Lesson 1: Foundations of Trauma

I. What is trauma?
  a. Psychological trauma is the experience of an event or enduring conditions, in which the individual's ability to integrate his/her emotional experience is overwhelmed and/ or the individual experiences a subjective threat to life, bodily integrity, or sanity. (Pearlman & Saakvitne, 1995)
  b. The circumstances of the event commonly include: threat to physical safety as the result of a disaster, abuse, or assault; abuse of power, betrayal of trust, entrapment, oppression, helplessness, pain, confusion, and/ or loss.

II. What events are considered *traumatic*?
  a. What constitutes trauma is broad—it includes one-time incidents like accidents, natural disasters, crimes, medical events, surgeries, deaths, sudden loss, loss of caregiver, adoption, violent events.
  b. It also includes responses to chronic or repetitive experiences such as child abuse, neglect, combat, urban/ community violence, concentration camps, battering relationships, refugee resettlement, persecution, torture, oppression, marginalization, and enduring deprivation.
  c. Witnessing any of the above may also trigger a trauma response.
  d. A lack of attachment in infancy and early childhood is a common type of trauma.

III. The definition of trauma intentionally does not allow us to determine whether a particular event is traumatic; that is up to each survivor.

IV. Types of trauma:
  a. Single episode trauma
  b. Chronic trauma
  c. Developmental trauma
  d. Complex trauma

V. Attachment: the lasting, psychological connection between human beings.
  a. Attachment is relevant to trauma in several ways:
    i. A lack of early attachment is, in and of itself, an experience of chronic trauma.
    ii. Poor attachment early in childhood can lead to difficulties in accepting support and help to heal from trauma.
    iii. A healthy attachment to a service provider can restore feelings of safety in healing from trauma.

VI. Impacts of trauma:

VII. ACE (Adverse Childhood Experiences) Study:

Lesson 2: THE IMPACT OF TRAUMA ON THE BRAIN

I. The brain's most important job is to ensure our survival.
   a. The brain focuses on the most important tasks of survival first; everything else is secondary.

II. During trauma:
   a. Our brain detects a threat.
   b. The left and right hemispheres of our brain "disconnect" when what we are experiencing does not fit into our understanding of the world.
   c. More R brain activity than L brain activity results
   d. Fight or flight instincts take over to help our body survive the threat.
   e. Language center "shuts down"
   f. Cortisol increases; serotonin decreases
   g. Immune functions are reduced
   h. More complex brain tasks are not possible
   i. Motor coordination is impacted
   j. Constant reinforcement of this pattern results in the formation of deeply entrenched patterns in our brain—this becomes our brain's default.
   k. Amygdala: warns of impending danger; activates the stress response. "Smoke detector" of the brain.

III. Three areas of the brain:
   a. Neocortex / the rational brain: Intellectual tasks/ decision-making (learning)
   b. Limbic/ the intermediate brain: Emotions (survival)
   c. Reptilian/ the primitive brain: Self preservation, survival, aggression (survival)
      i. During trauma, the functions of the neocortex are shut down.

IV. Symptoms of trauma:
   a. Shock, denial, or disbelief.
   b. Disorientation.
   c. Confusion, difficulty concentrating.
   d. Anger, irritability, mood swings.
   e. Anxiety and fear.
   f. Nightmares, jumpiness
   g. Guilt, shame, self-blame.
   h. Withdrawing from others.
   i. Feeling sad or hopeless.
   j. Feeling disconnected or numb

V. *Hypervigilance* is an enhanced state of sensory sensitivity accompanied by an exaggerated intensity of behaviors whose purpose is to detect threats.

VI. Arousal refers to the state of readiness or excitation of one's nervous system. The ability to maintain a healthy arousal level is often required for adaptive interaction with one's environment. (hyper/hypo-arousal)

VII. The term *dissociation* describes a range of experiences from mild detachment to more severe detachment from physical and emotional experience.

VIII. Complex trauma: involves traumatic stressors that: are repetitive or prolonged, involve direct harm and/ or neglect/ abandonment by caregivers, occur at developmentally vulnerable times in the victim's life, have great potential to compromise severely the individual's development.

Lesson 3: THE EXPERIENCE OF TRAUMA AMONGST PERSONS WITH DEVELOPMENTAL DISABILITIES

I. How common is trauma amongst persons with developmental disabilities?
   a. Very common—estimates that violent crime is over 4 times as likely; sexual abuse is 2 to 10 times more likely; only one in 30 cases of sexual abuse of a person with a developmental disability likely to be reported.

II. Connection between trauma and developmental disabilities:
   a. Abuse and neglect have profound influences on brain development. The more prolonged the abuse or neglect, the more likely it is that permanent brain damage will occur.
   b. Not only are people with intellectual/ developmental disabilities more likely to be exposed to trauma, but exposure to trauma makes developmental delays more likely and/ or more profound.
   c. **People with I/DD are more likely to be exposed to trauma AND exposure to trauma makes I/DD more likely.**

III. Vulnerabilities amongst persons with developmental disabilities:
   a. Cognitive disability interferes with:
   b. The ability to predict high-risk situations
   c. Understand what is happening in an abusive situation
   d. Barriers to reporting:
   e. Mobility challenges
   f. Restricted ability to communicate
   g. Not consistently perceived as credible reporters (Charlton, Kliethermes, Tallant, Taverne, & Tishelman, 2004)
   h. Trained to be compliant to authority figures (Valenti-Hein & Schwartz, 1995)
   i. 44% had a relationship with their abuser directly related to their disability (Davis, 2004)
   j. Increased responsiveness to attention and affection may make manipulation easier.
   k. Less likely to be provided with general sex education or any type of training around human sexuality.

IV. Myths of trauma and developmental disabilities
   a. People with IDDs do not have the same response to trauma as people in the general population (Charlton et al., 2004)
   b. People with IDDs cannot benefit from therapy (Mansell et al., 1998), including trauma-based treatments.
   c. Working with individuals with IDD requires extensive specialized training.
   d. Individuals with ODD will forget or get over the trauma.
   e. A challenging behavior is exclusively explained by the disability.
   f. Behavior modification is the only option for intervention.
   g. In order to heal from trauma, people need to be able to 'tell their story.'

V. Facts of trauma and developmental disabilities
   a. People with IDDs suffer from the same difficulties in life that the non-disabled population encounters
   b. Anxiety and depression
   c. Grief and trauma
   d. Job stress, divorce, separation, etc. (Charlton et al., 2004; Butz et al., 2000; Nezu & Nezu, 1994)
   e. Many different approaches have been found to be effective in treating people with IDDs.
   f. Although it generally takes longer for people with IDDs to make changes, those changes are stable once made.
   g. Focusing on behaviors often misses the underlying cause being communicated and/ or strips away a coping skill prematurely
   h. People with IDDs are less likely to recover spontaneously from trauma without treatment.
   i. All people heal from trauma differently, and 'telling the story' in the literal sense is not a requirement.

VI. Challenges

a. Care is often fractured, leading to a lack of consistent information.
b. Very few peer-to-peer support networks related to trauma to provide support to individuals and families
c. The chance for retraumatization is high, especially related to disruptions in placement.
d. Providers often feel insufficiently prepared or equipped to deal with trauma histories.
e. Population is under-identified and under-served
f. For clinicians, disability stigma creates fear and resistance to developing cultural competency for working with this population.
g. A lack of well-trained providers
h. Traditional evidence-based trauma interventions may exclude DD population
i. The default of focusing on behavioral issues misses the underlying trauma
j. Focusing on ”appropriate” behaviors may do harm
k. “Diagnostic overshadowing” prevents caregivers and family from looking beyond the disability

VII. Considering trauma and developmental disability

a. Take caution to not attribute normative trauma responses to the person’s disability.
b. People with intellectual/ developmental disabilities generally have the same types of symptoms following trauma that anyone else would: sleep disturbance, startle response, numbing, emotional constriction, disrupted sense of safety, shattered self-identity, etc.
c. Trauma responses generally represent a change from the person’s normal level of functioning.
d. Thus, continuity of care becomes essential to monitoring for trauma.

Lesson 4: A TRAUMA-INFORMED LENS

I. What does it mean to be trauma-informed?
   a. Trauma informed treatment is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of **trauma** and the prevalence of these experiences in persons who receive services.
   b. This approach to treatment not only acknowledges trauma as an ecological factor but <u>centers</u> it in the treatment planning and intervention processes.
   c. A trauma-informed approach focuses on *<u>recovery</u>* and *<u>resiliency</u>*.

II. What shifts when we use a trauma-informed lens?
   a. Techniques using aversive or restrictive practices are recognized as being contraindicated due to risk of re-traumatization, escalation and damage to the therapeutic alliance.
   b. People are always informed of what is about to happen before it happens.
      i. Trauma responses are seen as resilient adaptations instead of manipulations or problematic behaviors.
   c. Trauma responses are seen as protective actions and not problematic behaviors.
   d. Real empathy is demonstrated—the kind that takes hard work.
   e. It is recognized that trauma responses/ behaviors are rooted in deep psychological pain.
      i. The mind is doing its absolute best to cope-—even (or especially) when it doesn't look pretty.
   f. People have real choices—not fake ones.
   g. Limit setting and rule enforcing are recognized as being strategies that may enhance a sense of fear or panic.
      i. Recognizing the emotion behind the response and respecting boundaries is essential.
   h. Trauma is centered in all of our work and the supports that we design and implement.

III. Vicarious traumatization (VT) is a transformation in the self of a trauma worker or helper that results from empathic engagement with traumatized clients and their reports of traumatic experiences. (Courtois, 1993).

Resource List

The information in these videos has been collected from a wide variety of sources. Whenever possible, I have noted the source next to the information, but a great deal of information was compiled from multiple sources that I want to credit here. I also want to encourage you to continue your learning by accessing the resources included in this list.

Print resources:

- Charlton, M., Kliethermes, M., Tallant, B., Taverne, A., & Tishelman, A. (2004). Facts on traumatic stress and children with developmental disabilities. Fact Sheet on the effect of trauma on children with developmental disabilities from the National Child Traumatic Stress Network / Adapted Trauma Treatment Standards Work Group / Subgroup on Developmental Disability
- Cottis, T. (2009). *Intellectual disability, trauma and psychotherapy*. London: Routledge.
- Courtois, C, (1993). Vicarious traumatization of the therapist. *NCP Clinical Newsletter,* Spring, '93.
- Heller, L., & LaPierre, A. (2012). *Healing Developmental Trauma: How Early Trauma Affects Self-Regulation, Self-Image, and the Capacity for Relationship.* Berkeley, CA: North Atlantic Books.
- Herman, J.L. (2001). *Trauma and recovery.* New York: Basic Books.
- Houdek, V., & Gibson, J. (2017). *Treating Sexual Abuse and Trauma with Children, Adolescents, and Young Adults with Developmental Disabilities: A Workbook for Clinicians.* Springfield, IL: Charles C. Thomas Publisher, Ltd.
- Levine, P.L. (1997). *Walking the tiger: Healing trauma.* Berkeley, CA: North Atlantic Books.
- Mansell J. Deinstitutionalisation and community living: progress, problems and priorities. *Journal of Intellectual and Developmental Disabilities. 2006; 31*:65–76.
- Pearlman, Laurie A., & Saakvitne, Karen W. (1995). *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors.*New York: W.W. Norton, xix, pp.451
- Perry, B., and Szalavitz, M. (2007). *The Boy Who was Raised as a Dog: And Other Stories from a Child Psychiatrist's Notebook.* New York, NY: Basic Books.
- Servais L. Sexual health care in persons with intellectual disabilities. *Mental Retardation and Developmental Disabilities Research Reviews. 2006; 12:* 48–56.
- Sobsey, Dick (1994). *Violence and Abuse in the Lives of People with Disabilities The End of Silent Acceptance?* Maryland: Paul H. Brookes Publishing Company.
- Valenti-Hein, D. & Schwartz, L. (1995). *The Sexual Abuse Interview for Those with Developmental Disabilities.* James Stanfield Company. Santa Barbara: California.
- van der Kolk, B. (2015). *The Body Keeps the Score*. New York, NY: Penguin Books.

Online resources:

- ACE Response resources for ACEs and DDs: http://www.aceresponse.org/give_your_support/IDD_39_68_sb.htm
- Association of University Centers on Disability: https://www.aucd.org/docs/Assessing%20Trauma%20in%20Individuals%20With%20ID%20(compressed).pdf
- Resource Guide to Trauma-Informed Human Services: https://www.acf.hhs.gov/trauma-toolkit
- MA child trauma project: http://www.machildtraumaproject.org/index.php/about/activities
- Online trauma-informed care: https://ncfy.acf.hhs.gov/news/2016/06/new-online-training-trauma-informed-care
- National Child Traumatic Stress Network: http://learn.nctsn.org/enrol/index.php?id=38 (psychological first aid)
- National Association of State Directions of Developmental Disabilities Services: http://www.nasddds.org/resource-library/behavioral-challenges/mental-health-treatment/trauma-informed-care/
- Red Cross Disaster Mental Health/ Disaster Health and Sheltering: http://www.redcross.org/take-a-class/disaster-training
- West Virginia Integrated Behavioral Health- recognizing signs of abuse and providing effective symptom relief. http://www.dhhr.wv.gov/bhhf/Documents/2013%20IBHC%20Presentations/Day%203%20Workshops/Healing%20the%20Trauma.pdf
- Administration for Children and Families concept papers: https://www.acf.hhs.gov/trauma-toolkit