

number of citizens estimated over four million. The problems relating to school and social inclusion do not arise from the social distancing imposed due to health restrictions: the families of people with disabilities often live in conditions of loneliness and isolation and schools, or day residential centers, constitute, especially in the most complex cases, the only way of socializing outside the family context. For a family with a disabled member (approximately 94% of the 275,000 Italian students who benefit from school support or certified under law 104/'92 have a complex cognitive disability), the ordinary activities necessary for everyday life or leisure are often hindered, or precluded, so we can speak of a problematic condition extended to the entire family unit. By complex disability we mean the conditions of extreme fragility concerning the sphere of autonomy and self-management in the presence of various sensory, motor, cognitive and mental deficits. It is more correct to use the phrase "complex disabilities" instead of the "serious" label (Goussot, 2014; Salis, 2016) to highlight the person as the protagonist of an evolutionary path, of humanization and citizenship that goes beyond the condition of the deficit and that challenges systems to change according to an inclusive perspective. This is all more true in adulthood, as often the attention is oriented to early childhood forgetting that people with disabilities, since 18 years of age, have to travel a long existential path through adulthood and senility (Goussot, 2014). Although Italy is the European country that first legislated, over 40 years ago, the abolition of differential classes in schools, prefiguring ever wider inclusive scenarios, and despite the fact that Law 328/2000 recognized the value of the construct "project of life", the process of inclusion is still not accepted and spread throughout the territory and the ethical and scientific values that support it have not fully established themselves. The reality data describe a school with classes that are always crowded and difficult to manage, the presence of several disabled pupils per class group, insufficient support teachers, sometimes without training or specialization. Can we talk about the traumatic effects of the pandemic and the related lockdowns? Only over time it will be possible to make a real assessment of the impact that social distancing has produced on the balance and mental and social health of children and adolescents, with and without disabilities. However, some considerations are already possible. The first international data on the impact of the lockdown on children and adolescents come from China, the first country to have experimented with extreme containment measures, in a quantitatively significant measure so as to affect the daily lives of millions of people. The most salient behavioral manifestations concerned irritability, aggression, sleep and eating disorders, emotional dysregulation, attention and concentration difficulties with repercussions on cognitive performance (Gitterman and Germain, 2008). The lockdown, among other effects, has imposed a forced and prolonged

coexistence, often in small and inadequate spaces, without interruptions, putting a strain on the parental competence managed in the ordinary in different physical and relational times and spaces. The forced and sudden change has created disorientation and confusion, not only in children and adolescents but also in the adults of reference, triggering tensions and causing a tense and nervous family climate.

Due to their structure and organization, which responds to economic and work logics as well as social and cultural ones, families tend to delegate various responsibilities, especially the educational one: to school, to grandparents, to sports and social centers. All this suddenly became unavailable, forcing parents to govern situations further complicated by the stress and collective fear that the virus caused, while having to cope with work needs from home. Certainly, all this indicates the need to regain proper exercise of parental responsibility, reconstructing a physical structure as well as relational spaces and modifying attitudes of dysfunctional attachment, authoritarianism, overprotection, entanglement and sometimes of inverted parenthood.

The Covid 19 pandemic and the consequent social confinement have undoubtedly put parents in crisis and a use of media communication deliberately aimed at creating and feeding fear and anguish in adults has produced the pouring of these emotions on the smallest and most fragile (Halladay *et al.*, 2020). The anguish of adults is also rooted in concerns about work and the outcomes of the economic crisis, so the impact of lockdown and confinement has different effects depending on the social and economic context of the family unit. The syndrome of the nest, intended as a shelter, of the house as a protected and safe space is one of the declinations of this data, but there are others: violence, discomfort, tensions that before the pandemic were interrupted by moments of distance are dramatically aggravated. The phase following closure, still full of uncertainties and fears, generates a sense of bewilderment and difficulty in re-insertion, which affects everyone, from childhood to adulthood (Isidori and Vaccarelli, 2013). The lack of physicality in relationships and the sudden breaking of routines particularly affected little ones, children and people with cognitive and/or behavioral disabilities. The narrations of some parents are reported, significant in their eloquence:

S, mother of P. 12, Down syndrome (Tuscany).

Not being able to go to school anymore, not being able to attend the rehabilitation center and the education center has completely destabilized him. He, once quiet and sociable, has become irritable, grumpy, sometimes aggressive even if only towards objects. Despite our explanations he hasn't understood why he isn't allowed to go out and lead his life. He cannot sleep, he wants to eat all the time and obsessively repeats that he wants to go out. Nobody has contacted us for distance learning. I think he was

feeling desperate because he thought that everything outside our house no longer existed.

R. Father of S. autism spectrum syndrome with cognitive disability, 8 years old (Marche).

Keeping him at home was not possible. Crises followed each other continuously and we fell into the abyss. Nothing calmed him. So, before we could walk within 200 meters from the house, I took him out. We were stopped by diligent police forces and despite the evidence of my son's condition we were fined. Yes, not understanding what was happening, he had a violent crisis with acts of self-harm. No understanding, indeed, they told me that I was lucky that the period did not allow it, otherwise they would have asked for a TSO (compulsory psychiatric hold). I believe, with great bitterness, that there is a lot of ignorance around disability and I see inclusion as a mirage.

MR, mother of V, Angelman syndrome, 9 years old (Emilia Romagna).

The setbacks of this lockdown are devastating. I have the feeling that in two months I have lost all the work done over the years. She has lost her sphincter control, she wants to be fed, she cries to express needs that we often don't understand, and then crises break out violently.

L. mother of F., Down syndrome, 10 years (Sardinia).

Despite an attentive and present online support teacher, we were unable to make him concentrate in front of the video except for a few minutes. He has difficulty concentrating and is always tense and afraid, he constantly asks if he, us, his friends are going to die. He does not understand what happens but he is afraid of it.

I., mother of Y. 5 years old, cognitive impairment (Abruzzo).

The lockdown produced a sense of estrangement in all of us. She doesn't sleep, she always wants to be close to me, and I sometimes lose patience because I have a brother to take care of and work to do in smart mode. I fear that the trauma is something hard to deal with in the long run, not just the near future.

All the witnesses tell of the changed relational climate, of the emphasized emotions, of the lack of physicality in relationships. But there are also other types of psychological trauma: those of children with a sick and isolated parent at home. Those who have lost their grandparents, or those of the children of health workers on the front line in the hospital, forced to stay away from their parents, deprived of any contact. Certainly, difficult situations to explain, to understand and accept for the little ones and for those with a deficit. Children

often register changes on an empathic level by absorbing parental anxieties without understanding them. It is therefore very important to always tell them the truth, with a language suitable for their age and cognitive level. Not telling children the truth creates frustration, distrust and a feeling of being betrayed by their parents, it can generate real feelings of guilt (“it’s my fault if I don’t deserve the trust of my parents, it’s my fault if mom and dad are angry”). Lies prevents the child from processing pain and fear (illness, bereavement).

Thus, what is implicit becomes an inner persecutory ghost. The same approach affects the elderly, often far from the reality outside their home and alien to technology, therefore lacking the tools for decoding reality that must be assisted by reference operators capable of assuming a role of accompaniment to understanding and event processing. It is very important, in these cases, for adults and children, to recreate new reassuring routines, to establish spatial and temporal boundaries, not to leave the child or the elderly alone in front of the television and carefully sift the contents to which they are exposed. Paradoxically, a form of interaction has been reached, called DAD (distance learning), which has forced children and young people to excessive exposure to screens while the importance of limiting the use of smartphones, tablets, PCs and TVs has been so far upheld. It will be difficult to return to the limitations of these tools especially for children with disabilities.

Distance learning resulted for many in an excessive burden of homework and many children expressed rejection reactions. Parents were called to an unusual helping and supervisory role, often without having the necessary skills to cope with the school burden. In many families, problems have arisen related to the need to use IT tools at the same time by several children for distance learning and by parents for smartworking. Online education has widened the social divide and those who have found themselves without tools and supports have been cut off. In cases where the family is exposed to physical or verbal violence, the chances of requesting help and support have been more difficult, making the situation even more traumatic. Even in situations of separated parents, children have been forced to live a long period with one parent, deprived of a habit often built with great difficulty: even in these situations it is difficult to explain and understand. It is necessary to change the paradigm passing from the logic of distance to that of proximity. Readjusting to normality is neither simple nor taken for granted. Impossible to think of resuming everything from the point where it was abruptly interrupted.

The effects of distancing and fear have caused anxiety-depressive syndromes and traumas of various kinds that will need to be recognized and managed. We will have to get used to living with demanding means of protection, especially children and people with disabilities, and phobias and

mild traumas may be generated, such as resistance to accepting reality, which manifest themselves with headaches, eating disorders, tachycardia, anxiety, depression, sleep disorders.

In these cases, it will be important to deal with the change that will be endured in order to accept a reality that can no longer be the same as before, but will require a commitment to re-adapt. In many ways, the pandemic has produced a disruption of the care organization and now more than ever it is necessary to resist a pervasive medicalizing approach. It is necessary to reiterate how in the detection of individual needs (Maslow, 1943; 1987) we find at the base the need to be safe and be protected, founding principles of the informed trauma approach.

In families where there is a person with disabilities, the home educator, under the supervision of the pedagogist and psychologist, could resume the ranks of the informed trauma educational relationship, starting to work on emotions that should not be removed but addressed and processed (Salis, 2019b).

The more complex traumatic forms, on the other hand, such as post-traumatic stress disorder, must be faced with specialized multidisciplinary support, with particular attention to people with disabilities, who find it difficult to understand and respect the rules; to people with autism spectrum disorder and to those with psychiatric pathologies, in which panic attacks, anxiety and irritability are more likely to appear, which often results in crisis behaviors. How to deal with all this correctly? First of all, by recognizing the problem and creating a climate of acceptance and availability, of proximity to the precautions imposed. It is essential to create physical and temporal spaces to elaborate the new reality and weave the plots of new routines, without indulging in shame or a sense of perceived ineffectiveness. The narrative approach, sharing, mutual help groups can be a valid reference, with the support of experienced specialists. Upon resuming face-to-face teaching activities, teachers will have to consider the emotional baggage that has burdened the children, activating educational pathways of global care without teaching exclusively focused on disciplines and contents.

In the perspective of future research on trauma, the interdisciplinary dimension is central, which alongside neuroscience and psychology sees the role of special pedagogy increasingly valued, specifically in its narrative dimension. The trauma creates a dysregulation of the most ancient defense systems causing a dysfunctional activation of the alarm mechanisms that can be correlated to the environmental realities (figures of hearing and care) perceived as a source of danger and threat instead of safety and well-being. Such traumatic interpersonal experiences, often early and constant in individual history, can be supported with metacognitive educational interventions aimed

at identifying and managing emotions. The traumatized brain, first engaged in primary neurovegetative and behavioral responses (attack, flight, freezing, fainting) subsequently activates autobiographical resources on the basis of the need to build a sense and a meaning to integrate traumatic memories.

Trauma can hinder the balanced definition of the self, generating a perception of negative value, emptiness and shame that can be repaired through a personal narrative genesis aimed at seeking balance between the various parts of the self, in the remodeling of the relationship with the environment. The narration allows the emergence of the form and the care of the Self (Demetrio, 1995,1996) the narrative recognition could be extremely important in identifying the insidious trauma, that is the one referable to an apparent normality that in reality conceals exclusion, dehumanization and harassment (psycho-physical) experienced by people exposed to discrimination, specifically in this article, of disability. In insidious trauma, various forms of discomfort occur often erroneously attributed to subjective conditions. Very often the insidious trauma is not recognized and therefore not expressed and taken in charge with pervasive and creeping, even if invisible, effects. Also in these cases, the educational pedagogical work, carried out in everyday places and outside the clinical context, can bring considerable resources in the phase of identification and integrated management.

5. Conclusions

As we think about the implications of the global pandemic, we can see the ways in which our services have had to evolve and adapt to meet the needs of those in the community, especially vulnerable populations. The pandemic has also raised serious questions about children experiencing adversity: how do we identify, assess and respond to child maltreatment when those most likely to report to abuse are not interacting with the child? How is intimate partner violence magnified by the social isolation caused by stay at home orders? How are seniors and those with disabilities who rely on community based services accessing resources to support daily living when friends, family and service providers are not able to support them? The National Child Traumatic Stress Network provides extensive guidance for schools including educators, staff and administrators dealing in response to COVID 19. Included among their recommendations are to provide individual services to address traumatic stress, create trauma-informed learning environments and established community based interventions that raise awareness about trauma and establish cross-system collaboration and community partnerships (Halladay *et al.*, 2020).

As we work collectively to reduce personal and collective trauma, we must work to both reduce exposure to adversity and increase the capacity of communities and caregivers to be buffers for vulnerable populations. COVID19 requires to consider the intersecting individual, interpersonal and community variables. An individual's individual experience with abuse, neglect, household dysfunction, poverty, disability, mental health, substance abuse and other individual barriers will undoubtedly shape their experience during and following the global pandemic and requires intervention at the community, not just individual, level.

In the new post-pandemic world, it will be important to build relationships of closeness, empathy, recognition. Replacing the old ways of contact, such as hugs, gaze, facial expressions, smiles, warm tones and words suitable for a different way of communicating (Halladay, Goldman, Danna et al., 2020). However, it is urgent that politics and the system become aware of the need to plan dedicated objectives and actions and that the different disciplinary knowledge find complementary positions for a global, person-focused and informed trauma. The time is ripe for pedagogical skills to be adequately recognized and valued and to be able to constructively work alongside other professionals in the helping relationship, in compliance with the specific roles valued by the shared network action.

One of the general objectives is to really ensure that people with disabilities have full access to all social activities, with the right of active citizenship. Purposes that should already be guaranteed by the Constitution and by our legislative system. As far as school is concerned, we hope that the processes and tools for the inclusion of students with disabilities will be strengthened, with immediate solutions to ensure the accessibility of communication platforms and their contents, educational support in presence, and free instrumental equipment for families. On the issue of inclusion, it is necessary to strengthen inclusive projects and independent living, to respond to the needs of care and emancipation especially for the most marginalized. All organizations, scholastic and social, should be trauma-oriented, in order to guarantee each and every one safety, a sense of belonging and the serenity to face every existential path in its uniqueness and difference.

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