Adapted Trauma Focused Cognitive Behavioral Therapy for Children Who Have Intellectual Disabilities

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Breaking the Barriers: Forming Cross System Partnerships to Effectively Serve Individuals With Mental Illness and Intellectual Disabilities.

October 14-15, 2010  Hyatt Regency, Long Beach, California
Intercept Center at Aurora Mental Health

Collaborative program between Aurora Mental Health and Aurora Public Schools for youth with co-morbid major mental illnesses and developmental disabilities.
Intercept Center

• Collaborative program
  ◦ Aurora Mental Health Center
  ◦ Aurora Public Schools
• 10 children in therapeutic school
• 120 families served outpatient
• Individual, family, group therapy
• Psychiatric services
• Case management
Typical Diagnoses

- Mood Disorder NOS
- Attention Deficit/Hyperactivity Disorder
- Bi-Polar Disorder
- Psychotic Disorder NOS
- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Disruptive Behavior Disorder NOS
- Pervasive Developmental Disorder NOS
Adapted Trauma Treatment Work Group Subgroup for Developmental Disabilities

Facts on Traumatic Stress and Children With Developmental Disabilities

http://www.nctssnet.org
PTSD & Complex PTSD

- History of single or few severe traumatic experiences
- History of early onset and prolonged abuse neglect
- Severe anxiety and hyper-vigilance
  - often mistaken as oppositional/defiant behavior
- Impulsivity
- Mood disregulation
- Aggressive behavior
- Sleep disturbance
Best Practice Trends in Trauma Treatment

- Outdated methods delve immediately into processing trauma
- Phase oriented treatments now focus on skills building and mastery
- Positive approaches that emphasize strengths and recovery
- Guidelines and empirical support that build therapist confidence
Myths

- People with developmental disabilities do not have the same response to trauma as people in the general population
  (Charlton et al., 2004; Burrows & Kochurka, 1995; and Mansell, Sobsey, & Moskal, 1998)

- People with developmental disabilities cannot benefit from therapy (Mansell et al., 1998)
Facts

- Many different types of therapy have been found to be effective in treating people with developmental disabilities.
- People with developmental disabilities are less likely to recover spontaneously from trauma without treatment.
- Although it generally takes longer for people with developmental challenges to make changes, those changes are stable once made.
Community Realities

- Few mental health professionals are trained to meet the needs of People with developmental disabilities.
- We don’t have adequate research on how best to adapt trauma treatment for this population.
- With a 2001 population of 285 million people, we estimate 5 million people in the US have developmental disabilities.
- In any large scale disaster, nearly 2% of the population may require adapted trauma treatment.
Trauma May Take Many Forms

- Natural disasters
- Accidents
- Invasive medical procedures
- Physical abuse
- Emotional abuse
- Sexual abuse
Higher Incidence of Trauma Than General Population

- In spite of underreporting, people with disabilities have a higher incidence of most types of trauma.
- Meta analysis of abuse and disability show rates of 2.5 to 10 time the abuse of non-disabled.
- Sobsey (1996): Individuals with disabilities are 4 times as likely to be victims of crime.
- Sobsey & Mansell (1990): Risk of sex abuse in institutional setting is 2 to 4 times as high as risk in community.
- Valenti-Hein & Schwartz (1995): More than 90% of people with a D.D. will experience sexual abuse and 49% will experience 10 or more abusive incidence.
Abuse and Developmental Disability

- 44% had a relationship with their abuser directly related to their disability
  
  Davis, 2004

- 3 to 6% of maltreated People have a permanent developmental disability as a result of abuse or neglect

- Child maltreatment is a factor in 10 to 25% of all developmental disabilities

  Sobsey, 1994
Vulnerabilities

- Higher level of assistance from caregivers
- Higher level of stress on the family
- Cognitive disability interferes with:
  - The ability to predict high-risk situations
  - Understand what is happening in an abusive situation
- Barriers to reporting:
  - Mobility challenges
  - Restricted ability to communicate

Charlton, Kliethermes, Tallant, Taverne, & Tishelman (2004)
Vulnerabilities

- Trained to be compliant to authority figures

  Valenti-Hein & Schwartz, 1995

- Increased responsiveness to attention and affection may make them easier to manipulate.

- Less likely to be provided with general sex education or any type of training around human sexuality.

- Society’s tendency to label people who are different as bad.
Why is TF-CBT a Good Model to Adapt?

- It is a strength based approach
- It focuses on development of competency skills
- It uses cognitive behavioral treatment techniques which are relatively easy to adapt for people at different developmental levels
- It has already been structured for use across a wide range of developmental levels
Additional Reasons for Adaptation

- One of the reasons that trauma has such a negative impact on people with developmental disabilities is their impaired resilience.
- TF-CBT focuses on developing skills that are associated with greater resilience:
  - Strong self-esteem
  - Ability to self-sooth
  - Feelings of competency to deal with challenging situations
- Applicable for both single-episode trauma as well as complex post traumatic stress.
Adapting Psychotherapy for People with Developmental Disabilities

- Slow down your speech
- Use language that is comprehensible to the client
- Present information one item at a time
- Take frequent pauses during the session to check comprehension
Additional Adaptations

- Use multisensory input
- Make specific suggestions for change
- Allow time to practice new skills
- Do not assume that information will generalize to new situations
- Include multiple caregivers in various environments
Caution!

- The current presentation is based on Cohen, Mannarino and Deblinger’s model of Trauma Focused Cognitive Behavior Therapy (TF-CBT)
- The information in this presentation is a blend of standard TF-CBT training, original thought and modification of TF-CBT material for special populations.
- This work is not intended to replace standard TF-CBT training.
- The material presented here should not be used by those unfamiliar with TF-CBT.
Training Resource

- Those who wish to use this adaptation should first participate in standard TF-CBT training
- A free web-based training for TF-CBT is now available at:
  http://tfcbt.musc.edu/
- New certification standards are being developed
Other TF-CBT Training Resources

Format for TF-CBT

- Family Therapy Model
- Session is generally divided between
  - Time with client
  - Time with caregivers
  - Time working with everyone together
- In the non-adapted model a 90 minute session is generally used, although people with developmental disabilities may need a shorter session
- Sessions always end with time to do something fun together to allow the person to re-center before leaving therapy.
Who Can Act as Coach?

- Parent
- Group home staff member
- Teacher
- Advocate
- Any caregiver that is involved with the client and willing to commit to regularly attending sessions with the client (even by phone)
Phases of Treatment

- Assessment
- Address safety issues
- Psychoeducation
- Skills Development
- Trauma Narrative
- Trauma Processing
- Reintegration
Assessment

- NCTSN Baseline Trauma Assessment
  - Assess types and frequency of traumatic experiences

- Assessment of severity of trauma symptoms
  - UCLA-PTSD Index
  - Trauma Symptom Checklist
Adaptations to Assessment

- Be sure to include all significant caretakers—there are often several.
- Assess for secondary trauma due to societal or community response:
  - Assumptions that because of the developmental disability the client has not been impacted by the trauma
  - Assumptions that the client cannot benefit from therapy
  - Lack of availability of appropriately adapted treatment that has resulted in significant delays in providing assistance
Components of Treatment

✓ Assessment
  • Address safety issues
  • Psychoeducation
  • Skills Development
  • Trauma Narrative
  • Trauma Processing
  • Reintegration
Safety

- Is the client currently in a safe environment?
- What is the risk for re-traumatization?
- Does the client need extra help dealing with ongoing environmental stressors? (dealing with provocative peers, teasing at school, etc.)
- Are there cognitive distortions that increase the current perception of danger?
Components of Treatment

✓ Assessment
✓ Address safety issues
  • Psychoeducation
  • Skills Development
  • Trauma Narrative
  • Trauma Processing
  • Reintegration
Psychoeducation

- Provide general education about the impact of trauma on normal functioning
- Provide specific information about the trauma the client experienced in language that is accessible
- Teach child and parent about TF-CBT phases and how treatment will progress
- Risk Reduction
  - Identify “Red Flag” situations
  - Develop a safety plan
  - Develop appropriate assertiveness skills
Components of Treatment

- Assessment
- Address safety issues
- Psychoeducation
  - Skills Development
  - Trauma Narrative
  - Trauma Processing
  - Reintegration
Skills Development

- Feelings Identification
- Personalized Relaxation Skills
- Positive Self-Talk
- Cognitive Coping
  - Cognitive triangle
  - Relationship between thoughts, feelings & behavior
- Thought stopping
- Teach caregivers as well
Adaptations to Skills Development

- Restrict the number of feelings you teach
- Build a basic vocabulary
- Use multisensory teaching tools
- Use lots of repetition in creative ways
- Use lots of examples that related to the child’s everyday life
- Don’t become frustrated if the client doesn’t get the idea right away—continue to present the information in different ways
Components of Treatment

- Assessment
- Address safety issues
- Psychoeducation
- Skills Development
  - Trauma Narrative
  - Trauma Processing
  - Reintegration
Chapters to Include in the Narrative

- All about me
- Use the baseline trauma assessment to guide your work
- Some people work from the least threatening trauma to most challenging
- Some people prefer to write all the trauma components on slips of paper and to draw one at a time to work on
- After all known aspects of trauma have been covered ask about what the worst part was.
- Don’t assume you know what it was.
- Chapter on how they entered treatment
Narrative Adaptations for People with Developmental Disabilities

- Be creative in the ways in which the narrative is recorded
- Writing may not be practical
  - Dictate responses to the therapist
  - Draw pictures
  - Use a tape recorder, video or still camera
  - Role-play, sing or dance
  - Consider sand tray
  - Use play
- Go slowly—more time will be needed to absorb the information and to integrate the modified cognitions
- Don’t be frustrated if the client returns repeatedly to inaccurate or unhelpful cognitions—repetition is necessary for learning
Narrative Session Format

• At the beginning of each session check in on the client’s stress level
• If the level is high use skills to reduce it to the acceptable level you and the client agreed on
• With the client review the narrative that was developed last time
• Continue to use stress management skills as needed, checking in on stress level frequently
• Add any new information that the client brings up
• Go on to the next part of the trauma narrative
Session Format Continued

- After meeting with the client spend some time alone with the caregiver
- Review the information the client produced in the narrative
- Help the caregiver to deal with their own emotions regarding the narrative
- Discuss any distortions the caregiver is experiencing like
  - Unwarranted self blame
  - Unrealistic expectations of what the caregiver can do
  - Fears that the client has been damaged forever
Session Format Continued

- Each session should end with time to do something fun
- Depending on the client, this may be a group activity after you have talked with caregiver or it may be with the client alone
- Be prepared to suggest some fun things:
  - Origami—especially action figures like jumping frogs
  - Walks to interesting sites
  - Games, puzzles, puppets
  - Basketball, catch
  - Grooming the therapy dog
Components of Treatment

- Assessment
- Address safety issues
- Psychoeducation
- Skills Development
- Trauma Narrative
  - Trauma Processing
  - Reintegration
Processing the Narrative

- Review the narrative
- Identify thoughts that are not helpful
- Identify areas where thoughts and feelings are missing
- Identify places where the client’s thoughts are accurate and be prepared to praise them.
- Add to the chapter on starting therapy and the progress the child is making.
Adaptations to Processing the Narrative

- Go slowly
- Provide lots of support
- Review skills as needed
- It’s particularly important to use
  - Cognitive triangle—how you think about the trauma effects how you feel about it
  - Identify cognitive distortions or unhelpful thoughts
  - Then correct them in the narrative
Components of Treatment

- Assessment
- Address safety issues
- Psychoeducation
- Skills Development
- Trauma Narrative
- Trauma Processing
  - Reintegration
Reintegration Session Format

- Integration is generally done with caregiver and client together
- Begin by
  - Assessing the client’s readiness for this phase
  - Assessing the caregiver’s readiness for this phase
- Remind everyone about the rationale for these joint sessions
Reintegration Rationale

- The caregiver has the opportunity to demonstrate comfort in hearing and talking about the trauma, while also modeling appropriate coping;
- The client has an opportunity to share the narrative and experience a sense of pride (further reduces feelings of shame and distress associated with the trauma);
- Communication about the trauma is enhanced, and misunderstandings and areas of confusion can be cleared up; and
- The groundwork is laid for discussion of the trauma to continue after formal therapy is over.
  - For clients, you should emphasize the importance of communicating openly to eliminate any possible misunderstandings,
  - Caregivers should emphasize their desire to be helpful and supportive.
Reintegration Sessions

- The client shares the trauma narrative they have developed with the caregiver

- The caregiver:
  - Praises the client’s hard work
  - Asks open-ended, non-threatening questions, i.e., How did you decide to tell someone about what happened?
  - Answers the client's questions, i.e., Why is mom mad at me because her boyfriend got in trouble? Did I do the right thing?
Integration

- Caregiver and client discuss together
  - Lessons learned
  - Application of those lessons
  - Plans for the future
- Caregiver and client discuss the use of affect regulation skills for other life stressors
Adaptations

- Be sure the client has sufficient support in all environments
- Work on specific ways in which new skills can be generalized to various situations in the client’s life
Components of Treatment

- Assessment
- Address safety issues
- Psychoeducation
- Skills Development
- Trauma Narrative
- Trauma Processing
- Reintegration
Next Steps

- Develop an Adapted Manual for TF-CBT
- Include detailed suggestions for adaptation of the model at each stage of treatment
- Collect pilot data regarding the effectiveness of the modifications
- Make changes in the adaptations as necessary
- Conduct randomized controlled studies to be sure that the adapted model is effective in treating trauma in the same way the original model is
TF-CBT Adaptations for People with Developmental Disabilities

- Be sure to include all significant caretakers—there are often several
- Assess for secondary trauma due to societal or community response:
  - Assumptions that because of the developmental disability the client has not been impacted by the trauma
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  - Lack of availability of appropriately adapted treatment that has resulted in significant delays in providing assistance
TF-CBT Adaptations for People with Developmental Disabilities

- Be sure that all members of the treatment team are using the same type of language to address the trauma
- Simplify training techniques to increase comprehension
- Work explicitly on generalization to other environments
- Allow more time for the client to learn the skills and use more repetition
- Use multisensory interventions and tools to aid in learning
- Don’t assume that the material is too complex for the client to understand
THANK YOU!

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