harmful behaviours (A. Young, 1995). They develop complex coping strategies early in their emotional development. This is effective when manageable. If the individual's coping system breaks down, previously perceived normality becomes warped and underlying dysfunctions surface as emotional and behavioural disorders, which the school must then manage.

The manifestations of traumatic stress become even more concerning when its heritability is considered. (O'Brien, 2004) presents literature that supports the postulation that there are heritable components to traumatic stress, suggesting that children may display behaviours and experience symptoms idiomatic of traumatic stress, without having directly experienced a traumatic event. These children have parents who have direct experiences of trauma and have suffered detrimental, clinical consequences.

PTSD as an Emotional Disability.

Throughout this paper there has been a strong reference made between PTSD, traumatic stress and emotional disabilities. For the purpose of this paper these are synonymous as each has a close causal relationship.

It is well documented that children not only experience trauma differently to adults, but the experience manifests as different behaviours (American Psychiatric Association, 2000). As children progress through their schooling years and through perhaps the most influential stages in their social, emotional and psychological development, these manifestations can result in chronic deviances in learning potential. There is evidence to suggest that children develop emotional and learning disabilities following a severe trauma (Davidson & Mellor, 2001; Guetzloe, 2003).

Emotional disabilities frequently accompany (are comorbid with) physical disabilities, providing a compounding issue (Feld, Colantonio, Yoshida, & Odette, 2003). Treating half the problem is not effective management. Children have less life experience to draw upon to assist them in coping and managing their stress and subsequently must deal with their experiences in an environment that has less available resources.

The emotional disturbances that commonly follow a traumatic event are often as debilitating and disabling to a child as a physical condition and most are accompanied (comorbid) by emotional disabilities (Lightfoot, Wright, & Sloper, 1999). McKinney (2002) found that trauma damages certain brain structures responsible for emotional management. Behaviours that are associated include mild to chronic withdrawal, emotional numbness, lack of interest or concern for group ethics, suicidal ideation, self-harming, exaggerated aggression and over-competitiveness, exaggerated startle responses, inexplicable anxiety, fear or depression and severe mood swings, eating disorders, night terrors and excessive avoidance (American Psychiatric Association, 2000). This list is by no means complete. Most of these are emotional in nature.

Emotional disabilities, such as traumatic stress, are an ‘invisible’ disability because the afflicted are rarely seen by others as being any different. Their disability is not obvious and consequently does not receive the same level of attention as the ‘visible’ disabilities (Gable, 1999). Traumatic stress frequently manifests in depressive symptoms and can severely and chronically impair a child’s performance in the classroom and at home (Davidson & Mellor, 2001; Davidson et al., 2004). Using the tools of culture, one uses experience to further knowledge of themselves and the world around them (Gable, 1999). The framework must evolve from the central concept of experiential learning and modelling through the eyes of the child with a traumatic stress concern.

Inability to cope with emotional stressors.

Recent research has identified structural and functional abnormalities that result from severe traumatic stressors (Yehuda, 2004) and collaborations of further research indicates a strong possibility for these abnormalities to be intergenerationally transferred (O'Brien, 2004). The structures within the brain that are responsible for the processing and transfer of emotional information are significantly altered following trauma. More relevant to this paper is the suggestion that the first and second generation offspring of PTSD sufferers may be born with a predisposition to experiencing lower levels of stress-tolerance than their non-PTSD peers (O'Brien, 2004). If this is indeed the case then the current epidemic of childhood behavioural disorders may be a result of increased levels of trauma-related incidents in recent decades. A child who has acquired this emotional disability either through genetics or direct exposure will experience more difficulty in managing emotional stressors than their non-PTSD peers, and these will be experienced differently. Due to their lower tolerance for emotional stress, children who have experienced a traumatic stressor are more likely to develop conditions that are anxiety and depression related (American Psychiatric Association, 2000). Professor Fiona Stanley, Australian of the Year, 2003, states that more Australian children are reporting more frequently with depression and anxiety (Stanley, 2005). As will be illustrated in the next section, PTSD and traumatic stress influences the individual’s ability to self-manage their stress threshold. This lack in ability to self-manage will largely dictate their ability to perform socially and academically, and produces some conflicting issues for EQ Self-Management approaches in their Behaviour Management Principles.

SMT: Stress Management Threshold.

To further assert the need for further investigation into this issue it is important to illustrate the affects that trauma can have in a direct capacity and through secondary and tertiary influences. As mentioned, recent research suggests PTSD may have heritable components that can render an individual prone to attracting or experiencing trauma and having personality characteristics entwined with higher-than-normal levels of anxiety, depression and anger (Yehuda, Halligan, & Grossman, 2001). The child's ability to manage emotions is severely limited. It is vital to pursue this concept in more detail, as it represents a significant issue in educational systems.

In its simplest representation, trauma can affect an individual's ability to manage distress in three ways. The following figures illustrate each of these. They also indicate the different experiences faced by children when they encounter the primary school environment.

Figure #4 shows the stress management threshold (SMT) of an individual without any history of trauma influencing their ability to manage emotions. As they progress through the ups and downs of life their moods fluctuate accordingly. While their mood remains within the boundaries of the socially accepted range of "normal", they can manage their emotions (and subsequent behaviours) within their own personal threshold. When an event results in emotions and behaviours that exceed the socially deemed norm, they rapidly adjust their responses to bring their behaviour back within accepted boundaries. These individuals have more control over a wider degree of emotional responses and variances to emotionally stressful situations. EQ's curriculum is engineered predominantly to suit the learning needs of these children.

Figure #4: The normal SMT of an individual without familial or personal history of trauma.

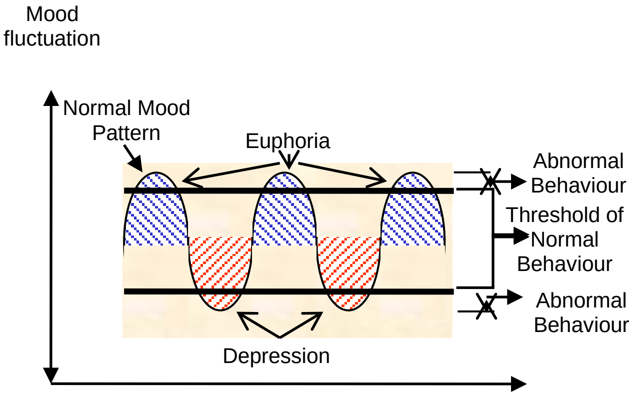


Figure #5 illustrates the SMT of an individual who has no familial history of trauma, then, for the first time, directly experiences a traumatic event and develops the subsequent reduction in threshold. To the observer this individual will display 'normal' behaviour where their emotional extremes will be brief, limited, and rapidly managed back to a socially acceptable perspective. However, immediately following the traumatic event, the individual's behaviour changes as their SMT is greatly reduced through a combination of chemical and structural alterations in their brain, and the individual perceives new levels of threat from their environment. Each feeds into the other to perpetuate the behavioural and cognitive effects of trauma.

Figure #5: The SMT of an individual without familial history of trauma, who then experiences a traumatic event.

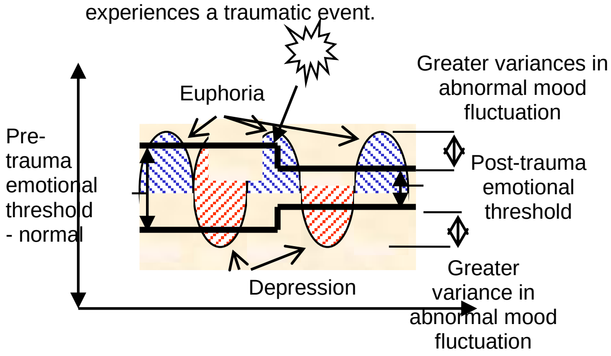
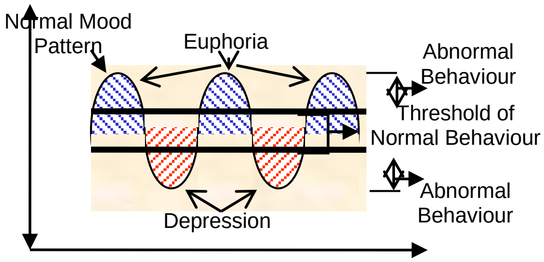


Figure #6 illustrates the SMT of an individual born with a vulnerability to traumatic stress induced conditions. Yehuda (2002) identifies this phenomenon as a ‘PTSD-prone personality’. An individual born under these conditions is likely to experience increased levels of abnormal behaviour while under emotional distress, due to a reduced capacity to manage them. Not only will their experience of each stressful event be more intense, it will last for a longer period of time and this condition will last their whole lives. To the external observer (such as the therapist, teacher or peer), their behaviour may seem ‘extreme’ or an over-reaction to the stress, yet the individual experiencing it may perceive their behaviour as quite appropriate and normal. A child with this SMT presents many issues to EQ as their two histories converge in the primary school environment.

Figure #6: The SMT of an individual with familial history of trauma.



From these figures it can be seen how the onset of trauma can limit an individual’s ability to manage emotional input and regulate their responses to that information. Notably, Attention Deficit Hyperactivity Disorder and Autism have similar traits and are included in EQ’s Ascertainment Policies. Recent research is emerging that suggest these recognised conditions have a strong causal relationship with PTSD (Xian et al., 2000).

PTSD as a Learning Disability.

Cuthbertson and Silovsky (1996b) claim that, as an emotional disability, traumatic stress consequently manifests as Learning Disabilities (LD). This section demonstrates the varying impact of trauma on a student’s performance abilities in the classroom by discussing a further category of disability that is associated with emotional disabilities.

LDs are among the most studied disorders in school- age children and account for frequent referrals by teachers to child mental health clinics Cuthbertson and Silovsky (1996b). It typically presents itself during the school-age years with problems in spelling, writing, reading and, or mathematics and originate from problems with auditory perceptual (phonetics – symbol recognition), visual discrimination (orientation and sequencing of letters) or comprehension and expression (listening and oral presentation) (Cuthbertson & Silovsky, 1996b).

"Learning Disorders are diagnosed when the individual's achievement on individually administered, standardized tests in reading, mathematics, or written expression is substantially below that expected for age, schooling, and level of intelligence. The learning problems significantly interfere with academic achievement or activities of daily living that require reading, mathematical, or writing skills." (American Psychiatric Association, 2000, p. 49).

Many children with any or all these conditions experience tremendous difficulties with work schedules at school and home. Such children will often give up rather than battling on with assignments (Cuthbertson & Silovsky, 1996a). The education system will perceive this as an inability on the child's part, rather than an inability by the education system to set appropriate levels and intensity of work for the student (Slee, 2001a). LD can present itself in many forms that impedes performance. One specific form of LD that displays similar symptoms to childhood trauma is social-emotional LD. The common characteristics of social-emotional LD include:

- Peer rejection and social isolation,
- Obsessed with narrow topics/interests,
- Failure to respond to normative behaviour of peer group,
- Inappropriate use of gesture,
- Difficulty interpreting emotional cues of others,
- Hyperverbal behaviour,
- Impaired ability to engage in interactive play,
- Problems with interpersonal space,
- Poor pragmatic communication skills,
- Poor adaptation to novel situations,
- Decreased appreciation for humour or metaphor,
- Abnormal affective expression, and
- Poor eye contact.

The primary deficit appears to be in the ability to interpret the behaviours of others from observation and to understand the impact of their own behaviour on others (Cuthbertson & Silovsky, 1996b). The DSM-IV-TR states that demoralisation, low self-esteem and deficits in social skills may be associated with learning disorders. LDs are strongly associated with Conduct Disorder, Oppositional Defiant Disorder, Attention-Deficit/Hyperactivity Disorder, Aspergers Disorder, Major Depressive Disorder, and Dysthymic Disorder (American Psychiatric Association, 2000). Many of these conditions are currently included in EQ's ascertainment policies and have strong associations with conditions caused by traumatic stress. Recent studies have shown that the same neurotransmitter systems that play a significant part in the regulation of symptoms of traumatic stress, also play the same role in ADHD (T. Brown, 2000). The dopaminergic system regulates arousal and motivation, critical for survival and adaptation.

(B Adkins, Smith, & Grant, 2005) lists traumatic stress as one factor contributing to cognitive impairments that can cause difficulties in visuo-spatial processing and the ability to tolerate stimuli resulting in chronic disorientation in several areas, with further difficulties existing in interpretation and understanding of communication and problem solving. Adkins and colleagues further assert that these effects potentially mold the manner in which children with this condition experience and respond to public spaces, such as the school's physical environment.

Fragmentation of Memory.

Perhaps one of the most significant impairments resulting from traumatic stress (either directly acquired or genetically inherited) is the fragmentation of memory. Many researchers have concluded that traumatic stress affects memory (T. Brown, 2000; Yehuda, Golier, Halligan, & Harvey, 2004). Specifically, it is stated that memory is fragmented resulting in poor storage and recall abilities (Kidd & Ford, 1998). Fragmentation of memory causes specific information to become lost or disjointed. Details for certain events become unclear and uncertain and therefore unreliable. A child with a history of trauma may therefore experience difficulties in memory storage and retrieval resulting in impaired learning potential. A child in this state may question their own knowledge and experience, in turn detrimentally affecting self-esteem. This suggests that children with influences of trauma are limited in their memory functions and must therefore adapt and acquire complex methods for storing and retrieving information that is different from their counterparts who are not influenced by trauma. The school years demand high levels of executive functioning in memory. If the student's memory is fragmented, then the consequences will impact on emotional, academic and social learning potentials.

LeDouox and Muller (1997) further assert that fear conditioning (such as that which creates PTSD) also significantly influences our abilities to process emotional information as it occurs and that much of this is resultant of the emotional programming we receive during our childhood from genetic, parental, school and peer relations. Further support for this assertion comes from (N. Kaslow et al., 1996). This suggests that children with this impairment may experience more extreme reactions to emotional stress and have poor memory of the event that triggered the emotive response. This is a criterion for PTSD (American Psychiatric Association, 2000).

It has very recently been concluded that fear conditioning (which frequently results in abnormal psychological and physiological aberrations, creates genetic changes in the individual's ability to store and retrieve memory at the synaptic level. At a recent seminar in Brisbane's Belmont Private Hospital (Sah, 2005), it was revealed that fear conditioning is claimed to be forcing genetic alterations in the receiving neuron's ability to fire. This postulation suggests that this genetic change may be transmitted to the subsequent generation in the form of memory impairments. In support, several prominent researchers investigating the effects of traumatic stress on memory have concluded that memory is certainly fragmented following a severe stressor (Davidson et al., 2004). Further studies in the children of sufferers of PTSD discover difficulties in memory encoding, storage and retrieval and, themselves, have fragmented memories (Yehuda, 2002; Yehuda, Halligan, & Grossman, 2001). This provides yet another reason to establish and implement a systematic framework for investigation and research into this issue. The educational implications of this should be very concerning.

The neurological impact of traumatic stress.

To fully understand and appreciate the immense impact trauma can have on an individual and how it can inevitably result in PTSD, we must illustrate the changes that take place structurally and neurologically to the brain immediately following the event. What must also be appreciated is the heritability of these structural and functional alterations.

There is a growing pool of evidence to support the postulation that children and grandchildren of PTSD sufferers may be born with a physical and neurologically functional disposition to developing PTSD and emotional disabilities themselves (O'Brien, 2004). There is a substantial pool of literature from the neurological community that strongly supports the assertion that traumatic stress impedes and significantly deteriorates learning (Yehuda, 2002, 2004). Research is identifying physical structures in the human brain that are altered both structurally and functionally with the impact of severe traumatic stress. In addition to memory and motivation, the appropriate functioning of these structures is essential for basic bodily and mental functions that are studied by psychological and physiological scientists.

There are several alterations that take place in a person’s brain immediately following a traumatic event. They are physiological, chemical and functional changes that, in severe cases are irreversible and permanent.

The effective and efficient teamwork between vital components regulate our emotional responses to our environment. If those components are damaged or altered in function, structure and/or capacity, then the team does not work well. The organs of the Hypothalamic-Pituitary Adrenal Axis are the components that do just this. It is the body’s central system for regulating and monitoring hormonal activity and stress response.

The first organ in the HPA axis is located in the central region of the brain. The hypothalamus is responsible for factors such as blood pressure, fluid and electrolyte balance, internal and external body temperature, appetite and body weight. To achieve all this, the hypothalamus is dependent on regular, reasonable inputs from other body organs. If the inputs vary dramatically, the hypothalamus must initiate compensatory mechanisms and processes to ensure the individual's survival and homeostasis (Yehuda, 2002).

The second component is also located in the central region of the brain, just below the hypothalamus. The pituitary gland is about the size of a pea and is responsible for growth, skin colour, kidney hydration, sexual reproduction and development and stimulating the third component, the adrenal gland.

The adrenal gland is located atop both kidneys and produce epinephrine (adrenaline) and norepinephrine (noradrenaline). Epinephrine is essential in the body's short-term reaction to stress (Pinel, 2002). It administers the flight/fight response. Norepinephrine is one of the stress hormones and affects attention and impulsivity. It activates the sympathetic nervous system during times of stress and increases heart rate, the synthesis of energy from stored fat cells and muscle activation. The locus ceruleus is located in the brain stem and is the origin of most norepinephrine pathways in the brain, responsible for a host of physiological changes initiated by a stressful event (Pinel, 2002). All other psychological effects result from these neurological changes.

The genetics of PTSD.

The proposal that the effects of traumatic stress can be genetically transferred is a controversial topic that has recently sparked a wave of research and argument on both sides. Several researchers agree that PTSD can be passed to the next generation through behaviour modelling, environmental influences and direct experiences (O'Brien, 2004). They agree that an individual may be born with a genetic predisposition to having a higher-than-'normal' risk of developing PTSD and/or any of the associated conditions after a mildly traumatic event. However, few researchers and mental health practitioners are willing to embrace the perspective that PTSD can be inherited. Those that do, argue vehemently that the flood of corticotropic steroids released by the pituitary gland and hippocampus at the moment of trauma, results in genetic alterations of specific gene codes and proteins associated with the functional development of specific brain structures and functions. Supportive evidence for this stems from research into the increasing incidences of childhood and adolescent conditions of attention deficit/hyperactivity disorder, oppositional defiance disorder, a wide array of specific learning disorders and anxiety and depressive conditions.

Current studies on PTSD and its effects are conducted mostly on adult subjects with a history of military service (Yehuda et al., 2000). There are further findings of studies conducted on road trauma (Matthews, 2005) sexual trauma (Friedman, Wang, Jalowiec, McHugo, & McDonagh-Coyle, 2005; McNally, Ristuccia, & Perlman, 2005), holocaust trauma (Yehuda, Golier, & Kaufman, 2005), natural disasters (Proctor, 2005), terrorism (E Brown & Bobrow, 2004; Fetter, 2005), and medical trauma

(Palmateer, 1982), that suggest strong heritable components.

Yehuda, Halligan, and Bierer (2001) demonstrated a significant specific association between parental PTSD and the occurrence of traumatic stress-related conditions in offspring. Stein et al. (2002) found that genetic influences on PTSD-proneness might be mediated through personality traits. Schiffman (2003) reports in the Jewish Post of New York, that a genetic alteration of the Dopamine Transporter (DAT) has been positively linked to PTSD. This report has been authenticated by Segman et al. (2002). The DAT gene, which itself was identified in 1963 is responsible for transporting Dopamine within the nervous system. Dopamine has also been found to have significant implications on Attention Deficit Hyperactivity Disorder (ADHD) and Conduct Disorders (Rowe et al., 2001), alcoholism (Johnson, 1996; Laine, 2001) and depression (Nierenberg, Dougherty, & Rosenbaum, 1998). Studies have shown these conditions to be genetically linked to PTSD (Donnelly, 2003; Tarrier & Gregg, 2004; Xian et al., 2000).

Stein et al. (2002) concluded that PTSD symptoms are moderately heritable in combat veterans after both combat related and non-combat trauma. Van der Kolk (1994) outlines the significant hormonal changes and adaptations the brain experiences during and after a severe traumatic event, (These are the same hormones utilized by the body for sexual reproduction and sexual development), and a rising concern towards recognizing that a range of neurobiological abnormalities are beginning to be identified in the younger population. Several studies have been conducted that investigate the genetic relationships between PTSD and other disorders such as generalized anxiety disorder and panic disorder (Chantarujikapong et al., 2001; Scherrer et al., 2000), borderline personality disorder (Golier et al., 2003) and alcohol and drug dependence (Chantarujikapong et al., 2001; Xian et al., 2000). Each study found a strong statistical relationship behind the genetics for each disorder and concluded that, not only was each of the disorders manifested by traumatic stress in the individual, but was causal in their offspring.

The DSM-IV-TR (American Psychiatric Association, 2000) describes the gender prevalence for genetically related disorders to PTSD as being significantly higher for women than men. Even Premenstrual Dysphoric Disorder is genetically implicated in PTSD, which is specifically a female condition (Perkonigg, Yonkers, Pfister, Lieb, & Wittchen, 2004). True et al. (1993) found through quantitative genetic analysis, that inheritance has a substantial influence on the liability for all symptoms relating to traumatic stress. Additional support stems from functional magnetic resonance imaging (fMRI) of the brains of PTSD positive patients, showing clear alterations in size, structure and function of areas of the brain responsible for the processing of emotional information (Smith, 2005). Further research needs to be conducted using fMRI to assess the size, structure and function of emotive management structures in the brains of siblings of PTSD positive patients, even while developing in utero. This information needs to be compared with the fMRI of infants without familial history of stress conditions.

Many researchers have concluded that PTSD in parents can result in myriad of mood and behavioural disorders in their children (Yehuda, 2002). These include, ADHD (Adler, Kunz, Chua, Rotrosen, & Resnick, 2004), Conduct Disorder (Koenen, Fu, & Lyons, 2005), Aspergers (Burger & Lang, 1998), Antisocial Personality Disorder (Goodwin & Hamilton, 2003), Depressive and Anxiety Disorders (Spencer, Wilens, Biederman, Wozniak, & Crawford, 2000; Tannock, 2000), and range in severity from very mild to chronic. The consequences have been found to lead to socially unacceptable behaviours such as violence and aggression, substance-related behaviours, eating disorders, conduct disorders and suicide that become a significant burden to both the individual and our society (Davidson et al., 2004).

PTSD and ADHD.

One such condition that has become a concern to society and many individuals is one that is closely associated with PTSD. ADHD is more common in children with conduct disorders and may also be associated with anxiety and mood disorders (American Psychiatric Association, 2000). Brown (2000) reports that there is a growing trend in the mental health field to suggest that the diagnosis of ADHD in a child is predicated by an anxiety disorder. PTSD is listed in the DSM as an anxiety disorder and in future editions will be listed as a combined anxiety/depressive disorder (American Psychiatric Association, 2000). Hudziak (2000) discusses the large volume of research that indicates the strong case for the heritability of ADHD. These studies show that the genetic factors behind ADHD and its related disorders impact various specific neurotransmitter systems in the brain and how it is a key (Gurvits et al., 2000). The identification of the same candidate genes and dopamine transporters for both ADHD and PTSD is a strong indication of the genetic link between the two conditions (T. Brown, 2000). The DRD4 and its alleles are significantly implicated in both conditions as well as in smoking and depression. Those with clinical PTSD are most often smokers, drinkers and reportedly experience depression (R. M. Young, Lawford, Feeney, Ritchie, & Noble, 2004). Among the most significant and devastating mental conditions frequently experienced by our youth is depression. It can lead to a range of dysfunctional behaviours and suicide. Maladaptive familial relationships are one of the principal contributing factors to childhood and adolescent depression. Traumatic stress is another (Yehuda, 2004) as familial PTSD frequently impacts on family cohesiveness.

Environmental/Parental Influences.

The environment can be divided into two principle categories of parenting and experiential learning. As discussed briefly earlier in this paper, a child can receive their emotional programming from their parents. The parenting styles can significantly influence the manner, method and ability of children to manage emotionally distressing situations.

The impact of parenting styles can never be underestimated in the development of personality. If a parent has experienced a traumatic stressor themselves, their parenting abilities may be marred. This is likely to be transferred to their child. A family member who has experienced the trauma directly can expose a sibling to residues of that trauma (Weingarten, 2004). The original trauma may date back to previous generations that have no relation to current political or conflict issues, and those may trigger dysfunctional behaviour in an individual, thereby affecting an entire family and community (Weingarten, 2004). Parents who have experienced trauma have the imperative drive to protect their children from harm and warn them about potential dangers. Sometimes these warnings themselves can be potentially traumatic for the child. Communication within families that comprises of messages with multiple, embedded meanings, needs deconstructing and evaluation before being developed into constructive, bonding communication that promotes understanding and empathy between parents and their children (Weingarten, 2004).

It is not only the parent with PTSD who may transfer their dysfunctions to their children, but their partner as well (Ewing, 2005). The partner may experience secondary trauma as a result of listening to the effects the trauma has had on its victim. In accordance with the DSM-IV-TR's definition of PTSD, this person can also experience similar reactions to the trauma. This is also applicable in si. tuations where the parent with the condition explains their experiences to that child. In cases where the partner is left to explain the confusing and concerning behaviours to a child, they may also be responsible for the transmission of a tertiary form of trauma to that child.

Silence is a key influence in the transmission of the elements of trauma from one generation to the next. Through silence, children learn what are acceptable topics for discussion, conversation and, therefore, learning. In some cases, children may employ the gift of imagination to fill the gaps and complete the story of their parent's distress. This can be detrimental for many reasons. By developing an inaccurate account of their parent's experiences, they may inaccurately represent that parent and their experience to others. Most trauma survivors cannot share their experiences or discuss their reactions with others as they may be avoiding recurrence of the memories and images associated with the trauma. This is particularly so for parents as they investigate huge amounts of resources in an attempt to protect their children from the same negative experiences they faced.

Shame and humiliation can foster the intergenerational transmission of trauma (Weingarten, 2004). An example of this is the racial discrimination experienced in countries like South Africa, Australia, North and South America. Those victimized experience the shame and must swallow the associated humiliation. The subsequent subservience results in bitterness and resentment towards the individual/society/culture that initially imposed that shame and humiliation. The children of such experiences can frequently inherit their parents' and grandparents' humiliation, and associated discrimination. Such groups can experience a multitude of traumas that are shared between its members. Commonly, the individuals within these groups will associate with one event that symbolizes and unifies them towards a common goal. In the case of the Australian Aboriginal, this event is the settlement of the white colonies and subsequent Stolen Generation where thousands of Aboriginal children were removed from their families and placed in missionaries and schools run by the intrusive white settlers. Removal from parents and family is indeed a traumatic event for any young person. (Consider the plight of foster parents and the children who are removed from their parents during Department of Family Services intervention). The trauma experienced by the Stolen Generation and children "rescued" by DFS is an area rich in research potential.

Combination of both.

There is no one answer to how trauma is transferred intergenerationally. A complex combination of genetics and environment that controls the quality and quantity of transference is the most probable. Genetics can predispose an individual to developing a personality that is prone to a reduced management threshold for stress and parents can create a debilitative or supportive environment. Regardless of how trauma is acquired, the various social management systems that perpetuate and control appropriate and inappropriate behaviours need to be aware of this issue and begin a systematic collection of the experiences of children with disabilities to accurately inform the evolution of policy.

CHAPTER IV: Putting it together.

This paper has contributed to the knowledge of the probable experience of students with PTSD and from families experiencing PTSD in the Queensland educational environment. In doing so, it has attempted to convince the reader that *the experience* of disability (in particular PTSD) needs to be understood before effective and applicable policy can be established that optimally supports the full inclusion of disabled children into the mainstream classrooms of EQ. the creation of a functional and informative framework may provide a better understanding of the experience of disability if we view it in terms of the meeting of two histories: the history of how the management and conceptualization of disability has become positioned in EQ, and; the history of the specific disability itself. This paper has followed this approach and will now bring together the insights provided.

Chapter II provided the first half of this meeting with some insights into the complexities in defining disability. It briefly discussed how the current learning environment can perpetuate many disabilities and provided historical evidence of the systematic neglect (and abuse) of individuals with disabilities to support this claim. It then discussed how EQ may be limiting the potential of its students by limiting its approach to management and conceptualization of disability and the implications of this.

Chapter III provided the second half of the meeting by focusing on the history of the specific case of PTSD as an example of a disability that both has significant detrimental, multi-tiered impacts on a child's learning potential, and is continually "brushed over" by the EQ Ascertainment system. Discussion into the evolution of PTSD as a diagnosis, a closer examination of the neurological, structural and behavioural impacts this condition has on the individual, and the age-specific differences it has on the appropriate emotional and social functioning of the child, provided further insight into the experiences a child with this specific disability has when negotiating and navigating the primary school system.

Together the combination of these histories extends our understanding of the experience of disability by investigating and describing how the two situations interact with each other and how they produce the vulnerable child in the primary school environment. The influence of the EQ mainstream primary school environment on the specific disability or impairment will produce further experiences that need to be studied, and reported to inform appropriate, effective and relevant policy evolution. These are expressed in the next section.

Implications.

Out of the research conducted, these experiences were found to most likely be a result of neurological changes that impact on memory, consequential logic, performance and assessment, anxiety, peer relationships, interest and participation in classroom activities, irritability, difficulty concentration, adjustment difficulties, depression and emotional numbing. These would produce reportable experiences that are considered outside the range of what is considered "normal". When a child with these pre-existing vulnerabilities is presented to the primary school environment, many problems surface for both the student and the school.

The research then examined the disabling influences from the primary school environment and found them to most likely be traditional assessment methods (particularly end of term/semester exams where high levels of pressure and stress are applied), oral presentations, discipline and reprimand, bullying, social participation (such as sports, group play, performances, Anzac Day parades), certain tightly enclosed spaces, physical structures, even rules governing toileting and hygiene. These all have potential disastrous influences on a student with traits of PTSD. Further issues arise when the vulnerable child experiences emotional distress (such as relationship breakdown, rejection and failure). Such children may report experiences of excessive anxiety surrounding performance expectancy and excessive depression (leading to Lack of self-worth, self-harming, suicide ideation and more) if they do not achieve that level. This contradicts the four questions established by the curriculum trials of the New Basics Report (Education Queensland, 2004) and raises the questions of (1) what is happening for the child with familial/personal history of PTSD at both the classroom and playground level, and (2) how can we optimally apply disability theories in the classroom.

The answers to these questions may require a deconstruction and reconstruction of the core elements of educational processes, not additional processes. Perhaps the key lies in the New Basics curriculum trial, where rich tasks are implemented into a restructured curriculum that organises its content into four classes of questions that education should answer for every child:

1. Who am I and where am I going?
2. How do I make sense of and communicate with the world?
3. What are my rights and responsibilities in communities, cultures and economies? and
4. How do I describe, analyse and shape the world around me?

(Education Queensland, 2000). One may see how this provides a channel for the new curriculum to interweave itself with the issues behind the experiences of disability. When these four questions are asked by the child with a PTSD history, the challenges to answering them will be similar for many conditions currently accepted for ascertainment (acknowledging PTSD's disabling effect) and, at the same time, different for many other conditions due to the complexity and extent of impact and impairment of PTSD. This may be the way to bring EQ to account for children with any class of disability and to bring theories of disability into applicability in the classroom and playground. It may require the reconstruction of the curriculum from the perspective of the disabled child. EQ's Principles of Inclusive Education (Education

Queensland, 2005a) paint a pretty picture of an idyllic situation, but don’t provide real support for those implementing the policy. (Slee, 2001a) claims that “*all too often curriculum, pedagogy, assessment and school organisation are absent from the pathological probing of disablement*.” (Pg 388). Slee proposes the leadership for inclusive schooling may not exist in new resource management systems, but in new approaches to design and delivery of curriculum for all. Perhaps the critics have been arguing the wrong points: scratching the surface instead of deconstructing the core issues that undermine the inclusion process. The inflexibility of the curriculum and pedagogy causes difficulties to both disabled students and those not labelled with a disability, but who nonetheless struggle against this inflexibility.

A proposed management approach.

Upon enrolment many schools currently require parents to complete a questionnaire that explores potential risks to the optimal education of their child. One strategy employs a simple expansion of this current questionnaire. A grading system where severe impact rates highest should be applied to these children after the two week maximum time frame allotted for CIRT assistance. This incorporates a strategy that closely monitors the students involved to assess their coping levels. Levels of affect are reduced when the child demonstrates functional readjustment. Students who demonstrate delays or difficulties readjusting are further assessed for additional support involving community groups. This same grading system can be applied to those students who arrive at school on the first day with pre-existing symptoms. This policy does not account for, nor consider the debilitating individual and social side-effects of trauma.

The same framework that is constructed to collect information concerning the experiences of disability from the student’s perspective should also collect information from the teacher’s perspective. There has been some research published in this area to illustrate the dilemmas and barriers faced when attempting to directly apply the policies on the coal face. This information from the teachers’ perspective can then contribute to the affective feedback informing the policy developers.

In addition to a reconstructed curriculum, new approaches to discipline, behaviour management and organisational structure need to be implemented to account for the experiences of children with PTSD associated impairments and all other disabilities. Traditional methods of discipline create deeper issues for children with these vulnerabilities, leading to further behavioural and conduct disorders. These elements of education require a re-think.

The investigative framework proposed in this paper, may serve to provide the questions and techniques for collecting relevant and appropriate information that will lead to suitable curriculum design and implementation that truly supports full inclusion of disabled children, not assimilation or reluctant acceptance. However, this may only be possible if certain issues are addressed that present significant (and perhaps, intentional) barriers. These include: involvement in the decision-making process for disabled students; applied research and findings; eliminating the administrative jungle; eliminating or reducing the level of contradiction in EQ polices and processes; early detection of the disability or impairment; removing the resistance to change by allowing a flexible system; Implementing a national, systematic, flexible assessment system that reduces stress for students with such impairments; ensured diagnostic accuracy by utilising a tool (such as DSM) that is current and flexible, and appropriate management processes. These issues are presented for discussion in more detail in appendix one.

Why study this phenomenon?

The current EQ disability policy is not directly responsive to the student's experience of traumatic stress conditions because EQ does not recognise traumatic stress as having detrimental impact on the student's social and academic potential. This is reflected in their Ascertainment Policy. From the research conducted on the information available it has become apparent that many social commentators and mental health researchers are beginning to agree that PTSD and its associated condtions that can create emotional disabilities are having a debilitating effect on the academic and social capacities of our young people. It is also apparent that our education systems are not equipped to manage this problematic.

Nicholson et al. (2002) describes poor educational outcomes and high drop-out rates of students as significant concerns for our social management systems, such as education and employment. The authors also describe these systems as influencing the rates of crime and suicide in Australia. It may be that the rising incidents of anti-social behaviour from our children are directly attributable to the education system's lack of ability to effectively manage emotional disabilities. It is also apparent that there exists very little collaborative research on this topic to assist policy makers.

The Australian Institute of Health and Welfare (AIHW) released data collected by the Australian Bureau of Statistics on the mental health and wellbeing of Australians and found that around 14% of children and adolescents (aged 4-17) identified as having depressive disorder, conduct disorder or Attention Deficit Hyperactivity Disorder. Data on anxiety disorders was not collected. 27% of those surveyed reported that their condition was caused by personal/family problems or death, with a further 11% reporting stress as the core cause of their condition (Australian Institute of Health and Welfare (AIHW), 2003). These figures indicate our society is witnessing an unprecedented increase in the devastating effects of traumatic and stressful events that have a detrimental effect on our children. From the material presented thus far, it seems a child born into a family with PTSD (or associated disorders) will have automatic and inherent barriers to gaining the opportunities for a full and rewarding educational experience in Queensland primary school.

Reason for exclusion: Difficult to diagnose = difficult to manage.

To shed further light on this, in January 2005 EQ reviewed its Ascertainment Policy (Manning, 2005). Several amendments were made and processes were improved to increase the benefits of inclusive education to children. Nothing significant changed in the process of disability/impairment recognition and ascertainment. Traumatic stress conditions and emotional disabilities as an impediment to learning (that may require additional support) were again rejected by the Review Board. The reason for this was revealed in a meeting with EQ's Senior Guidance Officer (SGO) for South East Queensland where it was stated that, although the Review Board recognised the impact on learning that emotional disabilities have, it was very difficult to account for them in the process of ascertainment. Emotional disabilities have many causes and effects. They also manifest in different behaviours in each individual. Therefore, if the cause, source, nature and prognosis are not accurately determinable, then an appropriate course of intervention and management is just as difficult to determine. The Review Board stated that further research needs to be conducted into this area before it can make a different decision (Manning, 2005) despite the growing supportive evidence.

Emotional disabilities that can have genetic motivators (such as clinical depression and anxiety) can compound the risk of misdiagnosis by mental health professionals. They incorporate a vast array of conditions that can frequently and easily be misinterpreted if assessing through the eyes of an adult, and not of a child. In support, (Shemesh et al., 2005) found that a child's self-reports of symptoms of traumatic stress were accurately associated with their clinical diagnosis of the condition, while the parents tended to be significantly less accurate. This indicates a possibility of diagnostic inaccuracy due to transference and represents a significant risk to pediatric mental health clinicians. It also strongly suggests that the previous approaches to managing this issue may have been inappropriate as it did not consider the perspective of the target group – the children who are affected by trauma.

An increase in the number of personal reports from children identified with such a learning disorder is essential for any change to occur, but will be difficult to obtain. A study by Binder and Campbell (2004) suggests that children who may be unable to talk about stressors may actually be suffering from their effects. This implies a double-edged sword in addressing the issue. It may be difficult to research this topic if children are unable to provide the required information. Deering (2000) supports and further enhances this view by asserting that researchers and clinicians need to understand the experience from a child's point of view and account for the individual child’s particular development level and sensitivity of perception. To fully engage the child’s perspective of a learning disability based on trauma (whether genetically inherited, directly experienced or vicariously experienced), schools and other support systems must further research the child’s perspective of this disabling condition.

What is required for EQ to recognise traumatic stress as disabling?

The difficulty in accurately diagnosing and managing this condition may extend to other classes of impairment. As EQ facilitates the medical model in its approach to conceptualizing and managing disability it focuses the responsibility for inclusion on the individual and treatment is medically based. When viewed through these lenses, the economic scale of managing emotional disabilities can be considered and extremely costly exercise and discouraging for EQ and the Government. When viewing the issue through the social lens, however, the costs are far outweighed by the benefits. With the right environment supportive to learning, children with disabilities can make meaningful contributions to the classroom, school, community and social culture. Children with emotional disabilities can, with appropriate and effective guidance and training, become valuable contributors to culture and leadership.

Before traumatic stress and its emotional manifestations can be recognised as an impairment and disability to learning, it must shift its approach from an individually focused medical mode to more of a social duty model. Research needs to support this social perspective and provide beneficial comparison to the medical model. The acquisition of the bigger picture may result in more effective and appropriate policies being developed and implemented that support all children with disabilities. Additionally, there needs to be substantial amounts of supportive literature that pressures authorities into accepting and conditions for ascertainment.

How EQ contributes to the disability.

Some of the reasons why emotional disabilities have not been included for ascertainment may be that the policies of inclusion themselves may inhibit the collection and investigation of “the experience” of emotional disability for students in EQ primary schools. They may inadvertently “brush over” the real issue. This leads to an absence of a conceptual awareness of the issue through the child’s eyes, and potentially significant mismanagement of the inclusion process. As hinted earlier, this may be engineered into the policies. The restricted supply of assessment and diagnosis templates in the Ascertainment Policy for impairments other than the six listed supports the assertion that EQ tends to turn a blind-eye to many learning impairments in its students.

Funding cuts.

Additional difficulties faced by families, schools and the students themselves stems from the reduction in funding from State Governments. This has forced families and schools to be creative and innovative in managing the learning paths of their disabled student's. Many schools are forced to manage the issues in-house and, utilizing links with community support agencies, barely meet the specific learning needs of each student. As stated by Queensland Minister for Education, Anna Bligh: *"Schools will work actively with their local communities to identify issues of mutual concern and generate innovative responses that build on community capacity. Education Queensland will foster relationships and partnerships with local community groups, government and non-government agencies and industry to support schools in delivering flexible individualised learning and training opportunities for young people in rural, remote and Indigenous communities."* (Education Queensland, 2005b, p. 12). This seems to suggest the government is backing out of direct management and involvement by taking a monitoring role. The gaps in definition and policy operation further suggest the department does not provide school staff with appropriate training and information on how to effectively investigate and manage the issue. The individual school is left to develop and co-ordinate liaisons with the community with the principal accepting responsibility. Although this document is targeted at rural and remote communities, it has been commented that most provincial and semi-metropolitan schools encounter the same management style form EQ (Manning, 2005).

Slee (2001a) asserts that schools are mechanisms of society that produce individuals who are either assets or liabilities. Those that cost more to educate and contribute less are high risk and low value, giving poor returns for investments. Those who cost minimal to education and contribute highly are sound investments. Children with disabilities are considered by this perspective, to be high risk and low value. When society placed a dollar value on the investment in a child's future impact on that society, then notions of inclusiveness become mere whispers in a cyclone. When funding to education is reduced, the first to feel its effects are the marginalized and disadvantaged.

The school environment as disabling.

The importance of the school environment in the effective and appropriate transferal of moral, ethical and spiritual direction can never be overestimated. This is where the community, culture and society pass to the next generation, the principals of cohesion, & leadership and is one of the systems identified by Michailakis (2003) that contributes to the identification and description of disability. It is where the individual child develops their sense of Self: Their identity, esteem and worth to their community and society. If this development of "Self" is marred or impeded, the child may develop dysfunctional and distorted appraisals of themselves and thus result in anti-social behaviours that detract from, rather than contribute to, the society in which they are schooled. Schools have both the power to immensely create and severely restrict potential in an individual. In the case of the disabled child, history has shown us that schools, as an instrument of control for the community and society, have operated in the latter capacity. However, with recent educational reforms (Lingard, Hayes, & Mills, 2002) and principles of inclusion, the tables are starting to turn. Children with disabilities are being included into an environment where they can contribute to the learning and understanding of other children. The peer societies of school children are expanding and exploring new opportunities in humanity.

A study by B Adkins et al. (2005) describes schools as contributing to the hindrances of students with cognitive impairments by limiting the space in which they operate. Little is known about this field, but the researchers highlight how people with this concern experience special orientation and the associated confusion. Many sufferers of traumatic stress report similar experiences. Getting lost takes on new ground, and is a new issue for EQ to effectively manage.

Disability is commonly perceived to be a condition that afflicts an individual, rather than an indication of a complex system of dysfunctional relationships between institutions and the society they reflect and create. If an individual in a wheelchair lived in a community of individuals in wheelchairs, that individual would be viewed as normal. However, in a society where the norm is not to be in a wheelchair, that individual and the community as a whole are viewed as disabled. It depends on the status quo. Consequently, it is not easily accepted that schools have the capacity to enable or disable groups of students (Slee, 2001a)

In agreement with Slee (2001a), Farran and Shonkoff (1994) state that the school must also be ready for the child. Children with unusual educational requirements promote education managers to respond with culturally, socially and individually appropriate strategies to accommodate their needs with a broad range of learning environments to foster optimum potential in each and every child.

In an earlier writing, Farran and Shonkoff (1994) describe the ‘school experience’ as disabling for the child, where they are immediately categorized into highly restrictive boxes of implied potential that dictates their life-long opportunities for further education, employment and socialization. The authors claim that the majority of children in special education are there because of failures in children’s early encounters with the educational system.

These explanations provide some insight into how the school system perpetuates many disabilities. If the school is aware of the disability and how it is contributing to its detriment, then that school may implement changes to minimise that detriment. However, if the school is not aware of a specific disability or impairment (such as PTSD and its associated conditions) then no such changes can take place without rigorous investigation.

Inappropriate labelling.

Tomlinson (1982) asserts the dangers in creating arbitrary divisions of the achievement continuum my placing children in early categories of expectancies and capacities. The subsequent labels can have derogatory effects on the learning potential of children. Premature labelling can be even more detrimental by producing a stigmatizing label that can remain with the child for several years and limit their potential. Many children who may appear developmentally delayed in certain areas will adjust appropriately with maturation. However, premature labelling can severely restrict these children's learning potentials as the label is rarely removed throughout their early schooling and thus limits their optimum potential. This may be a self-limiting systematic flaw in the Ascertainment Policy. It provides for the labelling of children early in their academic career and does not provide a review of the assessment for several years (Manning, 2005). Additionally it is commonly agreed upon by speech-oriented professionals that some delay is not considered abnormal for society and that it may be appropriate for some delay to occur, particularly in boys (Pinel, 2002).

Teachers' attitudes as disabling.

The argument presented in this section is not intended to criticize teachers for the valuable work they do. It is about assigning the role of the teacher its proper regard as conceivably the most valuable contribution to a continually evolving society and species. Teachers with reluctant or resistant attitudes towards inclusion of students with disabilities contribute to the disabling environment. Teachers construct the attitudes, opinions and potentials of every child they work with. They can influence the creation of leaders and initiators that may take humanity into the next phase. Much important research has been inspired by a teacher – as has many atrocities.

Teachers themselves are products of a biased education system. Slee (1999) claims that, as the majority of teachers are able-bodied adults, they rely on the dominant medical perspective of disability to develop instructional techniques, and as they have been taught, they may teach to others. Many studies have investigated teacher bias and how this affects labelling (Holt, 2003; Westwood & Graham, 2003). The majority found that early education teachers differed significantly to later education teachers in their perceptions of abnormal behaviour and traits of impairment. Accurate diagnoses of impairment and disability for the "invisible" conditions may not typically occur in the early developmental stages. This subsequently leads to inappropriate labelling, treatment and management.

However, on the flip-side, studies have also shown that teachers in general make every attempt to provide quality education to all their students, despite the barriers designed into the EQ system by the frequent additions to processes and paperwork that disables and impairs the teachers from doing their job effectively.

Kemp and Carter (2005) studied the behaviours of disabled kindergarten children and identified the skills needed for the child to be successfully integrated into primary schools. They examined teachers' experiences and discovered one of the most significant difficulties faced by teachers in the direct application of inclusion policies is "lack of time". This implies that most early childhood teachers consider full inclusion is beneficial and worth pursuing. However, due to major time constraints, much of the essential principles of inclusion cannot be implemented. To support this, Stephenson, Linfoot, and Martin (2000) found that, although teachers may express confidence in their ability to manage classroom behaviour, they feel the need for support in dealing with children who are easily distracted and/or aggressive.

Noble and Mullins (1999) confront the Australian principles of equity and diversity by claiming that teachers are faced with a wide range of complex and difficult issues in accommodating the specific learning needs of children with disabilities. While they found that improved teaching and assessment practices for students with a disability improves the learning experience for all students, they further claim that the educational environment often contributes to the disability rather than improving it.

School management.

It can be agreed that the most influential social system that establishes an individual on the road the rest of their life will follow, is the school system (Holt, 2002). Effective schooling can mold a young individual towards a functional, effective, contributory participation in society and influence their abilities in employment, relationship and mainstream societal environments. The average primary school student will invest a minimum of six hours per day at school molding, developing and adapting their beliefs, attitudes and behaviours to the influences of this environment. This investment is expected to prepare them for the rest of their lives; to become a burden to, or asset of the society in which they live. This is the challenge of our educational departments and facilities: To fully and adequately meet the social and learning needs of all its students, regardless of their level of ability.

It has been assessed and documented that the ages where children are most influenced in their psychosocial and emotional development is in the early school years (Peterson, 2004). The effects of trauma from environmental, genetic or both sources would have the most influence on the developing young person during this time, scarring the way for future psychological difficulties. The cycle of trauma transference can be applied to most disabilities, assisting in identifying primary school as the most suitable and appropriate environment to implement a management strategy.

The time invested in early schooling is precariously assumed to have a positive, beneficial outcome that prepares them for the adversities and successes of life.

The course of their education should provide them with the essential skills for social survival. It is the society that determines what is normal and acceptable. If the school is not equipped with the resources to manage a child with an emotional “difference”, it is compelled to segregate that child from the socially approved and accepted ‘normal’ children.

Education Queensland lists six conditions it recognises as an impairment or disability in children that negatively affects their learning potential while in the education system. Emotional disabilities is not one of them. This is of great concern. Despite the intensity and level of research invested by the USA on this issue, Queensland educational authorities appear reluctant to reciprocate the investment. Our culturally iconic attitude of “She’ll be right, mate” will simply not suffice.

CHAPTER V: Reflections and Conclusion.

Reflections.

In its attempt to convince the reader for a need to implement a framework that collects and presents data on the experience of all disabilities from the student's perspective, this paper has confronted EQ's policies of ascertainment and full inclusion, in brief, with the intention of generating discussion and action in this issue. There are several concerns illustrated in this paper regarding the optimal education of Queensland's disabled primary students. The implementation of an appropriate framework may alleviate these concerns and should be systematically applied to all classes of disability and impairment, regardless of their listing in the Ascertainment Policy. Figure #1 can be used as a visual guide for such a purpose. This framework can contribute to our understanding of the experiences of disability by enabling a contextual space where the two histories driving the evolution of the management of disability and the history of the specific disability/impairment meet to produce vulnerabilities.

Due to the philosophical boundaries of the disciplines that study and impact the field of disability, not all significant barriers to learning get the recognition and support they require or deserve. The proposed framework should be constructed in a manner that draws the disciplines closer to that of education to provide the optimal benefit to the children they claim to service and needs to look at the experiences from the child's perspective, not the adult's.

This paper represents only a small start for the experience of disability to deliberately inform policy on the need to collect relevant information. Drawn on the limited information available, this provides just one aspect of the entire picture of disability in schooling. There remains much to be done to have any real effect on the children with this vulnerability.

Yet one is left asking whether the inclusion of PTSD related experiences in the classroom and playground add value to the education of others. If school is intended to set the stage for "the real world" and that world is witnessing more traumatic events, then children need to be prepared for that. If, as Slee (2001a) suggests, schools are designed to perpetuate disabilities to create life-long clients and dependents, then schools can also be where children with histories of traumatic stress forge skills that best help the issues of the next generation of sufferers. If managed optimally through a sociological perspective, children with histories of traumatic stress can become assets to society. These children can become highly competent in areas of leadership, management and decision-making. They can rapidly consider all aspects necessary and, while considering the needs of others, make rapid, sound decisions. Due to their "ability" to not be emotional in their decision-making, they can be very task-oriented and perform well (Ewing, 2005). This presents a stark contrast to the prognosis of the medical perspective.

Leave enough alone?

One may ask whether it is better to leave enough alone and allow this condition to remain “invisible”. There may be an inherent risk of further disabling the student by identifying them and exposing them. Perhaps identification will manifest marginalization, ridicule from peers and provide further impairments to an already difficult process. As commented by Slee (2001b) the school can create an environment that either minimizes or acerbates the child’s condition.

Those adolescents who have developed complex coping strategies to deal with their disability from childhood may be masking their problem, thus reducing their access to special support services. Often they need to work harder for longer than their peers to achieve passing grades and be accepted. Consequently, these strategies have accumulative effect. As Young (2005) claims, this resiliency may account for the proportion of children and adolescents who have developed effective coping strategies to manage their emotional issues.

Conclusion.

We are currently witnessing an unprecedented increase in the percentage of students with disabilities in Australian Schools. This may be the result of many factors contributing to the nature and identification of disability, and these figures are predicted to increase in the near future (Dempsey, 2004). To optimize the full potential of all children and young persons it is crucial to nurture their academic and social development in the most favourable environment possible. For students with socially declared labels of disability or impairment, the environment with perhaps the most significant impact (apart from the immediate family), and therefore the environment they may be most vulnerable to, is the educational environment. It should, therefore, be the most favourable to the child.

The history of the medicalisation and management of disability by Queensland educational authorities has left several gaps in an already volatile and segregated system that perpetuates the further disablement of children, families and societies already burdened. The way in which disability is conceptualised, managed and treated in societal institutions seems overwhelmingly dictated by the popular model of conceptualisation at the time. Currently, this is the medical model, authenticated and validated by such diagnostic tools as the DSM. Yet this is itself, not without problems.

There is a growing pool of research-based evidence that indicates this issue has evolved far beyond the diagnostic abilities of the current version of the DSM, and that it may, in itself, be a tool that is flawed systematically. Since EQ relies heavily on the latest version of the DSM, and the medical opinion of qualified therapists who adhere to the DSM, it is feasible that the ascertainment system is, similarly, systematically flawed. How then, do we fix the problems this creates? When assessing a product or service, it is considered customary to acquire feedback from the individuals in receipt of that product or service. In EQ’s case, that would be the disabled students, their families, the teachers who apply the policies and the community. It seems alarming that EQ does not appear to fully utilise a system for collecting such vital feedback and implementing the recommendations into the next generation of policy evolution.

A reframing of EQ’s conceptualisation of disability from the medical perspective to a social one may shed new light on the issue and provide inventive initiative from within EQ. Several researchers support such a bold and radical paradigm shift. EQ has taken strong steps to coerce schools to engage with their local community organisations in the support of students with disabilities by limiting the funding to schools. Community support organisations can participate more in the management and treatment of students. However, they seem to encounter systematic and statutory barriers to participating in the decision-making processes of policy development and implementation. EQ is only showing half the picture.

Finding solutions will certainly be no easy task. There are many issues that need to be addressed that have existed in a system that resists change, supports its own internal validation mechanisms (regardless of the outcome) and upholds a status quo based on able-ness, economic rationalism and political agenda. Answering the four questions inherent in the restructured curriculum from the perspective of the child with a history of trauma will be the next vital step in research to follow from this paper. Collecting this data to support these assertions may assist in finding solutions for at least one class of disability.

EQ has made recent milestones in its management and treatment of all its students with disabilities. As society has evolved many of EQ’s practices have evolved alongside. The New Basics Project is currently carving new benchmarks in the quality of content and delivery of education. It may be here, that the framework can be applied. However, it may be apparent from the evidence presented in this paper, that EQ still has a long way to go before it satisfies the major concerns of its disabled clients. It must produce social participants who contribute to the mechanics and operations of society while both conforming to the pressures of that society and contributing to the creation of the next generation of norms and standards. To do this effectively, a systematic, scientific method of collecting, recording and reporting the data on the effectiveness of its services to all disabled students needs from their perspective to be implemented by EQ.

Farran & Shonkoff (2003) find it ironic that much of the debate of school readiness and disability could be avoided with the implementation of a coherent and coordinated infrastructure of support for children and their families during the first five years of schooling, and find it tragic that, although we have the knowledge to make these improvements, our political system lacks the will power to apply it. One questions if schooling was not compulsory in Australia, would EQ suffer or would it implement quality management and external auditing processes (as major profit-driven corporations must) to ensure customer satisfaction and loyalty? Perhaps this is a question to be answered by aspiring critics and researchers.

APPENDICES:

What are the issues to address?

A system with errors is not effective. When the errors concern the academic and social potential of children, it becomes a serious issue for the future of that society. This paper has attempted to illustrate a crucial error in Education Queensland's policies pertaining to inclusion and disability management relating to the systematic neglect of the experiences of its disabled students and to present a proposed framework to guide the collection of childhood experiential data to inform such policies. The systematic collection of such data would be no easy feat and would first need to resolve several core issues, such as those discussed in the following section. These would require fundamental changes to the content, structure and presentation of EQ's disability management strategy. As previously stated: no easy feat. Yet, with the implementation of the New Basics Project it seems these changes may now be possible.

Issue #1: Involvement in the decision-making process.

Disabled students, parents and community support agencies need to be consulted in the reconstruction of policy and curriculum. Studies have shown that disabled students gain improved quality of education and life outcomes when they are involved in the policy decision-making process (Parmenter & Knox, 1991). Byrnes (2004) documented the views and opinions of students with disabilities in New South Wales, concerning where they should be educated, the personal impact of the school setting, and how to involve the students in the decision-making process concerning their educational requirements. The students were *not* in favour of full inclusion of *all* disabilities into mainstream classrooms. Instead, they perceived value in a range of settings where each catered for students with different levels of learning support or disability needs. The students also believed that, like Slee (2002), it is not their situation that determines the location and environment in which they are educated, but that the location and environment should be equipped with the necessary resources to meet their learning requirements. Consequently the students were in favour of minimal movement between school settings to be able to access their support services. The current system appears top-heavy with influence form those with limited life experience in the matter. Therefore a critical issue is to incorporate a higher level of bottom-up influence.

Issue #2: Applied research.

It is evident there is not enough literature and research surrounding the children's experiences of disability. Less on the impact of traumatic stress on student's learning potentials. If there was the Ascertainment Policy might read differently. Research needs to be conducted in a manner that will ensure it is incorporated into future policy development and that all factors impeding a child's capacity to achieve fully are examined and accounted for. This is an issue that needs to be addressed if parents and community pressure is to change current policy. Research into the fragmentation of memory caused by trauma may assist in shedding light on the issue.

Issue #3: Administrative jungle.

To some, the most significant hindrance to the acceptance of students with disabilities is the administration process of the education system. (Tronc, 2004) claims Australia's justice system has contributed much of the administrative failure behind the concept of inclusion, insisting on written accounts and records of interactions between teachers, parents and students to avoid liability, particularly students with learning difficulties. Tronc continues to assert teachers should focus more on the acts of instruction and guidance, that on administration. This seems an increasingly difficult for EQ teachers as the system currently demands a high degree of administrative procedures from it teachers and guidance officers (Manning, 2005). Coupled with the mountain of administrative paperwork that parents must complete and submit, the process of ascertainment may become a confusing and frustrating issue for those responsible for the accurate and appropriate delivery of services. Perhaps this is an intentional design element.

Where a child is expressing learning difficulties, EQ provides assistance by managing a collaborative effort from numerous agencies related to children's health and development. However, studies have shown that parents expressed high levels of frustration and disappointment with the government and quails-government agencies forcing them to negotiate an exhausting merry-go-round of agencies and therapists. This may be compounded by the administrative quagmire of multiple accountability requirements demanded by the different levels of government before the parents were able to secure support services for their child. This is further acerbated by the broadness of definition and blurring of boundaries by the DDA of 1992, making it difficult for mental and health professionals to appropriately categorise disabilities (Shaddock, 2004). The New South Wales Parliamentary Legislative Council identified these issues within their own education system (New South Wales Parliment. Legislative Council. Standing Committee on Social Issues, 2003) and found similar outcomes in a South Australian study that investigated the existing and potential opportunities for children with disabilities to be included in the decision-making process for educational outcomes for all children across the State. It may therefore be safe to assume that similar issues exist in the Queensland education system. This reflects a costly exercise in time, human resources, professional resources and the patience of parents, mental health practitioners and the disabled children themselves. This issue is one that must be addressed rapidly if any real positive impact is going to result from the recent reform and further efforts.

Issue #4: Contradiction.

There appears to be many contradictions inherent in EQ’s policy on full inclusion. On the one hand EQ is advocating for the complete absorption of all forms of disability and impairment into mainstream classrooms, while on the other hand they are asserting their limitative Ascertainment Policy and procedures and exclusive special education processes by providing support for students with only six categories of impairment. Under EQ’s “Guidelines for Special Consideration in Assessment for Students with Disabilities, Learning Difficulties and Learning Disabilities” it states that all teachers are to ensure the curriculum is inclusive for students with disabilities (Education Queensland, 2005a). This is a big load for teachers to take on. Special consideration is only given to those students with a disability identified by the Ascertainment Policy. This confuses several Acts (Commonwealth Anti-Discrimination Act (1991), Commonwealth Disability Discrimination Act (1992), Queensland Education (General Provisions) Act (1989), Queensland Disability Services Act (1992)) and EQ’s own literature in providing equitable education opportunities to all students with disabilities. There needs to be common agreement on all aspects of implementation of policies and procedures by parents, teachers, mental and physical health professionals, students and the education system.

Issue #5: Early detection.

For integration of any child with a disability or impairment into the education system to be successful, their condition must be detected as early as possible. Perhaps the best place for this to happen is in the early developmental years, such as kindergarten. (Kilgallon, 2001) supports this assertion and states that teachers in early development centres are crucial to early detection and accurate identification of existing and potential learning impairments in young children. In a study by Van der Aalsvoort., M., Van Tol, and Karemaker (2004) it was found that practitioners utilizing a socio-cultural perspective when observing children at risk of developing or acquiring learning difficulties could predict with reasonable accuracy the odds of this happening. This could assist in the early identification of children at risk of developing emotional disorders and other “invisible” disabilities.

Issue #6: Resistance to change.

EQ is a system in flux. There have been several recent changes to EQ that have streamlined several processes and merged departments to be more effective (such as the New Basics Project) yet there still appears to be core resistance to change which can be measured by student attitudes and interpretations towards students with disabilities that can significantly influence the level of inclusion a school and community adopts. In a recent study, McDougall, DeWit, King, Miller, and Killip (2004) found that, after interviewing nearly 2000 students, a significant proportion (21%) maintained negative perceptions of disabilities. This indicates a lack of awareness, understanding and knowledge of the benefits of full inclusion in schools among its staff, teachers and students. It also reflects an inability to portray appropriate attitudes to its students by the school culture. As Slee (2001a) has commented, schools reflect and represent cultural and social opinion and ideology of their immediate surrounds. A school that is close to an area highly populated with families with a history of military service may be more supportive of students with physical and emotional disabilities and pervasive developmental disorders than a school surrounded by families without military histories. There seems an age-old attitude that still influences archaic principles towards children with a visible or invisible difference which may be part of the top-down approach. This situation must evolve to be more open to input from, and responsive to, those who experience the policy amendments. EQ must provide a way for this to occur in a systematic and flexible process.

Issue #7: National, systematic, flexible assessment.

Each Australian State Education Board has a different continuous curriculum and final exam that its students must sit before progressing beyond the traditional schooling system. If these standardized tests are not indicative of a national standard, how can Australia effectively critique its management of its students? It is thereby illaudible to suggest a national standard of education for Australian children that can be identified against international examples. As comment by Slee (2001a) this issue is complicated by the divergent histories of the development of supportive education. These have produced different Ascertainment principled for each State, although some commonalities exist.

The current assessment and ascertainment system employed by EQ commands the use of strictly controlled documentation and processes that gives EQ ultimate control over all variables. This highly structured milieu gives little flexibility in a changing environment where disabilities and impairments are evolving and therefore do not reflect the needs of the community which supports the school. The boundaries of standardization need to be loosened to allow for changes in classification and diagnosis of disability and impairment. This will assist in the development of a more accurate system of identification and management that incorporates cultural, social and economic variety in Queensland students.

Issue #8: Diagnostic accuracy.

It has been discussed in this paper that mental health professionals encounter difficulties with the accurate diagnosis and assessment of emotional conditions in children. Many be masked by the child and therefore difficult to reveal and treat. A method for mental health professionals to bring their discipline close to that of the education system would be highly beneficial to all young individuals. The proposed framework should be developed with the cooperation of the disciplines that impact on the quality of life and education provided to young people with disabilities and needs to be flexible to their changing definitions.

Issue #9: Management.

It has been established that EQ utilizes the medical model in its conceptualisation of disability. This approach supports the use of drugs and laboratory experiments in the intervention and treatment of disorders. Brown (2000) asserts the use of non-laboratory medicines, particularly in the management of behavioural and emotional disabilities. This approach could be implemented into the curriculum. The suggestion is made that natural management strategies such as exercise, meditation, diet and nutrition can be an effective behaviour management tool for children with such barriers to learning. There is an abundance of scientific and pseudo-scientific literature relating to the dietetic management of conditions such as ADHD, Conduct Disorder, Aspergers Syndrome and a range of others related to traumatic stress. Treatment must be multi-modal with pharmacology being but one tool. This is supported by prominent neuropsychotraumatologist, Jan Ewing (2005) who utilizes Nutrition, Understanding, Relaxation, Spiritualisation, Exercise (NURSE) in her effective treatment and management of the emotional consequences of traumatic stress.

These represent but a few of the potential issues created by an education system that has undergone recent systematic changes, yet still retains much of its original conceptual frameworks that dictate the direction and influence of policy development and implementation. To bring about changes in social management institutions we must investigate the systems that operate and control them, and, where issues are identified, address them with the cooperative mutual effort of all stakeholders, down to the last individual.

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