



WEST VIRGINIA INTEGRATED BEHAVIORAL HEALTH CONFERENCE

Trauma and People with Intellectual or Developmental Disabilities: Recognizing Signs of Abuse and Providing Effective Symptom Relief

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Abuse & Neglect - Overview

Approximately 25% of children with disabilities acquired the disability as a result of abuse.

52% of neglected children acquire a permanent disability.



Vulnerability is mediated by

- **Opportunity and Intent of the Perpetrator**
- Over 90% of the perpetrators are in an **authorized care providing position** (parent, other family/household member, school personnel, work or home services)
- Most frequently identified are: ***male***,
- Family members, transporters, care providers
- Abuses most frequently occur at home, day activity (school, work) and transportation
- ***Lack of information & preparation*** of the individual and their family about this issue & what they can do to lessen vulnerability by planning for attempted & completed maltreatment.



How to Identify Abuse in People with Disabilities

- Depends upon the type of disability the person has and
- Upon the type of abuse that occurred
- →



Physical Abuse

- Signs of physical abuse in people with and without disabilities are the same. **HOWEVER**
- ***Sometimes the signs of ABUSE are attributed to the DISABILITY and ignored***
- Sometimes the disability causes conditions that mimic signs of ABUSE and are mistaken, causing parents & other care providers to erroneously be accused of abuse.
- Physical neglect (failure to provide medicine, food, water, assistive devices, etc.) may cause an exacerbation of the symptoms of the disability leading to temporary mental aberration, physical symptoms, coma and even death.
- Often people do not disclose the abuse for multiple fears and no apparent sign that help is available.



Sexual Abuse

- Physical signs of sexual abuse are the same for both people with and without disabilities. **HOWEVER,**
- People with disabilities may not disclose the assault...by the time they do, all physical signs are gone (except STD's and pregnancy of course)
- People with cognitive disabilities may not show obvious signs of distress that expose the abuse, but may have changes in mood & conduct that signal something has happened.
- People whose care provider is the perpetrator may show *signs* that no one sees or notices, or is *attributed* by the observer to *causes other than assault*.
- People assaulted in medical facilities (acute care hospitals for example) rarely disclose the abuse due to threats of death or other retribution by those who know their address and threaten direct harm.



Signs of Emotional Abuse

- These are essentially the same as for people without disabilities, **HOWEVER**
- Verbal assaults, threats, and withholding of attention are powerful tools of abuse that are used but are “difficult to prove”, thus disclosure is delayed as the victim feels she has no “proof” of what has occurred.
- Depression, withdrawal, anxiety, fears and re-enactments may be observed or suspected.



Signs of Trauma

- Mood, conduct, communication
- Eating, sleeping, dressing skills/preferences
- Regression from skills already mastered
- Does not want to go to x location or with x person
- Questions related to sex, pregnancy are asked



Signs of Trauma

- Clothes are changed, soiled or torn
- Change in monthly menstruation
- Onset of increased sexualized conduct
- Diarrhea or constipation
- Gain or loss of weight



Signs of Trauma

- Indications of a sexually transmitted disease (STD)
- Itching, burning, pain with urination/defecation
- Self-molestation (replicating assaultive act upon oneself)
- Acting out what was done to him/her (replicating the assaultive act upon others)
- Self-harm or mutilation



Signs of Trauma

- Onset of new fears such as social anxiety, generalized anxiety, phobias
- Depression and sadness
- Irritability, anger
- Withdrawal
- Trouble thinking, concentrating, remembering
- Re-enactment & somatization



Signs of Trauma

- Change in normal behavior & personality
- Self-injury
- Sleep disturbances
- Change in normal behavior & personality
- Regression to earlier developmental stages
- Sleep disturbances
- Change in appetite
- Change in energy



Signs of Trauma

- Change in interest in normal activities
- Difficulty learning
- Angry, irritable, easily frustrated
- Wanting to stay home
- Onset of lying



Signs of Trauma

- Wanting to sleep with parents
- Signs of Post Traumatic Stress Disorder (PTSD)
- New disabilities psychiatric, physical, sensory, communication or other.
- Change in communication including selective mutism (when a previously verbal child stops talking after a trauma.)

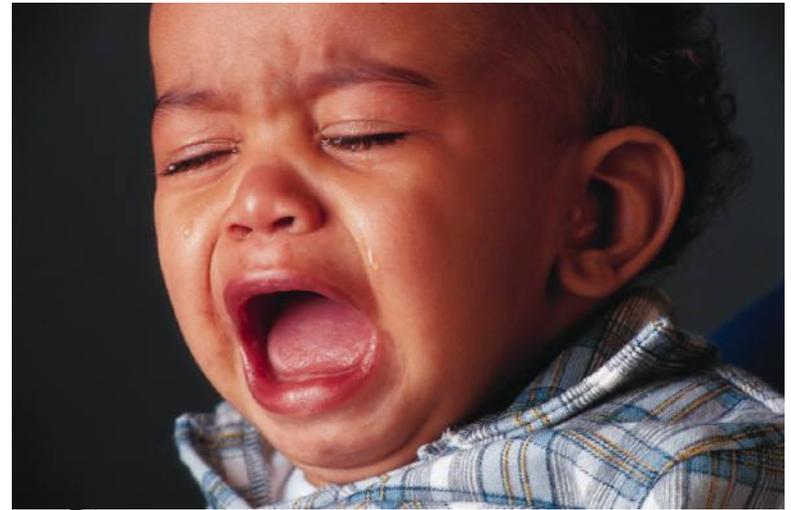


How can you know for sure?



- **ASK**
- Most people who have disabilities state that although they have been abused many times in their life, **NO ONE** ever asked about this aspect of their lives
- **PLEASE *be sure that you have something to offer if you decide to ask this question.*** Such as
 - Time to listen to their story
 - An effective response including reporting the abuse to the authorities
 - Suggestions for help such as a **GOOD** referral to therapy, groups, books, pamphlets, videos, peer groups
- Don't just **ASK** then leave them in the memory of the tragedies they have survived.

What is the “biggest” enemy ?



- **Negative attitudes toward people with disabilities.**
- **We are all products of our culture**
- **Our culture is disability-negative**
- **We all need to do personal work to discover then change any remaining negative attitudes sourced in myth and stereotype (sourced in fear and lack of contact)**



Barriers to Overcome

- **Stereotypes** blind us to seeing each person's individual needs while perceiving some imagined "group" characteristic. Stereotype: People with Down's Syndrome are all so loving and kind.
- **Myths** are false beliefs shared in a culture:
 - Myth: People with profound mental retardation are not sexual...therefore could not be sexual assault victims.
 - If a person with a disability is maltreated, it really doesn't effect the individual because the disability causes them not to have feelings...or the same feelings as their peers who do not have disabilities.



Attitudes, Stereotypes & Myths...lead to “Crazy Thinking” or “Not thinking”

- **Attitudes:** Living in a “disability-negative” society, negative attitudes towards individuals with Disabilities may underlie failures to address the needs of children & adults with Disabilities that are “usual fare” for their “generic” peers. (For example, awareness that individuals with Disabilities are victimized through sexual assault and domestic violence and proactive efforts to help.)
- **Poor thinking** occurs when a generic discussion is infused with the word “disability”, normal, rational thinking frequently goes awry...for example discussions of sexuality & normal sexual development. Physician performing a vasectomy on a teenager to preclude same sex orientation (multidisciplinary team decision).



Over time, perpetrators have offered a variety of reasons for the sexual contact or denying the sexual contact:

- She came on to ME
- It was consensual
- I was teaching her/him about sex
- I don't have a penis (wife did not concur)
- Or the staff colleagues, in one case....
- *She's* a nympho AND *he is* a GREAT guy
- How could I know he/she's disabled?
(special access bus drivers)



Treatment

- RAPPOR: Psychotherapeutic Intervention
- PODER: Realistic preparation for future assaults – a family based Risk Reduction approach. This is described within the NEW Risk Reduction Guidebook for Parents and Agencies that describes the Individual Response Plan strategy.



RAPPORT

- **R**eferral
- **A**ttitude Assessment & Patient Assessment
- **P**rovider Qualifications
- **P**re-Treatment Considerations
- **O**ne on one therapy
- **R**esources
- **T**ermination



RAPPORT describes some of the attitudinal and institutional barriers to providing effective treatment, and describes actual treatment strategies.

Effective treatment requires the following five steps:

1. Prompt identification of abuse
2. Prompt referral for treatment
3. Treatment provided by a qualified therapist to primary and secondary victims
4. Treatment terminated appropriately
- 5 Follow up treatment available as needed



Philosophical Tenets

- Do no harm Clinicians are expected to work within their area of expertise. When entering a new area, supervision is required.
- Know and implement recognized disability philosophies such as
 - Normalization/Social Role Valorization
 - Least restrictive alternative
 - Involvement in all community life
 - Expect ability (best seen in bilingual skills)
- With the goal of healing in mind, utilize the wide variety of treatment approaches now available, focusing on the child's (and family's) strengths to build upon, and strengthening areas of weakness where possible.



Kids with disabilities require modifications to the standard treatment protocols

- Because they may not understand and produce speech and language in typical ways
- Because they may behave differently
- Because they may have physical disabilities that require different space and movement options in the office
- Because they may have sensory impairments such as hearing impairments or vision impairments requiring accommodations (interpreters, large print or audio materials)
- Because their life styles, belief and culture differ from the typical child...consider the disability culture.



R-Referral

- Referral of children or adults with disabilities and their families for abuse treatment depends upon the first step in the abuse response to be well executed, namely for **abuse identification skills and knowledge to be well secured** among direct care providers including family members, volunteer and paid individuals
- **Reluctance to acknowledge the victimization** both on the part of the victim and those close to the victim (denial) may result in a complete failure to identify abuse, or in a delayed identification of abuse.
- One mother had never seen any **Public Service Announcement or any other informational brochure that stated or showed that children with disabilities are abused. She did not have a mental framework in which to understand what had happened.**



A - Attitude Adjustments

Attitudinal and belief barriers exist that prohibit the provision of appropriate treatment

Primary barriers to providing effective treatment intervention:

1. Children and adults with disabilities do not understand about abuse, and therefore are not effected by it;
2. Children and adults with disabilities do not experience physical pain;
3. Children and adults with disabilities do not experience psychological pain;
4. Children and adults with disabilities have a severely restricted range of emotions so that any impact of the abuse is short lived;
5. Children and adults with disabilities will not remember the abuse if no one talks about it.



6. Children with disabilities frequently lie about abuse and are probably exaggerating what really happened or fabricating a story to get attention.
7. People would never really abuse a child/adult with a disability;
8. Children and adults with intellectual impairments cannot benefit from (talk) therapy;
9. Children and adults with intellectual impairments cannot understand role play or other methods of traditional treatment for victims of sexual abuse.
10. If a child or adult has a developmental disability cannot have multiple personality adaptation, borderline personality, narcissistic personality; sociopathology, or other personality or psychiatric disorder.



These are actually true:

- persons with disability do experience both physical and psychological pain,
- can benefit from personal contact with a skilled mental health professional who knows how to provide treatment to abuse victims, and
- who has a belief in his or her own creative skills in providing treatment to persons who language or communication skills might vary from those who more frequently present for treatment.



Inaccurate beliefs about those in a particular group can "get in the way" of the treatment when allowed to continue unchallenged and unexamined



Similarities & Differences of Children with & without Disabilities

- **Similarities**

- reduced credibility due to age
- emotional impact of abuse
- physical impact of abuse
- long term effects
- short term effects
- continued vulnerability
- new to therapy process
- no voice in placement or treatment decisions
- cultural diversity
- capacity to benefit from treatment



Differences:

- reduced credibility due to disability
- impaired cognitive functioning
- impaired communication skills
- lack of exposure to vocabulary that describes sex, body parts considered sexual, and abuse;
- increased level of vulnerability
- family/care provider inability or refusal to address abuse
- lifetime training fostering passivity and compliance (whereas generic kids are in “independence training”)
- few personal choices allowed in daily routine



Information Gathering:

- In addition to receiving some of this information on paper prior to seeing the family, it is also wise to collect and/or verify this in the initial face to face interviews individually with the child or adult as well as in the format of the family interview



1. Nature of the assault
2. What have been the responses to the discovery of the assault on the part of: the victim; the family; victim's friends and other significant others; professionals who have had contact with the victim and the family;
3. general lifestyle of the child/adult
4. victim's disability and communication style
5. victim's normal behavior and attitudinal patterns
6. How have 3,4, and 5 changed since the abuse is likely to have begun?
7. How was the abuse discovered?
8. What does the victim/family understand about sexual abuse, long and short term effects, why do they believe this happened, (myths, causality, blame, effect, etc.).
9. What do they believe about the abuse and the victim's reaction
10. What do they hope to gain from therapy?



Assessment

- depression
 - anxiety
 - changes in behavior: sleeping, eating disturbances
 - changes in personality styles (withdrawal, aggression,)
 - Dissociation
 - Onset of sexualized behavior (includes talking, voyeurism, self and other directed sexual conduct);
 - "shut down" emotionally or expression of wide range of emotions including rage, grief, disbelief
 - Specific Symptoms of PTSD, and Rape Trauma Syndrome
-
- These are common in children with and without disabilities who have been victimized. However, recognition of these may be delayed in children with disabilities, or they may be incorrectly ascribed to a stage of the disability, rather than seen as sourced in possible abuse.



P- Pre-Treatment Considerations and Activities



P - Provider Qualifications

- licensed as a mental health provider,
- trained in disability issues and culture;
- trained in child and dependent adult abuse treatment;
- trained or familiar with developmental sexuality and the impact on sexuality of sexual abuse;
- familiar with victimology,
- Skilled in a variety of methods of conducting therapy including individual, family and group.
- In good standing with their licensing organizations, and
- Stays up to date on the literature and issues in child sexual assault treatment.
- Feels and demonstrate compassion and interest in the patient;
- Patient, as each communication may take longer than usual due to slower speech or communication abilities of the patient. Finally,
- The offices, materials and equipment must be accessible (ADA)



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Questions to discuss

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Physiological changes in the brain were identified in victims of trauma. (Journal of Interpersonal Violence, Vol. 9 No. 1 March 1994 pp119-120 in a study of veteran's to understand why symptoms persist over time.



Recognizing psychoneurological changes that result from PTSD in trauma victims with disabilities

- 1. The brain's noradrenaline system seemed to have been *reset* making these veterans prone to adrenaline surges decades later (p65). Anything reminiscent of the original trauma could trigger fight or flight alarm. *The result might be an anxiety attack that seemed totally unwarranted.*
- 2. The brain circuit linking the hypothalamus and the pituitary gland responded to crisis by triggering CRF - a stress hormone. This in turn secreted a chemical (ACTH) that activated a stress reaction, compounding the effects of adrenaline surges. The response of veterans with too much ACTH was *exaggeration of perceived danger; they experience the body reactions (sweat and pounding heart) and emotions (fear and anger) of their past trauma.*



- 3. The third area of the brain involved is in the opioid system which blunts pain during injury. It produces chemicals such as endorphins, which act like opium to dull pain while evoking a "pleasant, detached dreaminess" (p66). This may explain the walking wounded in battle, who continue to function while they are dying. Change in the opioid system may also clarify the "downers" of PTSD - emotional numbness, apathy, lack of zest which may alternate (or run side by side) with "uppers" like jumpiness, nightmares and irritability. Apparently the brains of trauma survivors, sensitive to upsetting physical or emotional cues around them trigger excess opioids to blunt their pain, and this numbing generalizes. In other words, physically and emotionally, - *trauma survivors with PTSD are alert to anything that might threaten their physical and emotional safety, they overreact to any perceived danger, and they numb themselves against the possibility of pain.*
- *These 3 changes in the brains of trauma victims reinforce each other, producing the major symptoms of PTSD - re-experiencing, numbing and arousal.*
- *The findings of this study of veterans has exquisite application to victims of trauma who have developmental and other disabilities, in which their PTSD symptoms may be misconstrued absent an understanding of the above.*



- parental support, coping strategies, attributional style, and history of abuse.
- how these interact with the individual's disability, experience of the disability, culture of disability, and family life; the individual's religious beliefs, self esteem & personality style should be assessed
- psychological tests should be reviewed & re-administered, for Axis II, personality disorders, depression, anxiety. Further, any changes from prior to the abuse to post abuse should be noted
- And finally, when meeting with the family and with the individual alone, note interactions, changes in communication style and mood.



O - One on One Treatment

- You should describe your treatment goals (reduce depression, anxiety, return to usual daily routine, etc.) and methods, and how you will know when treatment is completed.
- Mix a combination of family therapy with individual therapy.
- Remember that the parents may be secondary victims of the abuse, and experiencing many of the symptoms of trauma including nightmares, sleep and eating disturbances, depression and anxiety.
- Further, they may have a history of abuse that has been triggered when the child or adult was abused.
- Or this may be the family's first exposure to abuse or violence personally, and the individuals and the family system may be in shock.
- Remember the stages of shock: denial, anger, bargaining, depression and acceptance. Actually, these are the stages of death as identified by Elizabeth Kubler- Ross in her book *Death and Dying*, but I believe have direct application to the trauma victim as well.



Types of interventions:

- Open discussion of the abuse , with your level of comfort, may be one of the most powerful things you do. Your ease with using words that have never been spoken aloud before, your ease in listening to the horrors of what has occurred, will help the victims to put the abuse in perspective, making it "handle-able" rather than overwhelming.
- Your information that abuse, as horrific as it is, is quite common, alleviates a sense of aloneness, being singled out, being a freak, feeling that no one could possibly understand...or believe...what had occurred.
- Your information about increased risk for children with disabilities supports your plan for preparing for future assaults. (Remember, legally, assault = attempt to touch, battery = actual physical contact.)



Following are the 20 basic suggested therapeutic goals:

1. Reduce the level of depression
2. Reduce anxiety
3. Reduce sense of guilt or complicity in the abuse



4. Assist victim to express the rage and grief associated with the abuse in appropriate ways , both in the therapy session and at home



5. Teach basic information about normal human sexuality and interpersonal relationships; include information about homosexuality/heterosexuality, reproduction, eroticism and sexual response.

This should be completed at appropriate developmental levels, and consistent with the patient's stage in the healing process.



6. Teach basic information about violence and victimization, and appropriate and safe responses to attack (physical, verbal, emotional).

Include information about

- sexual assault including victim
- sexual molest,
- rape,
- incest,
- pornography, and
- other misuses of persons;



7. Teach basic information and skills in personal assertion, in an environmental approach.

This means that assertion skills are not learned nor used in a vacuum, but rather must become a part of the individual's daily life experience and personal skills. Therefore, the assertion skills taught in the clinical office must be practiced and continued teaching must occur also at home, at school, after school programs...all locations where the victim spends significant amounts of time each day or each week.

If skills are only used in an "emergency", they may be rusty or forgotten...in other words, useless or extremely limited in power and value.



8. Teach reasonable self protection techniques (see PODER Model) and develop an IRP with the client.
9. Teach an affective vocabulary to label emotions and feelings
10. Teach vocabulary to describe sexual acts or refer to sexual body parts or functions



11. Teach vocabulary to describe and define abusive or offensive conduct by others

12. If victim is non-verbal or has limited verbal skills, use cuing or other non-verbal techniques for expression of above. Use client's modality (FC, RPM, PECS, etc.)



13. Teach the victim to recognize and express emotions w/o needing the assistance or validation from others to do so.

14. Teach the victim to listen to their sixth sense and respond appropriately to the signals and warnings it may provide.



15. Help the victim to develop a sense of her/his own personality style, self worth and self confidence.

16. Help the victim to develop a personal value system



17. Help the victim to understand and develop a capacity for lasting relationships for both tender and genital love. If sex has been misused on a child or adult, teach that sex is not bad, but rather has been used badly, and the child or adult should be able to expect to experience positive sexuality in the future. An analogy might be that if a mugger steals a purse, the victim can still use a purse. The purse wasn't bad...it is just that someone misused it.



18. Help the child or adult to learn how to trust others, when to suspend the trust in the face of obvious danger or mistreatment. Teach that there is no category of person where trust considerations can be suspended completely.



19. Help the child or adult and parents to understand that the potential for repeat assaults is present, and to distinguish between what s/he can and cannot do when an assault begins (i.e., calling upon the Power Rangers is probably not a functional plan).
20. Plan with the family an action plan if they or the victim suspects or reports abuse. Provide the strength of character to be able to implement these as needed, but if threat of severe physical injury or death is present to submit to the abuse.



Use the following modalities as appropriate:

- Rapport development
- Safety in the clinical office
- Listen to the client
- Use clients “best” skills (talking, drawing, acting out, listening, hearing, finding safety)
- Alleviate symptoms using Thought Field Therapy
- Communication skills training
- Role play



Use the following modalities as appropriate:

- **Psycho education**
- Board games
- **Assertion skills training**
- Therapeutic metaphor
- **Relaxation exercises**
- **Guided imagery**
- Hypnotherapy



- Paradoxical and experiential interventions
- **Real-life problem solving**
- **Behavioral/Affective techniques**
- Cognitive approaches
- **Reframing**
- **Re-recording negative messages**



- **Correcting misinformation/giving correct information**
- **Play therapy**
- **Art therapy**
- **Sand tray therapy**
- **Truthful reassurance (no promise of safety)**
- **Support**



- **EMDR (Eye Movement Desensitization Restructuring)**
- **Brain Gym**
- **Directed discussion**
- **Reflection and clarification of feelings**
- **Interpretations**
- **Homework**
- **Biofeedback**
- **Biotuning**



- **Reality therapy**
- **Energy mind-body therapy**
- **Generalization training**
- **Environmental involvement to effect treatment goals (esp. w/ assertion, safety review/analysis procedures**
- **Increase intuition skills and follow-through**



- **Grief Work**
- **Pranic Healing**
- **Reiki**
- **Touch for Health**
- **Chakra work**
- **Envisioning and dream work**
- **Law of Attraction work**
- **Designing the dream life**



THERAPEUTIC SKILLS

- The therapist should take care to assure that all communications are clear, concrete, and explicit;
- Therapist should "check back" to assure client understanding as well as client's ability to internalize therapeutic intervention.
- Using the technique of Plain English is important.
- Repetition of material is a critical component of both the teaching and the counseling, in view of such issues as denial, dissociation, learning disability, depression, confusion, and other confounding variables that can easily occur in the therapeutic setting.



THERAPEUTIC SKILLS

- Repetition is important
- Repetition is important
- Treatment can be enhanced through the use of visual, aural and kinesthetic teaching modalities, use of positive reinforcement, and requesting that the client demonstrate learning or understanding through words or actions: behavior, drawings, or role play.
- Allow client to sit where they choose (or not) during session
- Be flexible



My Top 4 Modalities

1 Active Listening

- Asking what the person wants to say or show me
- Asking HOW they want to express it
- Giving time for them to do so
- Giving physical support for them to do so



2. Thought Field Therapy

- Immediate reduction/elimination of traumatic feelings
- Immediate reduction/elimination of trauma induced physiological pain
- Immediate reduction/elimination of trauma sx, sleep, appetite disturbances



Pro's (& Con's)

No language skills needed

No requirement to describe the abuse

No “time delay” in healing

Process cannot cause harm

Process can be learned & repeated prn

Treats trauma, phobias, nightmares, all sx of abuse.

Nothing is ingested, inserted or inhaled



(Pro's &) Con's

Treatment is unusual

Treatment response is unusual (unbelievable)

When patient no longer feels the sx, they then say the sx were “not so bad”.

No extended number of visits are needed

No rapport is required...less \$\$ for therapists

Mental health training is not needed (thus parents & victim can self treat)



3. Dramatic revelation

- Patient demonstrates through play their desired outcome
- Using art, body movement, humor, exaggeration



4. Rehearsing empowering responses to “next attack”

- Presumably patient can imagine that they did this in first attack.
- Provides positive empowerment feelings and actual skills for client



R- Resources

- There are many physical resources that the therapist can use during and following the treatment sessions or program.
 - materials designed for the child or adult with a disability who has been an assault victim, and
 - those for assault victims who do not have disabilities
 - Anatomically detailed dolls (get training)
 - Puppets, drawing paper
 - Therapist’ s ability to let child “take lead” within confines of the therapeutic session.



T - Termination

- Termination of treatment should be discussed and planned as carefully and concretely as the treatment had begun.
- The client, family and therapist as a team should plan then carefully execute the treatment termination in a planful way, assuring client readiness.
- Although the client may be reluctant to end the therapy, the appropriateness of ending the regular sessions is an important next step in the client's healing process.



How do you know if it worked?

- Later contact from the family
- Later contact to the family
- Learning about the child's psychological well-being, school performance, social life
- Learning about the family's well-being, communication, and continuing utilization of therapeutic suggestions.



When are you done?

- The client may let you know. For example, with one 9 year old, we again drew pictures of the perpetrator. After, she crumpled then stomped on the paper. Then, she exited the consultation room with the therapist trailing behind. She went to the bathroom, tore the picture into tiny pieces which she flushed down the toilet. She skipped back to the room. She was done.
- Others, you may need to terminate carefully, assuring the client that they are now ready to end regular visits. Provide information on how to continue the therapy as if they still visit you.
- Encourage client to call you prn.



Other Case Examples



Case Study

- 13 year old girl with autism
- Verified sexual abuse by her grandfather
- Treated for 3 weeks inpatient UCLA
- Non-Verbal
- Aggressive/violent
- No other prior treatment



Electively Mute Abuse Victim

- Was raped by her uncle
- Was housed at UCLA x 3 wks – 0 improvement
- First session: She and mother given “the talk” about how therapy would proceed, this is a common problem, you can heal, important to ensure no contact with uncle, we’ll play some games, work toward pt. regaining prior MH.



Electively Mute Abuse Victim

- I looked @ both as I spoke, allowing either to talk, said I did not expect pt. to talk at all.
- I mentioned use of (anatomically correct dolls),pt. verbally asked to see the dolls. I said no, too early in process, she wanted to see the dolls. I brought the dolls.
- She looked at these unique dolls. Surprised and pleased.



Electively Mute Abuse Victim

- She asked to “tell the story” of what had happened. Told a 45 m rendition, directing myself/mother as to our roles in the story using the dolls.
- This ended her elective mute defense
- Using listening, honoring her process, validating her pain, the door opened.



Case Study

- 17 year old male with Down Syndrome
- Severe mental retardation
- Limited verbal skills AND bilingual
- Sexually abused (sodomy) by 1-1 aide
- Sx.
 - Did not want to go to school
 - Nightmares
 - Pain w/ urination sans medical dx



17 yoa Male w/ PTSD, Psychosomatic Illness

- Mistake: allowed Mom to “tell the story”; after, talked about her feelings. Boy “disappeared” on the couch.
- Treated her trauma with TFT. Huge improvement in her.
- Treated his trauma & psychosomatic sx with TFT. “FX” response + emotional change (engagement, smiling) + no pain w/ urination.



Case Study

- A 9 year old girl told her mother that her Uncle and Grandfather had sexually abused her
- Her older sister, 11, said them same happened to her
- For several months the mother ignored the children's expressed wish not to go to their grandfather's house
- Following a report of this abuse, the stepfather was taken into custody for quite a period of time, although the children consistently denied any wrongdoing on his part.
- Referral by disability case management services center.
- What do we need to know prior to seeing the child? Who should be seen? What preparations need to be made?



9 year old girl w/ severe ID, non-verbal

- Family therapy- Agreements for no-contact
- Ind. Tx for each parent, shared tx for 2 sisters
- Used information, validation, drawing, acting out, and repetition of above. Child showed tx. was complete.
- Dev. IRP





Additional Resources

- Nora's "Green Book", a Forensic Interviewing Guide
- Nora's "Brown Book" on Forensic Interviewing & Treatment
- Nora's "Treatment Guide" for conducting psychotherapy with abuse survivors with disabilities.
- Sheila Mansell's book on Psychotherapy for Sexual Assault Survivors with Developmental Disabilities (available through NADD)
- Ruth Ryan's book on Treatment for Abuse Victims with Developmental Disabilities
- Nora's "Hot Pink" book on the rules of sex







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