Welcome to

INTERVENING WITH YOUTH WITH INTELLECTUAL & DEVELOPMENTAL DISABILITIES WHO HAVE EXPERIENCED TRAUMA

THE TRAINING WILL BEGIN SHORTLY

While you're waiting...

Icebreaker Question (answer in the chat)

If you could team up with one superhero, which one would you choose?

Survey & Certificate of Completion

Available following the training.

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CALTRIN
California Training Institute

Hi, We're CalTrin!

Who we are

- The California Training Institute
- Funded by the State of California, Dept. of Social Services, Office of Child Abuse Prevention (OCAP) to support child abuse prevention through professional development and extended learning opportunities.
- Designed for staff of family strengthening and child abuse prevention organizations in California, including Family Resource Centers, Child Abuse Prevention Councils, community-based organizations, and other child and family serving systems.

What we offer

- Live webinars & small group training
- Virtual, self-paced courses
- Job aids & other resources

This training was made possible with funding from the California Department of Social Services, Office of Child Abuse Prevention. Any opinions, findings, conclusions, and/or recommendations expressed are those of the CEBC /CalTrin and do not necessarily reflect the views of the California Department of Social Services.

UPCOMING TRAININGS

mark your calendars!

Visit caltrin.org to view and register for upcoming webinars or workshops

09/07 I Overview of the Protective Factors

09/19 I Families & Substance Abuse Disorders: A Protective Factors Approach

09/20 I Working with Asian American Families: A Strength-Based Approach

9/26 I Mental Health Matters in Early Childhood
CAMFT CEs available · Interpretación en español

9/27 I Direction, Alignment, Commitment Workshop

9/29 I Paternal Perinatal Mental Health: The Changing Face of New Fatherhood

Before We Begin...

DURING

Access the presentation slides now! The link can be found in the chat.

This presentation is being recorded.

DURING

Review interactive features for today's session. Locate the controls on the toolbar at the bottom of your screen.

- Chat
- Q &A

- If you need to step away…

AFTER

Complete the survey at the end of this webinar to receive your Certificate of Attendance.

A follow-up email will be sent to all participants within two days.

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Intervening with Youth with Intellectual & Development Disabilities Who Have Experienced Trauma

Presenter: Michael Gomez, PhD

CDSS California Department of Social Services
OCAP Office of Child Abuse Prevention, California Department of Social Services, grow strong families
Rady Children's San Diego | Chadwick Center for Children & Families

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Speaker SPOTLIGHT

MICHAEL GOMEZ, PHD
Psychologist

- TF-CBT National Trainer
- CE-CERT National Trainer
- NCTSN Affiliate Member

Intervening with Youth with Intellectual and Developmental Disabilities who have Experienced Trauma

Michael Gomez, Ph.D.
Psychologist, Bradley Hospital, Lifespan Institute
Warren Alpert School of Medicine at Brown University
NCTSN Steering Committee Member
NCSTN Trauma IDD Workgroup Co-Chair
Nationally Certified TF-CBT Trainer
Nationally Certified PCIT Therapist
Nationally Certified CE-CERT Trainer

Objectives

At the end of the presentation, learners will:

1. Be able to apply concrete skills for cases with trauma and IDD
2. Be able to differentiate between different traumatic stress presentations and how these relate to IDD
3. Understand how TF-CBT (as a good example of a therapy model for this population) applies to youth where trauma and IDD are present

Myths about Children with IDD

- Youth with IDD cannot engage in treatment
- Standard mental health treatment is ineffective for children with IDD
- Behavior modification is the only option
- Youth with intellectual disabilities do not experience trauma
- Working with this population requires *significant* specialized training
- A challenging behavior is explained by an intellectual disability
- Youth with IDD are protected from trauma because of their mental age (i.e., babies); they do not remember
- IQ scores tell you everything you need to know about a child

NOT TRUE

What are all these acronyms???

Let me throw a few at you

- FASD
- IDD
- ID
- RUNDMC
- ASD

FASD

- Need 4 Things
  1. Growth/Weight Deficits
  2. “CNS” Deficits (IQ is a big one here but not only one)
  3. Facial feature abnormalities
  4. ALCOHOL EXPOSURE
- Fetal Alcohol Spectrum Disorder
  1. Fetal Alcohol Syndrome (FAS) [you got all 4]
  2. Alcohol Related Neurodevelopmental Disorder (ARND)
  3. Alcohol Related Birth Defects (ARBD)

IDD vs. ID

- Intellectual and Developmental Disabilities (IDD)
  - Basically EVERYTHING we've been talking about
- Intellectual Disability (ID) – The new name for what used to be called Mental Retardation (MR)
  - 3 things
  1. HAS TO be before 18
  2. Significant problems with ADAPTIVE functioning
     - You HAVE TO have this!!!
  3. Significant problems with intellectual functioning

ID (cont)

- IQ – The Bane of My Existence as a Psychologist
  - IQ is not 1 thing, it's like 5 things
  - IQ does NOT mean your kid is stupid (or smart)
  - IQ only means one thing
- "EF" – So yup, they technically meet criteria for ADHD but it's a bit different than other kids
  - IQ are the players (LeBron)
  - EF are the coaching staff (Poppy)

- RUNDMC

Concrete take away for ID

- ID means that a child without ID at _____ age would take X amount of time and Y amount of trials to do a particular thing
  - The kid with ID CAN STILL DO THE THING
    - But they will need more time and more trials
- Adaptive behavior is the GPS for any intervention
  - Can make it super formal like Vineland or ABAS
  - Or less formal like how BCBA's do
- Neglect can REALLY muddy the waters for ID
  - 3 year old girl example at Oklahoma

ASD – Autism Spectrum Disorder

- Presence of things
  - This is where you see
    - Spinning
    - Lining up things
    - Knowing everything about Chevy cars since 1967
- If they only had these it would not be great but . .
- Absence of things
- These are SOOOO impairing
  - Ex: Social Communication vs. Linguistic Communication

"Autism is a cake."

Concrete take aways for ASD

- Qualitative vs. Quantitative deficits in Social Communication
  - ADHD is a good example of quantitative
  - ASD is the paradigmatic example of qualitative
  - Here's why that's very, VERY important
  - Atrophied muscle vs. Prosthetic
- They. Can. Still. ATTACH!!!!
  - It just looks REALLY different than neurotypical kids
    - But no less important
    - ASD Lived Experience Movement
  - The field of ASD is moving more towards how Culture is integrated into behavioral health to emphasize the diversity aspect

What is Trauma???

Diagnostic and Statistical Manual-V
PTSD Criteria

Traumatic Event

+

4 *clusters* of symptoms = PTSD

Symptoms last for more than 1 month and are distressing and impair functioning

Post-Traumatic Stress Disorder DSM-V

CHILDREN 6 AND UNDER, ONE OR MORE OF C OR D

"B" Intrusion Symptoms

- Recurrent/Involuntary /intrusive thoughts/ images
- Dissociative reactions/ Flashbacks
- Recurrent distressing dreams (in kids don't need trauma content)
- Trauma re-enactment play (kids)
- Distress to cues (internal external)

1 or more of these

"C" Avoidance

- Avoid memories, thoughts/feelings of event (internal reminders)
- Avoid (or try to) people/places objects/situations (external reminders

1 or both of these

"D" Negative Cognitions or Mood

- Inability to remember aspects of trauma
- Persistent /exaggerated neg. beliefs of self, etc.
- Distorted thoughts re: cause or outcomes
- Persistent negative emotional state
- Diminished activities interests
- Detached/estranged
- Can't experience Positive emotions

2 or more of these

"E" Arousal & Reactivty

- Irritable of angry outbursts
- Reckless / Self-destructive
- Hypervigilance
- Exaggerated Startle Response
- Problems concentrating
- Sleep disturbance

2 or more of these

Developmental Trauma Disorder

"A" Exposure

- Direct experiencing or witnessing (so typical A criterion)
- Significant disruption of protective caregiver (from separation or impairment)
- Emotional Abuse

Chronic – Lasts, at least, over a year

"B" Affective/Physio Dysregulation

- Inability to modulate, tolerate, recover from extreme affect states
- Disturbance in regulation of body functions
- Diminished awareness or dissociation
- Impaired capacity to describe emotions or bodily states

2 or more of these

"C" Attn/Behav Dysregulation

- Preoccupation with threat or impaired capacity to perceive threat
- Impaired capacity for self protection (e.g., extreme risk taking)
- Maladaptive self-soothing (e.g., rocking)
- Habitual (intentional or automatic) or reactive self-harm
- Inability to initiate or sustain goal directed behaviors

3 or more of these

"D" Self/Relation Dysregulation

- Intense preoccupation with safety of CG, or difficulty tolerating reunion after separation
- Persistent negative sense of self (e.g., worthlessness)
- Extreme and persistent difficulty in close relationships
- Reactive physical or verbal aggression
- Inappropriate attempts to get intimate contact (e.g., PSB's)
- Difficulty with empathy (too much or too little)

2 or more of these

Plus at least 1 sx in 2 of 3 PTSD B, C, D areas (DSM IV)

At-Risk for Trauma

2x as likely to experience emotional neglect, physical & sexual abuse

3x more likely to be in families with domestic violence

4x more likely to be victims of crime

2x more likely to be bullied

The Road to Recovery:

Supporting Children with IDD Who Have Experienced Trauma

NCTSN The National Child Traumatic Stress Network

Hogg Foundation *for* Mental Health

ADVANCING RECOVERY AND WELLNESS IN TEXAS

Module One: Setting the Stage

Module Two: Development, IDD & Trauma

Module Three: Traumatic Stress Responses in Children with IDD

Module Four: Child & Family Well-Being & Resilience

Module Five: IDD- & Trauma-Informed Services & Treatment

Module Six: Provider Self-Care

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ADVANCING RECOVERY AND WELLNESS IN TEXAS

Concrete Take Aways for Child Trauma Treatment

- Recommended components for ALL Evidence Based Trauma Treatments:
  - **Assessment (symptom and data driven)**
    - **Meaning a professional HAS TO ASK if trauma happened!!!**
    - **"Retrigger vs. Retraumatize"**
  - Psychoeducation
  - Stress management techniques
  - Direct exploration of the trauma
  - Exploring/correcting inaccurate attributions
  - ***With kids → INCLUSION OF CAREGIVERS***
- These also have a specific time range (NOT open ended) for when you should see improvement

Standard Model - TF-CBT Treatment

Approx 8-16 sessions

Gradual Exposure

Parenting Skills

Pscyhoeducation
Relaxation
Affective Modulation
Cognitive Coping

Stabilization and Coping Skills Development

Trauma Narrative and Processing

Reduction of distress to trauma memories and correction of problematic trauma-related beliefs

In vivo
Desensitization
Conjoint Sessions
Enhancing Safety

Integration, Skills Consolidation, Safety Planning

TF-CBT Pacing – Developmental Disabilities & Trauma

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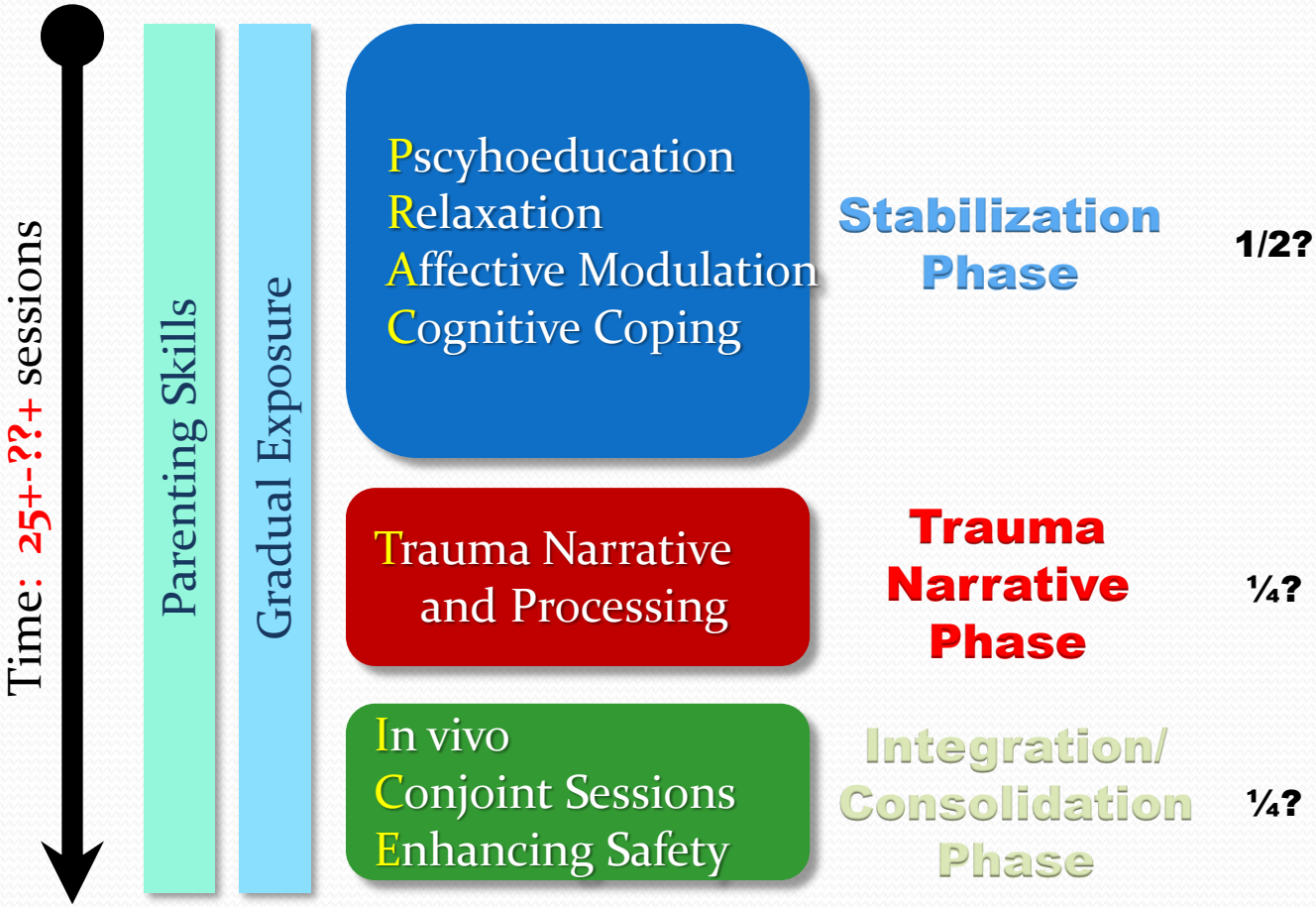

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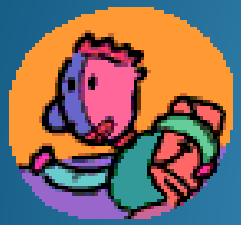
	IDD/ASD Differences and Challenges			
The "Matrix"	Verbal Language Comprehension	Visual-Spatial Competence	Willingness/ Motivation	Generalization of Skills
TF-CBT Skills: Psychoeducation/ Parenting Skills	In-range books and stories; flash cards	Behavior charts; trauma picture cards "What Do You Know" game	Visual schedule, routine, move slowly at first	Provide psycho-education to other systems (i.e., school, social services)
TF-CBT Skills: Relaxation	"Pizza" breathing; "noodle" practice	Movement-based Yoga practice; videos and apps	Interest-based alternatives; substitute distraction	Video modeling; practice yoga at home; chart progress with reinforcers
TF-CBT Skills: Affect Regulation	Emotion game apps, emoji charts; Zones of Regulation	"Check your engine" Alert Program; Parking Space game; feelings thermometers	M&M emotions game; Power Cards	Practice in school, community settings
TF-CBT Skills: Cognitive Coping	Thought bubbles, "worry bugs"; "true-false game"	Thought bubbles; Comic-Strip Conversations	Triangle of Life app; Playing CBT game	Stop sign at home/ school: "Stop and Think"; "When" reminders
TF-CBT Skills: Trauma Narrative	Have parent/caregiver in session as "interpreter"	Draw cartoon narrative/ use pictures/ collage	Short narrative session followed by special interest play	Consider keeping the narrative in "safe space" or clinician's office
TF-CBT Skills: In-Vivo Desensitization	Use roller coaster or child-specific analogies	Habituation chart	Reinforce small "ladder rungs"	Hierarchies for home, school, community
TF-CBT Skills: Safety Skills	In-range books and stories; Circles Curriculum/app	Pictures, tables, charts; Circles app	Address parents' concerns about topics; reinforce practice	Use Circles colors for door, bathroom, wear reminder bracelet; engage school personnel

What CBT looks like for a 3 or 4 year old

- https://www.youtube.com/watch?v=kkZe1v17UeM&list=LL&index=35

Here's what it actually looks like



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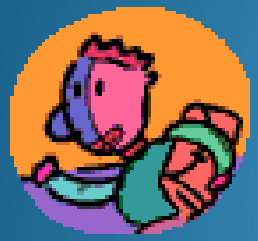

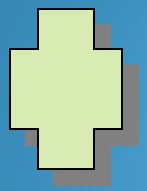

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“Don’t close any doors you don’t have to.”

What about when they get older???

- Short version: They will be fine. They will.
  - 3 types of problems
    1. Strep throat
    2. Stage 4 lymphoma
    3. Diabetes

- Longer version: But only if . . .

Child Trauma Treatment

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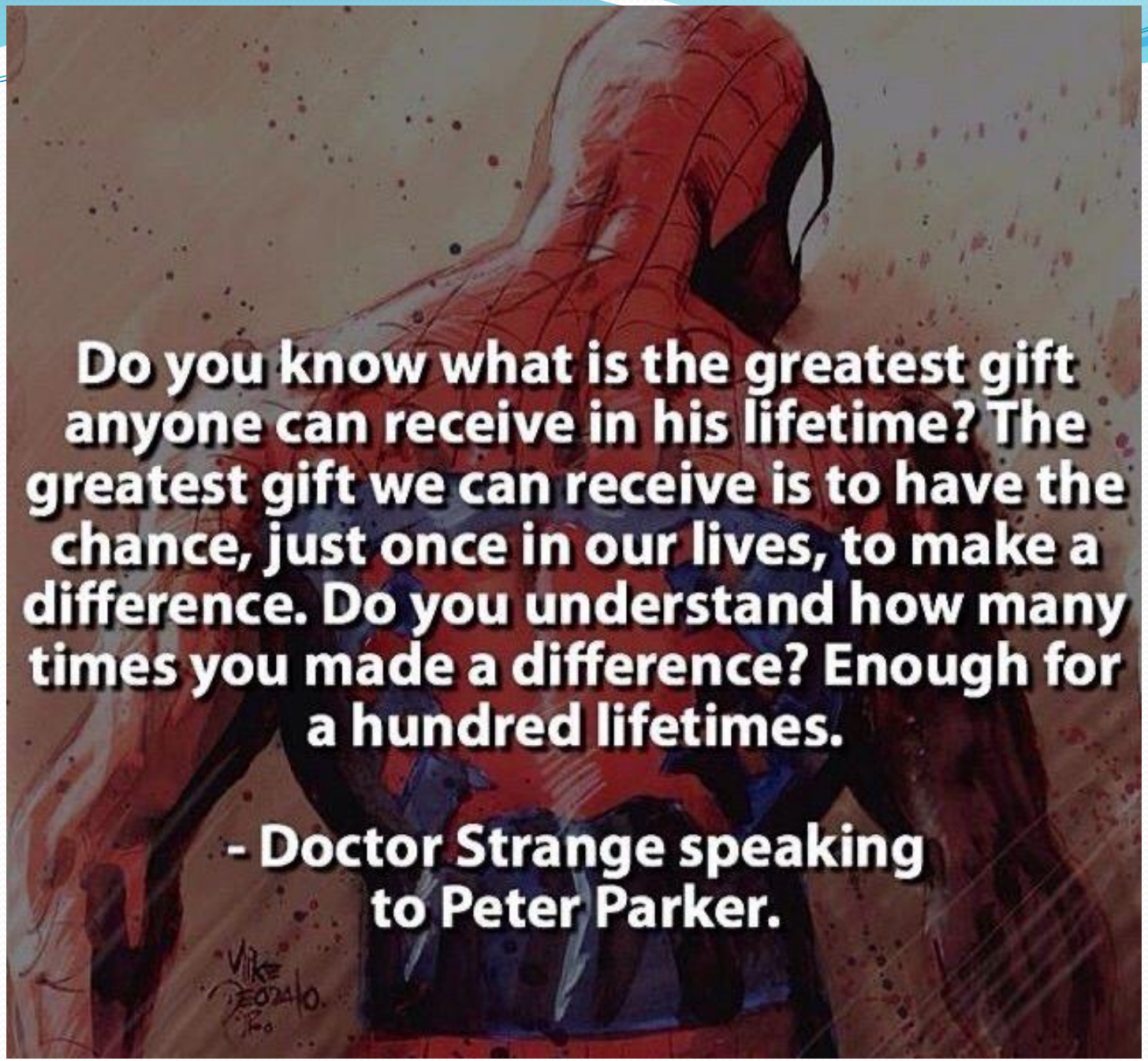
Dr. Gomez's Philosophy of Therapy


Do you know what is the greatest gift anyone can receive in his lifetime? The greatest gift we can receive is to have the chance, just once in our lives, to make a difference. Do you understand how many times you made a difference? Enough for a hundred lifetimes.
- Doctor Strange speaking to Peter Parker.

THANK YOU!

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Thanks for joining us!

WHAT'S NEXT?

- Survey and certificate in the chat now
- Follow-up email with resources within two days
- Watch your inbox for the next issue of *CalTrin Connect*

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