
Identifying and Supporting Trauma in Complex Cases of ASD
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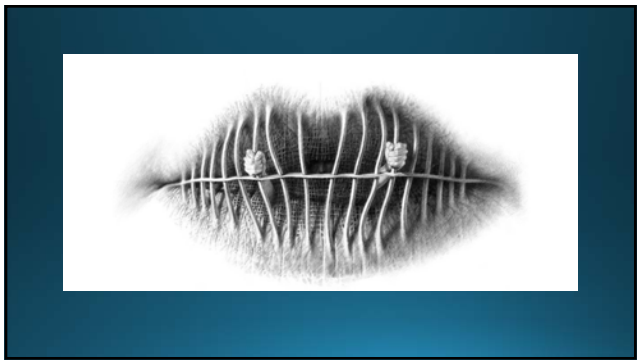
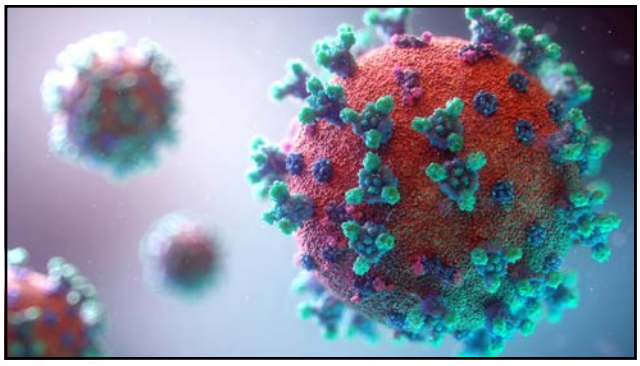
A BLOCK ABOVE
Behavioral Consulting
&
PARLEY
SERVICES


AUTISM


NO




LIAR
Stupid
selfish
TRASH



Learning Objectives

- Define trauma and discuss its impacts on individuals with ASD
- Discuss how symptoms of trauma can present themselves in individuals with ASD
- Discuss and apply how to work in conjunction with an ABA based intensive intervention program
- Discuss applications from Trauma-Focused ACT
- Discuss applications from Trauma-Focused CBT

Prevalence of Trauma

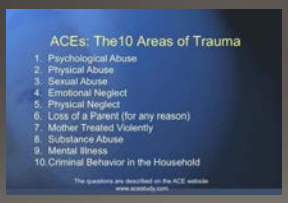
- **Felitti (1998):**
  - 52% of the population experienced at least 1 childhood trauma.
  - 2nd ACE was between 65%-93% (median 80%)
  - 2 or > ACEs was between 40%-74%

Prevalence of Trauma

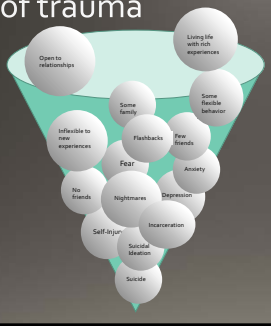
- **So what about in children with ASD?**
  - Prevalence rates are unknown
  - Inferences about vulnerability to trauma can be made:
    - Stack & Lucyshyn (2018): "Individuals with developmental disabilities may be at a greater risk for being maltreated as compared to their typical peers (Hibbard and Desch 2007 ; Kerns et al. 2015)".
    - Stack & Lucyshyn (2018): " Children with developmental disabilities struggle with their communication skills, are more likely to be socially isolated, and are prone to experiencing high levels of familial stress. These factors are common in individuals with Autism Spectrum Disorder (ASD), and make them more susceptible to maltreatment (Sullivan and Knutson 2000).

What is Trauma?

- **So why do we care about ACES anyway and what are they?**



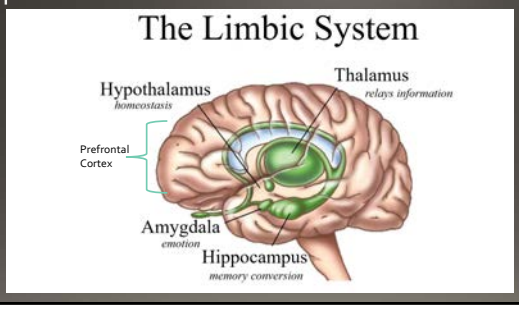
Impacts of trauma



Impacts of Trauma

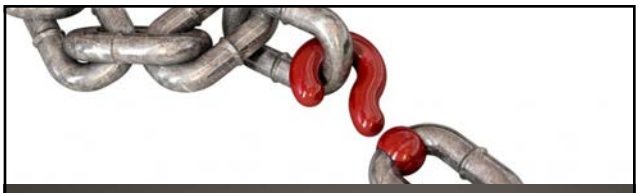
- Effects on development:
  - Neurobiological effects
  - Emotion regulation
  - Cognitive development
  - Behavioral symptoms in children with ASD
    - (Stack & Lucyshyn, 2018)

Impacts of Trauma



Impacts of Trauma

- Emotion regulation (ER)
  - Biopsychosocial model
  - 2 paths for ER:
    - Cognitive reappraisal
    - Expressive suppression



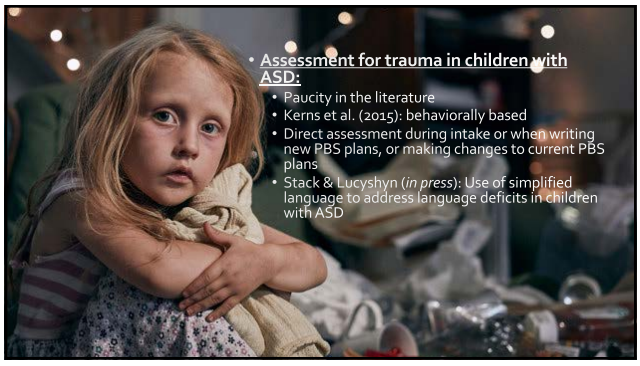
Impacts of Trauma: ER and ASD

Impacts of Trauma

- Cognitive development:
  - TD: Heightened states of arousal= difficulties learning (Van der Kolk, 2003; Stack & Lucyshyn, 2018)
  - ASD: Dearth of research (Stack & Lucyshyn, *In Press;* Stack & Lucyshyn, 2018)

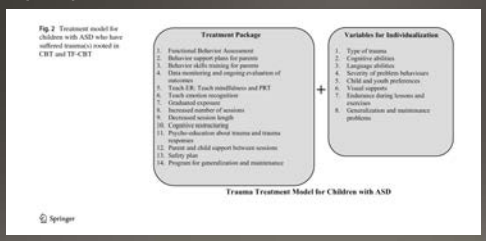
Impacts of Trauma

- Behavioral symptoms and ASD:
  - Increased fear
  - Increased tantrums
  - Increased "intrusive thoughts"
  - "Upsetting memories"
    - (Brenner, 2017)
  - Overlap/symptom overshadowing



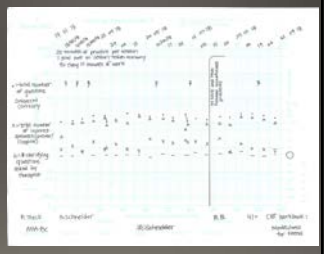
- **Assessment for trauma in children with ASD:**
  - Paucity in the literature
  - Kerns et al. (2015): behaviorally based
  - Direct assessment during intake or when writing new PBS plans, or making changes to current PBS plans
  - Stack & Lucyshyn (*in press*): Use of simplified language to address language deficits in children with ASD

Treatment Components: Stack & Lucyshyn (2018)



Treatment Components: Stack & Lucyshyn (2018)

- Functional Behavior Assessment (FBA)
- Behavior Support Plans for Parents & BI's
- Behavior Skills Training for Parents& BI's
- Data Monitoring and Ongoing Evaluation of Outcomes



Treatment Components: Stack & Lucyshyn (2018)

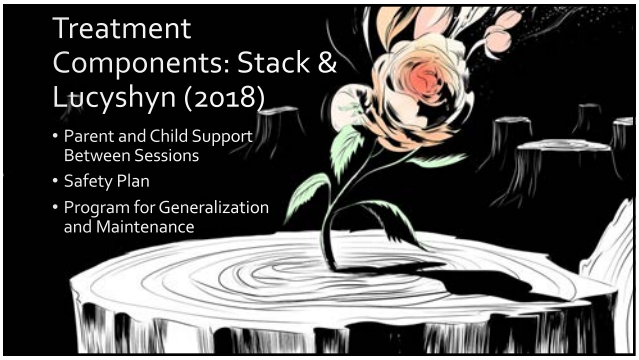
- Teach Emotion Regulation (ER): Mindfulness & PRT
- Teach Emotion Recognition
- Graduated Exposure
- Increased Number of Sessions

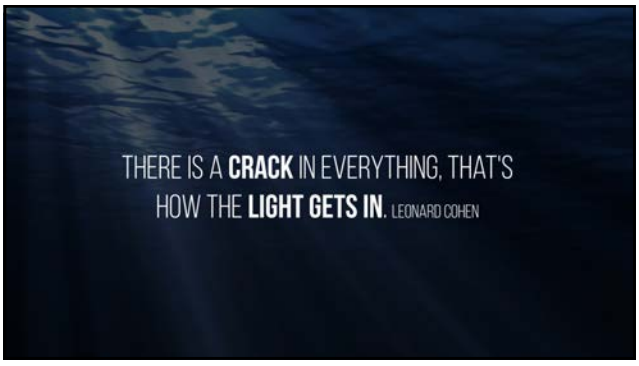
Treatment Components: Stack & Lucyshyn (2018)

- Decreased Session Length
- Cognitive Restructuring
- Psycho-education About Trauma and Trauma Responses

Treatment Components: Stack & Lucyshyn (2018)

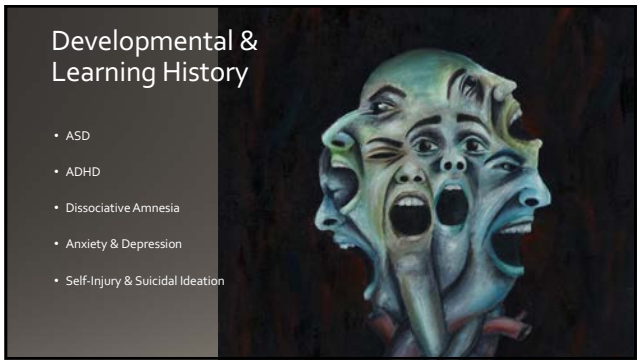
- Parent and Child Support Between Sessions
- Safety Plan
- Program for Generalization and Maintenance

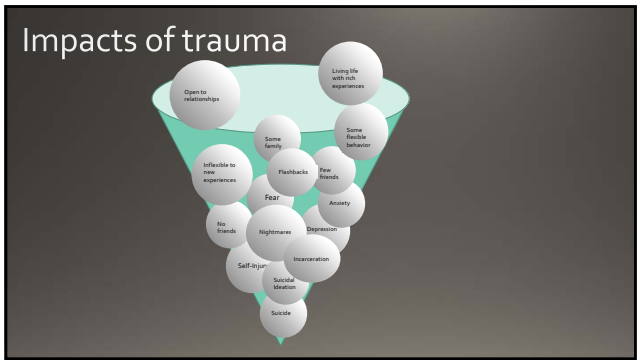


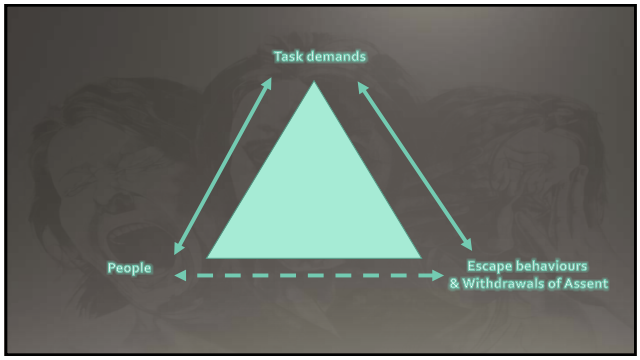


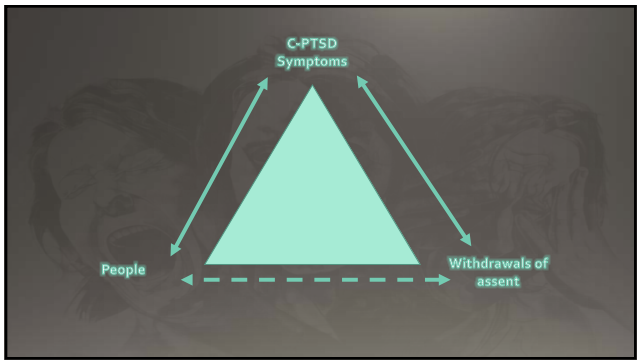

Case Study 1

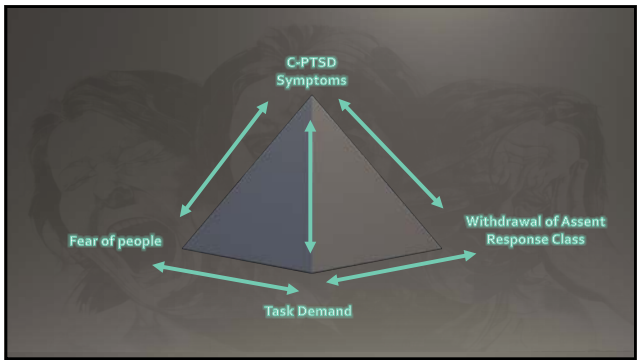

• 16 years old
• Lives with primary care giver
• Attends private school
• Limited social relationships
• Few hobbies
Case Study 1

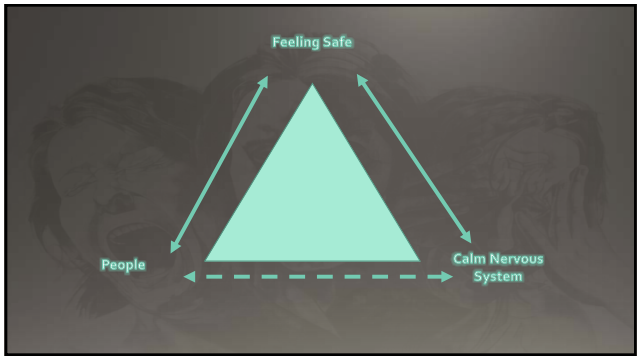

Developmental & Learning History
• ASD
• ADHD
• Dissociative Amnesia
• Anxiety & Depression
• Self-Injury & Suicidal Ideation

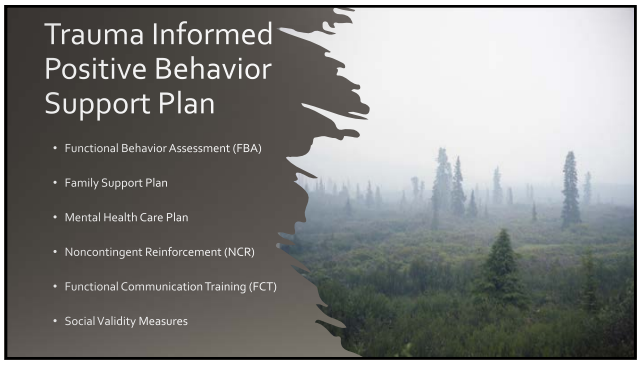

Impacts of trauma
Open to relationships
Living life with rich experiences
Some family
Some flexible behavior
Inflexible to new experiences
Flashbacks
Few friends
Fear
Anxiety
No friends
Nightmares
Depression
Incarceration
Self-injur
Suicidal ideation
Suicide

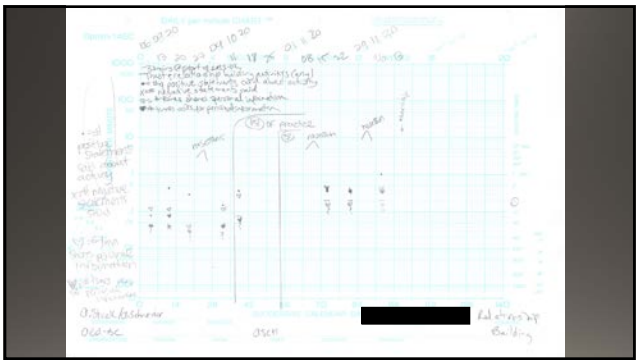

Task demands
People
Escape behaviours
& Withdrawals of Assent

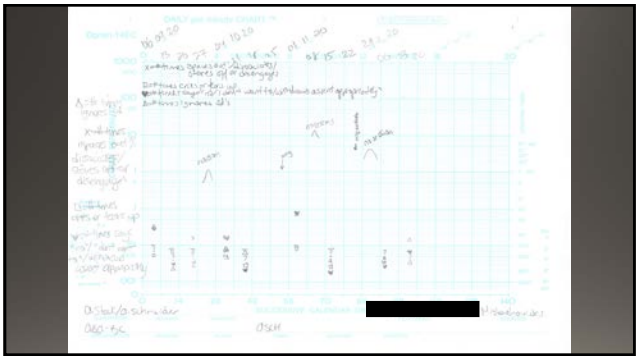

C-PTSD
Symptoms
People
Withdrawals of
assent


C-PTSD
Symptoms
Fear of people
Withdrawal of Assent
Response Class
Task Demand


Feeling Safe
People
Calm Nervous
System


Trauma Informed
Positive Behavior
Support Plan
• Functional Behavior Assessment (FBA)
• Family Support Plan
• Mental Health Care Plan
• Noncontingent Reinforcement (NCR)
• Functional Communication Training (FCT)
• Social Validity Measures





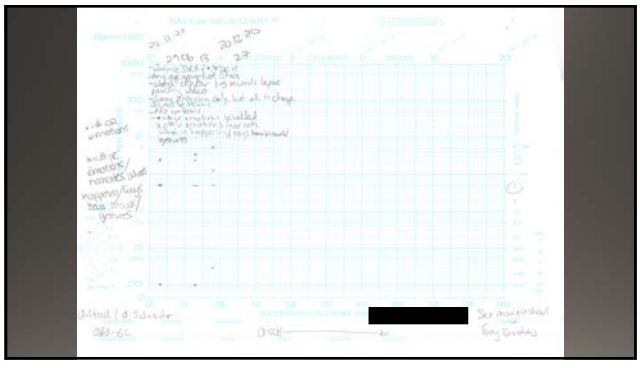

Treatment Components
• Modified Mindfulness Practices
• Modified Meditations

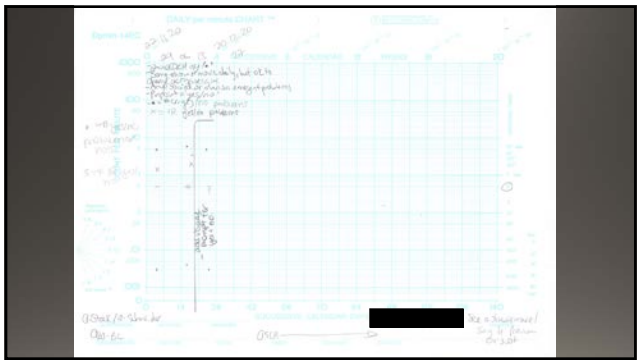
Treatment Components

- Modified ACT:
  - Gradually increase session length
  - Cognitive Diffusion
  - Psychoeducation about Anxiety and Depression
  - Mindfulness Strategies

Treatment Components

- Emotion Recognition in Self & Others
- Social & Conversational Skills
- Social Problems





Case Study 2

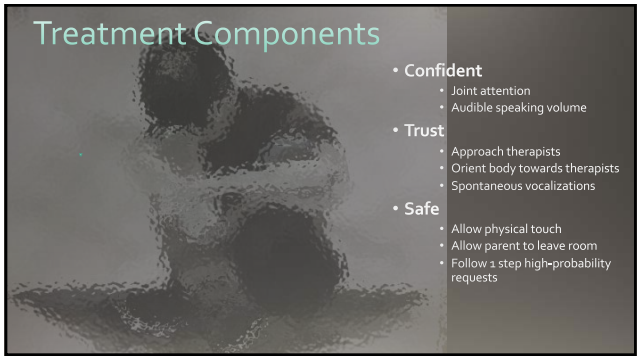
"What treatment, by whom, is most effective for this individual, with that specific problem, under which set of circumstances, and how does that come about?"

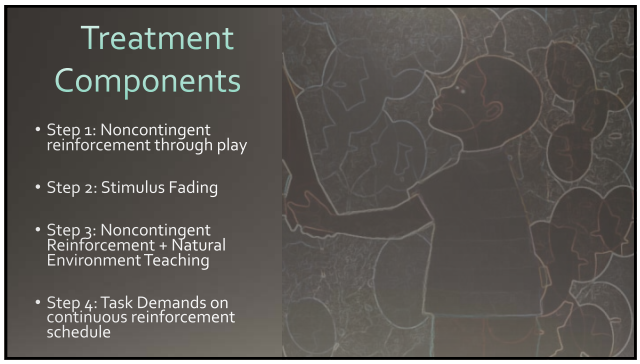
Paul, 1969, p 44

Profile

- Selective mutism
- Impaired mand & tact repertoires
- Refused physical touch
- Inflexible
- Routine driven
- Task avoidance & Elopement
- Food refusal
- Enuresis & Encopresis

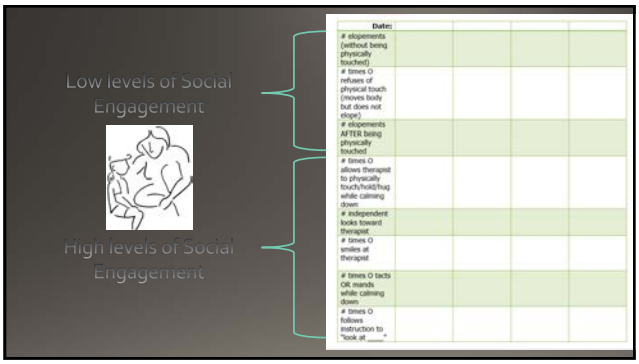

Developmental History

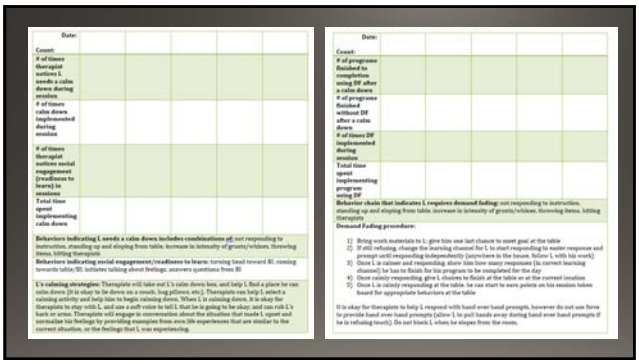

Treatment Components
• Confident
• Joint attention
• Audible speaking volume
• Trust
• Approach therapists
• Orient body towards therapists
• Spontaneous vocalizations
• Safe
• Allow physical touch
• Allow parent to leave room
• Follow 1 step high-probability requests


Treatment Components
• Step 1: Noncontingent reinforcement through play
• Step 2: Stimulus Fading
• Step 3: Noncontingent Reinforcement + Natural Environment Teaching
• Step 4: Task Demands on continuous reinforcement schedule


Treatment Components
• Calm Down/Co-Regulation Plan:
• Sitting with him
• Rubbing his back
• Holding and rocking him
• Cuddling
• Normalizing his feelings
• STOP:
• Talking if he yells or screams
• Touching if moves body away
• NEVER:
• Physically redirect


Social Engagement Hierarchy that indicates L is ready for instruction:
1. Looks towards therapist
2. Turns body towards therapist
3. Allows therapist to approach without walking away
4. Allows therapist to physically touch/hold/hug while calming down
5. Smiles at therapist
6. Follows instruction calmly and readily


Low levels of Social Engagement
High levels of Social Engagement
Date:
elopements (without being physically touched)
times O refuses of physical touch (moves body but does not elope)
elopements AFTER being physically touched
times O allows therapist to physically touch/hold/hug while calming down
independent looks toward therapist
times O smiles at therapist
times O tacts OR mands while calming down
times O follows instruction to "look at



Date:

Count:

# of times therapist notices L needs a calm down during session						
# of times calm down implemented during session						
# of times therapist notices social engagement (readiness to learn) in session						
Total time spent implementing calm down						

Behaviors indicating L needs a calm down includes combinations of: not responding to instruction, standing up and eloping from table, increase in intensity of grunts/whines, throwing items, hitting therapists

Behaviors indicating social engagement/readiness to learn: turning head toward BT, coming towards table/BT, initiates talking about feelings, answers questions from BT

L's calming strategies: Therapists will take out L's calm down box, and help L find a place he can calm down (it is okay to be down on a mush, bug pillows, etc.). Therapists can help L select a calming activity and help him to begin calming down. When L is calming down, it is okay for therapists to stay with L, and use a soft voice to tell L that he is going to be okay, and can rub L's back or arms. Therapists will engage in conversation about the situation that made L upset and normalize his feelings by providing examples from own life experiences that are similar to the current situation, or the feelings that L was experiencing.

Date:

Count:

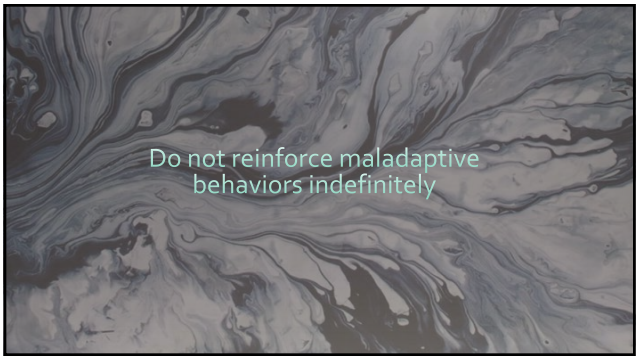
# of programs finished to completion using DF after a calm down						
# of programs finished without DF after a calm down						
# of times DF implemented during session						
Total time spent implementing program using DF						

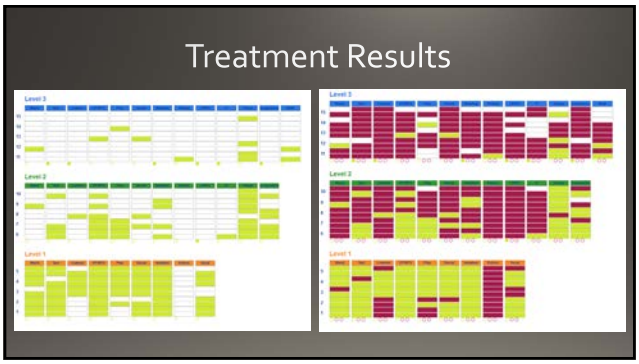
Behavior chain that indicates L requires demand fading: not responding to instruction, standing up and eloping from table, increase in intensity of grunts/whines, throwing items, hitting therapists

Demand Fading procedure:

1) Bring work materials to L, give him one last chance to meet goal at the table
2) If still refusing, change the learning channel for L to start responding to easier response and prompt until responding independently (anywhere in the house. Below L with his work)
3) Once L is calmer and responding, show him how many responses (in correct learning channel) he has to finish for his program to be completed for the day
4) Once calmly responding, give L choices to finish at the table or at the current location
5) Once L is calmly responding at the table, he can start to earn points on his session token board for appropriate behaviors at the table

It is okay for therapists to help L respond with hand over hand prompts, however do not use force to provide hand over hand prompts (allow L to pull hands away during hand over hand prompts if he is refusing touch). Do not block L when he elopes from the room.





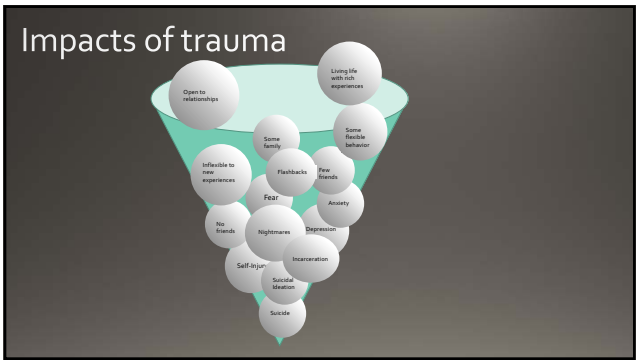
PARLEY

Supporting Trauma
in a Complex Case of ASD
with ABA and ACT

Bobbi Hoadley, M.Ed., BCBA, RCC
President & Practice Leader
at Parley Services

Case Study

- 40 year-old male
- Age 0-5: Normal development, “happy, bright and creative”
- Age 5: Childhood Anxiety Disintegrative Disorder
- Ages 5-8: Sexual abuse from Grandfather
- Adolescent diagnosis of ASD
- Age 34: Antisocial and asocial functioning; basically non-verbal (echoics)
- A lifetime of “experiential avoidance”



Case Study

Variable challenging behaviours:

- Chronic sleeplessness
- Bulimia
- Agitated disruptive behaviour and aggression
- Elopement
- Ripping and property damage
- Sexualized behaviours (exposing and touching) – self and others
- Fecal smearing
- Head banging and other SIBs
- Oppositional

Functional Assessment

- Avoidance and escape motivated isolation, disengagement, agitation or aggression.
- Attention-motivated oppositional or demanding behaviour as a means of exercising choice and control.

Acceptance and Commitment Therapy

Trauma Informed ACT

- People become identified with the content of their mental life to a large extent
- Disentangling people from their "minds" is one of the main goals of ACT
- Helping people get back in contact with another way of knowing the world
- Supporting experiential knowledge through present focus and meaningful engagement

Addressing Experiential Avoidance

First two years of Intervention: Acceptance & Contact with the Present Moment

- Trauma Informed Support
  - Safety
  - Trustworthiness & transparency
  - Inclusion
  - Collaboration & mutuality
  - Empowerment & choice

Addressing Experiential Avoidance

Acceptance & Contact with the Present Moment

- Lots of Mindful Physical Activity with some limits on Stereotypy (escape behaviour)
- Response interruption and redirection, differential reinforcement, shaping, extinction for social challenges to increase inclusion
- Functional communications

Acceptance and Commitment Therapy

Addressing Experiential Avoidance

Third year of intervention: Defusion

Support for PTSD

- Medication withdrawals to support
  - increasing verbal behaviour
  - graduated exposure
  - building insight in the place of fear

Addressing Experiential Avoidance

Third year of intervention: Defusion

- Flashbacks in the form of personal distress, fear, historical behaviour were all facilitated with “naming and reframing”
- Teaching regarding identification and naming of emotional content.

Current Functioning 2019

In Homeshare and with CSWs:

- Verbal tacts, mands and intraverbals
- Identifying feelings
- Engaging with others
  - Full eye contact
  - Social / reciprocal behaviour
  - Learning to read and write, play piano

Fourth Year of Intervention

Self As Context and Acceptance

- Carrying your pain and holding it lightly
- You are what you value and what you do
- Seeing yourself more clearly:
  - perspective-taking
  - (t)aiming your brain

Current Functioning 2020

In Homeshare and with CSWs:

- Medication reduction almost complete.
- Functional communication identifying feelings, and expressing distress and defusion alternatives.
- Systematic desensitization to multiple flashbacks.
- Defusion by labelling and present moment engagement and reassurance.
- Introducing future thinking.
- Disengaging with parents.

Contact Information

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ACBS
ASSOCIATION FOR CONTEXTUAL BEHAVIORAL SCIENCE
https://contextualscience.org/acbs

A BLOCK ABOVE
Behavioral Consulting

PARLEY SERVICES