

How to Provide Therapy to Children & Adults who are Victims of Trauma



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Your Presenter



1. Trauma Informed Care



Welcome !!!!

Today we will discuss trauma, how it effects both ourselves and those we serve.

With a goal of becoming “even better” in our interactions and support, we must also recognize that self-care and self-awareness are essential.

Today is not only to learn but teach, to receive and to give, and to be open to new ideas for healing and trauma-reduction.

What is YOUR intention for today?

SHARE INTENTIONS...



Our intention creates our reality. We are powerful beyond measure.

**"Every intention
sets energy into motion,
whether you are
conscious of it or not."**

- Gary Zukav

My intention today

1. make feeling good
my ~~top~~ priority

2. see #1 ↗

Principle Differences in Children and adults with Intellectual and Developmental Disabilities

- 1. Communication**
- 2. Cognitive processing**
- 3. Conduct**
- 4. Culture**
- 5. Creativity**
- 6. Trust**
- 7. Sensory Sensitivity**
- 8. Sensitivity**
- 9. Appearance**
- 10. Increase/discuss safety measures**

1. Principle Differences: Communication

Communication

CALL OUT

1. Principle Differences: Communication

Communication

- 1. Non-verbal communication modalities (FC, RPM, PECS, ASL, alphabet on cardboard/iPad). Need for support person & taking dictation letter by letter.**
- 2. Verbal: few words; difficult pronunciations**
- 3. If Deaf or hard of hearing: amplification; Ubi-Duo, interpreter**
- 4. Literal thinkers thus avoid sarcasm, jokes, metaphors, slang, common expressions or similes.**
- 5. Use Plain English, use language matching and slightly exceeding level of client (unless theirs exceeds yours!)**
- 6. ASD: Ask, “what should I ask you?”**

2. Principle Differences: Cognitive processing

Cognitive processing

CALL OUT

3. Principle Differences: Conduct

Conduct

CALL OUT

3. Principle Differences: Conduct

- 1. Seating: client may never sit, sit/recline in unusual spaces & places; sit everywhere during the session.**
- 2. Client may have unusual verbal or physical movement (Tourette's, etc.)**
- 3. If they have a seizure disorder you should know prior.**
- 4. Some ASD kids have screaming or loud noises**
- 5. Some move about touching everything during session (may have to "prep" room removing things from view/access.**

4. Principle Differences: Culture (Disability)

Culture

CALL OUT

4. Principle Differences: Culture (Disability)

1. Many children and adults may want/need parent in the room.
2. Most are “told” what to do rather than asked...so ask.
3. Many treated like younger person...use R-E-S-P-E-C-T
4. Often trained/encouraged to hug everyone (antithesis of safety training and cultural norm).
5. Must do as they are told, thus have never had their opinion or preference have any power. Demonstrate that you listen and honor their preferences. (It’s different in my office.)
6. Used to being ordered to do something, threatened with a (negative) consequence or encouraged with a positive one.

5. Principle Differences: Creativity

Creativity

CALL OUT

5. Principle Differences: Creativity

1. **By creating an atmosphere in your office of autonomy, choice, respect, client may express self in variety of ways: story, song, role-play, drawing, game-playing.**
2. **May have unusual method of communicating with you (bring things from home for you) showing bonding and trust**
3. **Example: Client gave away her SURVIVOR workbook to teach her cousin how to not get raped. (her conceptualization)**
4. **Example: Client asked for a resource (brochure) and learning there is none, suggested one be developed...which we did.**
5. **Some clients want to create a book about their life, to share the story and to help others.**

6. Principle Differences: Trust / Confidence

Trust

CALL OUT

6. Principle Differences: Trust / Confidence

- 1. Clients come to believe you can help them. Fe. several years after treatment, client asked family to “please call Nora.” This was how she began disclosure of new sexual assault.**
- 2. Clients may ask for your help to tell parents their secret. (especially true for revealing sexual orientation)**
- 3. Client may want to ask sex-related questions with parents not in the room. May involve the parent. Essential to maintain confidentiality agreements.**

7. Principle Differences: Sensitivity (All 6 senses)

Sensory Sensitivity

CALL OUT

7. Principle Differences: Sensitivity (All 6 senses)

1. **Some clients, esp. ASD may have acute ESP and ability to read your emotions.**
2. **Some clients, esp. ASD may have very heightened auditory capacity and really can hear you through doors/walls.**
3. **Some clients may have heightened visual acuity. Watch what you write!**
4. **Make sure room has no scents**
5. **Make sure rooms have no flourescent lighting (very disturbing sounds and flickering)**
6. **Do not have food around as those even with sensitivities may eat it or inhale the scent.**
7. **Do not touch client as this may be unpleasant or painful.**
8. **Most sense pain, may express it in a variety of ways. (Old myth is that people with disabilities & infants do not feel pain.**

8. Principle Differences: Sensitivity

Sensitivity

CALL OUT

8. Principle Differences: Sensitivity

1. **Motto: “Just because I can’t talk doesn’t mean I have nothing to say.”**
2. **Motto: “Presume competence.”**
3. **Motto: “Just because I can’t talk doesn’t mean I don’t hear you talking.” (Often c/o when paraprofessionals & professionals talk ABOUT client in front of client “forgetting” that they are present.**
4. **Do not use client’s wheelchair to rest upon...(natch!!)**
5. **Because of higher rate of victimization of verbal abuse, very sensitized to derogatory looks, words, actions.**

9. Principle Differences: Appearance

Appearance

CALL OUT

9. Principle Differences: Appearance

- 1. Client may have facial and other physical anomalies. Best to know ahead of time if possible for first encounter**
- 2. Client may have other facial or physical differences including movement**
- 3. May use limbs or body in ways new to you.**
- 4. May use voice in ways new to you.**

10. Principle Differences: Safety Measures

Increase/discuss safety measures

CALL OUT

10. Principle Differences: Safety Measures

Increase/discuss safety measures

- 1. Have an aide present to calm/interfere with outbursts**
- 2. Keep doors unlocked so parent/carer can enter anytime and patient can leave/re-enter anytime.**
- 3. Explain to patient & parent that this is to ensure that while alone with client, nothing bad will happen as you know carer might walk in anytime without knocking.**
- 4. From RRWB, encourage client/carer to examine your license, get a copy or write down # and expiration date, business lic., take your photo for their Individual Response Plan contact list.**

MYTHS & STEREOTYPES

Individuals with developmental disabilities are not viable candidates for psychotherapy.

A cognitive disability is a barrier to psychotherapy that cannot be overcome.

CALL OUT

Overview of Abuse & People with Disabilities:

Children and adults with intellectual and developmental disabilities are abused more than generic children and adults.

Therefore, trauma is the norm, not the exception.



Abuse & Neglect - Abusers

It is estimated that in 98% of cases of sexual abuse, the perpetrator is well known to, trusted by, and in a care providing position to the victim.

Perpetrators seek people with disabilities as they are less likely to be caught or be convicted.

Children with disabilities are abused more than generic kids by a factor of

Girls: 1 in 4 (25%)	Boys: 1 in 6 (17%)
x 1.7 = 43%	x 1.7 = 28%
x 3.4 = 85%	x 3.4 = 58%

A numeric palindrome...easy to remember.

- ◆ **1.7 DHHS/NCCAN (Westat Inc., 1991)**
- ◆ **3.4 Boystown Research Hospital (Sullivan & Knutson, 2000)**

Adults with disabilities are abused more than their generic counterparts

- **Annually abuse is reported involving**
 - 5 million vulnerable adults
 - 2 million elders
 - 1 million children
- **This means that adults with disabilities are abused more than children and elders combined.**

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.

Abuse & Neglect - Abusers

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Treatment

RAAPPOR:

Psychotherapeutic Intervention

TREATMENT...HOW I BEGAN

How I got started...

- 1. I was asked to do therapy.**
- 2. I could find no models or guidance. Everything said, “You cannot do therapy with people with “mental retardation.”**
- 3. I learned from the masters: children and adults with I/DD**

My background:

- Learned and taught birth control methodologies and helped with access in housing projects in Los Angeles.**
- Became one of first graduates of California Institute of Human Sexuality**
- Became a Certified Sex Educator under AASECT (American Association of Sex Educators, Counselors and Therapists.**
- Had and maintain a strong affiliation with Planned Parenthood, SIECUS, and SSSS, then later ABS**

After completing my employment with the Regional Centers for Developmental Disabilities, became a “vendor” (authorized service provider) and was asked to provide sex education services and later sexuality problem resolution services for these centers.

TREATMENT...HOW I BEGAN

While providing sex education and “intervention” services, I became increasingly aware of how pwdd are “dismissed” and underserved in their MH needs.

I co-founded the California Committee on Sexuality of People with Developmental Disabilities.

I became a Licensed Marriage and Family Therapist. I became a Licensed Psychologist. Neither had classes on how to provide therapy to people with developmental disabilities.

Case examples that taught me

FIRST CASE: Autistic man raped girlfriend. Translation: autistic man in throes of sexual rapture unable to transition timely when partner changed her mind. Huge legal ramifications, too.

SECOND CASE: Child with moderate I/D victim of sexual assault, cannot understand her language. (→RRWB)

THIRD CASE: Woman with I/DD incest victim. “Don’t tell anyone.” (-> SURVIVOR SERIES)

FOURTH CASE: Teen CSA victim, ASD, selectively mute referred from UCLA for treatment, as she “would not participate in therapy.” (Tx. Guide)

RAAPPORT

- ✓ **R**eferral
- ✓ **A**ttitude Adjustments
- ✓ **A**ssessment
- ✓ **P**rovider Qualifications
- ✓ **P**re-Treatment Considerations and Activities
- ✓ **O**ne-on One Treatment
- ✓ **R**esources
- ✓ **T**ermination

RAPPORT describes some of the attitudinal and institutional barriers to providing effective treatment, and describes effective 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 Least restrictive alternative

Involvement in all aspects of community life

Expect ability (best seen in bilingual skills)

Trauma-Informed Care

With the goal of healing in mind, utilize the treatment approaches available, focusing on the individual's (and family's) strengths to build upon, and strengthening areas of weakness where possible.

Victims with disabilities require modifications to standard protocols

- **Because they may not understand and produce speech and language in typical ways...or at all.**
- **Because they may behave differently**
- **Because they may have physical disabilities that require different space 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.**

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**
- **The mother initially (over a period of months) did not respond to 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 for therapy came from the 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?**

What I Learned

- **The 9 year old has a moderate intellectual disability.**
- **She talks but only her sister can understand her (like twins).**
- **The 11year old is in the school GATE program (gifted)**
- **No prior treatment efforts have occurred**
- **Mother and stepfather are positive to treatment**
- **Father is out of custody, but still “under suspicion”**

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.
- ◆ Most have never seen any Public Service Announcement or any other informational brochure that stated or showed that persons with disabilities are abuse survivors, and served by that agency.

- **Attitudes, beliefs in myths, and lack of information or awareness among service delivery staff effect whether or not referrals for psychotherapy occur. Many believe that individuals with disabilities cannot benefit from therapy.**
- **Additionally, actual existence of resources and myths about whether resources exist may effect referrals**
- **Knowledge of resources is effected by the public awareness documents produced by mental health treatment providers who make statements on their materials that they provide services to abuse victims with disabilities. Absent a statement, it is often assumed that services are not offered to this population of child abuse victims.**

A - Attitude Adjustments

Attitudinal and belief barriers exist that prohibit the provision of appropriate treatment. Primary barriers to providing effective treatment intervention include the following MYTHS:

- 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;**

A - Attitude Adjustments

Attitudinal and belief barriers exist that prohibit the provision of appropriate treatment. Primary barriers to providing effective treatment intervention include the following MYTHS:

- 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 disabilities cannot understand role play or other methods of traditional/conventional treatment for victims of sexual abuse.

10. If a child or adult has a developmental disability they cannot have multiple personality adaptation, borderline personality, narcissistic personality; sociopathology, or other personality or psychiatric disorder.

These are true:

- 1. People with a disability do experience both physical and psychological pain,**
- 2. They can benefit from personal contact with a skilled mental health professional who knows how to provide treatment to abuse victims, and**
- 3. 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

One example of this would be the belief that "all" "all" New Yorkers are abrasive and self centered; that all Californians are "airheads", or all Midwesterners have a farm mentality.

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 out-of-home 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

Some primary attitudes in this regard

include:

- ✓ **Spread**
- ✓ **Wildness**
- ✓ **Angelic Innocence**
- ✓ **Contagion**
- ✓ **Maniacal violent fiends**
- ✓ **Sex perverts/uncontrolled urges and conduct**

A-Assessment & Information Gathering

Information Gathering:

In addition to receiving some of the following 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

Questions to discuss

- 1. Nature of the assault (broad category: Sexual, physical, verbal).**
- 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;**

Questions to discuss

- 3. general lifestyle of the child/adult**
- 4. victim's disability and communication style**
- 5. victim's normal behavior and attitudinal patterns**
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
- 6. How have 3, 4, and 5 changed since the abuse is likely to have begun?**

Questions to discuss

- 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?**

- ✓ **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 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.**

What are the signs and symptoms of the victimization?

- ✓ **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**

ASSESSMENT

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 the disability or a stage of the disability, rather than seen as sourced in possible abuse.

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
- ✓ Uses trauma-informed strategies and practices

P - Provider Qualifications

- ✓ **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.**

P - Provider Qualifications

- ✓ **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)**

If an interpreter or communication support person will be needed, consult with the family about how they normally converse with the victim. It is the therapists' responsibility to pay for the support person. Consider: Victim's confidentiality; qualifications of the support person in maintaining the confidentiality; possibility of support person being a perpetrator or perceived agent of the perpetrator.

Support person's ability to handle the material.

P- Pre-Treatment Considerations and Activities

Consider the placement of furniture in the room and ease of entry and egress.

Do not expect (or demand!) that the victim sit or remain seated during the session. Many with Autism never sit or may use furniture as a protection rather than it's usual function.

Do not use flourescent lighting, but full spectrum or incandescent lighting.

Do not use incense or other odors (perfumes or body lotions).

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

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.

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 opoid 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.**
- 4. Change in the opoid 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.**

5. 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.*

6. These 3 changes in the brains of trauma victims reinforce each other, producing the major symptoms of PTSD - *re-experiencing, numbing and arousal.*

7. 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.*

Ask for their treatment goals.

Describe your treatment goals (reduce depression, anxiety, return to usual daily routine, etc.) and methods, and how you will know when treatment is completed.

O - One on One/Family Treatment

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.

O - One on One/Family Treatment

Further, parents may have a personal history of abuse that has been triggered when their 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.

O - One on One/Family Treatment

Remember the stages of (grief) shock:

denial,

anger,

bargaining,

depression and

acceptance / acknowledgement

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.

The First Appointment

Who attends the session?

Asking the client to provide basic data-Announce you will NOT ask them to describe the abuse.

Take control of the session (do not allow parents to “answer for” the client)

Use the session to “set the stage” for further appointments, begin to develop rapport with all family members.

Describe course of treatment and treatment modalities expected to be used.

Describe expected/desired outcome of treatment

Succeeding Appointments

See patient alone when patient is comfortable, and individual issues are to be addressed, or

Continue the therapy with the family present to

Maintain sense of safety & reaffirm this is a family problem, as well as an individual one. Make sure to ensure the parent can enter the treatment room at any time...in fact, create “excuses” for parent to enter from time to time to demonstrate client is always protected.

Support the client throughout treatment

Train family members to continue support after the session

Gain information and guidance from family to inform the treatment process

Provide therapy to these secondary survivors

What do you do?

Listen...listen...Listen

**Provide information to the client about assault,
expected reactions others have had**

Inquire as to feelings client is having about the assault

**Inquire if client wishes to talk about the assault (Let
them know most often clients do not want to [exercise
coming!!] but some do.) Up to them. You should not
ask for details about the abuse.**

**Inquire if client wishes to talk about the perpetrator,
wishes for what should happen to them.**

**Inquire how client will avoid perpetrator in the future,
who can help.**

Describing Sexual Abuse

Great exercise to acquire exquisite understanding of how this may feel.

GET READY! (Check notes for this slide.)

In a moment, you will be asked to turn to your table partner and describe in detail your first voluntary sexual experience.

From beginning (how did you get to the point you knew sex would happen) to the end (how did it end?).

Encourage client to express feelings, provide assistance by

Assuring that identifying feelings is helpful

Provide variety of names for feelings

Reduce negative feelings through TFT

Teaching client to “act out” negative feelings through exaggeration, art, fantasy, demonstration

When are you done?

The client may let you know. For example, with the 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 on their own. Encourage client to call you prn.

Intervention Options:

Open discussion of 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.

Intervention Options:

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.

NOTE: by providing each client a copy of the Survivor's Guidebook this is reified, plus provides a "transitional object" and "safety tool."

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 21 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)**
- 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.**

- 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.**
- 21. Work with the family to design a comprehensive Individual Risk Reduction Plan before termination occurs. (Use Risk Reduction Workbook.)**

Use the following therapy modalities as appropriate

Active listening

Role play

Psycho education

Adapted assertion skills training

Therapeutic metaphor

Relaxation exercises

Guided imagery

Hypnotherapy

TFT (Thought Field Therapy – Callahan Techniques)

paradoxical and experiential interventions

real-life problem solving

problem solving skills

reframing

re-recording negative messages

correcting misinformation

play therapy

art therapy

sand tray therapy

Truthful reassurance

support

EMDR (Eye Movement Desensitization Restructuring

Brain Gym

directed discussion

reflection and clarification of feelings

interpretations

homework

reality therapy

Energy mind-body therapy

generalization training

environmental involvement to effect treatment

goals (esp. w/ assertion, safety review/analysis

procedures

Best of the Best

TFT

This is by far the best trauma healing method I know.

Why?

It works very quickly (within the hour).

Relief is felt immediately.

The relief from distress lasts over time w/o repeating treatment.

Anyone can participate in the therapy, regardless of disability.

Does not require any special tools, or instruments.

My clients with I/DD now use this on their own and teach it to others, in their invariable desire to help others.

It provides what I have always wanted: a way to really relieve people from their trauma, anxiety, depression, guilt, etc.

TFT (Thought Field Therapy)

Case Study: The mother of a young adult with DS sought therapy for him as he had become severely depressed and began to c/o of pain with urination. A few months prior his Day Program staff anally raped him. It is unknown how many times or over what period of time this happened.

As she spoke of the/her trauma, he physically receded into the couch, no eye contact, turned away. I noted that her distress was severe, and she agreed to a TFT treatment, after which she was calm and not upset. She assisted me in treating her son for the trauma of the assault. I deduced the pain w/ urination was psychosomatic as medical problems were R/O. After tx. He had no pain w/ urination. He became engaged, played with items on the coffee table, engaged in lively conversation with me, and his physical features normalized (skin color, etc.)

Best of the Best

TFT (Thought Field Therapy)

Thought Field Therapy is a combination of western psychology that requires the patient to focus on the “bad feeling” and eastern medicine (Traditional Chinese Medicine [TCM]) energy meridian system.

The clinician guides the patient through a sequence of self-tapping on the upper body and face while focusing on the troubling thought. The procedure clears blocks to normal energy flow and releases the distress.

On the patient the change was dramatic, like watching an F/X movie. He cleared the trauma completely.

We are all connected

... and effect each other literally (electronically), and energetically.

Remember that!!!

(Prior to this meeting, I intended that the room be filled with great connection, communication, upliftment, inspiration and joy.)

Energetic transmission

Psychological transmission

Emotional Transmission

Take hands of a neighbor,

- A: transmit any emotion.
- B: what do you feel (careful not to analyze or doubt)

Electric transmission

Rosie



Energy Stick



The therapist should take care to assure that all communications are clear, concrete, and explicit;

Using the technique of Plain English is important.

Therapist should "check back" to assure client understanding as well as client's ability to internalize therapeutic intervention.

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.

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,(SURVIVOR series); and those for assault victims who do not have disabilities

Anatomically detailed dolls-BE PREPARED for unintended consequences. Complete the training in their use before using.

Puppets, drawing paper

Therapist' s ability to **let child “take lead”** within confines of the therapeutic session.

Inquire at each new session changes (positive or negative) since last session

Ask about current life situation

Ask about dreams

Ask about wishes for life improvements

Ask about others in the family,

REMEMBER that the fact you can easily discuss the assault and other life issues is itself therapeutic, as well as your ability to actively listen.

MOST PEOPLE WITH DEVELOPMENTAL DISABILITIES ARE NEVER ASKED ABOUT THEIR THOUGHTS, OPINIONS, FEELINGS.

T - Termination

Termination of treatment should be discussed 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?

With TFT you know immediately. The negative feeling state is gone replaced with normal well-being.

Later contact to and from 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.

Successful Treatment is wonderful but...

What about preparing the client for
the nearly inevitable “next” assault?

Working with the parents and the victim, develop an Individual Response Plan, to prepare for future violations.

When the plan is completed, encourage the family to revisit the plan monthly, and make changes as the child matures & changes, including skills development.

Discuss future contact, if any.

Terminate therapy.

A Risk Reduction Workbook for **Parents and Service Providers** to use with Individuals with Intellectual and Developmental Disabilities

Available at: disabilityandabuse.org/books

A Risk Reduction Workbook for **Individuals with Intellectual and Developmental Disabilities**

***Available at:* disabilityandabuse.org/books**

Case Examples

Using examples, how does all this work in real life?

Call for psychotherapy from the mother of a woman with Down Syndrome who was sexually assaulted 5 years prior:

Pre-Treatment Questions:

- Current sx?
- Date of onset of current episode? Triggers?
- Prior tx?
- Client request for help?

Pre-Interview Information

Client residential arrangement

Client family hx & current situation

Client communication style

Need for an interpreter

Need for special equipment

Client health status

Need for medications

Recent change in medications

Perpetrator/Case information

Who is the Perpetrator?

Relationship of Perpetrator to client

Current whereabouts of perpetrator

Case information: charges, convictions

How was case handled by law enforcement?

Later contact with client by perpetrator

Additional Crime History

Prior assaults on the client

What was effect upon the client?

What is current effect upon the client

What happened legally in the case?

Any legal involvement of client as a violator of the law?

(Use when case involves sexual abuse or other
sexuality issue.)

Sex Education:

Who trained? When? Was instructor certified?

What was curriculum?

Did client benefit?

Abuse Awareness

Who Trained? When?

What was curriculum?

Did client benefit? How was this measured or documented?

Other Case Examples

Young woman with autism, c/o sexual assault by stepfather (from UCLA, selectively mute.)

Acceptance of her silence + mention of use of dolls was magic.

Young woman assaulted by father (needed “to talk to Nora”)

Young woman suddenly electively mute

Young man with DS assaulted by TA (uses FC & ASL) gets tx with TFT, gleams, says, “good job.”

Young woman with ASD with hx. Multiple S.A.’s self-treats with TFT & teaches roommates.

Acquire books, articles of relevance and interest:

***“Sexual Assault Survivor’s
Guidebook for People with
Developmental Disabilities”***

Additional Resources

For law enforcement “Forensic Interviewing Guide”

For law enforcement “Forensic Interviewing & Treatment”

**For parents & service providers “Abuse Risk Reduction”
“TFT for Healing” 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**

Additional Resources

Karyn Harvey's book, "Trauma-Informed Behavioral Interventions: What Works and What Doesn't?"

For parents & service providers "A Risk Reduction Workbook for Parents and Service Providers for Individuals with Intellectual and Developmental Disabilities" from Baladerian

"Your Tapping Book" to give to clients to self-treat anxiety, panic, anger, rage, depression.

CHECK for new titles at: norabaladerian.com and new information at disabilityandabuse.org

Get more information...
www.disabilityandabuse.org

For more information:

Visit our Website: www.disabilityandabuse.org

JOIN our listserv from the website and learn along with others! Get great advice! Give Good Advice!!!

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Check the “What’s New” section

email:nora@disability-abuse.com (**We say, “nora at *disability minus abuse dot com*” !!!**)

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The End!
Thank you for coming!!