IDD and Trauma: Adaptations of TFCBT and CBT for Depression

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What is Trauma?

• A stressful situation which overwhelms an individual’s coping mechanisms and causes a sense of disconnection from feelings of control, connection, and meaning
• Trauma may lead to symptoms of post-traumatic stress or a diagnosis of post-traumatic stress disorder; not everyone who experiences trauma develops PTSD
• A traumatic response is a normal response to an abnormal situation
• Different Types of Trauma
  — Accidents, Natural Disasters, Illness verses Interpersonal, Relational/Attachment Trauma
  — “Big T” versus “Little t” Trauma
  — Simple versus Complex Trauma

Prevalence of Trauma Among Children

• 60% exposed annually
• 3.5 Million CPS reports, 794,000 substantiated annually in US
• In NC, 5000 sexual abuse and assault cases reported to law enforcement, 1,000 of each substantiated annually

Prevalence of Trauma Among Women

• Lifetime prevalence 51%(6% men), 10%(5%) develop PTSD
• Severe physical/sexual abuse in homeless 91%
• Sexual assault during military service 33%
• Lifetime prevalence of domestic violence 44%
• Robbery victimization 1-4 per 1,000(2-4 men) age 12 and older
• Aggravated assault 2-4 per 1,000(3-4 men)

Prevalence of Trauma Among MH SA
Public Sector Populations

• Exposure to multiple traumas 90%
• History reported by 75% of SA clients
• 55-99% of women in SA treatment
• 85-95% of women in MH treatment
• 11-38% of men(33-59% of women) in SA treatment have PTSD and SA Dx

Prevalence of Trauma Among IDD

• Underreported due to lack of communication, credibility, and inability to make a report
• More likely to experience trauma, especially physical and sexual abuse in adults and kids
• 2.5 to 10 X higher rates of child maltreatment
• PTSD rates from 2.5 to 50%
• Interpersonal violence/crime rates 4-10% higher than general population
Prevalence of Trauma Among IDD

- Lifetime prevalence of sexual abuse 90% and 10 or more abusive incidence 49%
- 44% had relationship with abuser related to IDD
- Child maltreatment evident in 10-25% of all IDD

IDD and Trauma: Increased Vulnerability

- IDD clients are trained to be compliant, dependent on care givers for long periods of time, inadequate supervision, a strong desire for acceptance and fear of rejection, social isolation, impaired communication or mobility, cognitive delays limit understanding of what is happening, easier to manipulate, less critical thinking, less likely to receive sex education and recognize sexual abuse, discrimination, poverty and more comorbidity

Examples of Trauma

- Sexual Abuse and assault, physical abuse and assault, community and domestic violence, historical or intergenerational violence, serious accidents, unexpected loss of loved one, medical procedures or conditions, war and terrorist attacks, institutional abuse, second hand exposure

Examples of Trauma More Likely for IDD Clients

- Neglect or omission of adequate, accidents, bullying, hospitalizations, restraints, withholding, stealing or overdosing medications, financial abuse, relocation, hate crimes, caregiver relationship transitions, violence at the hands of housemates or caregivers or witnessing such

Adverse Childhood Events (ACE)

- Emotional abuse, emotional neglect
- Physical abuse, physical neglect
- Sexual abuse
- Drug addicted or alcoholic family member
- Incarceration of a family member
- Loss of parent to death or abandonment
- MI, depressed, or suicidal family member
- Witnessing domestic violence against mother

Increased Health/Social Problems with Higher ACE Scores

- SUD, Depression, suicide attempts, early initiation of sexual activity, adolescent and unintended pregnancy, SDT’s, multiple sexual partners, risk for intimate partner violence, early initiation of smoking,
- COPD, Fetal death, ischemic heart disease (IHD), liver disease
Negative life Events More Prevalent for IDD Clients

- Staffing changes, people moving in and out of positions, periods of time covered by non regular caregivers, separation from family/caregiver, serious injury or illness, death of close friend of relative, moved house or room or changes in decorations or furniture, increased arguments with others, change in daily routine, subjected to verbal abuse, witnessed physical violence or verbal abuse, medication changes, physical restraint or violence

Factors Effecting The Response To Trauma

- Previous trauma experience(s), coping skills of the victim prior to the experience, the nature of the trauma, how close to the trauma, relationship to the abuse or victim, perception of the person involved about the experience, chronicity and severity of the trauma, level of stress of life experiences at the time of the trauma, response of the support system to the event

Increased IDD Vulnerability to Effects of Trauma

- Limited range of coping/adaptation skills
- Less experience in managing negative life events
- Early separation from parents or family system stress may limit stress management ability
- More vulnerable to stress related thoughts, feelings, and behaviors
- Decreased psychological flexibility

Increased IDD Vulnerability to Effects of Trauma

- Less social support or ability to gather such
- Fewer protective factors that would limit the effects of trauma (i.e. effective parenting or caregiver supports, social connections, good communication, problem solving, and self regulation skills, positive beliefs about self, beliefs that life has meaning, spirituality/faith, socioeconomic advantages, pro-social peers and friends, stable and safe effective communities

Effects of Trauma: Neurological

- Trauma activates stress hormones and neurochemicals which acutely results in flight, fight or freeze and chronically changes brain functioning and structure due to neuroendocrine system impacts, over activation of HPA axis in the brain and constant production of stress hormone cortisol, and impact on emotion and fear response (amygdala) and memory (hippocampus)

Effects of Trauma: Biological

- Somatic complaints, sleep disturbance (DFS, nightmares), headaches, urological problems, stomach aches, fatigue, forgetfulness, confusion, concentration problems, flashbacks, sexual numbing, increased flight, fight or freeze response, and chronic health problems
### Effects of Trauma: Emotional
- Shock, numbness, restricted range of affect, disconnectedness, fear, anger, impatience, worry, anxiety, sadness, depression, powerlessness, ineffective, overwhelmed, untrusting, unsafe, inner turmoil and pain, self blame, self doubt, shame, and secrecy

### Effects of Trauma: Cognitive
- Distrust of others or expectations they may be harmed by everyone
- Overestimation of and preoccupation with danger
- Low self esteem and self blame
- Helplessness and hopelessness about the future
- Shame, stigma, or survivor guilt

### Effects of Trauma: Behavioral
- Crying, agitation, irritability, rage, passiveness, diminished interest in activities, self injurious behaviors, suicidality, reenactments(right the wrong), disassociations, risky, impulsive behaviors, compulsive behaviors, problems with eating, rigid behaviors, substance abuse, and panic/phobias

### Effects of Trauma: Social
- Isolation detachment, over working, relationship strains/dysfunction, neglect of responsibilities, poor or overprotective parenting, feeling unlikable or strange in social situations, avoidance of sexual or trauma related activity, passive avoidance, disengaged from the dating process, and re-victimization

### Trauma and PTSD in the IDD Client
- Symptoms overlooked due to attributing behaviors to IDD(diagnostic overshadowing)
- Assessment is difficult due to receptive and expressive language deficits
- Age and developmental level influence expression of PTSD symptoms and ability to cope with trauma
- Higher IQ-greater ability to avoid exposure
- More vulnerable to PTSD and trauma effects

### Effects of Trauma: IDD
- PTSD symptoms more like those in children
- Behavioral reactions-regressive or aggressive
- Inappropriate or unusual statements, stereotypical behaviors, inappropriate speech, reduced self care, reduced adaptive behavior
- Reenactments-repetitive themes or aspects of the trauma expressed in interactions with others played out as victim or victimizer to gain mastery or control over the experience
Effects of Trauma: IDD

- Interpersonal disruption-avoids connecting or relating-worries about who is working, repeated statements about unrelated events, inability to assert or protect oneself, distant, preoccupied and daydreaming, phobic mannerisms to avoid cues or situation that trigger unpleasant sensations or memories, refusal to participate in activities or work without reasons, decline in skills after prior gains

Effects of Trauma: IDD

- Interpersonal disruption-aggression-bold or secretive acting out including aggression toward self, others, property or pets, testing and breaking rules, and increased impulsivity
- Exacerbation of pre-existing psychiatric conditions (i.e. depression, panic disorder)

Key Developmental Capacities Shaped by Trauma

- Ability to modulate, tolerate, or recover from extreme affect states
- Regulation of bodily functions
- Capacity to know emotions or bodily states
- Capacity to describe emotions or bodily states
- Capacity to perceive threat, safety or danger

Key Developmental Capacities Shaped by Trauma

- Capacity for self soothing
- Ability to initiate or sustain goal directed behavior
- Coherent self, identity
- Capacity to regulate empathic arousal

Traumatic Stress Symptoms

- Re-experiencing-thoughts and feelings pop into one’s mind, reliving what happened, feels like it’s happening again, get’s upset at reminders
- Avoidance-tries to block it out and not think about it, to stay away from reminders, feels numb or no emotions

Traumatic Stress Symptoms

- Increased arousal-always afraid something bad will happen, more easily startled/jumpy, trouble with sleep or concentration
- Dissociation-things feel unreal, like a dream, trouble remembering parts of what happened
- Flashbacks, hyper-vigilance, terror, anxiety, difficulty with problem solving, numbness, depression, SA, self injury, eating problems, poor judgement, repeated victimization, aggression
### Symptoms as Adaptations
- The event is over but not one's reactions
- The intrusion of the past into the present presents as distressing intrusive memories, flashbacks, nightmares, or overwhelming emotional states
- Re-experiencing is the key to many symptoms
- Symptoms represent an attempt to cope they best they can with overwhelming feelings

### Symptoms as Adaptations
- Ask what purpose does the symptom serve
- Every symptom helped one cope in the past and is still in the present in some way
- If we understand how the behavior is adaptive, we may be able to substitute a less problematic behavior
- One instinctively uses the same self protective coping strategies (i.e. hyper-vigilance, dissociation, avoidance, numbing)

### Trauma Informed Care
- Trauma informed refers to all of the ways in which a system understands trauma and the ways to be responsive to the impact of traumatic stress and thus decreases the risk of re-traumatization as well as contribute to recovery from traumatic stress

### General Recommendations
- Recognize the primacy of trauma, expect it, incorporate knowledge about trauma into all aspects of care, be hospitable and engaging, ask respectably and be prepared to listen, see symptoms as attempts to cope and survive, see both vulnerabilities and strengths, our primary goal is to empowerment and recovery, avoid re-traumatization, and coordinate care/case manage

### Core Principles of Trauma Informed Care
- **Awareness**- knowing the role of trauma
- **Safety**- ensuring physical and emotional safety
- **Trustworthiness**- making tasks clear and maintaining appropriate boundaries
- **Choice**- respect/prioritize choice and control
- **Collaboration**- share power as we can
- **Be Strength-based** versus punitive

### IDD Screening and Assessment TIC
- Identify trauma history as early as possible. Such is complicated by lack of preparation of discomfort by clinician, challenge of rule out of symptoms that may present as anxiety or depression, client’s shame, secrecy, or denial of trauma, or co-occurring SUD often seen as primary
- Universal screening that is relatively brief/ non threatening of client and through caregivers
IDD Screening and Assessment TIC

• Develop rapport and trust
• Give explanation of prevalence data as rationale for questions to remove sense of isolation and shame
• Ask about witnessed violence physical abuse, sexual assault or unwanted sexual touch, threatened violence etc. inform client of reasons to set limits on disclosure

IDD Screening and Assessment TIC

• Remain non-judgmental, sensitive, and patient
• Identify risk behaviors and help explain client behavior through lens of what has happened
• Get input from client for treatment goals designed to reduce the negative impacts of trauma on client’s life
• Symptoms can impact behavior, judgement, school/work performance and social connections even if subthreshold for Dx

IDD Screening and Assessment TIC: Questions

• Can you tell me a little bit about what happened to you? Where would you like to begin? In what ways do you feel your experience continues to effect your daily life? How do you cope with your experience? When you had this experience, did you think you would be seriously hurt? Do you dream or have nightmares about what happened? Do you ever feel like it is happening all over again? What reminds you about it?

Assessment for PTSD in IDD Clients

• Difficult due to diagnostic overshadowing and lack of standardized instruments other than DM-ID Fletcher et al 2007
• Caregivers are not able to report as they don’t have the information or do not recognize events as traumatic
• Differential diagnosis is essential as misdiagnosis is possible such as autism, IED or schizophrenia

Assessment for PTSD in IDD Clients

• May need to rely on others to recognize significant departures from baseline behavior that may signal a traumatic response
• Time delay between trauma and manifestation of symptoms can complicate diagnosis, temporal factors are relevant

PTSD Assessment Tools in Research with IDD Clients

• The Lancaster and Northgate Trauma Scale
• Bangor Life Events Schedule for ID(BLESID)
• Pediatric Emotional Distress Scale PEDS
• Behavior Problems Inventory BPI
• Adaptive Behavior Scale-residential and community SABS
• Ward Anger Rating Scale WARS
• The Brief Symptom Inventory BSI
• Impact of Events Scale IES
Avoid Re-traumatization

• Violating boundaries, breaking trust, unclear expectations, inconsistent rule enforcement, chaotic treatment environment, rigid agency policies that preclude safety, obtaining UDS in non-private manner, disruption in routines, disrespectfully challenging the client’s report of trauma, labeling rage or other feeling about the trauma as pathological, minimizing, discrediting, or ignoring client feelings, unnecessary staff changes

Effectiveness of TIC with IDD

• Better subjective health and lower prevalence of chronic illness among women with co-occurring disorders
• Marked reductions in use of restraints and seclusion in psychiatric care for kids
• Increased client satisfaction, staff patience and consistency and ability to deescalate, and decreased counter-aggressive actions between clients and staff (Keesler 2014)

Trauma Specific Interventions

• Interventions designed to address violence, trauma, and related symptoms
• Goals to increase skills that allow clients to better manage symptoms and reactions and to eventually reduce debilitating symptoms and prevent further traumatization or violence

When to Start Trauma Treatment

• No major current crisis or instability, client is using safe coping skills and wants to do this work, reaches out for help when in danger, not using substances such that emotionally upsetting work may increase use, suicidality has been assessed, system of care is stable and consistent, and staff are available with formal training

Key Messages in Trauma Recovery

1. It is not happening now- The trauma is over. It is in the past. You are here in the present
2. You are safe-The adults here are responsible for your safety and you are worthy of care and protection
3. You are not inherently dangerous/toxic- What is inside you (thoughts, feelings, dreams, impulses, etc.) cannot hurt you or others
4. You are good-Whatever you have experienced and whatever you have had to do to survive, you are a good, strong person who can contribute to your community
5. You have a future

Providing TIC

• To the best of your ability and within your given time constraints- Loose the labels, let her tell her story, give her time and space to tell her story, let her lead, respect her voice and choice, recognize her perspective and cultural context, offer support and validation (communicate care and concern, avoid passing judgement), ask questions, listen to what she has to say, offer information and assistance
Increase Protective Factors and Resiliency

- Environment - A reliable support system (friend/family), access to safe and stable housing, timely and appropriate care
- Behaviors - good self care (sleeping, eating, exercise, practicing good boundaries, using positive coping strategies)
- Traits - a sense of meaningfulness, internal locus of control, perspective to see change as a challenge, a vigorous approach to life

10 Foundations for Safe Trauma Therapy
From Trauma Essentials by Babette Rothschild

1. First and foremost: establish safety for the client within and outside therapy.
2. Develop good contact between therapist and client as a prerequisite to addressing traumatic memories or applying any techniques—even if that takes months or years.
3. Client and therapist must be confident in applying the “breaks” before they use the “accelerator.”
4. Identify and build on the client’s internal and external resources.
5. Regard defenses as resources. Never get rid of coping strategies or defenses; instead, create more choices.

Special Considerations with Sexual Trauma Survivors

- Men and women are statistically equally likely to have experienced some form of sexual abuse; Males are less likely to disclose
- Female perpetrators are more common than we think and a man CAN be raped by a female
- Shame is especially high in this population
- The body’s natural response/reflex to sexual touch frequently needs to be addressed to reduce shame
- Disruptions in sexual activity are common (hypersexual vs. little/no sexual interest)
- Not every person who has a “non-consensual” sexual experience views this experience as traumatic

Trauma Specific Treatment Models (none normed for IDD)

- Cognitive Processing Therapy CPT
- Trauma Focused CBT
- Exposure Therapy
- EMDR
- Skills training in Affective and Interpersonal Regulation
- Stress Inoculation Training
- Narrative Therapy

Integrated Treatment for Trauma and SUD

- A Women’s Path to Recovery
- Alcohol Behavioral Couple Therapy ABCT
- Boston Consortium Model Trauma Informed SA Treatment for Women
- Forever Free
- Helping women Recover and Beyond Trauma
- Seeking Safety
- Trauma Recovery and Empowerment Model

(Rothschild, 2011, pp. 13-16)
Adaptations of Evidenced Based Treatment for IDD

- A Manual of Cognitive Behavior Therapy for People with Learning Disabilities and Common Mental Disorders
- TFCBT
- EMDR
- DBT

CBT for IDD

- A Manual of Cognitive Behavior Therapy for People with Learning Disabilities and Common Mental Disorders-Therapist Version, Angela Hassiotis, Marc Serfaty, Kiran Azam, Sue Martin, Andre Strydom, Michael King,
- Camden & Islington NHS Foundation Trust and University College London, 2012

CBT for IDD and Depression or Anxiety

- Several studies have concluded that people with learning disabilities have the necessary prerequisite skills to engage in many of the interventions associated with CBT (Dagnan et al, 2000; Joyce et al, 2006; Sams et al, 2006). These skills include the ability to link situations to emotions (Dagnan et al, 2000); the capacity to differentiate between thoughts, feelings, and behavior (Sams et al, 2006); and an aptitude for correctly identifying emotions (Joyce et al, 2006)

CBT General Adaptations

- Be more specific and didactic and present key concepts in extremely concrete ways
- Provide extra support in the form of visual aids such as pictures, drawings, and signs for certain tasks such as mood monitoring, presenting temporal concepts, and identifying automatic negative thoughts
- Take therapy at a slower pace, using repetition, and encouraging “overlearning”

CBT for IDD and Depression or Anxiety

- The individual’s level of comprehension, level of expression, ability to self-report, and self-regulation skills are important factors in their suitability for CBT

CBT General Adaptations

- The involvement of a caretaker or support worker is essential in assisting the client to move successfully through the program as they assist the client with homework assignments and help the client bring this material into sessions
Communication Tips

- If you do not understand, it is important that you do not pretend to have understood
- Give the person plenty of time to respond
- Listen carefully
- Look at the person when he or she is talking
- If you still cannot understand, ask the client if it is okay to ask the support worker for help with communication

Communication Tips Being Understood

- Use simple, straightforward, everyday language and limit the number of key concepts or ideas you communicate to no more than three per sentence
- Use concrete examples, simple sentences and language
- Use context as communication constantly
- Regularly asking them to summarize or repeat what has been discussed

Communication Tips Being Understood

- Speak slowly using everyday words
- Think about how to ask questions
- Link your explanation with everyday things
- Write the key information down
- Use pictures or symbols
- Focus on non-verbal communication
- If facing echoed speech or perseveration, be patient, suggest a break, distract the client, or shorten the session

Communication Tips

- Agree to a short two-to three minute talk on the subject he or she wishes to discuss, then go back to the topic at hand
- Socratic questioning may help the reluctant client express thoughts, feelings, ideas, and beliefs
- Be sensitive to any cultural issues the person may have with regard to eye contact, personal space, and gestures that may have different meanings than what you are accustomed to

Communication Tips

- Avoid leading questions and keep suggestibility at a minimum
- Make sure clients understand what has been said and give clear instructions without leading them

CBT Treatment Protocol

- Three Phases
  - Early/initial phase (sessions 1–4)
  - Middle phase (sessions 5–14)
  - Final phase (sessions 15–20)
Phase I Goals

- Complete a language assessment and evaluate the client’s suitability for CBT
- Explain the role and extent of involvement of the support worker in therapy to the client
- Address the reasons the client has been referred
- Describe the CBT model of treatment and the importance of homework
- Confirm that the client will attend all sessions
- Provide psychoeducation

Goal 1 Assess Language and Suitability

- Assess cognitive level and language skills—Test for the Reception of Grammar TROG 2
- Assess memory, reading ability, writing ability
- Assess Attentional control and perceptions about how much he or she controls and influences events in life
- Assess the client’s motivation and willingness to engage in therapy

Goal 2 The Role of The Caregiver in Therapy

- Why including the caregiver is useful
- The extent to which the caregiver will need to participate in sessions and homework
- How much information the client is comfortable sharing with the caregiver
- The caregiver will keep information confidential

Goal 3 Reasons for Therapy

- Explain and elicit the client’s understanding of the emotional and behavioral difficulties (i.e. “I am seeing you because I hear you feel sad/scared/worried/etc.”)
- Explore presenting complaints and the client’s perception of how much the problem affects him or her

Goal 4 CBT and Homework

- Explain what CBT is, how it works, the rationale for treatment, what the aim will be, what the rules of therapy are, and how important homework is during the process
- Homework should be tailored to the client’s needs, relevant to the topics covered, build on skills practiced, and encourage the client to engage in the kinds of changes necessary while still being realistic and manageable

Improve Homework Compliance

- Involve the client in deciding what tasks he or she will be doing outside the session
- Set tasks that provide a no-lose situation
- Make sure the client understands the task and the reason for doing the task
- Make sure the client understands the benefits and importance of doing the homework tasks
Homework Rating Scale Questions

• How well did the client understand what to do and the reason for doing the task?
• How well did the client do in completing the task?
• How much of the task was the client able to do?
• How difficult/easy did the client find the task?
• How much did the client enjoy the task?
• How well did the task match therapy goals

Homework Rating Scale Questions

• How much did the task help the client gain control over his or her problems?
• Did the task help the client progress in therapy?
• If the homework task was not completed, you should ask the support worker to fill out the "Resource 2—Checklist of Reasons for Not Completing the Homework Tasks and bring to discuss at next session.

Homework Assignments

• Create a list of issues or problems that the client would like to address during therapy
• Complete a weekly activity schedule WAS
• Sheet 1—What Is Cognitive Behavioral Therapy?
• Sheet 2—Linking Thoughts, Feelings, and Behaviors for Depression
• Sheet 3—Linking Thoughts, Feelings, and Behaviors for Anxiety
• Sheet 4—Linking Thoughts, Feelings, and Behaviors for Anger

Goal 5 Attendance

• Secure a commitment from the client to attend all the sessions
• Use MI strategies such as developing discrepancy, avoiding arguments, and supporting self efficacy

Phase 1 Summary

• What skills does the client possess that will help him or her?
• Does the client understand what treatment entails?
• What materials and tasks can help the client to practice and improve these skills?
• Does the client have any concerns or worries about the treatment?

Psycho-education

• Info Sheet 5—What Is Depression?
• Worksheet 3—When I Feel Depressed
• Worksheet 4—Good and Bad Things in My Life”
• Recommend the picture book Feeling Blue published by the Royal College of Psychiatrists website (Royal College of Psychiatry, 2009)
• http://www.rcpsych.ac.uk/publications/booksbey ondwor ds/bbwonlineversions/feelingblue/blueco ver.aspx
Psycho-education Anxiety

- Use an informational body map to illustrate common physiological symptoms associated with anxiety as well as a blank version that allows the client to point to and discuss physical symptoms he or she experiences when feeling anxious.

Psycho-education Anxiety

- Info Sheet 6 — What Is Anxiety?
- Info Sheet 7 — Signs of Anxiety (Body Map)
- Worksheet 5 — When I Get Anxious I Feel (Body Map)
- Anger-keep an anger diary for a week so you and the client can begin to make the link between his or her triggers and the resultant thoughts and feelings. The more the client can understand the links between what triggers his or her anger and how he or she responds to it, the more the client will feel able to manage it.

Triggers to Anger in IDD

- Problems with communicating feelings
- Feeling misunderstood
- Feeling scared or intimidated
- Believing that they can't trust themselves due to past experiences (e.g. a past example of reacting to a situation with anger and physical aggression and worrying it might happen again).

Anger Management Strategies

- Role-play to help the client try out new behaviors
- Gently challenge dysfunctional assumptions and help the client to come up with a more balanced view of a given situation
- Behavioral—walk away, get calm, rethink
- Help the person recognize what he or she is feeling and help him or her feel confident enough to communicate it effectively.

Phase 2 The Middle Sessions 5-14

- Discuss and work through different life situations and how to better manage them
- Manage anxiety and depression
- Discuss relaxation techniques and healthy living
- Explore the client’s thoughts, feelings, and behaviors and establish the links between them
- Train the client to use alternative techniques to cope with negative thoughts and unhelpful behaviors.
- Explore additional skills that will encourage the client to use CBT techniques independently.

Session Format

- Set an agenda with client
- Review the previous session
- Review Homework
- Discuss and Address Problems: Set Goals and Work Toward Resolution
- Create goals that are specific, realistic, position, can be monitored, and time limited
- Worksheet 7 — My Goal
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<thead>
<tr>
<th>Session Format</th>
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<tbody>
<tr>
<td>• Establish Homework Task(s) for the Next Session</td>
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<td>• Session Summary and mutual feedback</td>
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<td>• Remind client of next session</td>
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<tr>
<th>Foci of Treatment</th>
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<tr>
<td>• Relaxation and Healthy Living</td>
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<tr>
<td>• Reducing Anxiety and Stress Levels: Using Relaxation Techniques</td>
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<td>• Healthy Living Techniques-reduce caffeine, improve sleep habits, exercise, increase prosocial contacts</td>
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<th>The Midpoint Review</th>
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<td>• Approximately halfway through this phase, spend a session or two reflecting with the client and the support worker about progress being made in treatment and the client’s goals for the remainder of treatment</td>
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<tr>
<td>• Begin by Discussing and Identifying Feelings-Resource 3—Image Bank-target simple emotions</td>
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<tr>
<td>• Make the thought-feeling link-Work to establish a set of examples from the client’s personal experience in which the client felt a particular emotion and a particular thought arose as a result</td>
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<td>• Finally, Establish the Relationship Between Thoughts, Feelings, and Behaviors</td>
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<td>• Unnecessarily focusing on negative thinking for too long is detrimental to the therapeutic process</td>
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<tr>
<td>• Worksheet 8—Thoughts and Feeling Diary</td>
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<td>• Worksheet 9—Thoughts, Feelings, Behaviors</td>
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<td>• Worksheet 10—Good Times</td>
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<td>• Worksheet 11—Bad Times</td>
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<th>Specific Cognitive Techniques</th>
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<td>• Identifying and Challenging Key Thinking Style Errors</td>
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<td>• See table</td>
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<td>• Worksheet 12—Unhelpful Ways of Thinking</td>
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<tr>
<td>• Worksheet 13—”How I Am Thinking” Diary</td>
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<td>• Worksheet 14—A Different Way of Thinking</td>
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Specific Cognitive Techniques

- Using the Survey Method to Challenge Beliefs
- Schemas Work-negative schemas (attitudes and assumptions) are formed due to an individual’s negative experiences in childhood such as parental criticism, criticism from teachers, and peer rejection
- Common Negative schemas-I’m a failure (self) Everyone thinks I’m stupid. (world), I’ll never be good at anything. (Negative view of the future)

Schemas Work

- Worksheet 15—My Good Thoughts About Me
- Worksheet 16—My Thoughts About Me That Are Not Nice
- Worksheet 17—My Worrying Thoughts About Me
- Worksheet 18—My Worrying Thoughts About Things That Will Happen
- Worksheet 19—My Good Thoughts About Things That Will Happen
- Worksheet 20—Core Beliefs
- Worksheet 21—My Core Beliefs

Addressing Anxiety States

- Worksheet 15—My Good Thoughts about Me
- Worksheet 17—My Worrying Thoughts about Me
- Worksheet 18—My Worrying Thoughts about Things That Will Happen
- Worksheet 19—My Good Thoughts about Things That Will Happen

Specific Cognitive Techniques

- Guided Discovery-provide the client an opportunity to learn how to overcome problems that he or she has not come across before by applying his or her skills to such situations

Specific Behavioral Techniques

- Positive Reinforcement
  - It is important to provide people with depression lots of praise, as they tend to focus on negative aspects of themselves
  - Helping depressed people identify positive events is an essential step in the healing process, as they are likely to view all events as negative
  - Fundamentally, you need to work toward encouraging people who are depressed to be nice to themselves, as they have likely internalized negative voices and this, in part, drives the depression

Specific Behavioral Techniques

- Assign Graded Tasks
  - Prepare a list of situations of gradually increasing difficulty, assign these tasks over time, and then ask the client to complete each task and monitor his or her mood or anxiety while completing the task without running away or engaging in safety behaviors (behaviors aimed at preventing the feared consequence from happening)
Specific Behavioral Techniques

- The client must stay with the situation until the anxiety reduces or the mood improves. The biggest problem with exposure paradigms is that the client is liable to leave the provoking situation when it reaches its emotional peak. This negative reinforcement makes it much more difficult for the client to engage in the provoking event the next time.

Specific Behavioral Interventions

- Designing and Implementing Behavioral Experiments
  - Help clients test beliefs, recognize negative thoughts and replace them with more positive ones, and build strategies to cope with difficulties appropriately.

Additional Skills

- Assertiveness Training
- Info Sheet 8 - Assertiveness Scale. Parameters
  - Voice intensity (loud vs. quiet)
  - When to respond (impulsive vs. appropriate)
  - Duration of response (focused vs. lengthy)
  - Eye contact
  - Body language (threatening vs. appropriate)
  - Ability to listen (listening to others vs. talking constantly)

Additional Skills

- Worksheet 22—How to Be More Assertive: Aggressive to Assertive
- Worksheet 23—How to Be More Assertive: Passive to Assertive
- Worksheet 24—How I Can Be More Assertive

Additional Skills

- Social Skills Training
- Role-plays of social situations
- Behavioral experiments that get the client to engage with people around them
- Reframing thoughts so that clients don’t automatically assume people perceive them negatively
- Picking up on positive stimuli from the people around them by keep records in positive data logs
- Working to help the client understand that others may be empathetic
- Worksheet 25—Important People in My Life
- Worksheet 26—Things People Like About Me
The Final Phase Sessions 15-18

- Goals
- Summarize the key points covered in the treatment
- Go over the main skills and strategies covered
- Bring the treatment to an end
- Address and put in place measures for relapse prevention

Ending Treatment

- Ask the client to list strategies he or she has learned and utilized to cope with depression and anxiety and discuss ways in which the client can continue to use these techniques to manage future situations and events
- Discuss how the client feels about the treatment process

Possible Questions

- What have you learned from these sessions
- How do you think therapy has helped you?
- Did you enjoy (and what did you enjoy about) the treatment?
- What have you learned about managing depressive thoughts?
- What have you learned about managing anxiety?
- What strategies do you now have to deal with depression and anxiety? How can you use these strategies to better manage depression and anxiety?
- In what ways can you continue to improve your depression and anxiety management skills? Are there specific areas that need improvement?

Phase 3 Final Sessions

- After Treatment: Relapse Prevention
- Create a list of problems/situations that the client thinks may cause his or her symptoms to recur, develop a list of cognitive and behavioral strategies to deal with them, explain how to recognize and identify early signs of relapse to both the client and the support worker

Phase 3 Final Sessions

- Worksheet 27—Things I Learned in CBT
- Worksheet 28—Important Things to Remember from My Work with the Therapist
- Resource 4—CBT Certificate

Adaptation to Trauma Focused CBT TFCBT

- Why TFCBT manual is good to adapt: It is strength based, focuses on development of competency skills, uses CBT techniques which are easy to adapt for IDD clients, already structured for use across a wide range of developmental levels, focuses on greater resilience (i.e. strong self esteem, ability to self soothe, feelings of competency to deal with challenging situations, applicable for single episode or complex trauma
TF CBT

- Before adapting TF CBT for IDD, staff should be trained in TFCBT! [http://tfcbt.musc.edu/](http://tfcbt.musc.edu/)

TF CBT Format

- Family Therapy Model
- Session generally divided between time with client, caregiver, and both together
- 90 minute session (shorten for IDD)
- Sessions end with time to do something fun together to allow the client to re-center before leaving

Who Can Act as Coach

- Parent, Group home staff, teacher, advocate, any care giver involved with the client on a regular basis willing to commit to regularly attending sessions with the client

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 or Trauma Symptom Checklist)
- Adaptations—include all significant caregivers, assess for secondary trauma due to societal of community response (myth that client has not been impacted or can not benefit)

Safety

- Is the client in a safe environment, what is risk for re-traumatization, does client need extra help in dealing with ongoing environmental stressors (i.e. bullying, teasing etc.), are there cognitive distortions that increase the current perception of danger
## Psychoeducation
- Provide general education about impact of trauma on normal functioning
- Provide specific information about the trauma the client experienced in language that is understandable
- Teach about TF-CBT phases and how treatment will progress
- Risk reduction - identify red flag situation, safety plan, increase assertiveness skills

## Skill Development
- Feelings identification
- Personalized relaxation skills
- Positive self talk
- Cognitive coping (cognitive triangle, relationship between thoughts, feelings and behaviors)
- Thought Stopping
- Teach Caregiver as well

## Skill Development Adaptations
- 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 related to everyday life
- Continue to present information in different ways and be patient for understanding

## Trauma Narrative: Chapters to Include
- All about me, Chapter on how they entered Rx
- Use the baseline trauma assessment to guide
- Work from least to most threatening trauma
- Write all trauma components on slips of paper and draw one at a time to work on
- After all known aspects of trauma have been worked on, ask what was the worst part, don’t assume you know

## Narrative Session Format
- Check in on client's stress level at beginning of each session, if high, use skills to reduce it
- With the client, review the narrative developed last session, continue to use stress management skills as needed
- Add any new information that client brings up
- Go on to the next part of the trauma narrative
- Spend time alone with caregiver and review information client produced in the narrative

## Narrative Session Format
- Help caregiver deal with their own emotions, discuss any distortions caregiver is experiencing like unwanted self blame, unrealistic expectations of what they can do, fears the client has been forever damaged
- End each session with fun time, this may be a group activity with caregiver or client alone
Narrative Adaptations for IDD

- Be creative in the ways in which the narrative is recorded (i.e. dictate responses, draw pictures, role play, sing or dance, sand tray, use play
- Go slowly - more time is needed to absorb the information/integrate the modified cognitions
- Repetition is essential for learning - client may return repeatedly to inaccurate or unhelpful cognitions

Trauma Processing

- Review the narrative, identify thoughts that are not helpful and areas where thoughts and feelings are mission, identify places where the client’s thoughts are accurate and praise them, add to the chapter on starting therapy and the progress the child is making

Trauma Processing Adaptations for IDD

- Go slowly
- Provide lots of support
- Review skills as needed
- It is especially important to use the cognitive triangle, identify cognitive distortions as unhelpful thoughts, and then correct them in the narrative

Re-integration Session Format

- Integration is usually done with client and caregiver together
- Begin by assessing the client’s and caregiver’s readiness for this phase
- Remind about rational 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

Reintegration Rationale cont.

- The client can share the narrative (communicating openly) and experience pride further reducing feelings of shame and distress
- Communication about the trauma is enhanced and misunderstandings and confusion is clarified and the groundwork is laid for discussion of the trauma to continue after therapy ends (caregiver emphasizes 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 what happened), and answers the client’s questions (i.e., why is mom mad at me because her boyfriend got in trouble)
Integration

- Client and caregiver discuss together lessons learned, application of those lessons, the use of affect regulation skills for other life stressors, and plans for the future
- 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

TF-CBT Adaptations For IDD

- Be sure all members of treatment team are using the same language to address trauma
- Simplify techniques to increase understanding
- Work hard on generalization to other settings
- Allow more time/repetition for skill learning
- Use multisensory tools to aid in learning
- Don’t assume the material is too complex for the client to learn

Resources

- www.seekingsafety.org
- www.samhsa.gov/ntic
- www.istss.org
- www.issd.org
- www.ptsd.va.gov
- www.sidran.org
- www.nctsn.org

Questions

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