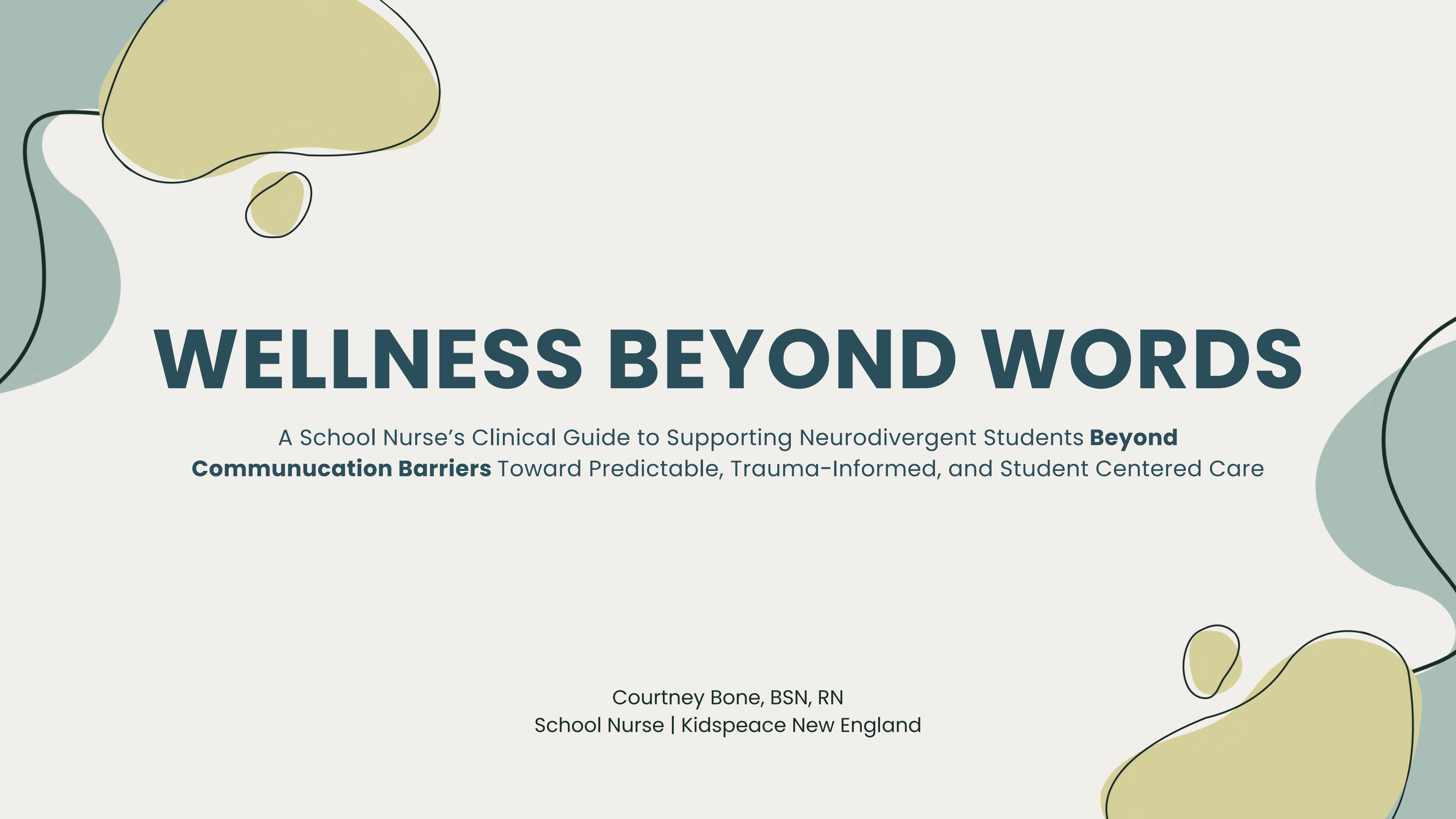




WELLNESS BEYOND WORDS

A School Nurse's Clinical Guide to Supporting Neurodivergent Students **Beyond
Communication Barriers** Toward Predictable, Trauma-Informed, and Student Centered Care

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PART ONE

UNDERSTANDING THE LANDSCAPE

Understanding Neurodiversity, Language, and the Students We Serve

START WITH LANGUAGE

Clinical Language & Clinical Thinking

Small shifts in **clinical language** can reshape **clinical thinking**.

NEURODIVERSITY

The concept

Natural variation in human brains and cognition. A population-level fact — not a diagnosis, not a deficit.

NEURODIVERSE

The group

A group that includes both neurotypical and neurodivergent individuals. A classroom is neurodiverse. Best avoided for a single individual.

NEURODIVERGENT

The individual

A person whose neurocognitive functioning diverges from dominant norms. One person is neurodivergent.

Source: [Walker \(2021\)](#) · [Singer \(1999\)](#).

A PARADIGM, NOT A LABEL

Judy Singer & the Neurodiversity Paradigm



JUDY SINGER

Australian Sociologist

Coined "neurodiversity"

Reframed neurological difference as natural human variation — not pathology to be fixed.

A civil-rights framing

Argued for recognition, accommodation, and voice, drawing on disability sociology.

Why it matters here

It shifts our question from "what is wrong with this student?" to "what does this student need to access care?"

THE LANDSCAPE

Common Conditions

These conditions frequently co-occur and present with overlapping clinical features.

AUTISM SPECTRUM DISORDER

1 in 31

8-year-olds — CDC, 2024

May prefer literal language, routine, and calm sensory input during exams.

ADHD

11.4%

ages 3–17 — CDC

Fidgeting or leaving mid-task may be self-regulation — not defiance.

ANXIETY & SOCIAL ANXIETY

1 in 4

teens, lifetime — NIMH

Stomachaches or going quiet in your office may signal anxiety, not evasion.

SENSORY DIFFERENCES

1 in 6

children — JAMA Pediatrics

Bright light, touch, or sound can escalate distress fast — adjust the room first.

LEARNING DISABILITIES

up to 1 in 5

show dyslexia symptoms — IDA

Instructions or forms may need to be read aloud, or simplified.

TIC DISORDERS (TOURETTE)

1 in 50

ages 5–14 — CDC

Tics can look like disruption — they’re involuntary, not intentional.

How Children Communicate

Verbal, symbolic, and augmentative forms

Verbal & Linguistic

Spoken Language

Words, phrases, and sentences used to share needs, thoughts, and ideas out loud.

Sign Language

Formal (e.g., ASL) or informal signs used to represent words and concepts.

Echolalia

Repeating previously heard words or phrases — often functional communication, especially in autistic children.

Visual & Symbolic Supports

AAC

Augmentative & alternative communication — devices, apps, and boards that support or replace speech.

Object Exchange (PECS)

Handing over a picture or object to make a request.

Writing & Drawing

Using written words or images to express ideas.

How Children Communicate

Body-based, preverbal, and behavioral forms

Body-Based & Nonverbal

Gestures & Body Language

Pointing, reaching, waving, and nodding to convey meaning.

Facial Expressions

Smiles, frowns, and raised eyebrows signaling emotion or intent.

Eye Gaze & Joint Attention

Looking toward a choice or a caregiver to show shared interest.

Touch & Proximity

Pulling a hand toward a want or leaning in for contact.

Preverbal & Behavioral

Vocalizations

Early sounds like babbling, cooing, crying, and laughing.

Tone of Voice

Pitch, volume, and rhythm that carry meaning beyond the words themselves.

Behavior as Communication

Meltdowns, protests, or withdrawal that express needs or frustration.

DEFINING THE PROBLEM

What Is a Communication Barrier?

Anything that **prevents a student** from accurately expressing, receiving, processing, or responding to **health information**.

Barriers are rarely about **willingness**, but about **conditions** — and many are **modifiable**.

Language load

Jargon, idioms, long instructions, rapid-fire questions

Environment

Noise, light, smell, crowding, alarms, public questioning

Trauma state

Hypervigilance, freeze, distrust of adults or touch

Processing & timing

Need for longer latency; one thing at a time

Inaccessible tools

No AAC, no visuals, no yes/no route

Assumptions

Reading silence or behavior as refusal or capacity limit

CLINICAL CONSEQUENCE

How Barriers Affect the School Nurse

When communication is inaccessible, **every stage** of the nursing process is affected, from assessment to intervention.

— Incomplete Assessment

Pain, symptoms, and history missed or distorted.

— Misread Behavior

Shutdown or distress labeled "refusal" or "noncompliance."

— Delayed Care

Medication and procedures postponed while access is negotiated.

— Safety-Plan Gaps

Allergy, seizure, and emergency plans built on incomplete data.

— Eroded Trust

Repeated misattunement makes the next visit harder.

— Escalation

Unmet need rises to crisis before it is recognized.

REFRAME

Behavior as Data

Behavior may signal distress, pain, sensory overload, trauma response, an unmet need, a medical change, or a skill gap — **behavior is data.**

What you see	A possible message
Elopement / Running	"I cannot regulate here — I need out."
Shutdown / Silence	"I am overloaded; I cannot process speech right now."
Aggression / Self-Injury	"Something hurts, or I cannot bear this sensation."
Refusal	"I do not feel safe enough to comply yet."

Source: Carr & Durand (1985)

The Amygdala Hijack: Why Language Fails

Under perceived threat, the amygdala activates the stress response — fight, flight, freeze, or fawn — and the prefrontal cortex is down-regulated. Executive function, flexible thinking, and verbal expression diminish precisely when we ask for them. Escalation is, neurologically, a loss of communication capacity.

1 Threat detected

The amygdala fires before conscious thought — a tone, a touch, a sound, an unfamiliar demand.

2 Prefrontal cortex goes offline

Reasoning, sequencing, and language drop. The "thinking brain" yields to survival.

3 Communication collapses

Speech, compliance, and eye contact fall away. What looks like defiance is dysregulation.

Escalation = Decreasing communication. | **Regulation** = Restoring it.



THE SCHOOL NURSE LENS

A child who **cannot** communicate distress is not **refusing care**. They are asking us — in the only language their nervous system has left — to **change the conditions of care**.

CLINICAL APPLICATION

The Window of Tolerance

Siegel's model of the arousal zone where a student **can think, feel, and communicate**. Outside it, **language and access collapse**. Co-regulation and a low-sensory environment widen the window and bring the student back into it.

HYPERAROUSAL

Fight · flight · fawn — escalation, panic, aggression, rapid speech

WINDOW OF TOLERANCE

Think · feel · speak · engage — optimal for assessment, communication, and clinical decision making

HYPOAROUSAL

Freeze · shutdown · dissociation — stillness, silence, flat affect

Assessment findings obtained within the **student's window of tolerance** are more likely to reflect their true **needs and abilities**.

Source: Siegel (2012)

SEQUENCE MATTERS

Regulate Before You Assess

For students experiencing distress, assessment findings are often **more reliable after regulation** has been established.

1

Reduce Demand

One voice, one task.
Pause questions. Lower the stakes.

2

Modify the Environment

Dim, quiet, fewer people; offer ear defenders or a fidget.

3

Co-Regulate

Calm, steady presence; narrate; sit beside, not over.

4

Assess

Re-enter with yes/no, pointing, or visuals once regulated.



THE SCHOOL NURSE LENS

Before we ask, “What is wrong with this student?” we must first ask: **“What is this nervous system trying to survive — and what does it need before I can accurately assess it?”**



PART TWO

Tools That Build Access

Low-tech, high-impact strategies that fit in a drawer, a badge, or a pocket.

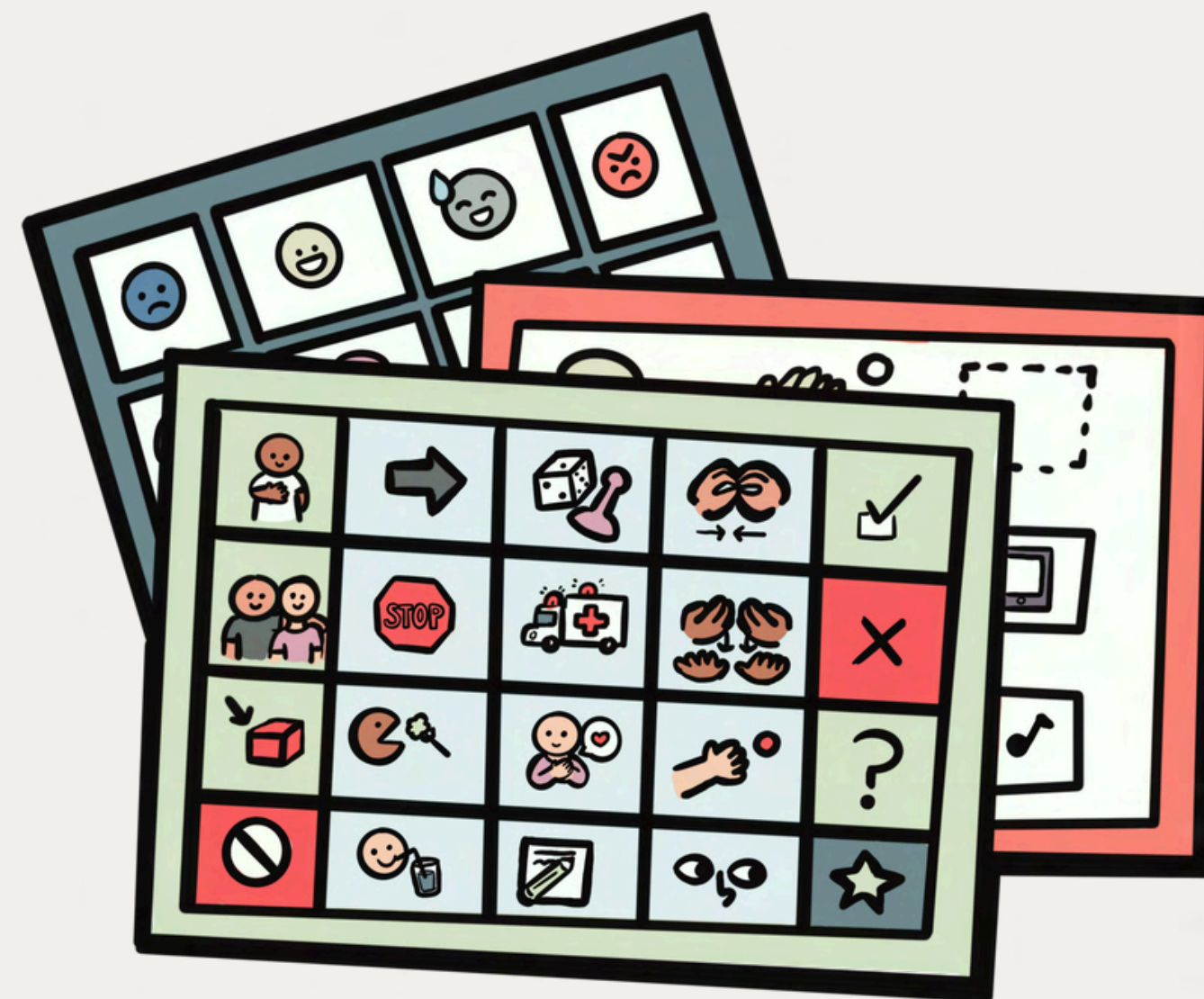
Communication Boards

What it is

A fixed grid of symbols or words a student points to in order to express needs, symptoms, and choices. A form of augmentative and alternative communication (AAC).

Why it works

Bypasses the need for speech under stress; gives a reliable yes/no and symptom route when words will not come.



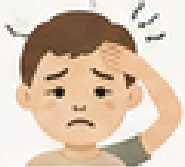
Communication Boards



School Health Office

How can I help?

♥ Point, look, or touch. ♥

 I don't feel well	 I need water	 I need a snack	 Too loud / I need quiet
 I need a break	 I need ice	 I need heat	 I need a tissue
 I need the bathroom	 I need a bandage	 I need medicine	 I have a headache
 My stomach hurts	 I feel worried / upset	 I have a question	 Something else

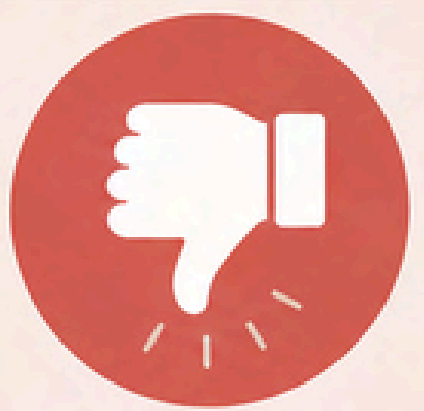
You are important. We are here to help. ♥

Yes or No

Point, look, or touch.



YES



NO

Social Narratives

What it is

Short, individualized, first-person stories that describe a situation, what will happen, why, and how the student can respond. Based on Carol Gray's Social Stories methodology.

When to use

Before planned care: vision screening, blood draw, glucose check, inhaler teaching, returning after an absence or incident.

Structure of a narrative

- Descriptive — where, who, what
- Perspective — how people feel / why
- Directive — what the student can do
- Affirmative — reassurance it is okay

Use with care

Evidence promising but mixed — pair with prediction and adult support, not as a standalone fix.

Social Narratives

Getting My

First, I walk to the nurse's office.



The nurse will put the cuff
around my arm.



The cuff will get tight and hug my arm. This only lasts a short time.



Then, the cuff
will get loose.



The nurse will take the cuff off.



I am all done!



The nurse is here to help me stay healthy and safe! ❤️💡



Social Narratives

TAKING MEDICINE

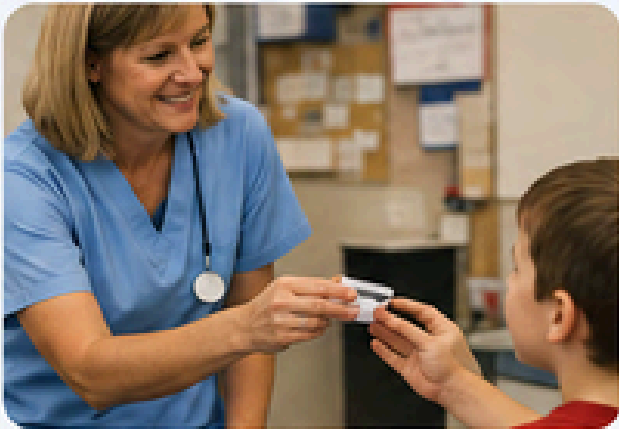
1

I sit down.



2

The nurse hands me my medicine.



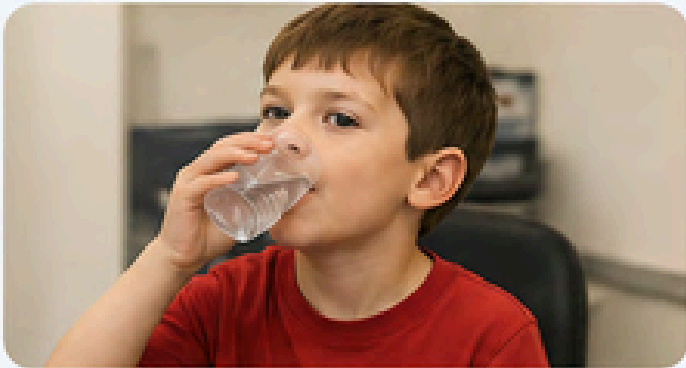
3

I put the medicine in my mouth.



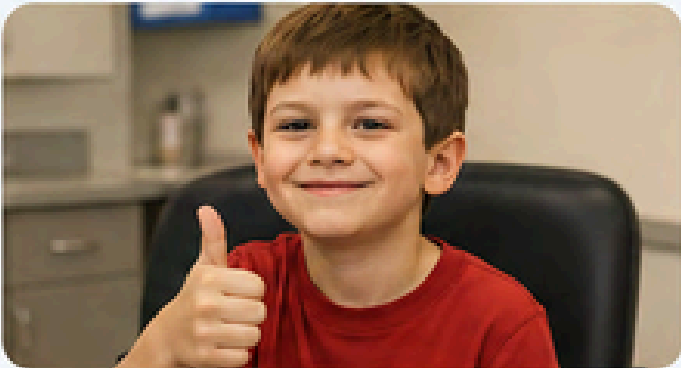
4

I take a drink and swallow the medicine.



5

I am all done!



The nurse is here to help me stay healthy and safe!

First–Then Boards & the Premack Principle

The Premack Principle

A more probable (preferred) behavior can reinforce a less probable one. Making the preferred activity contingent on completing the harder task makes the contingency explicit and predictable.

Known as "grandma's rule": first the vegetables, then dessert.

In the health office

FIRST

temperature check

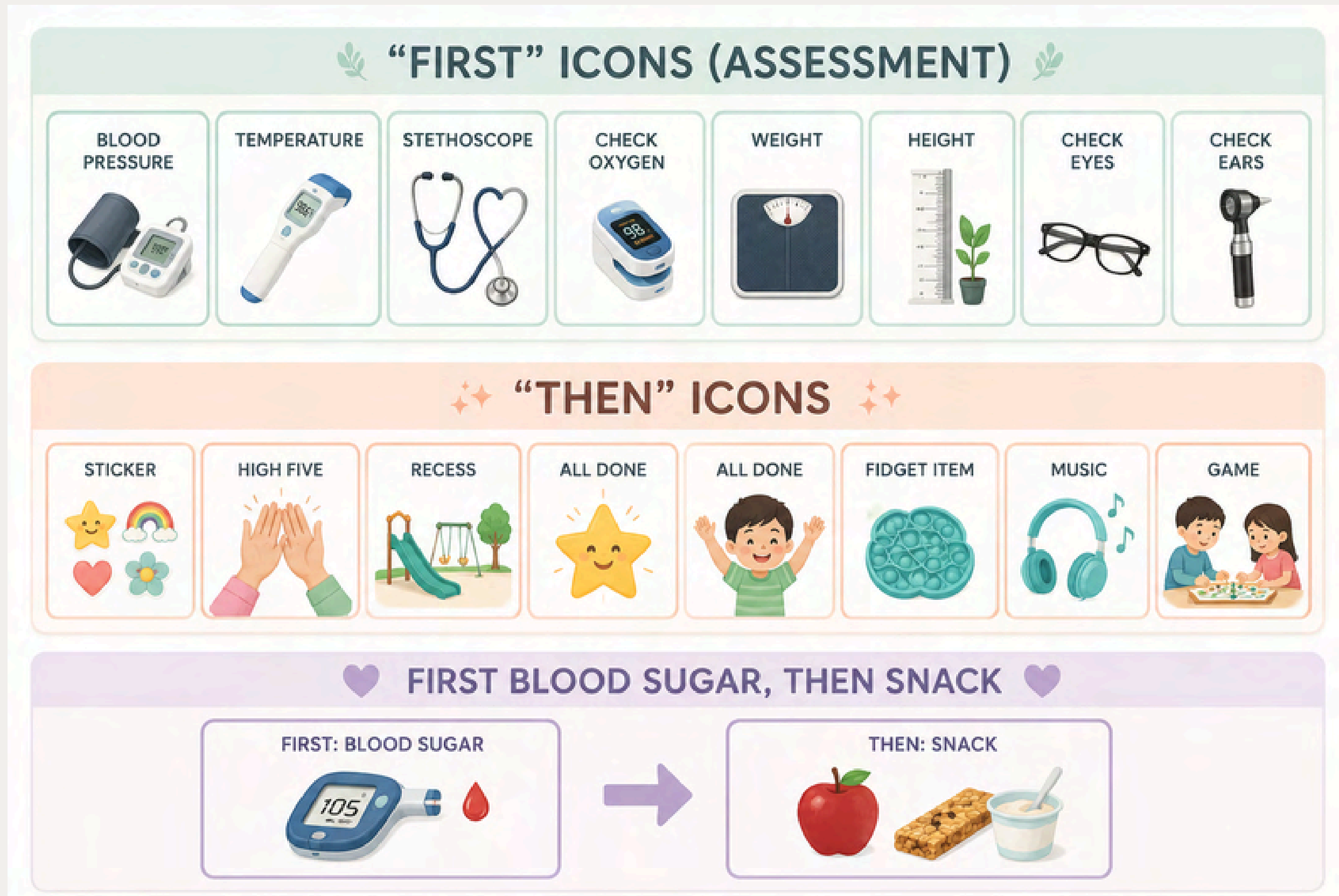
then

THEN

water + 5 min of preferred music

Support, not coercion — the "then" is genuine and delivered.

First–Then Boards & the Premack Principle



A CLINICAL INTERVENTION IN DISGUISE

Predictability Is Huge

For a dysregulated nervous system, **the known is regulating**. Predictability lowers the **cognitive and sensory cost** of the visit before you ever touch a thermometer.

Visual schedules

A picture sequence of the visit posted at eye level.

Sequence strips

Step cards: check-in → temp → talk → return to class.

Transition warnings

"Two more minutes, then we stop." (visual timer)

Consistent routines

Same greeting, same room, same order — every visit.

Narrate the next step

"Now I will listen to your breathing. Next, we are done."

"First-then" framing

Tells the brain how long and where the finish line is.

WHEN SELF-REPORT IS LIMITED

Pain Assessment

Assessment should integrate validated observational tools, behavioral indicators, caregiver knowledge, and individualized baseline function.

Validated Assessment Measures

r-FLACC adapts the FLACC scale for children with cognitive impairment — score face, legs, activity, cry, consolability.

Alternative Pain Localization

Body chart pointing locates pain; pair with a validated tool for documentation.

Behavior & Physiologic Indicators

Grimace, guarding, rocking, ↑HR/BP, withdrawal, new agitation, change in baseline.

Caregiver and Baseline History

Caregivers know the student's pain signature and what is "normal for them."

*Clinical judgement is **strengthened** by integrating **multiple sources** of assessment when self-report is limited.*

FLACC Pain Scale

for Non-Verbal Patients



Used to assess pain in non-verbal children and individuals who are unable to communicate their pain.

CATEGORIES	0 RELAXED	1 MILD DISCOMFORT	2 MODERATE DISCOMFORT	3 SEVERE DISCOMFORT
 FACE Expression on face	 No particular expression or smile	 Occasional grimace or frown, withdrawn	 Frequent to constant quivering chin, clenched jaw	 Constant quivering chin, clenched jaw
 LEGS Position of legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up	Kicking, or legs drawn up
 ACTIVITY Tonus or activity level	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking	Arched, rigid, or jerking
 CRY Vocalizations	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints	Crying steadily, screams or sobs, frequent complaints
 CONSOLABILITY Response to comfort	Content, relaxed	Reassured by occasional touching, hugging, or being talked to	Distracted or reassured by frequent touching, hugging, or talking to	Difficult to console or comfort



SCORING

Add all scores for a total between 0-15.
Higher score = greater pain



NOTE

Use clinical judgment and consider the individual's baseline behaviors, medical condition, and environment.



WONG-BAKER FACES®

Pain Rating Scale



0

NO HURT



I have no pain.

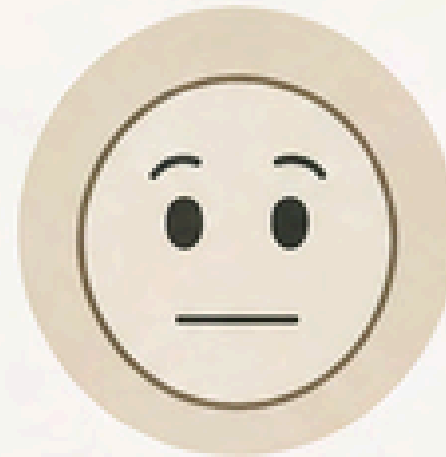


2

HURTS
LITTLE BIT



I have a
little pain.



4

HURTS
LITTLE MORE



I have a
little more pain.



6

HURTS
EVEN MORE



I have even
more pain.



8

HURTS
WHOLE LOT



I have a lot of
pain.



10

HURTS
WORST



I have the
worst pain.

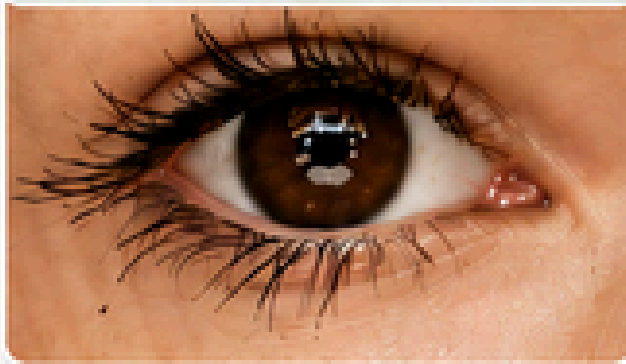


Use the faces above to help us understand how much you hurt.
Point to the face that shows how you feel.



WHERE DOES IT HURT?

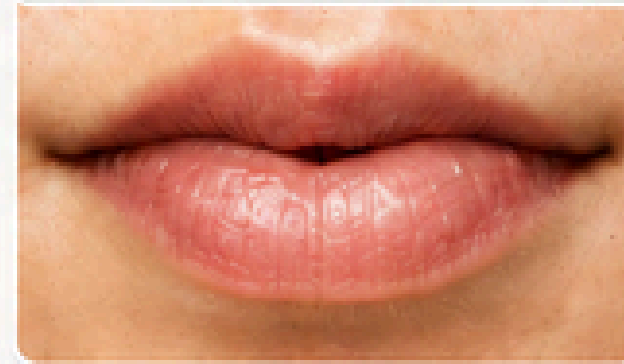
EYE



NOSE



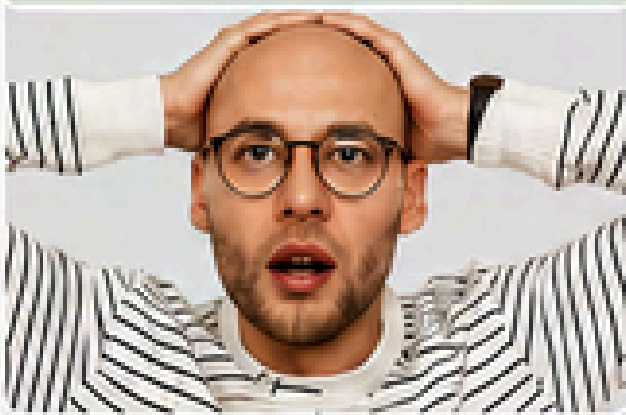
LIPS



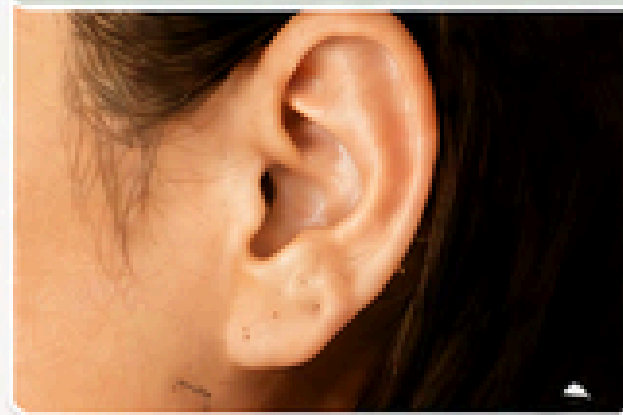
TEETH



HEAD



EAR



NECK



CHIN



The Environment as a Barrier

An overstimulating environment increases cognitive and sensory demands, reducing a student's ability to process language, communicate needs, and participate in assessment. Consider whether the environment itself is contributing to the barrier.

Lighting

Fluorescent buzz, glare, flicker

Sound

Ice machine, alarms, crowded hallway, intercom

Smell

Cleaners, alcohol swabs, perfume, food

Touch

Unexpected contact, cold stethoscope

Visual

Clutter, bright posters, strangers

Timing

Unpredictable waits, rushing

MODIFY THE CONDITIONS

Engineering a Lower-Stimulus Health Office

Sensory stressor	Accommodations
Fluorescent glare / flicker	Task lamps, natural light; reduce flicker.
Alarm & intercom noise	Close door; mute non-essential; ear defenders “dead phones” if available.
Smells	Ventilate; pre-warn (“this smells sharp”); fragrance-free.
Unexpected touch	Narrate before contact; warm equipment; let them hold it first.
Visual clutter & crowding	Clear surfaces; one nurse, one student; curtain for privacy.
Unpredictable waits	Visual timer; “two more minutes”; posted sequence.

MODIFY THE CONDITIONS

Engineering a Lower-Stimulus Health Office



- Bright, harsh fluorescent lighting
- Stark, plain environment with no calming elements
- Noisy potential (hard surfaces, minimal soft materials)
- Little visual organization or clear signage
- No options for student choice or regulation
- Clinical feel may increase anxiety



- Softer lighting (lamps + natural light control)
- Calming colors, plants, and nature imagery
- Added soft textures (rug, blanket, lamp) to reduce harshness
- Visual supports and clear, simple signage
- Student choices and regulation tools available
- Warm, welcoming environment promotes safety and trust



THE SCHOOL NURSE LENS

A therapeutic environment is
a **clinical tool** – not an extra.

Trauma-Informed Care in Child Health Systems

The AAP frames trauma-informed care (TIC) as relational health care — the capacity to form safe, stable, nurturing relationships that buffer and heal the effects of trauma.

The Four R's

Realize	the widespread impact of trauma on health and behavior.
Recognize	the signs and symptoms in students, families, and staff.
Respond	by integrating this knowledge into policy and practice.
Resist	re-traumatization through safety, choice, and trust.

Six principles of a trauma-informed approach

- Safety
- Trustworthiness & transparency
- Peer support
- Collaboration & mutuality
- Empowerment, voice & choice
- Cultural, historical & gender awareness

FROM PRINCIPLE TO PRACTICE

Trauma-Informed Care in the Health Office

Ask permission before touch

"May I listen to your breathing?" — and accept no.

Narrate every step

Tell what, why, and when — before it happens.

Offer choice

"Left arm or right arm?" Choice restores sense of control, lowers threat.

Preserve privacy

Curtain closed; avoid questioning in front of peers.

Avoid power struggles

Recognize when flexibility may improve engagement without compromising safety.

Use predictable routines

Same greeting, same sequence — the known is regulating.

ACCESS IS A CIVIL RIGHT

Access Is Equity — and Law

For students with disabilities, communication access is protected by law and is central to a Free Appropriate Public Education. School nurses help secure that access through the health plan and the team.

Section 504

No qualified student with a disability may be denied access to health and educational services.

IDEA

Communication supports can be required services within the IEP.

FAPE

Access to care is access to education; the nurse helps deliver both.

The Nurse's Role

- Collaborate with the 504 / IEP team
- Individualized Health Plan (IHP) involvement
- Build the Emergency Care Plan (ECP)
- Document the communication profile
- Presume competence — build the bridge

PUTTING IT TOGETHER

A 5-Minute Nurse-Office Protocol

1

Safety screen

ABCs, level of distress, emergency?

2

Regulate

Reduce demand & sensory load; co-regulate before asking.

3

Access

Communication board, yes/no, visuals, caregiver voice.

4

Assess

Now obtain symptoms, pain, history — accurately.

5

Document & Plan

Record method, triggers, what worked, the plan.

ACTION YOU CAN TAKE MONDAY

Build Your Health-Office Communication Kit

■ Laminated communication board

Core symptom + need vocabulary; yes/no; pain scale.

■ First-then cards

Reusable "first / then" strips with preferred-activity tokens.

■ Social narrative templates

One-page, fill-in stories for common procedures.

■ Body chart + pain scale

Point-to pain location; 0-10 and faces; r-FLACC on file.

■ Sensory supports

Ear defenders, fidgets, sunglasses, weighted lap pad.

■ Documentation prompt

Capture method, triggers, regulation tools, the plan.

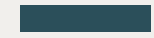


THE SCHOOL NURSE LENS

When words fail, the **school nurse** can still create **access to care**. We do not treat diagnoses in the health office. **We meet nervous systems where they are — and carry them back toward wellness.**

BEYOND THE NURSING LENS

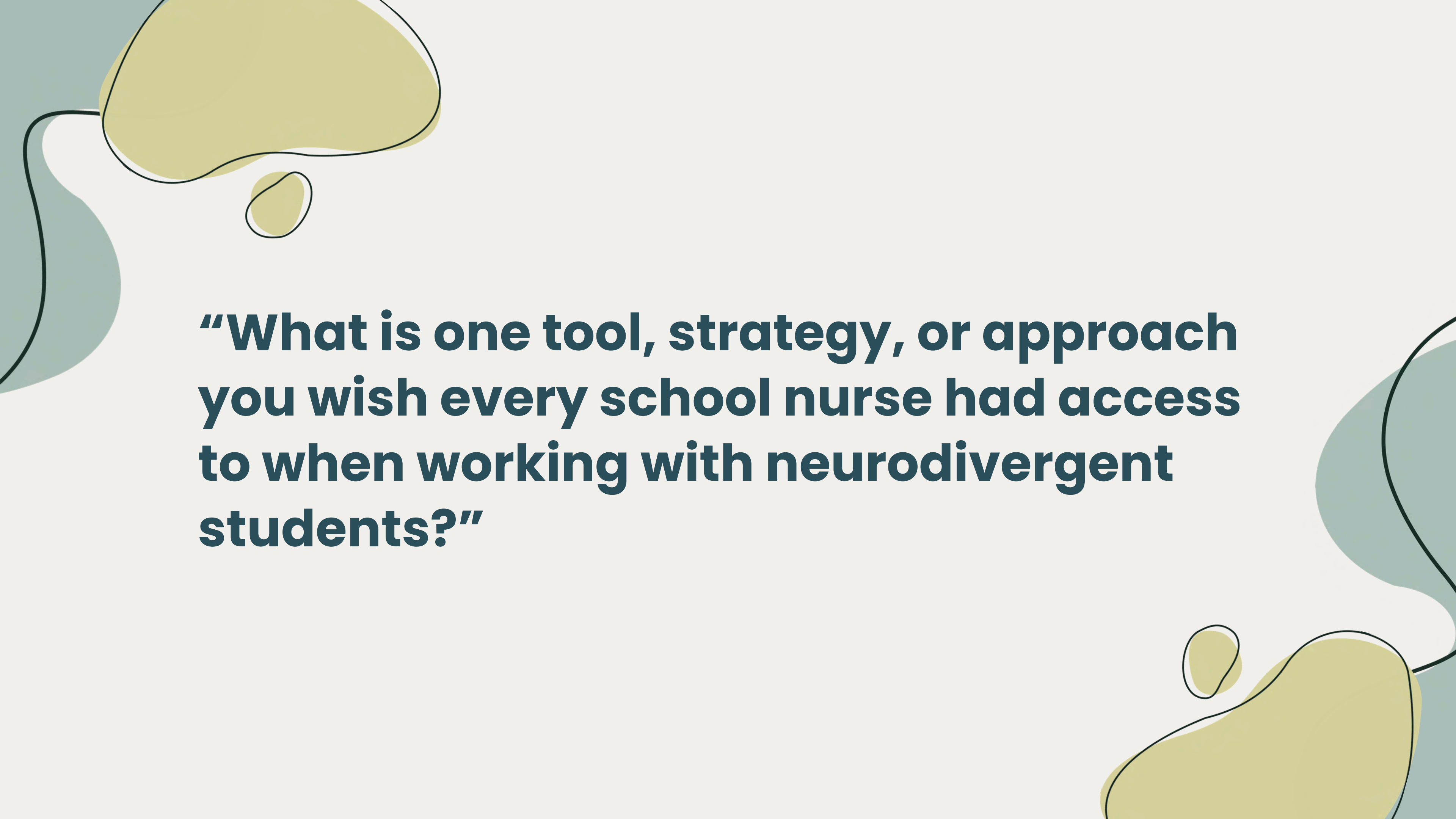
Interdisciplinary Perspectives



Interdisciplinary collaboration improves clinical decision-making by integrating complementary expertise, resulting in more comprehensive assessments, coordinated interventions, and individualized care.

- ◆ Every discipline observes **different aspects** of student functioning.
- ◆ Shared language promotes consistent support **across environments**.
- ◆ Collaboration **improves assessment accuracy** and **clinical decision making**.
- ◆ Small strategies from **other disciplines** can have a meaningful impact on student outcomes.





“What is one tool, strategy, or approach you wish every school nurse had access to when working with neurodivergent students?”

BUILDING BRIDGES

INTERDISCIPLINARY PERSPECTIVES



Paige Hanson

Pediatric Speech-Language Pathologist

"Many neurodivergent students communicate best with AAC. Providing them with a visual to point to can alleviate communication differences and help them express what they are feeling. For example, a symbol board tailored to nursing."



BUILDING BRIDGES

INTERDISCIPLINARY PERSPECTIVES



Nicole Bailey

Pediatric Occupation Therapist

"I wish that every school nurse had access to sensory tools and environmental sensory strategies. When working with behaviorally challenging or neurodivergent kids, meeting them where they are at sensory wise often has the ability to increase self-regulation, active participation and communication.

Sensory items such as tactile fidgets and environmental options such as lower lighting and alternative seating like a beanbag chair or wiggle seat can make a huge impact in providing high quality, student-centered care."



BUILDING BRIDGES

INTERDISCIPLINARY PERSPECTIVES



Kelly Gagliardo

Licensed Clinical Social Worker (LCSW)

“Effective communication between providers and school nurses concerning changes in medication, diagnoses and environmental changes that impact mood; and collaboration on utilizing identified calming strategies, preferred methods of communication and considering sensory needs related to textures or touch can completely change a student’s experience when visiting the nurse’s office.

Along with interdisciplinary communication and collaboration, I believe that the most important tools that a school nurse can utilize are kindness and patience, as these are essential for building the trust and safety needed to make these interactions with students more successful.”



BUILDING BRIDGES

INTERDISCIPLINARY PERSPECTIVES



Cynthia White

Board Certified Behavior Analyst (BCBA)

“Preparation and training are essential. Nurses benefit from learning practical strategies from professionals experienced in neurodiversity, such as allowing processing time, minimizing sensory demands, using a calm tone, and supporting self-advocacy. Challenging behavior serves a function, and thoughtful, patient responses can reduce escalation. Extra time and flexibility during health encounters also help build trust and improve communication.”





Thank You!

Questions?

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