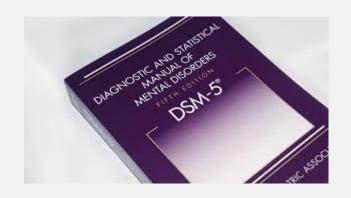
ASD AND TRAUMA: TALK OUTLINE

- ❖ Trauma in ASD
- Sequalae of trauma in ASD
- ❖ PTSD in ASD

 Later this afternoon – assessment and treatment of trauma and PTSD in ASD

TRAUMA IN ASD

TRAUMATIC LIFE EVENTS



"Exposure to actual or threatened death, serious injury, or sexual violence in one"

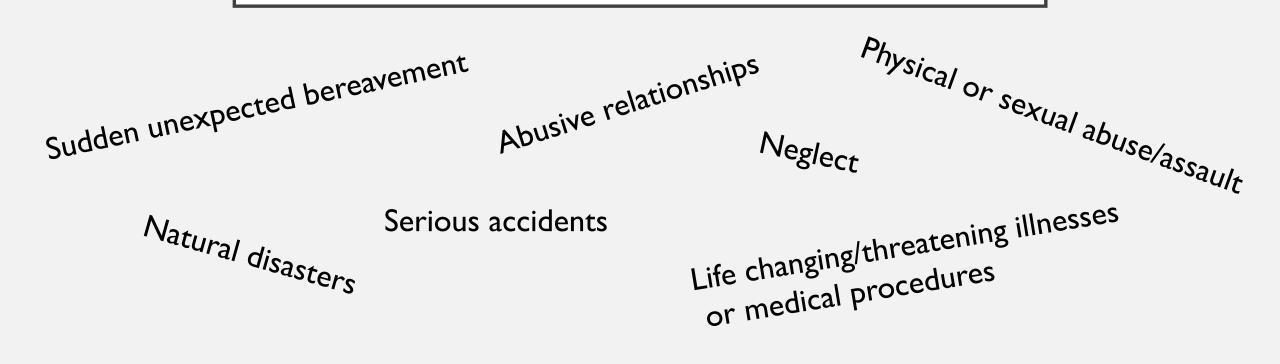
experienced/witnessed/learned about it happening to relative or close friend or in course of professional duties

"Exposure to a stressful event or situation of exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone"

"Exposure to an extremely threatening or horrific event or series of events"



TRAUMATIC LIFE EVENTS



75% experience trauma by age of 17

SUSCEPTIBILITY TO TRAUMA EXPOSURE IN ASD





++ trauma exposures = ++ risk of PTSD development

(Ford & Courtois, 2009)

SUSCEPTIBILITY TO TRAUMA EXPOSURE IN ASD

 55.6% of individuals with ASD have experienced at least one traumatic event in their lifetime

(n=36, age=17-22; Taylor and Gotham, 2016)

 Physical and sexual abuse and assault highest prevalence. Women with ASD 2-3 X more at risk of sexual victimisation

(Rumball, 2018; Mandell et al. 2005; Brown-Levoie, Viecili & Weiss, 2014)

- 95% young adults with ASD report victimisation
 (N=39; Paul, Gallot, Lelouche, Bouvard & Amestoy, 2018)
- > Restricted range of 'typical' traumas investigated

INTERPRETATION OF 'TRAUMA'

- Experience and understanding affected by:
 - > Developmental and cognitive level
 - > Expressive language abilities
 - > Parental/systemic responses and behaviour
 - > Sensory sensitivities
 - Confusion or ambiguity about social interactions/rules
 - Distress regarding changes in routine
 - Distress regarding prevention of stereotypes and restricted behaviours



TYPICAL TRAUMAS





ATYPICAL TRAUMAS



IMPACTS OF TRAUMA IN ASD

TRAUMA SEQUALAE IN ASD

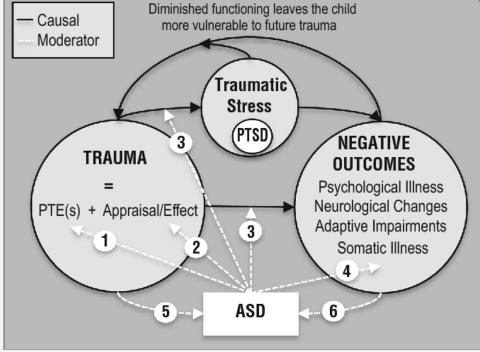
- Range of mental health problems
- Physical symptoms stomach upset, extreme fatigue
- Social issues housing, finances, unemployment, relationship problems
- Appetite and sleep disturbance
- Disruptive behavioural presentations and irritability
- Increased activity levels OR lethargy and loss of interest
- Increases in ASD-related difficulties in communication, daily living, motor skills and social skills found to remain at 12-months post-trauma

(Mehtar and Mukaddes 2011; Valenti et al. 2012; Howlin & Clements, 1995; Mandell et al., 2005; Brenner et al., 2018)

TRAUMA AND ASD

Trauma exposure

Trauma interpretation



Trauma: Trauma occurs when a potentially traumatic event (PTE) is appraised as threatening and adversely effects the individual. Trauma results in a variety of negative outcomes (e.g., depression, physical illness, adaptive impairments) that may or may not be mediated by traumatic stress. Traumatic stress and other negative outcomes, in turn, increase a child's risk of experiencing future PTEs, trauma and traumatic stress.

Trauma & ASD: ASD may influence the experience of trauma at multiple levels, moderating what PTEs are encountered (1), what PTEs are appraised as harmful and threatening (2), the risk of developing traumatic stress and other negative outcomes (3), and the manifestation of trauma-related symptoms/outcomes (4). Experiencing trauma may, in turn, influence the presentation of a child's ASD symptoms and overall development, either directly (5) or via associated illness (6).

Symptoma Symptom

Nature of trauma

PTSD IN ASD

PTSD DIAGNOSIS (>6 YEAR OLDS)

Re-experiencing

- -Intrusive memories
 - -Flashbacks
 - -Nighmares



Avoidance

Trauma-related
-Internal thoughts
-External stimuli

Altered arousal and reactivity

-Easily startled/on edge -Sleep disturbances -Irritable

-ve alterations in cognition/mood

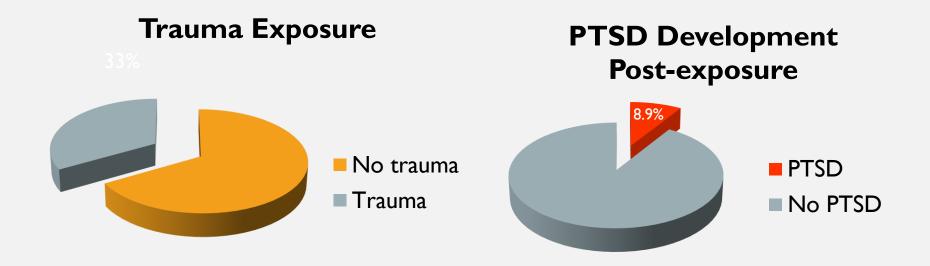
-Impaired recall- limited affect / numb-Negative self/world view or blame

POST-TRAUMATIC STRESS DISORDER (PTSD)

- PTSD symptoms are normal after a traumatic event.
 For most, symptoms will improve over I-3 months.
- Diagnosis requires symptoms > I month
- Rate of PTSD 3.5-9% in community (higher in at risk groups)
- Comorbidity very common: 60-80% PTSD + 'comorbidity'



TRAUMA AND PTSD DEVELOPMENT



Individual differences are key!

ASD AND COMORBIDITIES

- Report fear, anxiety and stress as prominent in their every day life
- Additional psychiatric difficulties:
 - ➤ Separation anxiety
 - ➤ Social anxiety
 - ➤ Generalised anxiety
 - **≻**OCD
 - ➤ Specific phobia
 - ➤ Panic disorder
 - ➤ Agoraphobia



What about PTSD?

ASD AND PTSD

Conditional probability 67%

Age group and rating period for PTSD diagnosis (Studies Included)	N: total sample	Mean rate of PTSD	Mean age (range)	Mean % Females
Children and Adolescents: Current PTSD (White 2012; Reinvall 2016; Storch 2013; Hollocks 2016; Wood 2009; Wood 2015; White 2013; McConachie 2014)	382	2.85%	12.13 (6.5-17)	21%
Children and Adolescents: Lifetime PTSD (Mehtar 2011)	69 ¹	17.4%1	11.7 (6-18)	23%
Children and Adolescents: I2-month PTSD (De Bruin 2007)	941	0%1	8.5 (6-12)	II.7% ¹
Adults: Lifetime PTSD (Hofvander 2009; Taylor 2016)	158	0.8%	23.85 (16-60)	25%

Rumball, F. (2018). A systematic review of the assessment and treatment of posttraumatic stress disorder in individuals with autism spectrum disorders. Review Journal of Autism and Developmental Disorders, 1-31.

ASD AND PTSD

Disjointed memories and flashbacks in ASD:
 Naoki Higashida 'The Reason I Jump'



• PTSD + mood disorder = Increased suicidal thoughts and actions (Storch et al., 2013)

Most research to date from case studies, or wider studies recruiting for anxiety disorders





ASD AND PTSD



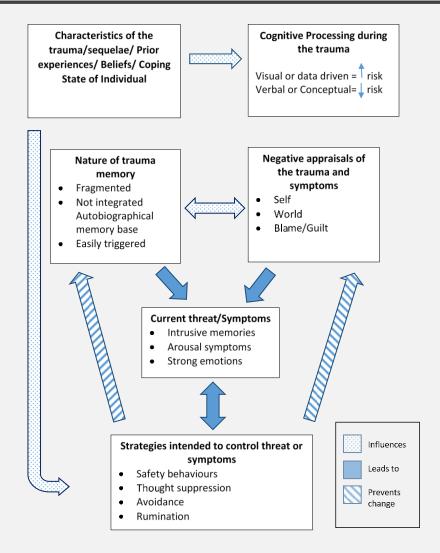


PTSD IN ASD

GENERAL RISK FACTORS FOR PTSD

Pre-trauma	Peri-trauma	Post-trauma
History of mental health problems	Event characteristics: Ongoing or chronic or severe traumatic events – particularly interpersonal/disgust/loss control.	Poor social support. Unhelpful responses of family, school or system. Social withdrawal
History of other traumatic events	Processing focused on imagery, sensory details and lack of wider context	Avoidance and suppression
Females	Guilt/Shame	Rumination
Lower IQ	Overwhelming fear response	Catastrophic appraisals
Neurodevelopmental disorders	Dissociation	Emotion regulation difficulties

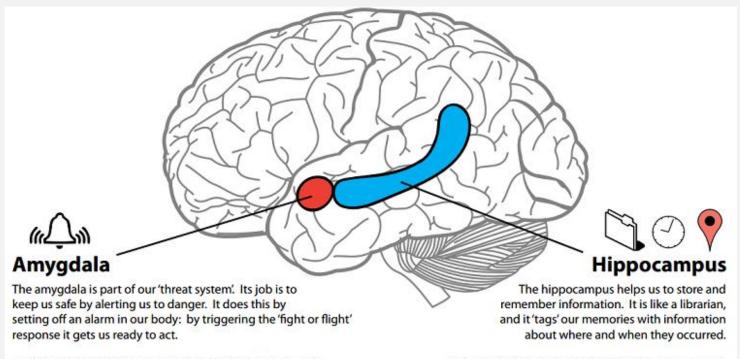
COGNITIVE MODEL OF PTSD (EHLERS & CLARK 2000)





DUAL PROCESSING MODEL OF PTSD DEVELOPMENT





Unfortunately it isn't very good at discriminating between real dangers 'out there', or dangers that we are just thinking about: it responds in the same way. This means that it can set the alarm off when we are thinking about an unpleasant memory from the past, even though the danger has passed.

When our 'threat system' is active the hippocampus doesn't work so well. It can forget to tag the memories with time and place information, which means they sometimes get stored in the wrong place. When we remember them it can feel like they are happening again

Situationally accessible memories (SAM)

- Intrusions and flashbacks

Voluntary memories (VAM)

- Negative beliefs

RISK FACTORS FOR PTSD IN ASD

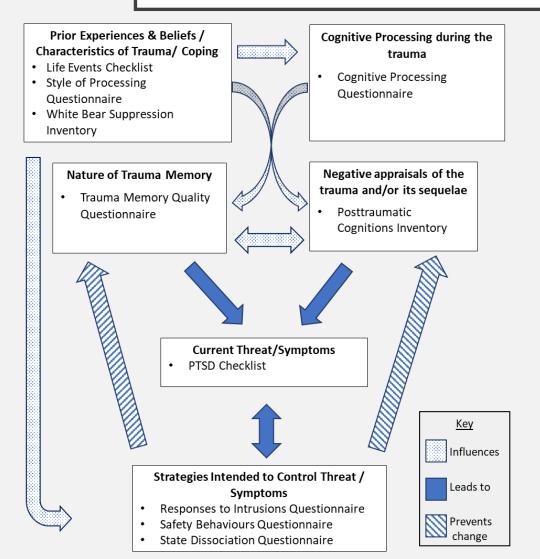
Pre-trauma	Peri-trauma	Post-trauma
Neurodevelopmental disorder	Interpersonal traumas or loss of control	Social difficulties. Lack of social support. Social withdrawal
History of other traumatic events	Detailed focused processing (weak central coherence)	Suppression
Existing comorbidities (~40%)	Sensory sensitivities	Rumination
Intellectual disability (~60%)	Emotional dysregulation: Overwhelming fear response or dissociation	Rigidity of thought & Intolerance of uncertainty

Kerns et al. (2015); Hoover (2015); Haruvi-Lamdan et al. (2017); South & Rodgers (2017)



COGNITIVE RISK FACTORS FOR PTSD IN ASD





CONCLUSIONS

- Range of life events are experienced as traumatic in ASD
- Increased risk of developing PTSD in ASD
- Similar cognitive, emotional and behavioural factors associated with PTSD in ASD

Clinical Implications

- Routine screening for range of traumas and trauma symptoms is crucial
- Existing evidence-based PTSD therapies may be effective for treating PTSD in ASD

TRAUMA-FOCUSED THERAPY FOR ASD TALK OUTLINE

- Assessment of trauma and PTSD
- Treatment of PTSD in ASD
 - Current evidence base
 - TF-CBT and adaptions

ASSESSMENT OF TRAUMA AND PTSD IN ASD

HOW DOES PTSD PRESENT?

Examples		
Physical	Headaches, stomachaches, nausea, eating problems, sleep problems, easily startled	
Emotional	Sadness, anger, irritability, fear, guilt, shame, numb	
Cognitive	Blame, hopelessness, "changed", confusion, difficulty concentrating	
Behaviour	(Younger children: repetitive play, re-enactment) Withdrawal, restlessness, lashing out/destructive, avoidance (trauma reminders/feelings), impulsivity, regression, on edge	
Other (memory)	Unable to remember part/s of trauma, Nightmares (sleep difficulties), flashbacks (spaced out/seeing things)	

Do these look like any other mental health problems?

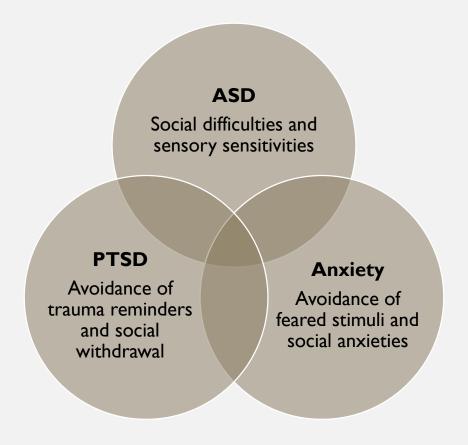
• Trauma-focused avoidance/distress/flashbacks are the main feature differentiating PTSD from other mental health problems.





CO-MORBIDITIES ARE COMMON!

DIFFERENTIATING PTSD AND ASD



DIFFERENTIATING PTSD AND ASD

ASD	Overlap/ Observed behaviours	PTSD	
Deficits in social-emotional reciprocity	Lack of interest in peers	Social withdrawal	
Deficits in social communication	Failure to share emotions	Reduction in positive emotions	
Repetitive use of objects	Repetative play	Intrusive memories	
Inflexible adherence to routines/sameness	Outbursts	Irritability/Anger	
Sleep problems common in ASD	Sleep difficulties	Trauma-nightmares / difficulties falling or staying asleep	

OVERVIEW OF ASSESSMENT

- Clinical interview
 - Presenting difficulties, their onset and modifiers, and their impact
 - Past and current physical and mental health
 - Risk assessment
 - Salient historical and contextual factors
 - Social circumstances and functioning
- Self-report (and informant-report) standardised questionnaires
- Semi-structured assessment tool re trauma and PTSD (client and/or caregiver)
- Assessment of co-morbidities or differential diagnosis
- Timeline of current behaviours: fluctuations in symptoms across time and when first emerged.



OVERVIEW OF ASSESSMENT

Where possible/feasible

- Behavioural observations of symptoms and interactions
- Multiple informants and collateral information (with permission of client/guardian) support staff, teachers, social workers.

Key when communication impairments may affect disclosure

BARRIERS TO ASSESSMENT AND TREATMENT

- Misconception that individuals with developmental disabilities could not understand/appreciate trauma and loss so do not experience associated pathology (Clements, Focht-New, & Faulkner, 2004)
- 70% clinicians assessing ASD refer out for PTSD assessment, as felt not feasible or mandated (Ahlers, 2019)
- 70% clinicians informally assess for trauma related symptoms in ASD, but only 10% universal screen (Kerns, 2019)
- Misconception that people with developmental disabilities cannot benefit from traditional verbally oriented therapies (Mansell, et al., 1998)
- Lack of professionals who are comfortable/trained in identification and treatment of PTSD in ASD (Kerns et al., 2019). 69% ASD clinicians felt they did not have sufficient knowledge in trauma assessment (Ahlers, 2019)

ASSESSING TRAUMA IN ASD

Adapted measures

- Children with ASD **The interactive trauma scale** (Hoover & Romero, 2019). A app/web-based self-report measure of trauma exposure (including aversive experiences of bullying and teasing) and PTSD symptoms. Good convergent and discriminant validity in ASD.
- Youth with ASD 27 item measure for assessing range of aversive events. Parent-report rating how affected the youth was by that event on a scale of I (not at all) to 5 (extremely) (Taylor & Gotham, 2016)
- Diagnostic Manual Intellectual Disabilities (DM-ID, Fletcher, Loschen, Stvrakaki & First, 2007)
 - 1) identify traumatic events 2) assess changes in functioning post-event

General population measures

- The Life Events Checklist (LEC-5; Weathers at al. 2013a).
- Traumatic Events Screening Inventory for Children Brief Form (TESI-C- Brief) & Parent Report (TESI-PR)

TRAUMA ASSESSMENT: ADAPTIONS/CONSIDERATIONS

explaining terminology and offering encouragement open ended
questions & closed
questions about the
experience of
specific trauma types

completing questionnaires together with the individual

Allow time at the end of the assessment session to debrief/stabilise

risk issues and safeguarding should be considered where risks to self or others are ongoing

Don't push specific details and be aware of triggering of flashbacks and dissociative experiences

ASSESSING PTSD IN ASD

Adapted measures: Sequalae of Trauma

- Trauma symptom investigation form in ASD (TIF-ASD; Mehtar & Mukaddes, 2011)
 - Affect of trauma on core ASD symptoms: Verbal communication, behavioural problems, stereotypical and ritualistic behaviours, self-care and vegetative symptoms. Psychometric properties unknown.

Adapted/validated measures: PTSD measures

- Children (validated ASD) Anxiety Disorders Interview Schedule (ADIS C/P):
 Child and Parent Interview Schedules received preliminary support for its validity and reliability in ASD populations (Wigham and McConachie 2014; Ung et al. 2014)
- Adults (adapted & validated ID ONLY) Impacts of events scale-Intellectual Disabilities (IES-ID) Shown to have good psychometric properties in ID
- Adults (adapted & validated ID ONLY) Lancaster and Northgate Trauma Scale (LANTS) – questionnaire, self-report and informant-report version. Good internal consistency and reliability in ID

Very limited
PTSD
measures
validated for
ASD

ASSESSING PTSD IN ASD

Gold standard PTSD measures

- PTSD Checklist (PCL-5)
- Clinician Administered PTSD Scale (CAPS-5)
- Trauma Symptom Checklist for Children (TSCC) is a 54-item self-report measure of post-traumatic stress and related psychological symptomatology in children ages 8-16 years who have experienced traumatic events

Other general population measures

DISC, CAPA, K-SADS and SCID

Knowledge ASD, trauma, trauma sequalae and comorbidities

PTSD ASSESSMENT: ADAPTIONS/CONSIDERATIONS

operationalise terms such as "anxiety" or "trauma" and to use the individuals own idiosyncratic language

PTSD/ASD/suicidality:
Ask about historical
and current self-harm
and suicidal
behaviours/thoughts

Difficulties describing thoughts/feelings: allow adequate time for engagement and discussion

Consider
ASD/PTSD
symptom overlap

ensure that the client is not at ongoing risk from others. If so - safeguarding referral

CONSIDERATIONS IN NON-VERBAL INDIVIDUALS

PTSD can be identified in individuals with ASD and ID using DSM-5 criteria, however alterations in arousal and negative alterations in thoughts and behaviours more easily identified than reexperiencing and avoidance symptoms. (Kildahl et al., 2019)

Difficulties assessing

- Trauma exposure (criterion A) traumatic events that have been covered up or have no visible signs
- Specific intrusive thoughts of the trauma (criterion B);
- Avoidance of trauma related thoughts or emotions (criterion C);
- Inability to recall key features of the trauma (criterion D);
- Overly negative thoughts and assumptions about oneself or the world (criterion D);
- Exaggerated blame of self or others for causing the trauma (criterion D);
- Feeling isolated (criterion D);

may result in false negatives when insufficient criteria are reported to facilitate clear diagnosis

CONSIDERATIONS IN NON-VERBAL INDIVIDUALS

PTSD symptom (DSM-5)	Assessment in non-verbal clients			
Trauma exposure (criterion A)	Requires an informant to be aware that the trauma has occurred, for example sudden unexpected death of a close relative or physical signs of abuse or assault.			
Flashbacks (criterion B)	Behavioural signs that the individual is dissociating from their current environment, such as unresponsiveness and/or seeming to respond to stimuli which are not physically present, which has begun or worsened since the trauma, may indicate a possible flashback; particularly when this behaviour appears to be consistently triggered by stimuli which could act as trauma-reminders. Flashbacks, as internal states, cannot be diagnosed with any degree of certainty however as this requires conjecture.			
Nightmares (criterion B)	Distressed awaking in the night; which has begun or worsened since the trauma. However, again as an internal state, one cannot ascertain the trauma-related nature of the nightmare itself.			
Emotional and/or physical distress to trauma reminders (criterion B)	Screaming, jumpiness, self-harm or distressed facial expressions on exposure to particular conversational topics, TV programmes/content, people (e.g. specific ethnicities, men), places (e.g. school, a particular road) or objects (e.g. fire, water, belts). The trauma-specific nature of emotional distress is key to this diagnostic criterion, in order to differentiate from other forms of avoidance which may relate to phobias or anxiety.			
Avoidance of trauma reminders (criterion C)	Walking away, putting hands over ears or closing eyes on exposure to particular conversational topics, TV programmes/content, people (e.g. specific ethnicities, men), places (e.g. school, a particular road) or objects (e.g. fire, water, belts). The trauma-specific nature of avoidance is key to this diagnostic criterion, in order to differentiate from other forms of avoidance which may relate to phobias or anxiety. Rumball & Spain (2020)			

CONSIDERATIONS IN NON-VERBAL INDIVIDUALS

PTSD symptom (DSM-5)	Assessment in non-verbal clients			
Negative affect (criterion D)	Tearfulness, fearfulness, anger/aggression, which has begun or worsened since the trauma.			
Decreased interest in activities (criterion D)	A reduction in or refusal to participate in activities, which has begun or worsened since the trauma.			
Difficulty experiencing positive affect (criterion D)	Reduction or lack of laughter, smiling, affection or other positive interactions with others; which has begun or worsened since the trauma.			
Alterations in Arousal and Reactivity (Criterion E)	As behaviourally observable symptoms, all of Criterion E PTSD features can be assessed by careful observation and informant report. However, symptoms must have begun or worsened since the trauma.			
Symptoms last for more than I month. (Criterion F)	Symptoms must have been present for at least one month.			
Symptoms create distress or functional impairment (e.g., social, occupational). (Criterion G)	There must have been a deterioration in functioning since the trauma.			
Symptoms are not due to medication, substance use, or other illness.	Symptoms must not be due to side effects of medication or a change in medication that coincided with trauma exposure, a physical or genetic disorder, and not solely explained by ASD and/or ID features, or better explained by another mental or physical health diagnosis. Rumball & Spain (2020)			

EVIDENCE-BASE: PTSD TREATMENT IN ASD

GENERAL CONSIDERATIONS

- Is PTSD the main presenting problem?
- Creating a supportive, safe environment
- Psychoeducation (anxiety, trauma, PTSD)
- Stress reduction and stress/crisis/risk management techniques
- Finding a way to tell their story express the trauma and move forward
- Interventions based on the individual's expressive ability and cognitive development (Clements, Benasutti, & Henry, 2001).
- Supporting the emotional needs and issues of caregivers
- Facilitation to live as normal and meaningful a life as possible and opportunities to make supportive relationships

NICE GUIDELINES FOR PTSD

- Low intensity psychoeducation, support groups and short-term psychological therapies may be provided in a primary care setting
- Longer-term psychotherapies for more complex cases provided in secondary and tertiary care settings and pharmacology.
- Evidence based treatment in outpatient setting (typically 8-12 sessions when trauma is a single event, although more sessions may be necessary for multiple traumas, severe PTSD or complex cases).
- Evidence based psychological treatments for PTSD include:
 - trauma-focused cognitive behaviour therapy (CBT)
 - Eye movement desensitisation and reprocessing (EMDR)
 - some limited evidence for the effectiveness of stress management and group-based CBT interventions
- Treatment should be offered at any point after the first month post-trauma, so long as the individual is currently safe (i.e. low risk to self and from others)
- Comorbidities: if severity wont interfere with the effectiveness of PTSD treatment, in most instances treat PTSD symptoms first

16-20+

sessions

EVIDENCE-BASED TREATMENT OF PTSD IN ASD

Evidence predominantly from case series/reports

Psychoeducation, medication, talking therapies (client and parent based approaches) and psychosocial
interventions (care staff or school staff receiving and/or administering psychoeducation and/or interventions
are helpful treatments for PTSD symptomatology in ASD.

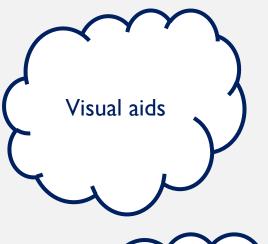
Successful psychological therapy included individual TF-CBT therapy (n sessions = 12 Carrigan 2017), behavioural therapy using systematic desensitisation to trauma reminders (Ryssessions = 9, Kosatka and Ona 2014).

EMDR

- Quasi-experimental study: EMDR, delivered over a maximum of 8 session (Lobregt-van Buuren et al. 2019). PTSD symptoms, psychological distress and reduce post therapy,
- EMDR is a feasible and possibly effective therapy for the reduction of PTSD ASD.

Research has yet to investigate contraindications for the use of different psychological treatments

TF-CBT: I. STABILISATION AND EDUCATION



Psychoeducation - client, caregivers, support team

- Trauma
- Fear/anxiety response
- Emotions, thoughts, bodily sensations, behaviours
- Rational for therapy

Reclaiming life

encourage reintegration with community, support structures, creating a routine and structure in week. Diary planners.

Caregiver support to reinforce skills

Teaching re labelling emotions and fear reactions

Visual plan to outline steps of treatment

TF-CBT: I. STABILISATION AND EDUCATION

Emotion Regulation and Self-soothing

- Relaxation
- Grounding
- Mindfulness
- Safe place imagery

Teaching new skills using concrete steps

List of
triggers and
if-then rule
based coping
plans

Coping/ relaxation skills: Consider sensory soothing

Encourage
practise with
parental
involvement &
reinforcement

TF-CBT: I. STABILISATION AND EDUCATION

Safety planning/interventions

Self Harm: Can be associated with flashbacks (high affect or internal voices) or dissociation (confusion), e.g. head-banging anger aggression, breaking objects.

- Grounding
- Emotionally regulate
- Involve/train the system
- Suicidality
 - Risk/safety plan

Only moving onto next stage therapy if this can be safely managed

Safe people?

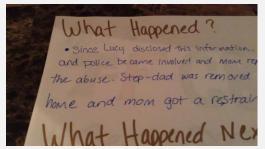
Share safety plan with caregivers / significant others

Rules re social safety: safe/unsafe behaviours

UNDERSTANDING TRAUMA CONTEXT

Orally dictated and in writing/ pictures

Trauma narrative is a psychological technique used to help survivors of trauma make sense of their experiences, while also acting as a form of exposure to painful memories.



Moved Baby Forte gr.

Bom Moved back to File gr.

Bay Tomeline

Of My Tipping

Life

Tiping

And Baby Total gr.

Bay Tiping

Life

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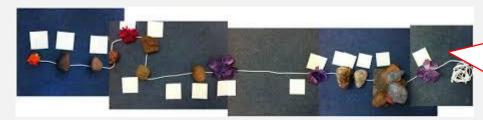
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Life

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Construct a story: Visual aids, puppets, play, drawing, play-doh

Useful tool from Narrative Exposure-Therapy



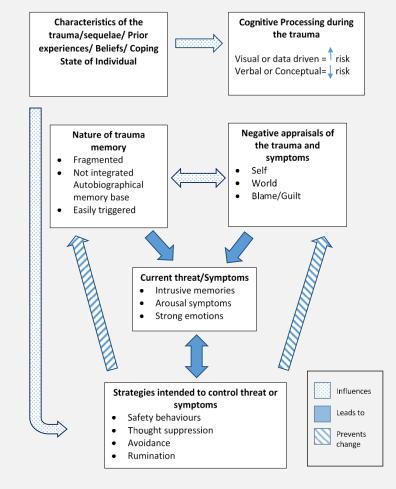
Remember to end with stabilisation and grounding

If unable to elicit trauma narrative – focus on stabilisation (I) and other CBT techniques (3)

TF-CBT: 2. IMAGINAL EXPOSURE









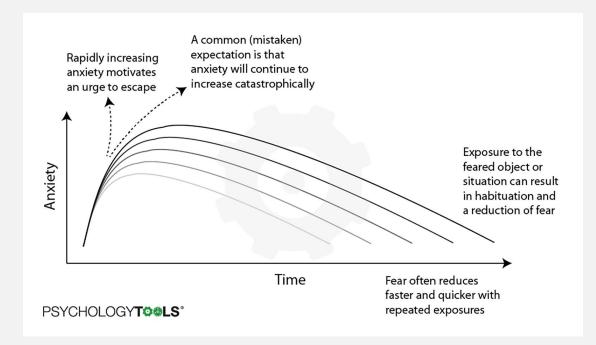


TF-CBT: 2. IMAGINAL RE-LIVING AND RE-SCRIPTING

Exposure/reliving:

- First person imaginal reliving to elicit and affect and key cognitions/fears. Repeating exposure to facilitate habituation.
- Record each reliving and ask client to listen to it between the sessions.

Confuse
Pronouns:
First person
tense is
preferable but
not crucial



I.5-2 hour sessions if tolerated or meet more regularly

TF-CBT: 2. IMAGINAL RE-LIVING AND RE-SCRIPTING





Exposure/reliving:

- Probe:
 - Affect: Subjective Units of Distress; "what are you feeling now"
 - **Cognitions:** "what is going through your mind now" "what are you thinking now"
 - **Bodily sensations:** "where do you notice that in your body" "what are you feeling in your body right now"
 - Sensory aspects: prompts to increase visualisation of the image, smells "take a deep breath what can you smell now"
 5 Senses

Personalise and adapt rating systems













ouch

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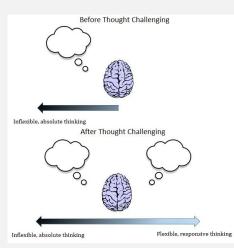
mell

Taste

TF-CBT: 2. IMAGINAL RELIVING AND RESCRIPTING

Re-scripting:

- Discussion and challenging unhelpful or inaccurate cognitions adding in new helpful alternative cognitions.
- Imagery work incorporating in a new person, object, outcome into the reliving.
- Personalised metaphors or analogies can be useful when someone is visual thinker. Links to special interests.
 - e.g. Struggles/discomforts in sessions = wizards training in Harry Potter
- Soothing/grounding in therapy room soothing smells, sounds (play music), colours, textures (holding something). Sensory preferences and sensory soothing.
- Add these new helpful cognitions and images into the reliving (to re-script the reliving narrative). Continue to record each iteration and client to listen to this between the sessions.







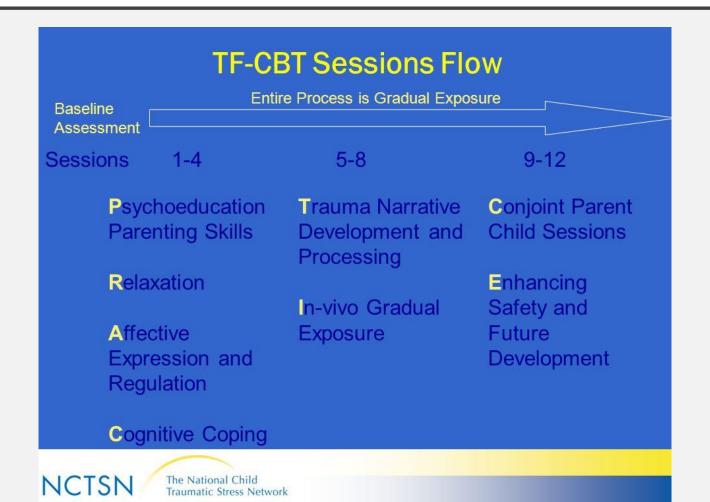
TF-CBT: 3. ADDITIONAL CBT TECHNIQUES

Addressing secondary emotions and stuck cognitions:

- In vivo exposure
- Behavioural experiments
- Surveys
- Imagery work
- Further psychoeducation
- Thought challenging
- Compassion CFT models and compassion approaches to shame and guilt
- Moving on with life and rebuilding identity ACT values work

In vivo
exposure:
Concrete and
scaffolded

EXAMPLE: TF-CBT SESSION PLAN



ADAPTIONS: PTSD TREATMENT IN ASD

TF-CBT: GENERAL ADAPTIONS FOR ASD

- Building rapport and safe environment can take longer but crucial!
 - > Prioritising stabilisation and safety first
 - Compassion modelling and teaching self-compassion
 - > Test out range of grounding/soothing techniques together to find best fit
 - ➤ Increase session duration and/or number of sessions if necessary
- Alexithymia and/or Communication difficulties
 - > Psychoeducation re emotions and bodily sensations
 - Visual prompts/scales
 - > Visual and auditory mediums of communicating
 - > Referring to bodily sensations rather than affect
 - > Simplify language and find common language to explain key concepts
- Executive function difficulties (e.g. distractibility, decision making, completion of tasks) and social/daily living difficulties
 - > May need to support/develop compensatory strategies in first instance
 - > Co-working in combination care co-ordinator or wider community support team.
 - > Working with caregivers, who have the potential to generate an ongoing socially therapeutic environment, may assist in maintenance of treatment gains.

TF-CBT TREATMENT MODEL FOR CHILDREN WITH ASD

Functional	\square	haviour /	Assessment
EUITCUOHAI	De	naviour <i>F</i>	422622HIEHL

Behaviour Support Plans (parents)

Behaviour Skills Training (parents)

Evaluating outcomes

Teaching emotion regulation (mindfulness and relaxation)

Teach emotion recognition

Graded exposure

Cognitive restructuring

Psychoeducation re trauma and fear response

Safety Plan, Parent and child support between sessions

Programme for generalisation and maintenance

- Relationship between behaviour that challenges and the trauma
- Teaching alternative responses and ways to regulate emotions
- Role play, coaching and feedback with parents to teach them the behavioural skills
- Personalised and standardised assessments to measure progress/change
- Using visuals and special interests to increase engagement, reinforcements/tokens for practising or using strategies
- Naming emotions and links to bodily sensations
- Using a structured trauma hierarchy and within-activity schedule, practising across multiple occasions and environments. Increased number of sessions, reduced session lengths
- Clarifying connection between thoughts, feelings, behaviours. Using visual support/images of happy endings and simplified language. Using worksheets where verbal responses are difficult.
- Teaching both child and parents. Regular breaks where sustained attention is challenging
- Visual safety plan (re risk to self and risk from others). Photos of safe adults
- Developing a clear staying well plan and generalisation training

EMDR ADAPTIONS FOR ASD

Barol & Seubert, (2010)

- Longer to develop rapport and gather history from client and system (Phase 1: history and treatment planning)
- Using a biographical timeline (Barol, 2001)
- Longer to develop skills in self/other awareness (mentalising), emotion awareness and regulation, self-soothing, tecniques to interrupt rumination/perseverative thinking
- More attention on supporting and educating system (family and support staff)
- More direct intervention/discussion/prompts during trauma processing phase
- Modifying and individualising the rating scales (e.g. SUDS as visual scale)
- Simplifying language (re cognitions) for developmental level or using images to represent a key cognition
- Processing and soothing emotional and somatic aspects even in absence of cognitive content can be helpful.

Lobregt-van Buuren, E., Sizoo, B., Mevissen, L., & de Jongh, A., (2019)

- Difficulties spontaneously sharing information: Asking about trauma and related symptoms using concrete
 questions and a visual scale (e.g. ADIS-ID)
- Communication difficulties: Using the standard child EMDR protocol, which employs concrete language
- Including an initial session to get to know the therapist, discuss goals and complete questionnaires

RESOURCES

Information on trauma/PTSD in ASD:

- Fact Sheet on Children with Developmental Disabilities National Child Traumatic Stress Network, www.NCTSNet.org (Avrin, Charlton, Tallant, 1998)
- Trauma And Autism Spectrum Disorder A Reference Guide. Bernier Lab University of Washington Center for Human Development and Disability, www.Bernierlab.uw.edu (Earl, Peterson, Wallace, Fox, Ma, Pepper & Haidar, 2017)
- working with ASD and comorbidities: https://oyh.org.au/sites/oyh.org.au/files/ASD-manual_0.pdf

Information on PTSD

Useful information about PTSD, including what PTSD is, treatment options and tips on coping with PTSD symptoms.
 https://www.ptsd.va.gov/; https://www.ptsd.va.gov/; https://www.ptsduk.org/

Support services:

- Samaritans (24/7 free crisis phone line) Call 116 123;
- Shout (24/7 free crisis text line) Text 85258
- SupportLine (survivors of abuse) Call 01708 765200; info@supportline.org.uk

Apps: Smiling Mind (mindfulness and relaxation exercises), **PTSD coach** (symptom tracking and information), **Daylio** (mood tracking)

ANY QUESTIONS?

Acknowledgements

- Collaborators: Prof Francesca Happe, Dr Nick Grey, Dr Anke Karl, Prof Chris Brewin
- Project students: Lucinda Brook,

APPENDIX: DIAGNOSTIC CRITERIA

PTSD DSM-5

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see the DSM-5 section titled "Posttraumatic Stress Disorder for Children 6 Years and Younger" (APA, 2013a).

1. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

- Directly experiencing the traumatic event(s).
- Witnessing, in person, the event(s) as it occurred to others.
- Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.
- 2.Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
 - Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
 - Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). **Note:** In children, there may be frightening dreams without recognizable content.
 - Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
 - Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
 - Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
- 3. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
 - Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
 - Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- 4. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
 - Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia, and not to other factors such as head injury, alcohol, or drugs).
 - Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
 - Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
 - Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
 - Markedly diminished interest or participation in significant activities.
 - Feelings of detachment or estrangement from others.
 - Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

PTSD DSM-5 (CONTINUED)

- 5. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
 - Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
 - Reckless or self-destructive behavior.
 - Hypervigilance.
 - Exaggerated startle response.
 - Problems with concentration.
 - Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
- 6.Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.
- 7. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- 8. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

- **1.Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
- **2.Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). **Note**: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify whether:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

PTSD ICD-10

Arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. Predisposing factors, such as personality traits (e.g. compulsive, asthenic) or previous history of neurotic illness, may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence. Typical features include episodes of repeated reliving of the trauma in intrusive memories ("flashbacks"), dreams or nightmares, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. The onset follows the trauma with a latency period that may range from a few weeks to months. The course is fluctuating but recovery can be expected in the majority of cases. In a small proportion of cases the condition may follow a chronic course over many years, with eventual transition to an enduring personality change (F62.0).

- A. Exposure to a stressful event or situation (either short or long lasting) of exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone.
- B. Persistent remembering or "reliving" the stressor by intrusive flash backs, vivid memories, recurring dreams, or by experiencing distress when exposed to circumstances resembling or associated with the stressor.
- C. Actual or preferred avoidance of circumstances resembling or associated with the stressor (not present before exposure to the stressor).
- D. Either (1) or (2):
- (I) Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor
- (2) Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor) shown by any two of the following:
 - a) difficulty in falling or staying asleep;
 - b) irritability or outbursts of anger;
 - c) difficulty in concentrating;
 - d) hyper-vigilance;
 - e) exaggerated startle response
- E. Criteria B, C (For some purposes, onset delayed more than six months may be included but this should be clearly specified separately.)
- Geneva, World Health Organization, 1992

PTSD ICD-II

Post-traumatic stress disorder (PTSD) is a disorder that may develop following exposure to an extremely threatening or horrific event or series of events. It is characterized by all of the following: 1) re-experiencing the traumatic event or events in the present in the form of vivid intrusive memories, flashbacks, or nightmares. These are typically accompanied by strong or overwhelming emotions, particularly fear or horror, and strong physical sensations; 2) avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event or events; and 3) persistent perceptions of heightened current threat, for example as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. The symptoms persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

C-PTSD ICD-II

Complex post-traumatic stress disorder (Complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). All diagnostic requirements for PTSD are met. In addition, Complex PTSD is characterized by severe and persistent 1) problems in affect regulation; 2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and 3) difficulties in sustaining relationships and in feeling close to others. These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

ACUTE STRESS RESPONSE ICD-11

Acute stress reaction refers to the development of transient emotional, somatic, cognitive, or behavioural symptoms as a result of exposure to an event or situation (either short- or long-lasting) of an extremely threatening or horrific nature (e.g., natural or human-made disasters, combat, serious accidents, sexual violence, assault). Symptoms may include autonomic signs of anxiety (e.g., tachycardia, sweating, flushing), being in a daze, confusion, sadness, anxiety, anger, despair, overactivity, inactivity, social withdrawal, or stupor. The response to the stressor is considered to be normal given the severity of the stressor, and usually begins to subside within a few days after the event or following removal from the threatening situation.