

# Trauma

Where does it come from? What does it do?

# “The smallest sound”

Participation activity

# “Smallest sound” reflection

- In the chat: What was the “smallest sound” you heard?
- Acceptance and Commitment Therapy exercise
  - Common across several mindfulness approaches
- Teaches:
  - Separation between self and experience
  - Listening and focus
  - “Open to what comes up”
- Why start this way?
  - A break from many demands on your attention
  - Set aside a moment to focus
  - Experience something you can use with your clients/consumers/staff

# Take care of yourself

- Depending on your experiences this topic can be difficult
  - If you need to:
    - Take a break
    - Sit out an activity
    - Leave it for another time
- Hearing stories of abuse/trauma can evoke
  - Your own memories
  - Feelings of injustice/unfairness
  - helplessness
- We need to be “In it for the long haul”

# Some background to today

- Potentially traumatic experiences are all around us
  - Personal experiences and historical trauma
- For most, the effects are not long lasting
- Some of the time these events cause lasting effects
  - Biological changes
  - Behavioral reactions
- How do we find out more about traumatic events?
  - For people who do not communicate verbally?
  - For people with other diagnosed disorders?
- Reasons for hope: interventions and resilience
- How do we prevent further exposure to traumatic events?

# Myths about trauma and neurodiversity

- .NOT TRUE: Neurodiverse people cannot engage in trauma treatment
- NOT TRUE: Standard mental health treatment is ineffective for neurodiverse people
- NOT TRUE: People with neurodevelopmental disorders only respond to punishment or reinforcement
- NOT TRUE: Youth with neurodevelopmental differences don't usually experience trauma; they are usually supervised more closely
- NOT TRUE: Working with people exposed to trauma requires significant specialized training.
- NOT TRUE: If you can't find the reinforcer or antecedents for a challenging behavior, it must just be "part of the disorder", "its just a sensory sensitivity"
- NOT TRUE: Neurodiverse people are not aware enough or don't have the memory to remember traumatic events
- NOT TRUE: IQ scores, the diagnosis and medical records tell you everything you need to know about a person

Adapted from Road to Recovery training <https://learn.nctsn.org/course/view.php?id=370>

# Resource: Road to Recovery Training

**CONTACT US**

For support issues, contact the NCTSN Help Desk at [help@nctsn.org](mailto:help@nctsn.org).

For questions, visit our [FAQ page](#).

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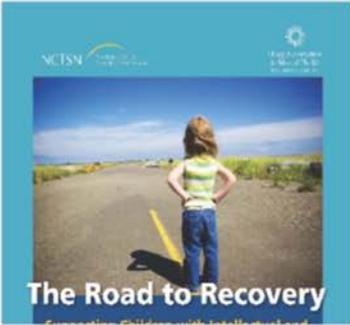
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## Trauma and Intellectual and Developmental Disabilities (IDD) Toolkit

The Road to Recovery: Supporting Children with Intellectual and Developmental Disabilities Who Have Experienced Trauma Toolkit was developed by the National Center for Child Traumatic Stress (NCCTS) and the NCTSN Trauma & IDD Expert Panel, a national selection of individuals with expertise in trauma and IDD.

[Home](#) [Curriculum](#) [Videos](#) [Resources](#)



**The Road to Recovery**  
Supporting Children with Intellectual and Developmental Disabilities



**Download the Toolkit**

The Road to Recovery: Supporting Children with Intellectual and Developmental Disabilities Who Have Experienced Trauma Toolkit consists of a Facilitator Guide, Participant Manual, Slidekit, and Supplemental Materials. Together, they are designed to teach basic knowledge, skills and values about working with children with IDD who have had traumatic experiences, and how to use this knowledge to support children's safety, well-being, happiness, and recovery through trauma-informed practice.



**Overview Videos**

Videos that provide information on the structure of the training, target audience, essential messages, and learning objectives for each Module, as well as a tour of the binder each of the five sections and key components.



**Expert Briefs**

Access a collection of 15 briefs written by members of the NCTSN Trauma and IDD Expert Panel. Topics include a range of special considerations for supporting children with IDD who have experienced trauma.

Trauma exposures: experiences

# Neurodevelopmental disorders: Higher risks for PTE

- Risks

- Increased bullying
- Greater medical needs
- Continued use of restraint/seclusion
- Physical punishment
- Higher risk of sexual abuse
- Sensory sensitivities

- Potentially 4 fold higher risk for exposure in DD population

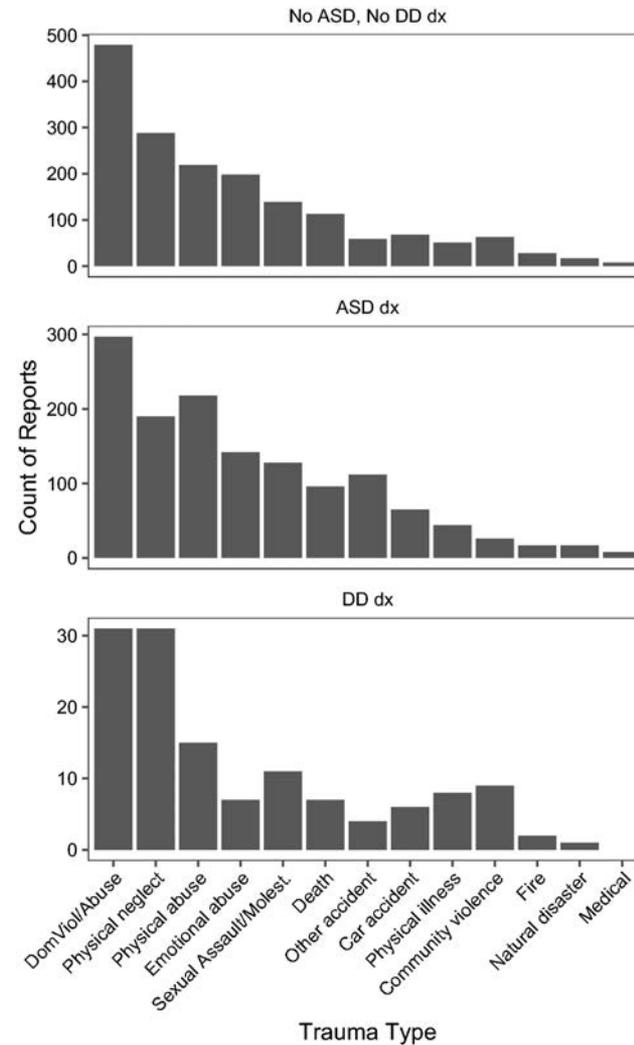
- Nearly half of victims with disabilities did not report abuse to authorities. Most thought it would be futile to do so. For those who did report abuse, nearly 54% said that nothing happened. In fewer than 10% of reported cases (Kerns et al. (2015)) was the perpetrator arrested.

# From exposures to reactions

- Exposures

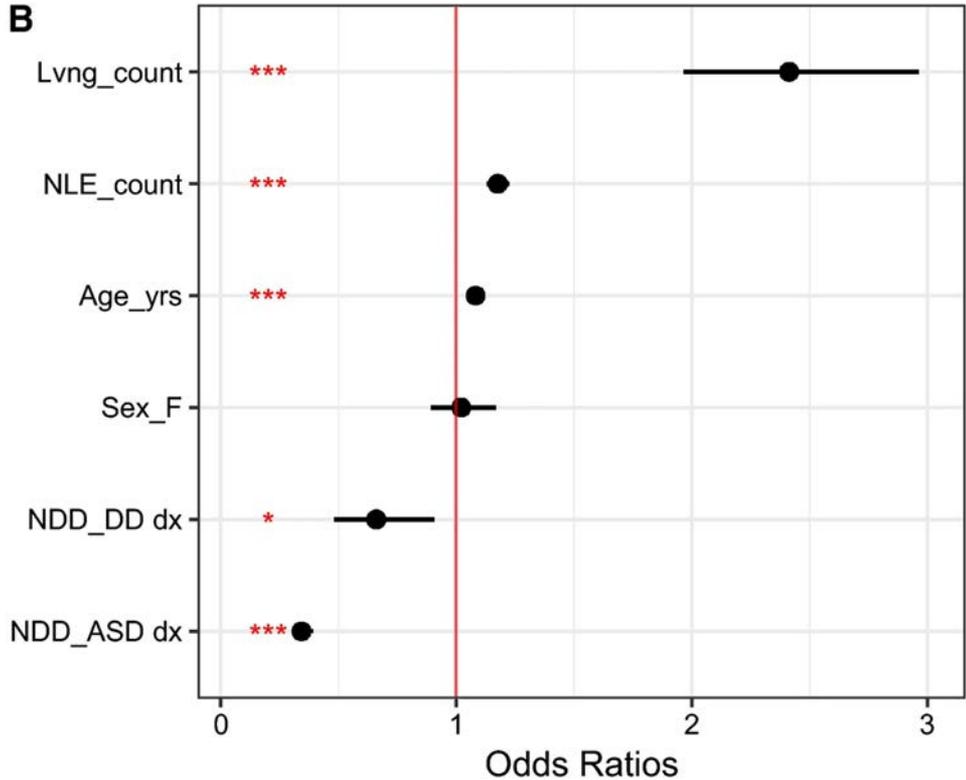
- Potentially Traumatic Experiences (PTE's)
- Adverse Childhood Experiences (ACE's)
- more than 75% are exposed to at least one traumatic event in general population (Breslau and Kessler, 2001).
- More than 70% of people with disabilities reported they had been the victims of abuse.
- More than 63% of parents and immediate family members reported that their loved one with a disability had experienced abuse.

# Types of PTEs



Hoch & Youssef, 2019

# Reporting trauma



# Barriers to assessment and treatment

- Communication difficulties
- Multiple settings/caregivers
- Difficulties accessing treatment
- Difficulties adapting treatment to lower verbal ability
- Competing paradigms
- **Diagnostic overshadowing**

**“Nearly half of victims with disabilities did not report abuse to authorities. Most thought it would be futile to do so. For those who did report abuse, nearly 54% said that nothing happened.”**

**– An Unseen Population: IDD and Trauma, Colleen Horton NCTSN Brief**

<https://learn.nctsn.org/mod/resource/view.php?id=11675>

Data from: Baladerian, N. J.; Coleman, T. F.; Stream, J. (2013). Abuse of people with disabilities – victims and their families speak out – A Report on the 2012 National Survey on Abuse of People with Disabilities. Spectrum Institute Disability and Abuse Project

# Formal Diagnoses: PTSD and other trauma related disorders

- PTSD
  - 0.1% of typically-developing children in the population aged 9–16 years, with another 0.9% showing subclinical symptom levels (Copeland et al. 2007)
  - Lifetime 6.8% develop PTSD ([Kessler et al., 2005](#)),
- Other related diagnoses
  - Acute Stress
  - Disinhibited Social Engagement
  - Reactive Attachment Disorder
  - Adjustment Disorders
  - Unspecified Trauma and Stressor Disorder

## Screening

*Gathering information that will be helpful in treatment*

# What are the reactions we are looking for?

- Re-experiencing
  - “Flashbacks”, nightmares
- Avoidance
  - Avoid sights, sounds, smells associated with trauma,
  - Social withdrawal
- Hyperarousal
  - Startle, fear response, insomnia, irritability

What does this mean for supporting individuals?



## “Trauma Detectives”

In the Chat:

What are  
traits/behaviors of  
great detectives



# Traits/Behaviors

- Curiosity
- Observation
- Inductive Reasoning

# Becoming a great trauma detective

- Have the conversation
- Link together information in background assessments
- Notice strong reactions or lack of reactions
- Inductive reasoning
  - Build from what you see to create a theory of behavior causes
- Be brave
- Get support

Ways to ask

# Background to conversations

- Normalize
  - “We know that lots of people have experienced things that are scary or that might be traumatic”
  - “It sounds like you have been through a lot in the past few years, I imagine a lot of the things that happen might have been disturbing or scary for you or for others in your life”
- Delegate: Not trying to investigate, not trying to process
  - “We aren’t going to go in depth on all the things that happened right now. I want to go through a list of events that happen to lots of people and talk through whether any happened to you”
  - Will process it later, now we want to get an idea of possible exposures and reactions

# Self awareness

- Don't carry exposure assumptions
  - Because of SES, Race, Ethnicity, Age
  - Because of what you consider traumatic or “daily life”
- Don't carry effect assumptions
  - Due to extreme nature of exposures
  - Due to type of exposure
- Be ready to get your own help with things that disturb you.
- Know who you are passing the information on to for treatment and collaboration

Experiences that might be traumatic

# Example tool Child and Adolescent Trauma Screen (CATS)

[https://istss.org/clinical-resources/child-trauma-assessments/child-and-adolescent-trauma-screen-\(cats\)](https://istss.org/clinical-resources/child-trauma-assessments/child-and-adolescent-trauma-screen-(cats))

- Sachser, C., Berliner, L., Holt, T., Jensen, T. K., Jungbluth, N., Risch, E., ... & Goldbeck, L. (2017). International development and psychometric properties of the Child and Adolescent Trauma Screen (CATS). *Journal of affective disorders, 210*, Which one is bothering you the most now? \_\_\_\_\_  
189-195.

**Stressful or scary events happen to many people. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to you. Mark No if it didn't happen to you.**

1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.  Yes  No
2. Serious accident or injury like a car/bike crash, dog bite, sports injury.  Yes  No
3. Robbed by threat, force or weapon  Yes  No
4. Slapped, punched, or beat up in your family  Yes  No
5. Slapped, punched, or beat up by someone not in your family  Yes  No
6. Seeing someone in your family get slapped, punched or beat up.  Yes  No
7. Seeing someone in the community get slapped, punched  Yes  No
8. Someone older touching your private parts when they shouldn't.  Yes  No
9. Someone forcing or pressuring sex, or when you couldn't say no.  Yes  No
10. Someone close to you dying suddenly or violently  Yes  No
11. Attacked, stabbed, shot at or hurt badly  Yes  No
12. Seeing someone attacked, stabbed, shot at, hurt badly or killed  Yes  No
13. Stressful or scary medical procedure.  Yes  No
14. Being around war  Yes  No
15. Other stressful or scary event?  Yes  No  
Describe: \_\_\_\_\_

From discovery  
to intervention

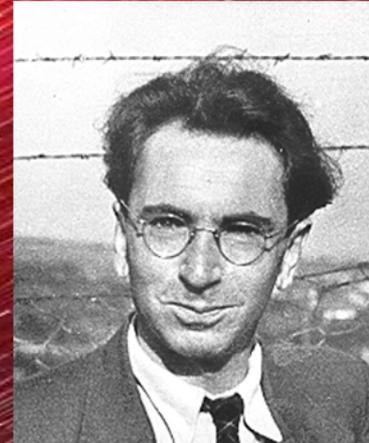


THE RESILIENT GROWTH MODEL OF TRAUMA:  
TRAUMAGENESIS  
RECIPROCAL INHIBITION  
NEUROCEPTION  
INTEROCEPTION

A new path for trauma intervention

***Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom.***

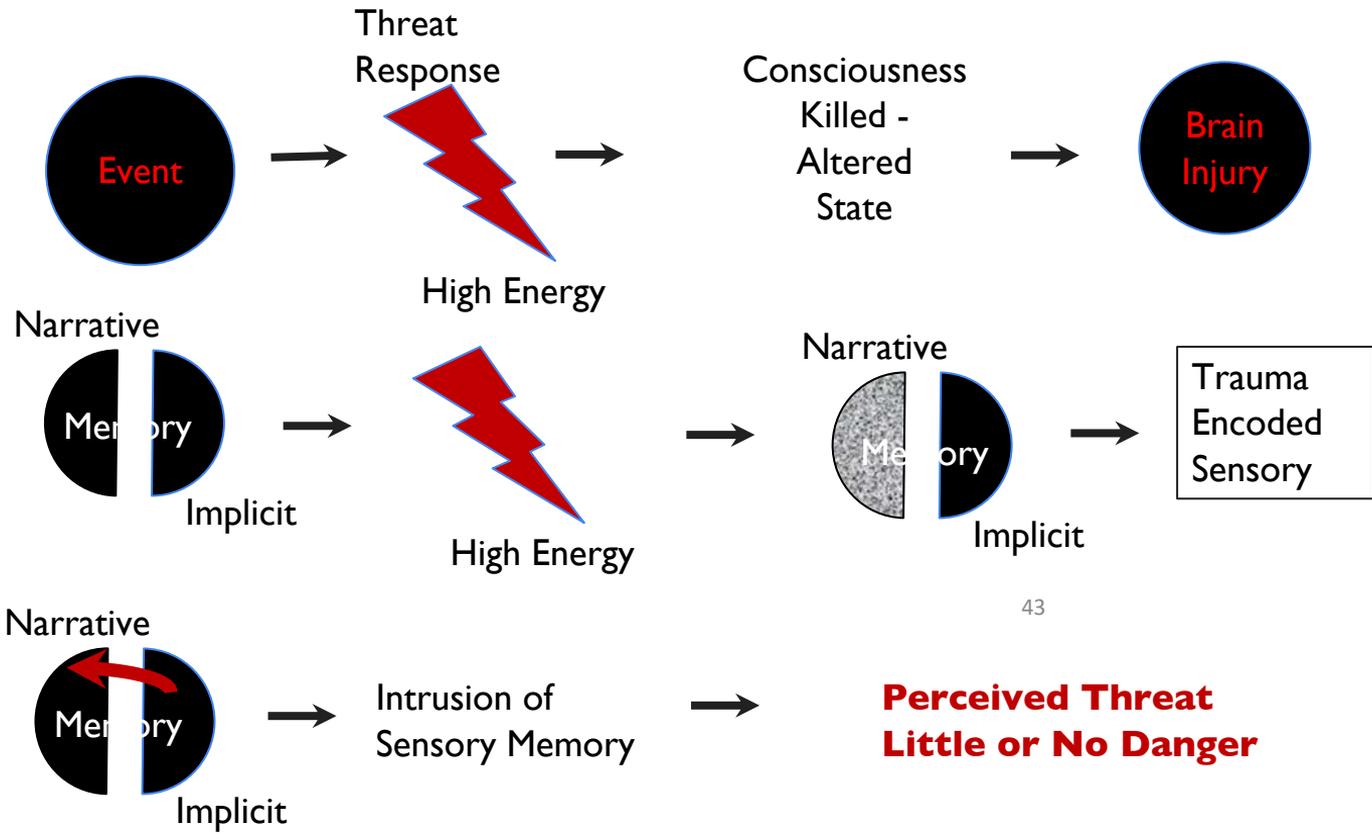
- Viktor Frankl



# FFTT PHASE I: EDUCATI ON

- Tools for Hope
  - Am Safe vs. Feels Safe (100% safe)
  - Stress is caused by perception of threat not by environment
  - ANS > PNS + SNS
  - Polyvagal Theory (optional)
  - SNS activation with perception of threat/SNS dominance without intentional relaxation while in context of perceived threat
  - Loss of cognitive & motor fx with chronic SNS dominance
  - ANTIDOTE = relaxation

# WHAT CAUSES TRAUMA



# TRAUMAGENESIS

## HOW DO WE GET TRAUMATIZED?

Painful (threatening)  
experiences

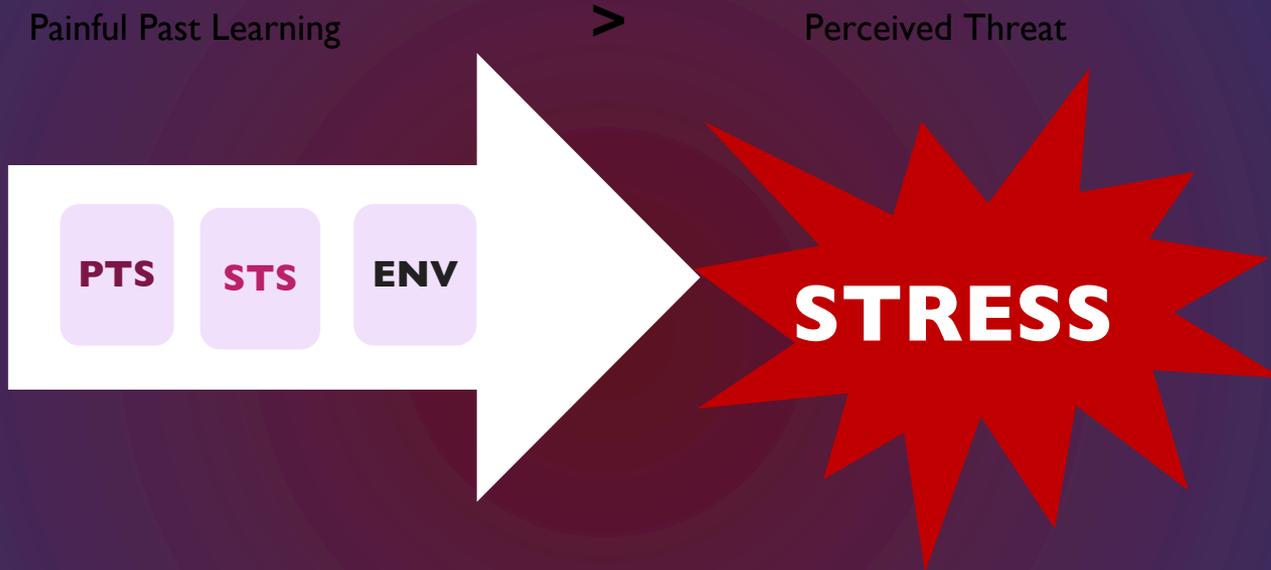
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Learning

Perceived Threat in similar  
future contexts



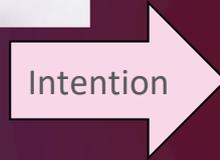
# PATHWAYS of Traumagenesis



**PTS** – Posttraumatic Stress  
**STS** – Secondary Traumatic Stress  
**ENV** – Environmental/Ambient

# Reactivity

(Aggression or Avoidance)

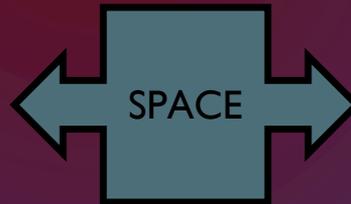


STIMULUS



Failure to regulate the ANS

# Intentionality



Maintaining integrity no matter the external stimulus

# NEUROCEPTION

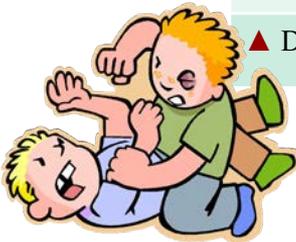
**DETECTING  
SAFETY IN THE  
ENVIRONMENT  
ESPECIALLY  
WHEN  
PERCEIVING  
THREAT**



# Perceived Threat



Physiological	Brain Mechanics	Other Effects
▲ Heart Rate	▲ Basal Ganglia & Thalamic Fx	▲ Obsession
▲ Breathing Rate	▼ Neo-cortical Fx	▲ Compulsion
▼ Breathing Volume	▼ Frontal Lobe activity ▼ Executive Fx ▼ Fine motor control ▼ Emotional regulation	▼ Speed & Agility
Centralized Circulation		
▲ Muscle Tension	▼ Temporal Lobe Activity ▼ Language (Wernicke's) ▼ Speech (Broca's)	▼ Strength
▲ Energy	▼ Anterior Cingulate	Constricted thoughts & behaviors
▲ DIS-EASE		Fatigue



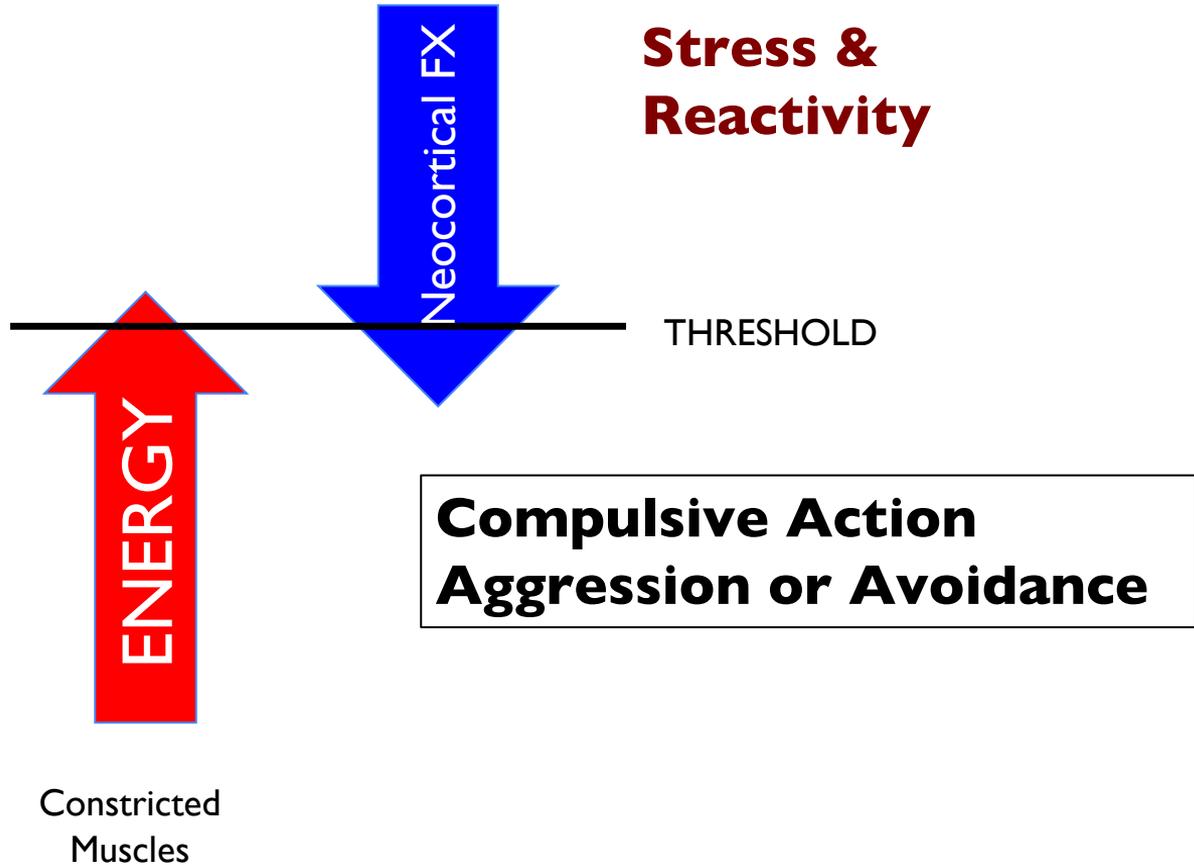
Fight



OR

Flight

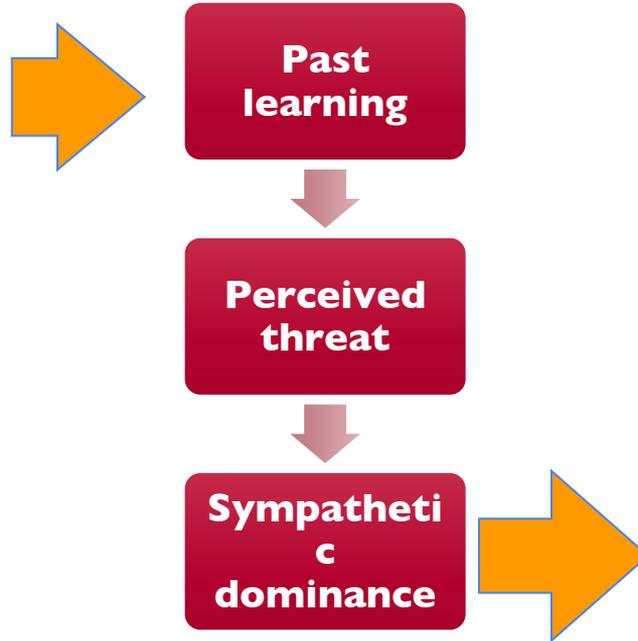




# CAUSE AND

**Painful Learning**

**Perceived Threat**

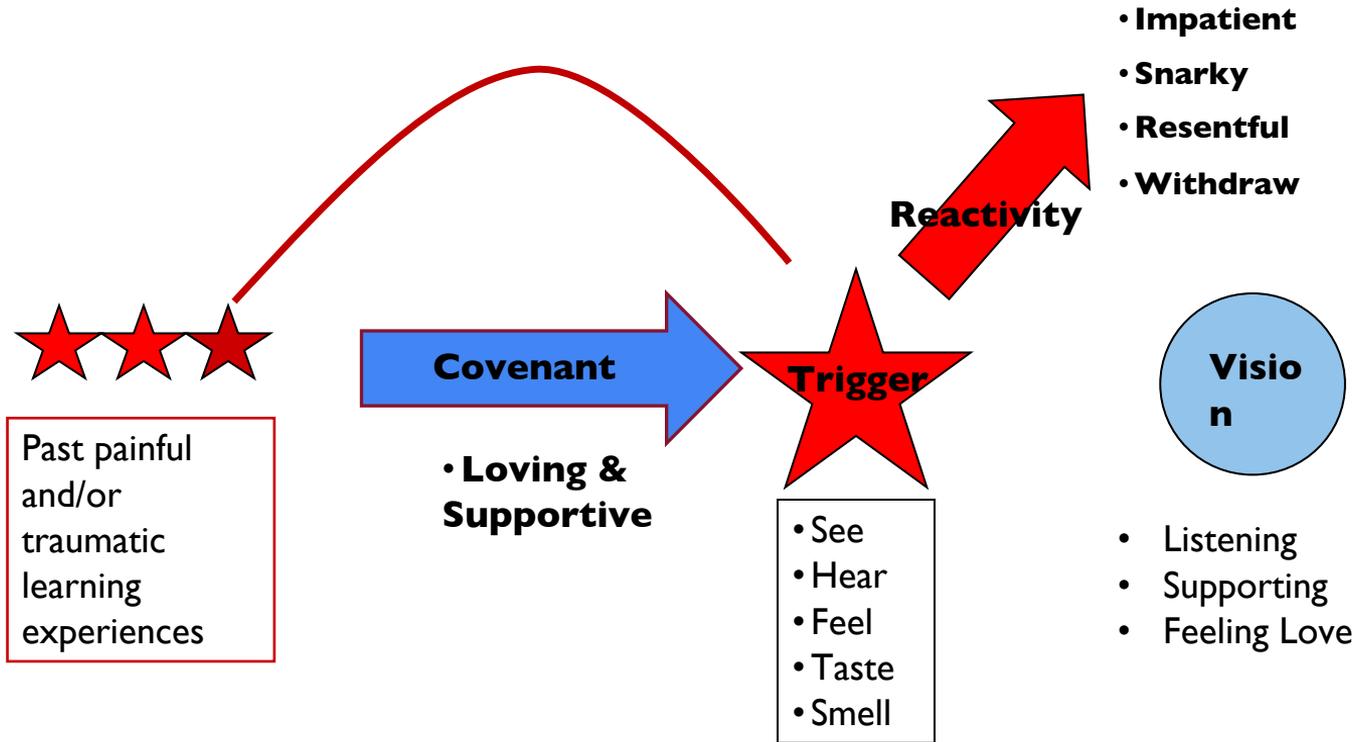


# INTEROCEPTION

*You want to know what heals trauma? ... Interoception heals trauma*  
- Bessel van der Kolk

- Present “felt sense” on one’s own physiological processes
- Becoming sensitive to “feedback” from one’s body
- Lowering threshold of awareness of dysregulation
- Monitoring rising levels of energy (SNS activation) and recognizing when there is the need for conscious and intentional intervention (i.e., releasing constricted muscles)

Interception + Acute Relaxation x 100/day = No Stress

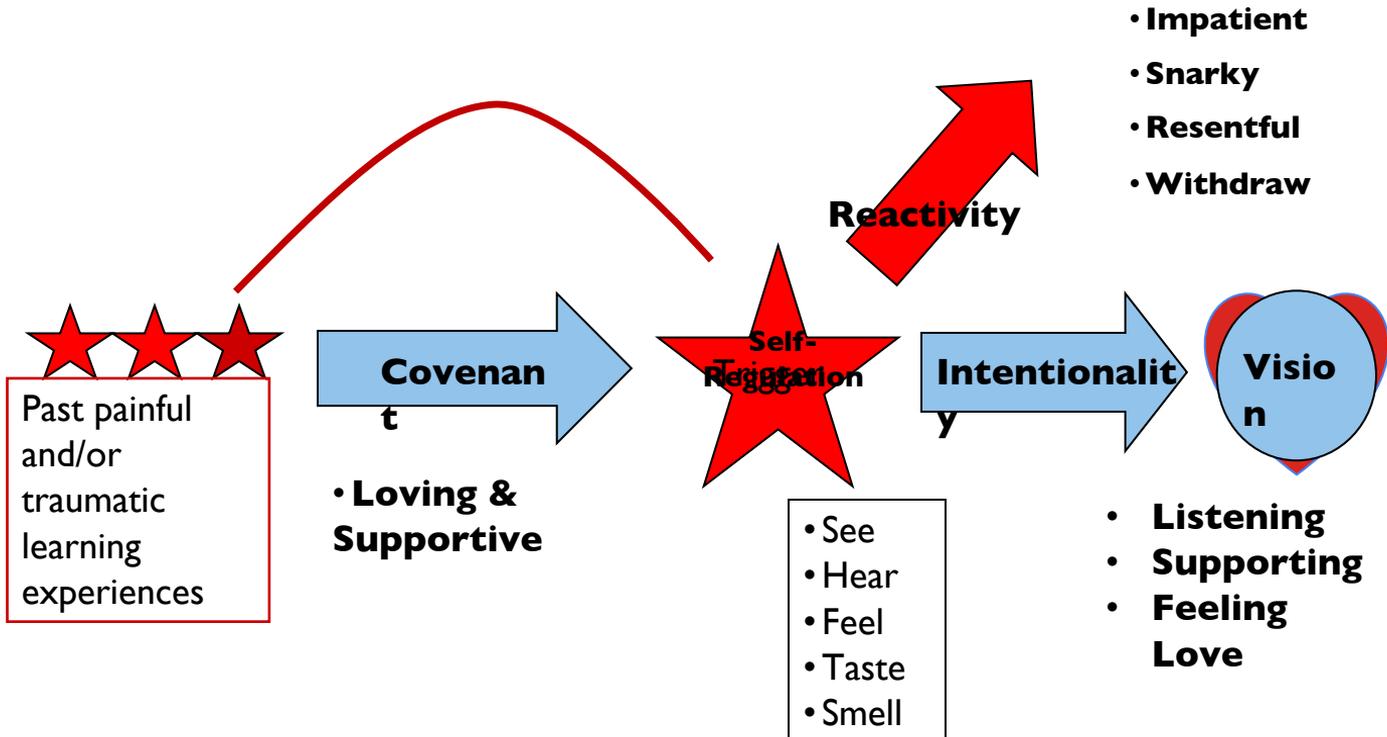


***Margaret, you should/you need***

# TRIGGERS – EXTERNAL OR INTERNAL MOVE US INTO INVOLUNTARY MOBILIZATION

- What does that look like?
- How is it different from an acting out behavior?

Trauma informed and solution focused strategies are what will resolve this state; it is critical to be able to tell the difference and choose your response.



*Margaret, you should/you need to*

Reasons for hope

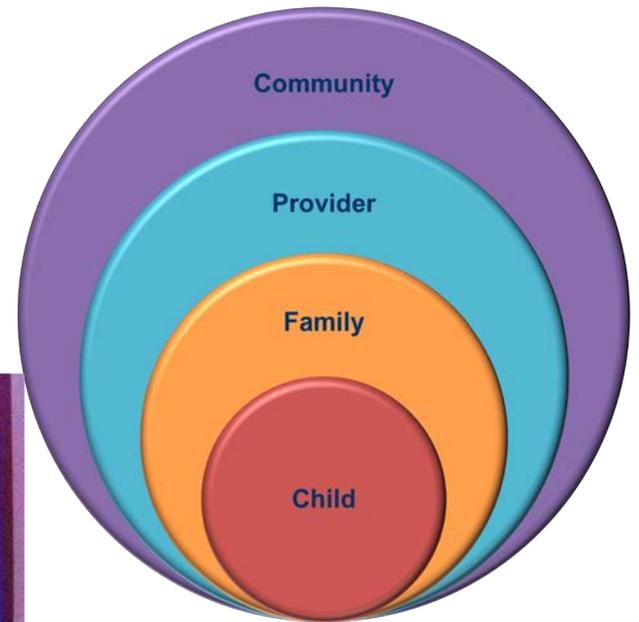
Interventions can work for people with  
neurodevelopmental disabilities

# Trauma informed behavioral interventions

- Avoid Restrictive Procedures!
- Provide safety from triggers
  - Do not attempt “exposure therapy”
- Allow choice and self determination whenever possible
- Screen to identify possible triggers and reactions
- Take trauma reactions seriously, watch for body reactions

# Universal practices

- Become aware of potential triggers
- Build up resilience in the family system
- Find and nurture strengths and abilities
- For you: find inspiration in the strength of survivors
- What are the levels of help you can find?
- “Marathon, not a sprint”



Graphics: Road to Recovery NTCSN <https://www.nctsn.org/resources/road-recovery-supporting-children-intellectual-and-developmental-disabilities-who-have>

Referring out: Trauma treatments

# Best supported treatments (most likely to work)

- Trauma Focused Cognitive Behavior Therapy (TF-CBT)
  - Ages:3 to 18 years old
  - Adaptations for ASD and developmental disabilities:
  - Includes behavior therapy to rebuild daily life and reduce caregiver child stress
  - Graded exposure through art/music/talking
  - Strategies to avoid retraumatization
  - <https://tfcbt.org/>
  - AspireMN
- Eye Movement Desensitization and Reprocessing (EMDR)
  - Adults
  - Little evidence in developmental disabilities/ASD
  - <https://www.emdria.org/>
- Attachment Biobehavioral Catch-Up (ABC)
  - Young children 6-24 months
  - Involves parents/caregivers in rebuilding attachment
  - <https://www.abcintervention.org/>
- Child Parent Psychotherapy (CPP)
  - Age 0-5 years
  - Young children/caregiver focused
  - [https://childtrauma.ucsf.edu/child-parent-psychotherapy-resources#:~:text=Child%2DParent%20Psychotherapy%20\(CPP\),health%2C%20attachment%2C%20and%20For](https://childtrauma.ucsf.edu/child-parent-psychotherapy-resources#:~:text=Child%2DParent%20Psychotherapy%20(CPP),health%2C%20attachment%2C%20and%20For)

# Other emerging treatments

- Acceptance and Commitment Therapy (ACT)
- Prolonged Exposure
- Brief Eclectic Psychotherapy
- Cognitive Processing Therapy
- Narrative Exposure Therapy

# References

- Forward Facing Institute - [forward-facing.com](https://www.forward-facing.com)
- Road to Recovery (trainings for anyone working with children with neurodevelopmental disorders and trauma)

<https://www.nctsn.org/resources/road-recovery-supporting-children-intellectual-and-developmental-disabilities-who-have>