

Mental Health and Children with Complex Learning Difficulties and Disabilities (CLDD) by Dr Rob Long

The mental health difficulties that children and young people with CLDD are frequently under reported. The number of children considered to have CLDD is difficult to ascertain. This is due in part to increased survival rates of premature babies and those with severe illnesses and different definitions being used (Carpenter et al, 2015). In England it was estimated that there were some 10,000 children with a severe learning disability (Health & Social Care, 2018).

It is generally accepted that children with CLDD have some or all of the following:

Cognitive impairments
Communication difficulties
Sensory and physical disabilities
Emotional, behavioural and social difficulties

Co-occurring conditions

The term CLDD reflects the possibility that a child may have more than one disorder that exists independent of another. Such co-occurring conditions can make diagnosis difficult as well as the best form of support for the individual. How the different conditions interact can exacerbate symptoms and make for a child having a very unique learning profile.

Learning profile

The best way to understand how a child with CLDD learns is to get to know each child. However a framework which can give some general insights to the differences in learning style comes from Zigler's 2 Structure Model (1977). Ziegler proposed that there were to discernible and distinct learning profiles.

1. CLDD children with global learning delay. These children had no recognised syndrome or chromosomal abnormality. They would progress through the same cognitive stages of development for other children but at a much slower rate and their achievement level would be lower.
2. CLDD children who have learning difficulties caused by either a recognised syndrome or chromosomal abnormalities. These children are likely to have a peaky learning profile. That is there will be areas of definite strengths and areas of marked weaknesses. They may reach the same milestones as everyday children or not reach them at all. Teaching support for these children is a much more complicated matter.

In addition there can be CLDD children who have some communication skills and use speech but lack an understanding of what may said to them. Adults may assume that what they have said, a request for example, has been understood by the individual. The adult can wrongly interpret the lack of response as 'defiant behaviour'. This ability to communicate but lacking understanding can mask underlying SEMH issues. Professionals that support CLDD children learn to make structured observations under such circumstances which enables simplistic assumptions to be avoided and a more thorough analysis made.

CLDD, Evolution and Social, Emotional and Mental Health (SEMH)

Reframing mental illness

From an evolutionary point of view, the brain is designed to adapt to the environmental context in which it finds itself. Bowlby (1969) wrote of 'Environmental Evolutionary Adaptedness'. Defined as:

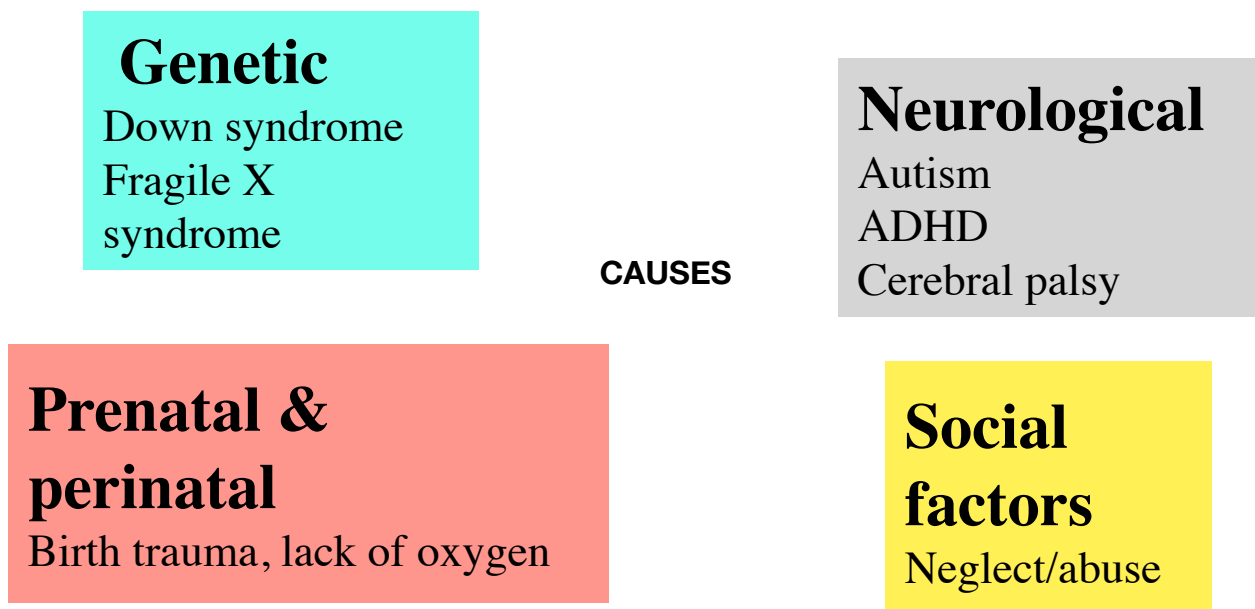
“A compound idea representing the sum of a populations exposure, over a given time frame, to external conditions and stimuli threats and opportunities, including nutrients, social pressures, threats from parasites, predators and competitors as well as climate and general habitat.” (P. 7 Abed and John-Smith, 2022).

This suggests that there are SEMH difficulties faced by children that are their response to stressful conditions.

Causes of CLDD

CLDD is more often the result of a complex interaction of the different factors See Fig. 1.

Fig.1



Research shows that while biomedical psychological factors give rise to CLDD, there is a continuum of vulnerability with disadvantage, deprivation and disability all contributing to. Some children sadly face the consequences of each of these (Carpenter et al. 2015).

CLDD & SEMH

The mental health difficulties that children and young people with CLDD are frequently under reported. This is often because the problematic behavioural, such as aggression, self-harm and rocking are attributed to their learning or medical difficulty. This can result in prolonged distress for the individual.

Studies have shown that children with an IQ below 70 are at an increased risk of mental disorders (National Library of Medicine). In fact some 40% of children with an intellectual disability will have a diagnosable mental disorder (Totsika, 2022).

An IQ score gives no information as to what an individual child's social, educational or medical needs are. While every child inherits unique genetic information from their parents, their lived experiences are unique. Their environment and experiences will help shape and determine their hopes, ambitions, fears and personality. When you meet one child with Down's syndrome you have met one child with Down's syndrome. The level of support a child will need depends on their adaptive functioning in different contexts, not their IQ score.

How to know if a child has SEMH difficulties

1. Know the child - what is their normal functioning, their idiosyncrasies
2. Monitor and assess changes in behaviour. An increase or decrease.
3. Liaise with family/carers to compare behaviour in different contexts.
4. Be aware of uncharacteristic extreme behaviours, self harm, obsessive or compulsive behaviours, running away.
5. Physical changes, weight gain or loss, incontinence.
6. Loss of existing skills, communication, personal care, physical pain with no obvious cause.
7. Behaviour changes are long term (over 2 weeks) and occur in different contexts.

With regard to behaviour, as Imray (2008) explains:

There is no such thing as behaviour without reason (all behaviours have a reason behind them) and that reason always has a meaning. (P1)

Seeing behaviour as a form of communication means that professionals understand that problematic behaviour displayed by a CLDD child may be a sign of distress or indicating that some basic needs are not being met, for example safety or hunger. Punitive responses, sanctions, to such behaviours serve no purpose. They will not work and are more likely to worsen the situation, causing distress to the child and frustration for the adult.

The brain, SEMH and CLDD

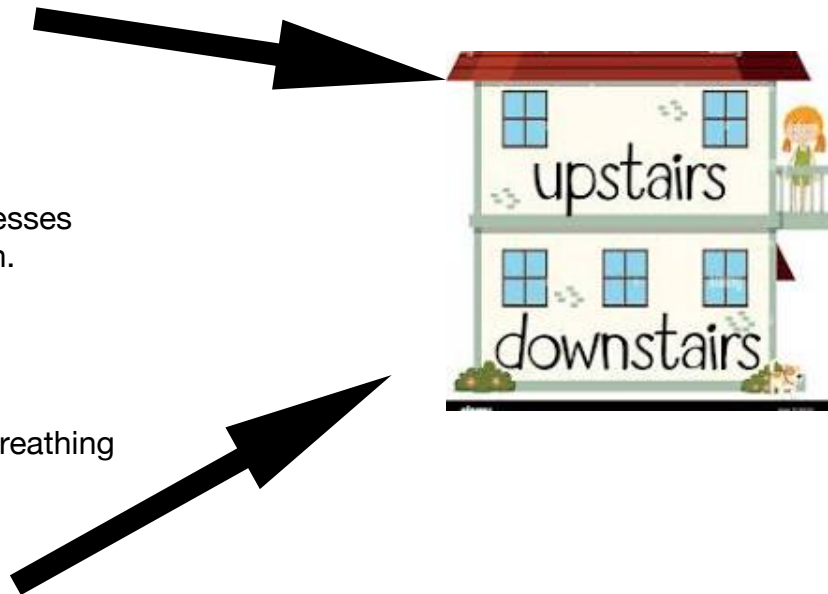
A very basic model can throw light on why children who face CLDD are more likely to experience SEMH issues. Simply put, we can use the 'upstairs down stairs model' (SEL Sketches). Upstairs is where thinking processes occur. Namely:

- Decision making
- Planning
- Emotional regulation
- Empathy
- Self-awareness
- Morality
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We know that these are processes that our children struggle with.

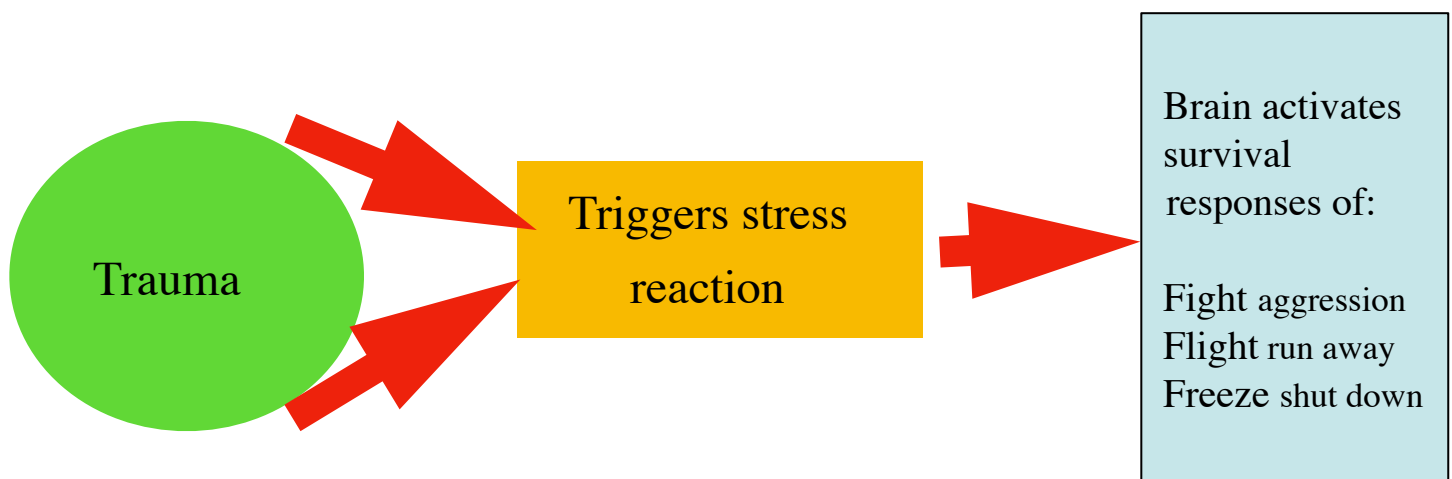
And down stairs is where:

- Flight, fight, freeze
- Autonomic responses - breathing
- Strong emotions
- Sensory memories
- Action before thought



Trauma and CLDD Children

As we shall see next, when our children experience trauma it is the down stairs brain that becomes active. This will trigger innate emotional reactions of anger, fear, and anxiety. These in turn will result in fight or flight responses. See Fig. 2.



Basic survival responses are heightened in a child with CLDD through:

- Communication difficulties - they communicate through their behaviour
- Emotional dysregulation - stronger responses
- Cognitive impairments - poor understanding of cause /effect
- Over active amygdala (down stairs brain) - sensitive to threats

A definition. Trauma

“refers to either a singular event (e.g., an accident or illness) or series of events (e.g., ongoing neglect or harm; childhood physical, sexual or emotional abuse; war, deprivation) which are experienced as being emotionally overwhelming and distressing, and which make a person feel powerless and scared, to the extent that it challenges their capacity to cope.”

(Rees, 2024, P. 70)

Are children with CLDD more likely to experience trauma?

Yes. There are many inter related reasons for this.

Developmental differences

- Emotional regulation
- Communication
- Sensory processing

Adverse Childhood Experiences

- Neglect or abuse
- Medical trauma (painful/invasive procedures)
- Bullying or social exclusion
- Family stress (parental mental health issues, etc.)

Communication Challenges

Limited or atypical communication
which can make it harder to report abuse
or seek help

Cumulative Impact

The interplay between disability & trauma is often cyclical:

For a child with CLDD trauma can be confusing and scary because:

- No control over their environment
- Not able to make sense of what has happened
- Fear over it happening again

A trauma informed approach is a positive way to support children who have experienced trauma of some sort. Such support will involve:

1. Psychological Safety Routines/visual timetable/ calm down spaces/ reduce sensory overload
2. Sensory integration support. Tailoring surroundings to the child's sensory profile.
3. Supportive communication
4. Build emotional regulation skills. Visual aids, social stories, calming techniques.
5. Strong, attuned adult relationships: To help co-regulate the child using play based activities

Children with CLDD rely on trusted adults to co-regulate before they begin to self-regulate, that is able to manage their own emotional states. Co-regulation involves an adult being in an attuned relationship with the child. There are two excellent approaches to achieve this relationship. Briefly, they are P.A.C.E (Hughes, DATE) which is an educational therapy tool standing for Playfulness, Acceptance, Curiosity and Empathy. The other is W.I.N.E. Wonder, Imagine, Notice and Empathy (Davies.)

Anxiety

Children who have CLDD are especially susceptible to anxiety for many reasons. While their level of understanding may vary, their innate emotional responses are controlled by their lower brain and will respond to external stresses as dangers the same as other children.

Common causes of anxiety in children with CLDD are:

Limited ability to cope with negative feelings
Communication difficulties make it difficult to explain
Anxiety triggered through being sensory sensitive - hyper or hypo.
Experiencing bullying or peer exclusion
Medical treatments.
Lack of or changes in routines.

Indicative signs of anxiety

Stimming (self-stimulating behaviour) for example rocking or hand flapping
Acting out (aggression) V acting in (avoidance) An increase or decrease in any behaviour, eating more or less, sleeping more or less
Physical complaints (headaches, stomachaches)

What are schools doing?

There are many support strategies, here's a few examples from Rees (2024) adaptable to individual children.

Regular check-ins with a key member of staff
create a calm box with meaningful activities that aid self regulation
Use intensive interaction to help children engage and self regulate
At signs of stress introduce simple sorting activities
Provide frequent opportunities for breathing relaxation and movement
Develop ways to support transitions to reduce anxiety level.

Positive Psychology, well-being and mental health

Schools vary in how they support children with CLDD and SEMH difficulties. The following model developed by Seligman (2011) is a useful model for supporting the wellbeing and mental health of all children.

Positive Emotions

Goal: To enable children to experience and express happiness and fun , through comfort and safety.

How: Sensory rooms are available, for example, to support a child with limited verbal skills the pleasure of playing with water

Engagement

Goal: To create flow-like states through immersive experiences.

How: Tactile sand tray activity with hidden objects to be discovered.

Relationships

Goal: Foster trust, a sense of belonging and being valued - which is achievable irrespective of traditional social interaction skills.

How: Bonding with a TA through shared music sessions, smiles, and touch cues like hand-over-hand interaction.

Meaningful activities

Goal: Provide activities with an intrinsic sense of purpose and value.

How: Helping water plants and seeing/experiencing their growth.

Achievements

Goal: Support feelings of mastery and progress in a range of diverse areas.

How: Changing activities successfully and calmly earns a sticker each day. After a week a certificate is given and menu of 'treat' activities.

H for health has been added to the PERMA Model.

Health

Goal: To encourage physical activity to release tension.

How: Regular exercise, walking, and outdoor activities.

Children with CLDD benefit from an environment that provides psychological safety, predictability, caring and unconditional positive regard. To achieve this many schools are trauma and attachment informed and develop nurture-based approaches.

Schools and colleges supporting children with CLDD follow the mantra 'understanding precedes action'. The need to assess the needs of children to then decide how best support each individual optimises success. With a wide range of specialised staff and a wide range of facilities the mental health of these children are positively addressed.

Compiled with the support of:

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