



Trauma and Crisis Informed Support

The Series of EASA Presentations:

1. Signs and Symptoms of Mental Illness
2. Comprehensive Assessment Planning
3. Collaborating Across Other Systems
4. Adapting Therapy Practices
- 5. Trauma and Crisis Informed Support**



Learning Objectives

1. Understand the risk factors, vulnerabilities and frequency of trauma for individuals who have intellectual disabilities
2. Build understanding of trauma informed support and recognition of symptoms for individuals with IDD and MI.
3. Identify methods for adapting trauma treatment and supports for individuals with IDD.
4. Identify components of safe, effective crisis prevention and intervention strategies to improve healing .



Trauma

Results from exposure to an incident or series of events that are emotionally disturbing or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, and/or spiritual well-being.

Exposure to conditions that:

Cause harm to wellbeing

Overwhelm the ability to cope

Interfere with daily life or ability to function

Subjective experience:

Two people may experience the same thing with very different outcomes



Types of Trauma

Single or event — occurs one time (car accident, one instance of abuse, witnessing a death).

Complex (in contrast to single) — over time, prolonged (repeated abuse, target of bullying, moving frequently, living in a situation of continuous conflict).

Direct — death of a loved one, car accident, illness.

Vicarious (in contrast to direct) — through experience of others (hearing about abuse from a friend, being a therapist listening to others' experiences, child or abused parent).

A major trauma could be:

- Natural or manmade disasters
- Catastrophic illness
- Invasive medical procedures
- Loss of a loved one
- Humiliation
- Bullying
- Sexual assault/physical assault
- Deprivation and powerlessness to act on one's own behalf



What makes an experience traumatic?

Proximity

Scope (numbers affected)

Severity (intensity)

Warning/No warning

Intentionality/Preventability

Duration: Whether chronic or single event (acute)

Interpersonal or Non-Interpersonal

Availability of Social Supports/Validation

Availability of Intervention Services/Response



Traumatized Systems of Care

Trauma expands beyond individuals: Important to look within and at the container being held for individuals within systems of care

Lose their ability to provide safety, perpetuate physical and emotional violence and trigger mistrust.

Often: low employee and service user satisfaction, high rates of staff burnout and turnover, use of authoritative management practices, higher rates of wonder error, negligence, and even abuse

(Bloom and Farragher, 2011)



Abuse and Disability

People with intellectual/developmental disabilities are at greater risk for being victimized or abused.

Child Maltreatment is a factor in 10-25% of all developmental disabilities

Studies indicate as many as 90 percent of people with intellectual disabilities will experience abuse at some point in their lifetime

49% reported 10 or more abusive incidents

The more severe the disability the greater likelihood of abuse:

44% had a relationship with their abuser directly related to their disability

- This includes women with disabilities, people with cognitive or developmental disabilities, people with psychiatric illness and people with multiple disabilities.



Abuse and Disabilities

3.4 times more likely to be neglected

4 times more likely to be victims of family violence than their peers without disabilities

4 times more likely to experience aggravated assault and robbery.

Men and women with IDD 7x more likely to experience sexual assault in their lifetime (shapiro 2018)

- 3 times more likely to experience sexual abuse as children
- only about 1 out of 30 of sex abuse cases being reported for this population (1 out of 5 for general population)



Possible Trauma Events for Individuals with IDD

Abuse: verbal, physical, sexual

Bullying

Identified as being different

Being restrained or forced seclusion (re-traumatizing)

The “R” word, other disparaging language

Constant threats (perceived or actual)

Moving away from family, loss, grief

Uncertainty of safety and basic needs being met

Witnessing violence

Loss of home or job or support services

Add medical and dental problems, costly prescriptions

Vulnerabilities

Higher level of assistance for longer periods of time from caregivers

Invasive daily living functional support more common

Higher level of stress on the family/caregivers

People are less able to meet parental expectations

Taught to be compliant to authority figures

Increased responsiveness to attention and affection may make them easier to manipulate

Less likely to be provided with sex education or any type of training around human sexuality

Caregiver's assumptions that they are not developing sexually or sexual



Vulnerabilities, Cont'd.

Cognitive disability interferes with :

The ability to predict high-risk situations

Understand what is happening in an abusive situation

Barriers to reporting

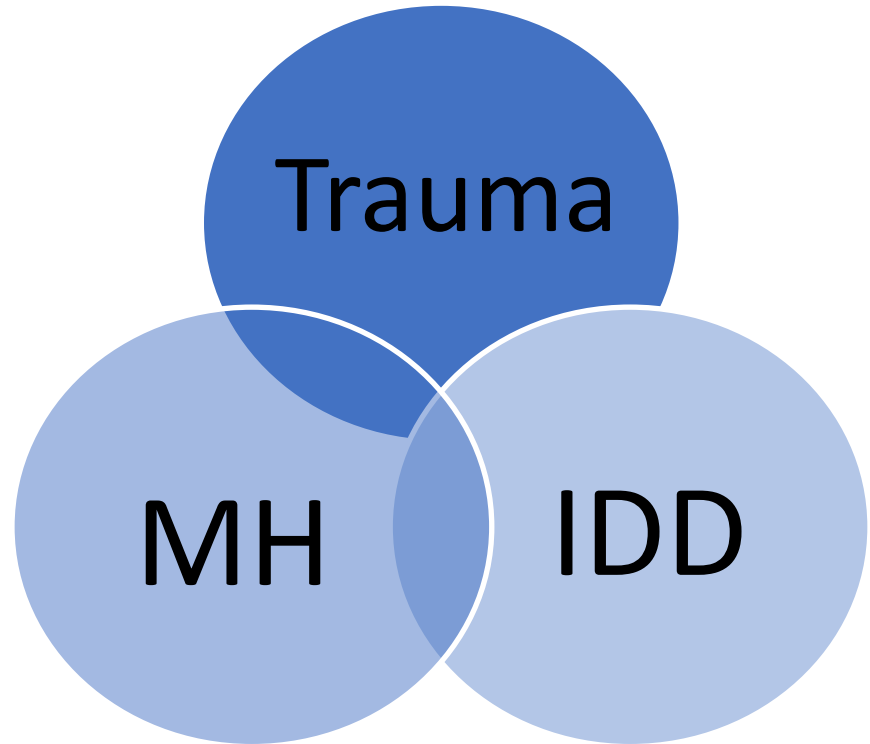
Mobility challenges

Restricted ability to communicate

Not perceived as credible reporters



- Overlap may be significant
- Watch for diagnostic overshadowing



Risk Factors for Developing Trauma Disorders

Risk Factors	Protective Factors
Multiple traumas	Timely and appropriate care
Acquiescence/passivity	Social supports
Lack of control	Safety awareness
Underdeveloped/ineffective coping skills	Previous experience
Communication difficulties	Good communication skills
Mood or anxiety disorder	Wellness supports
Age at time of event	Coping skills
Likely to have less inductive and deductive reasoning	Experiences cognitive dissonance
Isolation and exclusion	Stable housing and work

When is trauma support needed?

When responses to the experience or sequence of experiences are problematic after the event and have not abated over time

There is a significant change in normal level functioning and the person has not returned to their prior level of functioning. Explore the extent of the remaining changes both in the body and the emotions present for the individual

Individuals with IDD generally have the same types of symptoms of trauma that anyone else would

- Trauma history does not necessarily mean treatment is needed

It is about the participants perception, not necessarily about the facts of what happened



Trauma and the Body

The body stores trauma. The physiological response to threats (real or perceived) takes its toll over time and can manifest as somatic symptoms:

- Gastrointestinal issues
- Exaggerated pain response
- Migraines
- Muscle tension and soreness

Trauma and Emotions

Emotional states of trauma include anxiety, anger, horror, helplessness and sadness. An individual's experience can fluctuate and include:

- Avoidant behavior, overreaction
- Increased arousal
- Sleep disturbance
- Exaggerated startle response, hypervigilance
- Difficulty concentrating
- Outbursts of rage and fear
- Numbness
- Emotional Constriction
- Shattered self identity

DSM-5: Trauma- and Stressor- related Disorders

Include: Reactive Attachment Disorder, Post-traumatic Stress Disorder, Acute Stress Disorder.

Individuals can experience symptoms of psychosis in the context of Post Traumatic Stress Disorder (PTSD).

PTSD is the most common.

- History of exposure to traumatic events (stressors)
- Presence of intrusion symptoms: reliving trauma, flashbacks
- Avoidance behaviors in effort to escape distress
- Alterations in arousal and reactivity following the trauma (e.g., irritable aggressive behavior or self-destructive behavior)
- Symptoms persist longer than one month after trauma

Trauma brings the past into the present.

Case Example

A young adult male with expressive difficulties is resistant to certain rooms and refuses going a certain way in the school building he attends. He talks of objects he states are scary. He gives visual feedback of what these look like with his arms up and moving outward. He is visibly upset holding his hands in fists with a tight jaw to describe this making the descriptions harder to understand. He has changed his overall behavior in which he is missing more days of school and is having a harder time concentrating. This has started since going back to school however this is a new school.

What might be happening for this young man?



Behaviors That May Stem from a History of Trauma

Verbal threats

Physical aggression

Running away

Entering others' personal space

Refusing medications

Difficulty sleeping

Withdrawal

Hoarding

Eating quickly

Eating non-edibles

Challenges with toileting

Trauma and ASD: Symptoms and Diagnosis

Pathology	Trauma symptomology	Autism traits
Impaired stress response	<ul style="list-style-type: none"> • Sensitivity to traumatic reminders • Alternation in neuroendocrine stress response system 	<ul style="list-style-type: none"> • Sensitivity to traumatic reminders • Alternation in neuroendocrine stress response system
Disturbance in sense of self and identity	<ul style="list-style-type: none"> • Suicidality • Self-mutilation • Low self-esteem • Risk-taking • Depersonalization 	<ul style="list-style-type: none"> • Self-mutilation • Low self-esteem • Depersonalization
Interpersonal and relationship problems	<ul style="list-style-type: none"> • Attachment disorders • Social withdrawal • Promiscuity • Antisocial behavior 	<ul style="list-style-type: none"> • Attachment disorders • Social withdrawal • Antisocial behavior
Affect dysregulation	<ul style="list-style-type: none"> • Use and abuse of substances to regulate mood, sense of self and behavior • Attention problems • ADHD symptoms • Impulsivity • Hypervigilance 	<ul style="list-style-type: none"> • Attention problems • ADHD symptoms • Impulsivity • Hypervigilance

Guiding Principles to support Treatment

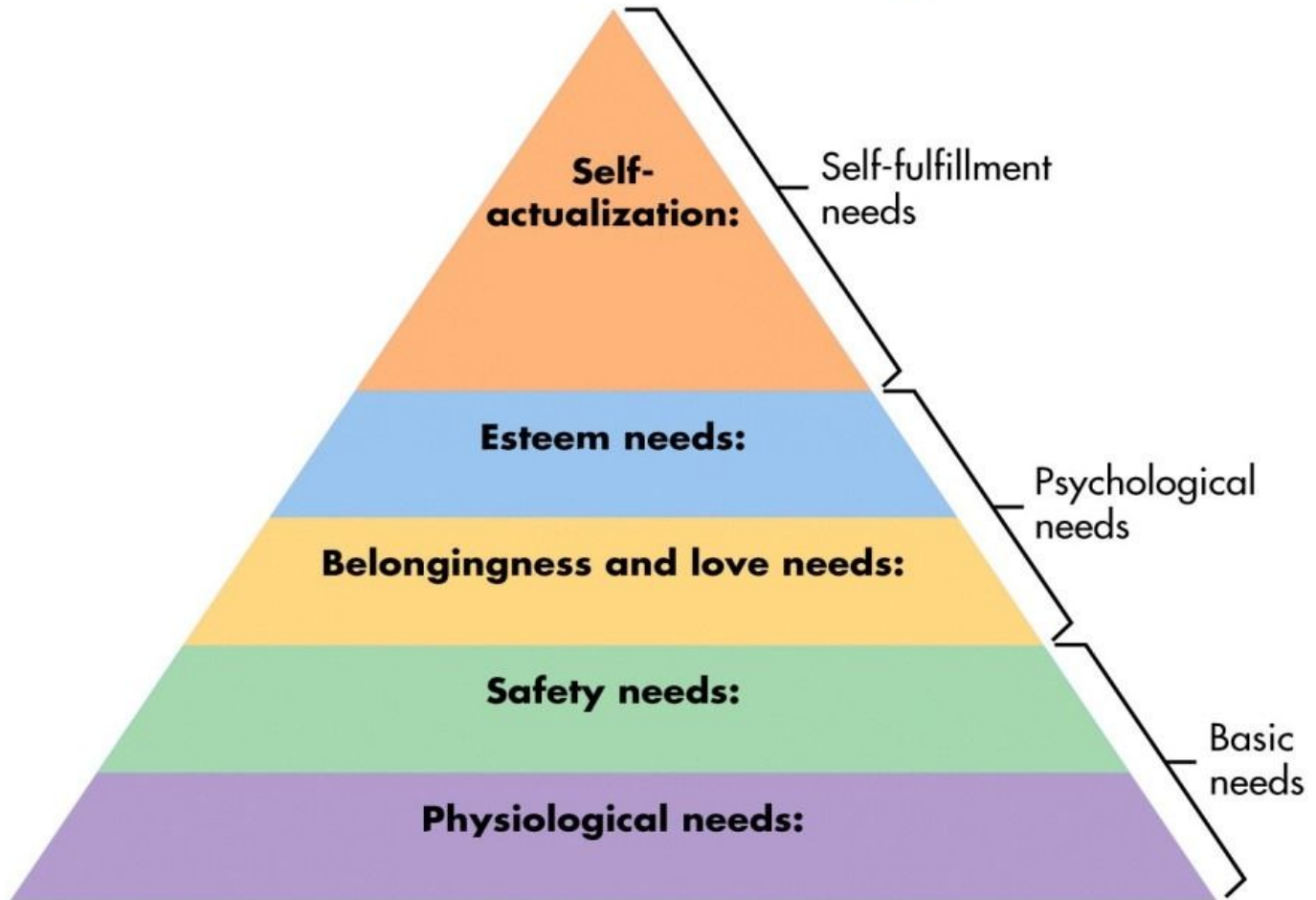
When assessing if trauma focused treatment is indicated and what is the best fit for care:

- Understanding an individual's trauma history should not feel like an investigation to obtain details.
 - It is on their time in their way to tell their experience

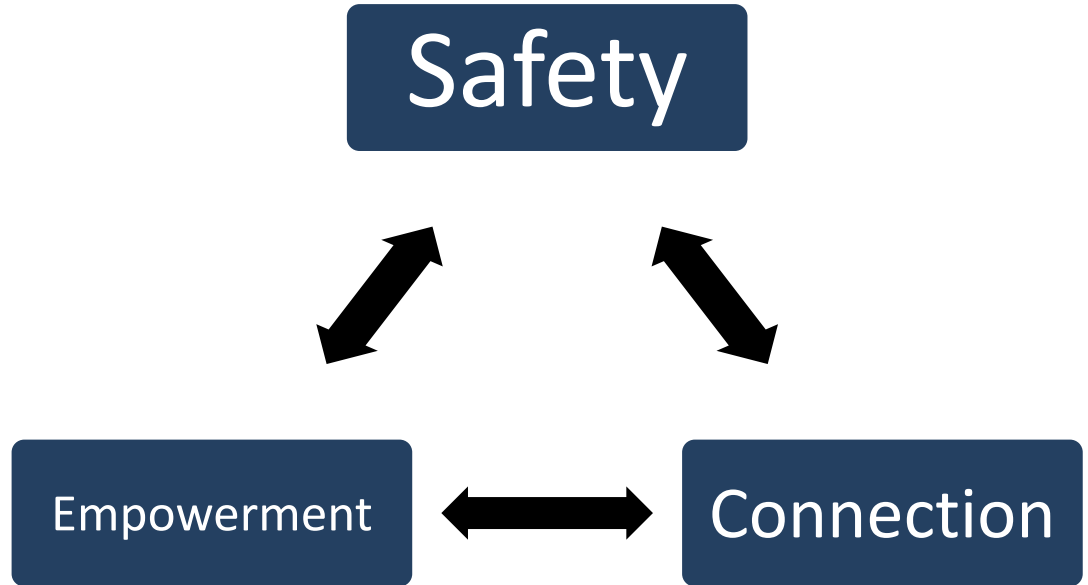
Must address physiological and safety needs first!

Participant needs to feel safe from threats real or perceived prior to the team member discussing presenting symptoms or experiences





**The 3 Keys
to
Recovery
from
Trauma**



Trauma Approach: Safety

People need to feel safe from threats that are real or perceived. This includes:

- Be mindful of behavior that can stem from trauma history
- Introduce relationships slowly
- Creating a structured, predictable, flexible environment
- Be aware of your own body language
- Avoid any kind of re-traumatization from our support strategies
- Provide choice

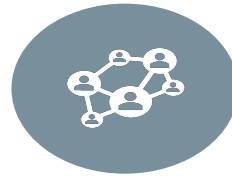
Techniques to Help People Feel Safe

- Redirection/Refocusing
- Reframing
 - Change the topic or setting or activity to avoid triggers
- Awareness of your own body language
- Find more supportive and comfortable staff, home, job, neighborhood
- Teach coping skills: breathing, humor, prayer, music

Trauma Recovery: Connection



Include individuals in hiring staff, choosing therapists, other team members.



Build relationships with trusted people first; expand to new members once rapport is established.



Create and develop valued roles in the community.



Support meaningful activities.

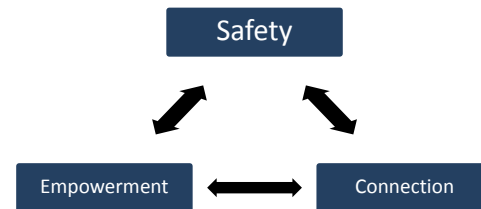
Trauma Recovery: Empowerment

- Provide and honor real choices.
- Support informed decision-making.
- Encourage leadership and organization of others in need of healing support.
- Create and nurture opportunities for self-care, including healthy diet, exercise and sleep.
- Assist in the use of tools and resources.

Case Example: “Kristina”

Kristina is a 24-year-old woman who lives in a group home with two other women. She has anxiety and mild intellectual disability. Kristina is generally a happy and social person. She has a job in a plant nursery watering flowers. When she has free time, she likes to go shopping, go to movies and go out to eat. She does best when her schedule and work are predictable. Kristina tends to stick to activities with which she feels successful.

Kristina has a history of being teased when she was at school, specifically being called names and being told she’s *stupid* and *ugly* and excluded from activities. Sometimes at work when a customer asks her a question she can’t answer, she will hear her old classmates’ voices in her head and run to the breakroom to cry.



Understanding Information Processing

With IDD it is important to understand the pathway to information processing:

- Target areas that need extra support for the interventions that may be used with a trauma informed practice
- Interventions and therapeutic approaches are similar with adaptations and modifications



Observe → Input → Interpret → Process → Evaluate Options → Plan → Act

Alarm system "Express Route"

Observe

Interpret

DANGER

Act

React (Flight - Flight - Freeze)

~~Process~~

~~Evaluate Options~~

~~Plan~~

Components of Information Processing of the Trauma

Need to tailor strategies for self-regulation, self-monitoring, and self-awareness for individuals with IDD to support interpret, process, and evaluate when working through the trauma response

Key target areas:

Emotional Regulation

Executive functioning

Perspective taking

Pragmatic language and social interaction



Adaptations with the Trauma and PTSD Assessments

Need to adapt for developmental and age appropriateness

People who have cognitive disabilities sometimes do not have family/caregivers to serve as good historians

At times child/adolescent tools may be more appropriate depending on IDD developmental age

May need to be more reliant on history, behavioral observation and report from supports

Communication and socialization challenges may present as more childlike in symptoms...ex. Repetitive play or verbalizations

May have decreased ability to understand certain events were traumatic



Assessing Trauma

Trauma screening tools:

- Clinician-Administered PTSD Scale (CAPS-5) Gold standard, semi-structured interview:
<https://www.ptsd.va.gov/professional/assessment/adult-int/caps.asp#obtain>
- Structured Clinical Interview for DSM-5 (SCID-5-CV)
- Life Events Checklist (LEC), used to evaluate presence of traumatic events:
https://www.ptsd.va.gov/professional/assessment/documents/PCL-5_LEC_criterionA.pdf
- PTSD Checklist for DSM-5 (PCL-5), 20-item self-report screen that can be combined with LEC Child and Adolescent Trauma Screen (CATS), Youth report:
<https://www.apaservices.org/practice/reimbursement/health-registry/ptsd-screening-assessment.pdf>
- Child and Adolescent Trauma Screen (CATS), Caregiver Report:
[https://depts.washington.edu/hcsats/CBT/Assessment/Child%20and%20Adolescent%20Trauma%20Screen%20\(CATS\)%20Caregiver%20Report%20\(7-17%20years\).pdf](https://depts.washington.edu/hcsats/CBT/Assessment/Child%20and%20Adolescent%20Trauma%20Screen%20(CATS)%20Caregiver%20Report%20(7-17%20years).pdf)
- Trauma Screening Questionnaire:
<https://www.ptsd.va.gov/professional/assessment/screens/tsq.asp>
- Traumatic Events Screening Inventory for Children (TESI-C), semi-structured interview that included child and caregiver self-report version to screen for traumatic events and assess post-traumatic stress:
<https://www.ptsd.va.gov/professional/assessment/documents/TESI-C.pdf>



Additional Resources

- https://www.integration.samhsa.gov/clinical-practice/SAMSA_TIP_Trauma.pdf
- National Center for PTSD, includes information as well as list of validated measures for assessing trauma and post-traumatic stress:
<https://www.ptsd.va.gov/>
- https://www.ptsd.va.gov/professional/consult/2017lecture_archive/07192017_lecture_slides.pdf
- Tip Sheet on Trauma and Psychosis:
<https://easacommunity.org/PDF/trauma-and-psychosis-mr.pdf>
- https://www.nasmhpd.org/sites/default/files/Fact_Sheet_Trauma_PTSD_FEP.pdf
- OnTrackNY website:
<https://ontrackny.org/>
- NAVIGATE website:
<https://navigateconsultants.org/>
- National Association for Dual Diagnosis (NADD) website, mental health and ID/IDD:
<https://thenadd.org/>
- National Child Traumatic Stress Network
<https://www.nctsn.org/what-is-child-trauma/populations-at-risk/intellectual-and-developmental-disabilities>
- A Trauma-Informed Toolkit for Providers in the Field of Intellectual & Developmental Disabilities
<https://www.pacesconnection.com/fileSendAction/fcType/0/fcOid/468137553002812476/filePointer/468137553002812517/fodoid/468137553002812512/IDD%20TOOLKIT%20%20CFDS%20HEARTS%20NETWORK%205-28%20FinalR2.pdf>



Questions?

What is a crisis?

A crisis occurs when a person is feeling threatened, suffers sudden loss or change or cannot access skills or resources.

- a situation when support needs for a person are greater than what the setting can offer.
- might occur when a person's level of behavioral health challenges overwhelm a home or job site.

Trauma can trigger or exacerbate a crisis.



Impact of Crisis

- Consider the risk factors (history of behaviors) and protective factors (social supports, community) that determine how severe a crisis can become.
- Strengthening these protective factors for a person prior to a potential crisis is a crucial prevention step.

The need for IDD Crisis Services

- When a behavioral health crisis occurs, the primary means of response are to take an individual to the Emergency Department or call 911.
- Law enforcement may become involved at the individual's home or job or in the community.
- Hospitals may provide medication to calm the individual and send him/her home, may use restraints, may not screen for pain, GI symptoms, medication side effects, etc.

Collaboration between systems

Negative outcomes result from faulty systems, rather than ineffective people

A dual diagnosis task force:

- Review high-risk individuals
- Able to identify key needs, resources, and interventions
- Make recommendations



Being Proactive

Use behavior and health information to help prevent or prepare for a crisis.

Describe how to recognize patterns of escalating behaviors or symptoms and ways to intervene as early as possible.

Case Example: “Connie”

When Connie gets on the crowded bus to go to work, she will sometimes repeat the same phrases over and over when she is anxious. If someone bumps into her, she can get into verbal or physical altercations. Today, the bus is very crowded and she is telling the driver, “Make room, make room, make room.”

What immediate steps can be taken?



Factors That Can Precipitate a Crisis with IDD



The exacerbation of mental illness



Medication challenges



Environmental stressors



Lifestyle challenges



Interpersonal stressors (staff, roommates, coworkers)



Physical stressors (illness, pain)



Trauma

More Factors That Can Precipitate a Crisis

Inadequate
behavior
supports

Grief and loss

Effects of
medication

Transition

Loss or
change in
services

New
Diagnosis

Components of a Crisis Prevention Plan



What needs does the behavior seem to meet?



List known antecedents/triggers



List protective factors: What is valuable and important to him/her?



Communication skills: Describe the primary methods used by this person to communicate (vocal speech, signs, gestures, communication books, electronic devices or behavior etc.).

Risk Assessment Tool for Behavioral Crisis

Utilize risk assessments applicable to the general population. Take into account how the person's developmental disabilities affect both risks and protective factors. Note whether recent changes have occurred in any risk or protective factors.

Flag all areas where there are risk issues. Also consider factors that may protect from harm.

Components of a Crisis Prevention Plan

Describe the behavior in operational terms (specify how the behavior is performed):

Behavior	Operational Description

Crisis Intervention and Prevention

Stage of Behavior	Response
Baseline: Normal, calm	Positive approaches: clear communication, structure, routine, sensory needs
Prevention (early warning signs, i.e. anxiety or agitation)	Be supportive, modify environment to meet needs & decrease stressors (de-escalation strategies)
Escalation (defensive or resistant, verbal threats)	Reduce risk, verbal techniques, maintain safety, distraction, validation
Crisis (aggression, risk of harm to self or others)	Continue positive interaction, safe response strategies, i.e., remind the patient with DD of pre-established boundaries; remind him/her about outcomes and next steps without threatening
Resolution and calming	Re-establish routines and re-establish rapport; prevent future escalation

Crisis Prevention and Planning

Comprehensive Risk Assessment

<https://easacommunity.org/PDF/Comprehensive-Risk-Assessment.pdf>

Crisis Plan

https://easacommunity.org/documents/Crisis_Plan.doc



Finding your Crisis Coordinator with IDD Services

<https://www.oregon.gov/DHS/SENIORS-DISABILITIES/DD/PROVIDERS-PARTNERS/Documents/DD-County-Directory.pdf>

Families, Allies, and Young Adult Crisis Resources

<https://easacommunity.org/crisis-resources.php>



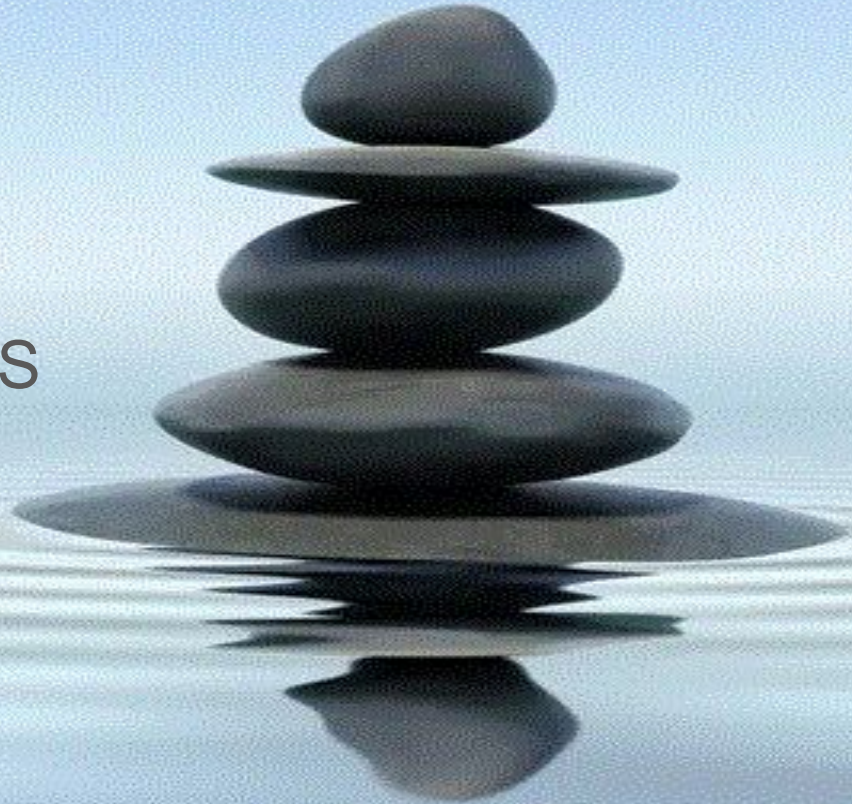
Questions?

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Trauma-Informed Project-resources and publications

<http://www.traumainformedcareproject.org/resources.php>

My Book About Recovery by Karen Harvey (2007)—available free at:

<https://aaidd.org/docs/default-source/events/harvey-my-book-about-recovery.pdf?sfvrsn=2>

<http://pid.thenadd.org/>

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Healing Neen (brief documentary): <https://vimeo.com/15851924>



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