PTSD & ID:

Post-Traumatic Stress Disorder & Intellectual Disabilities

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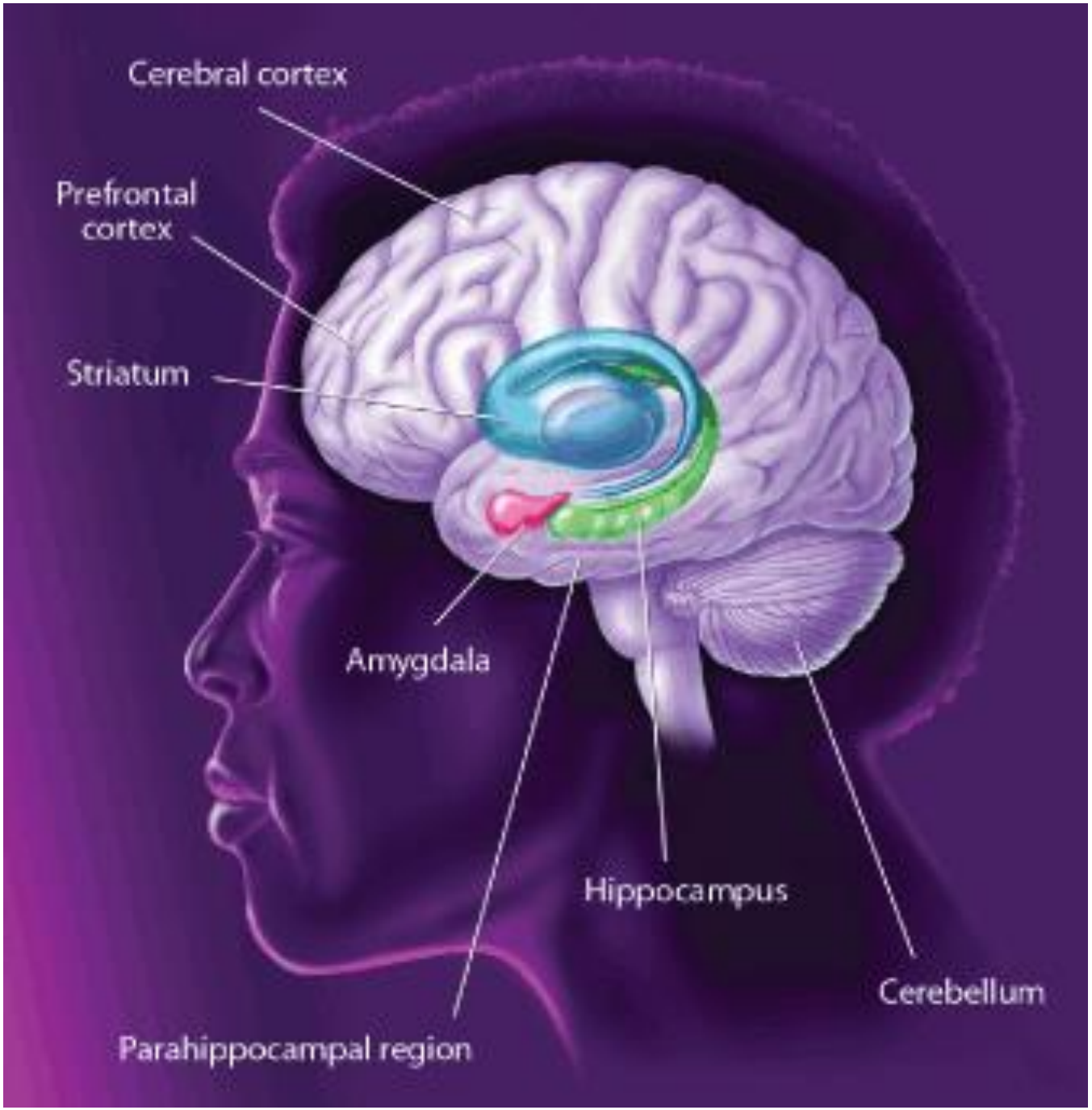
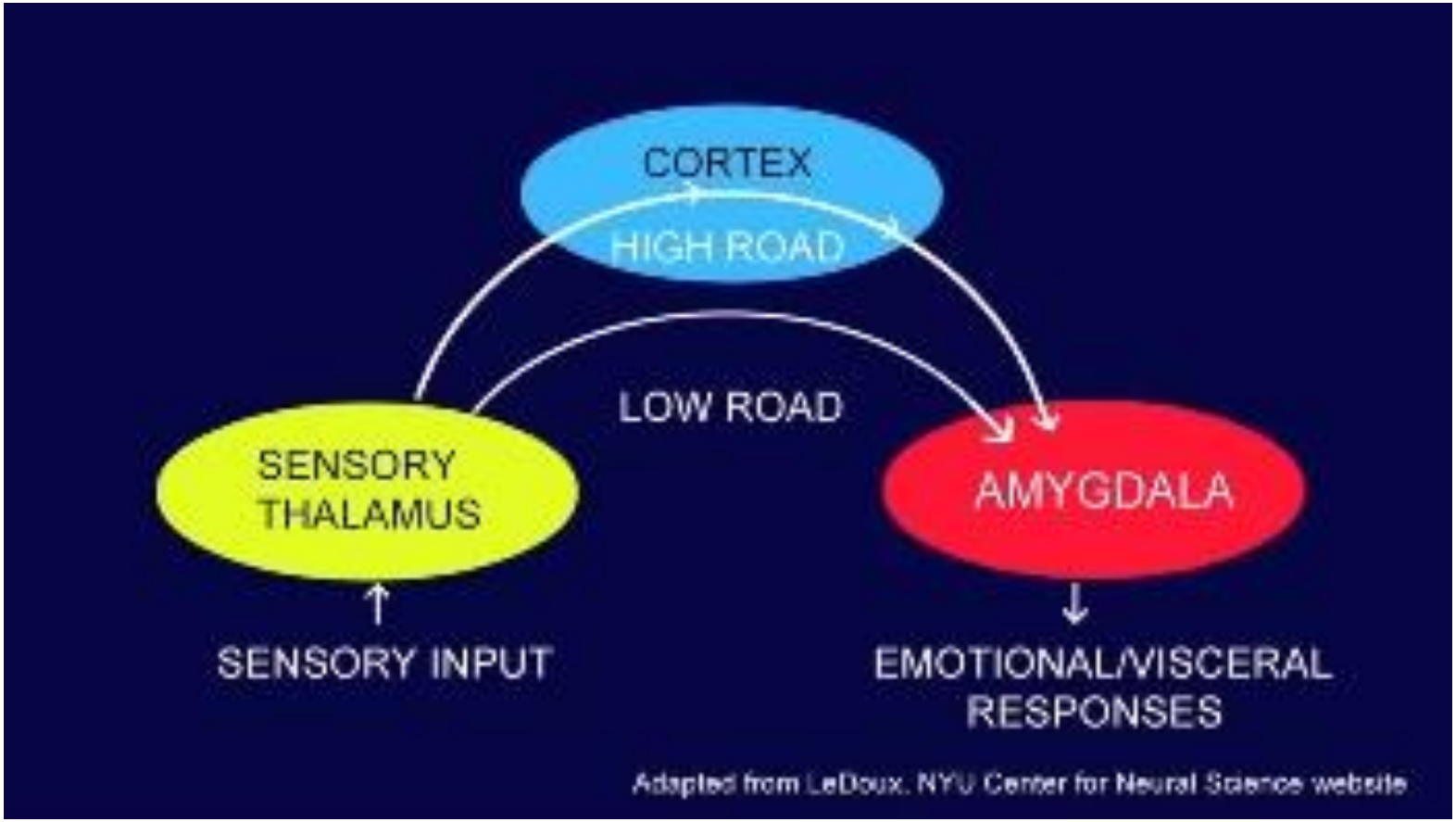
DSM-5

- Trauma:
  - Definition: Any event (or events) that may cause or threaten death, serious injury, or sexual violence to an individual, a close family member, or a close friend. (p. 830)


Cerebral cortex
Prefrontal cortex
Striatum
Amygdala
Hippocampus
Cerebellum
Parahippocampal region


CORTEX
HIGH ROAD
LOW ROAD
SENSORY THALAMUS
AMYGDALA
SENSORY INPUT
EMOTIONAL/VISCERAL RESPONSES
Adapted from LeDoux, NYU Center for Neural Science website

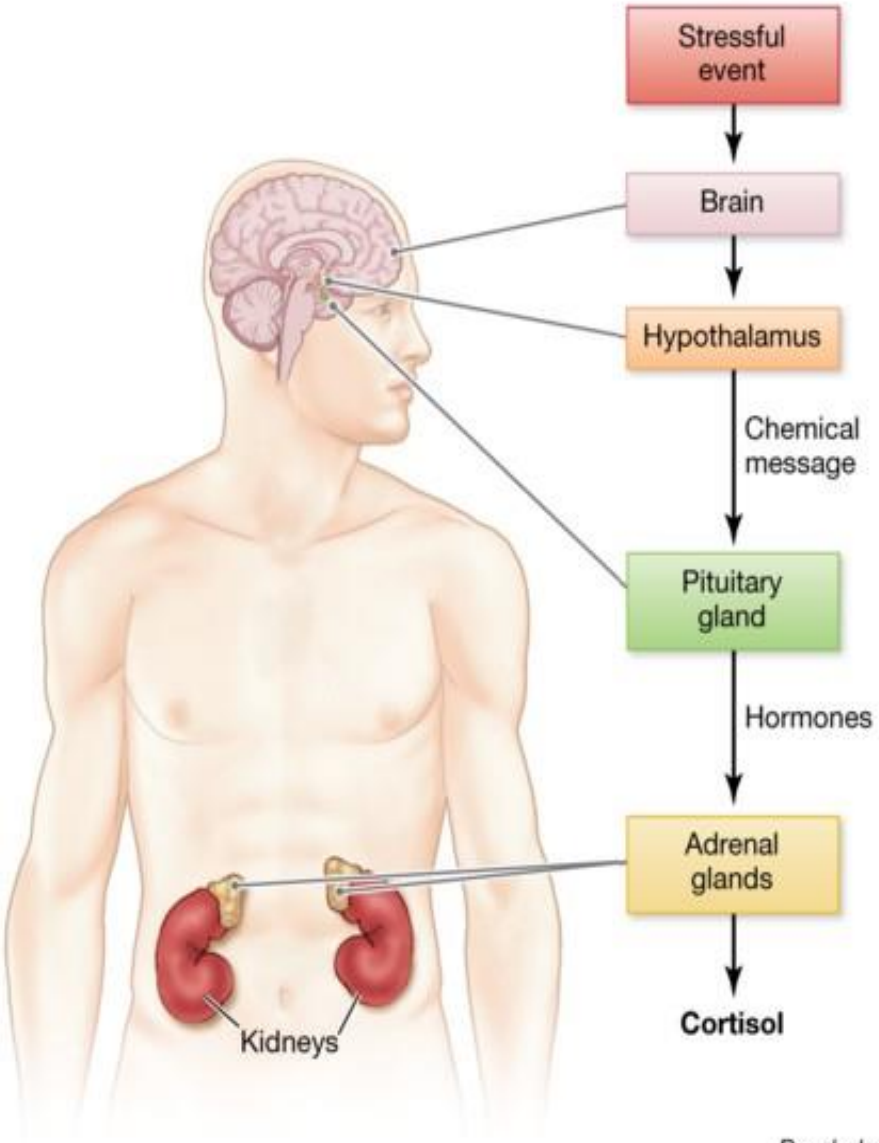
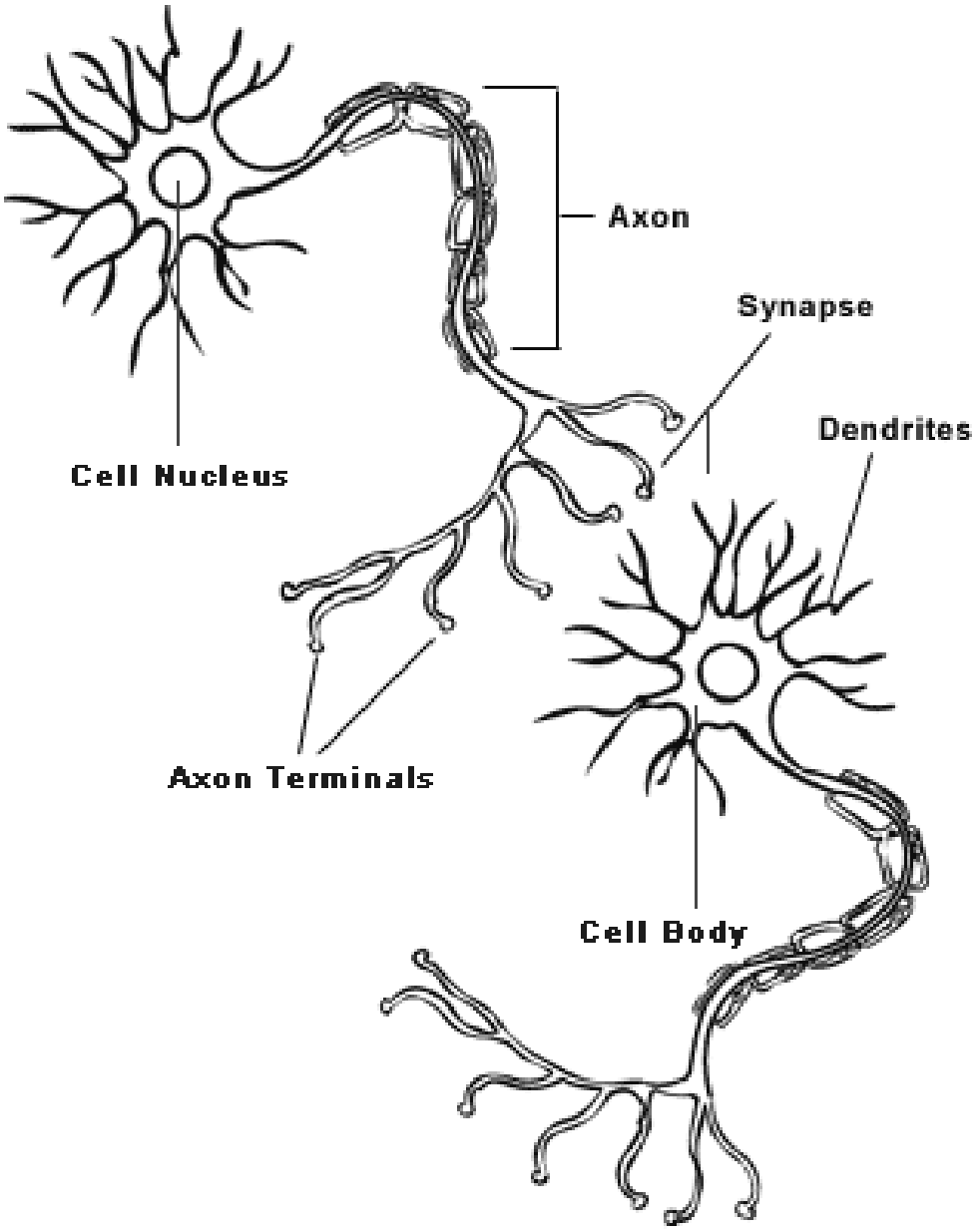
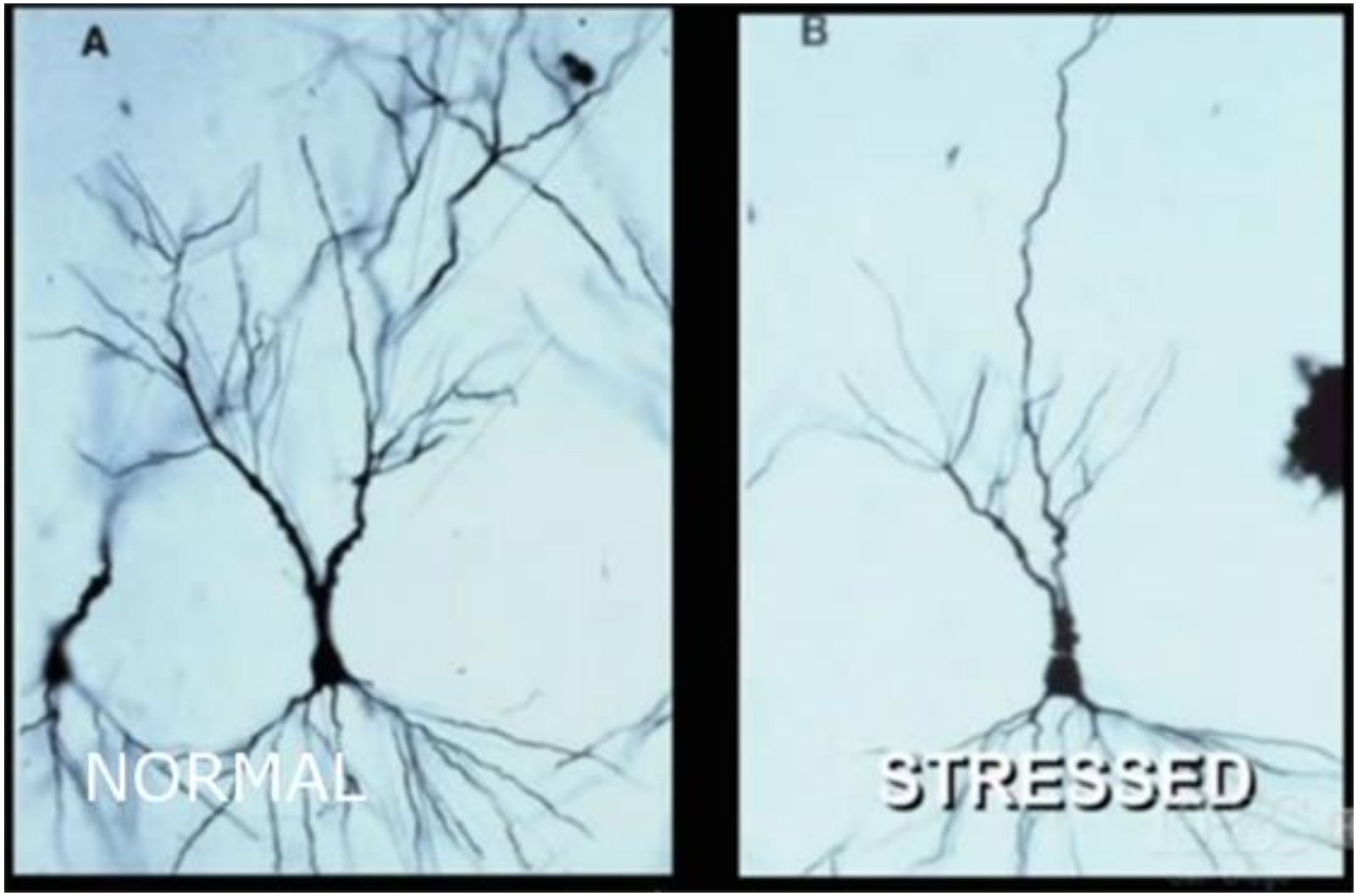
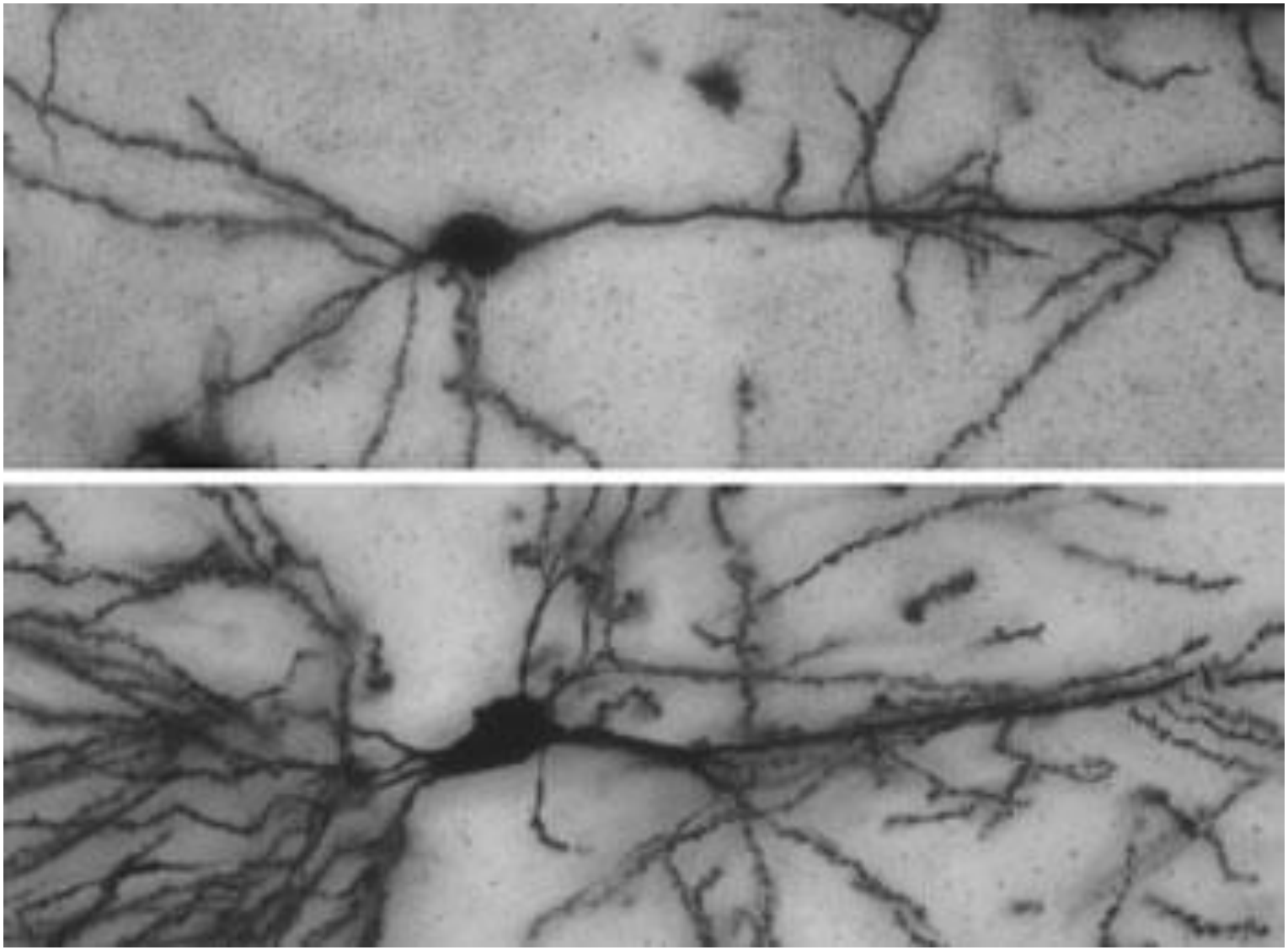
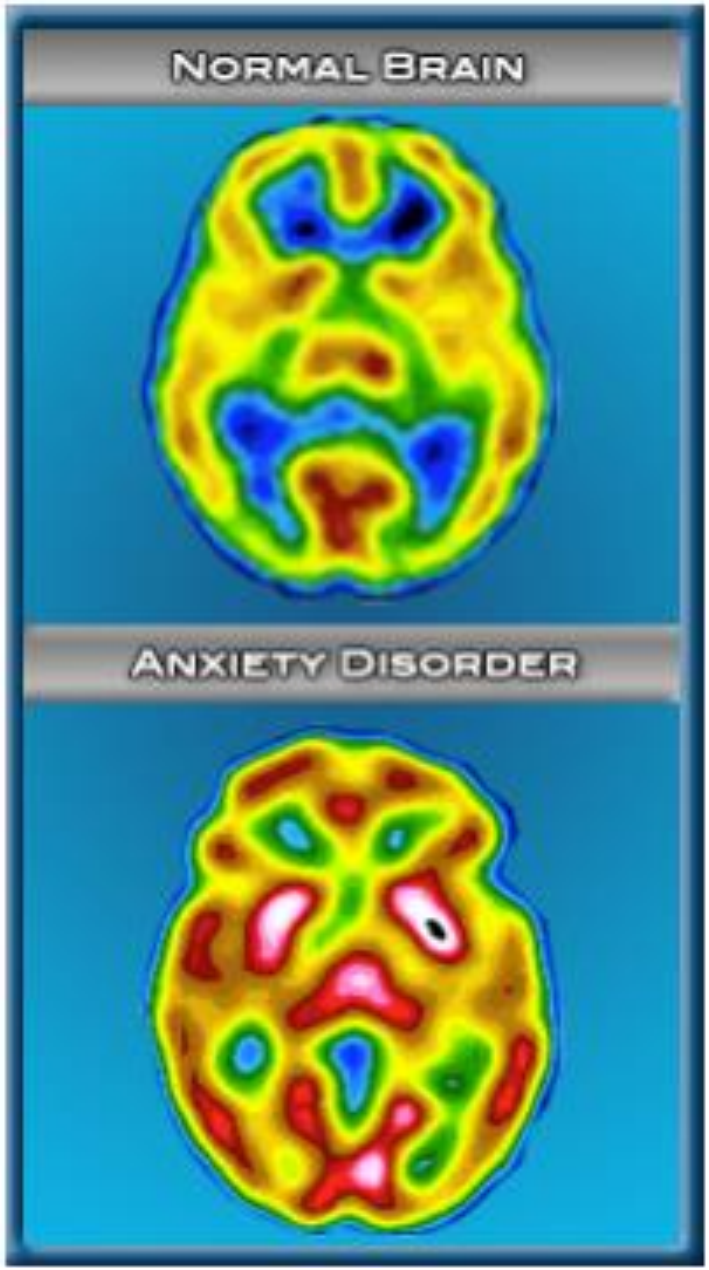


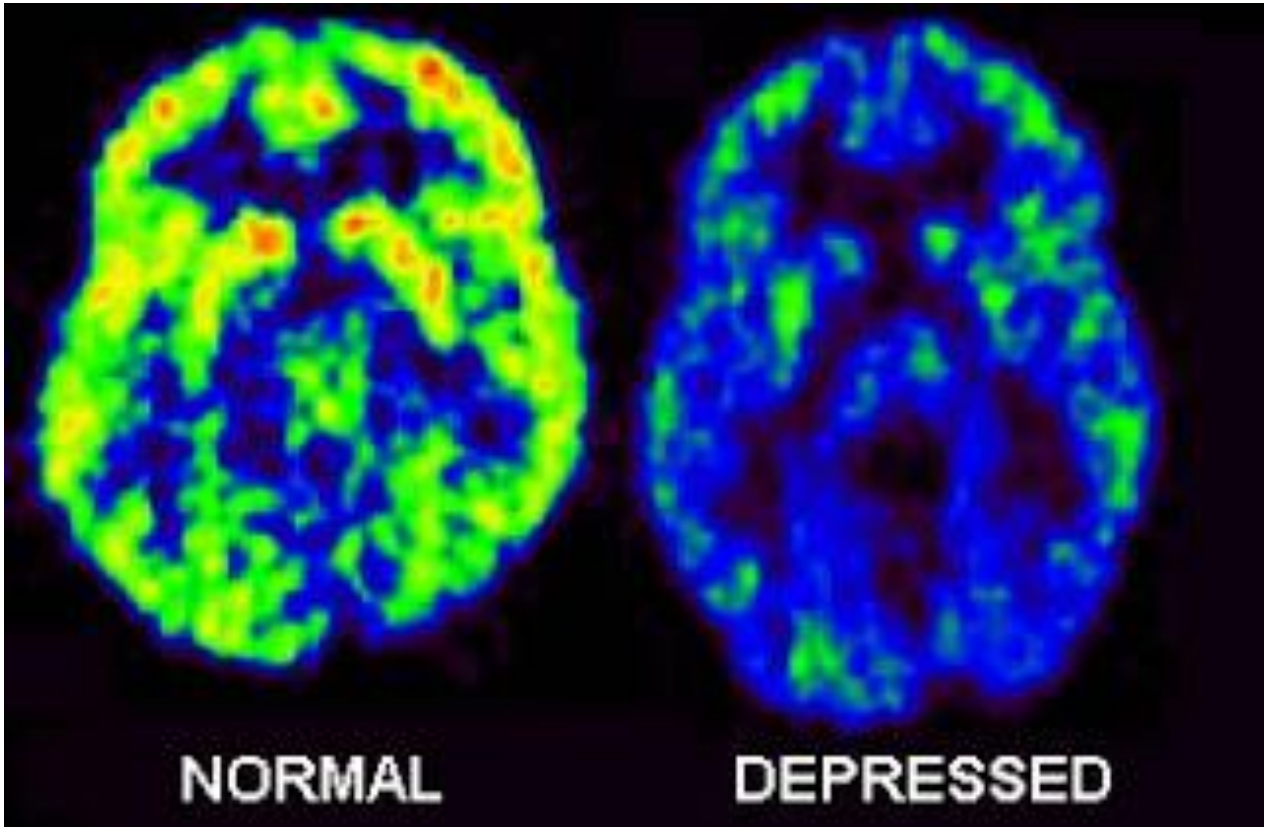
FIGURE 10.6 Hypothalamic-Pituitary-Adrenal (HPA) Axis

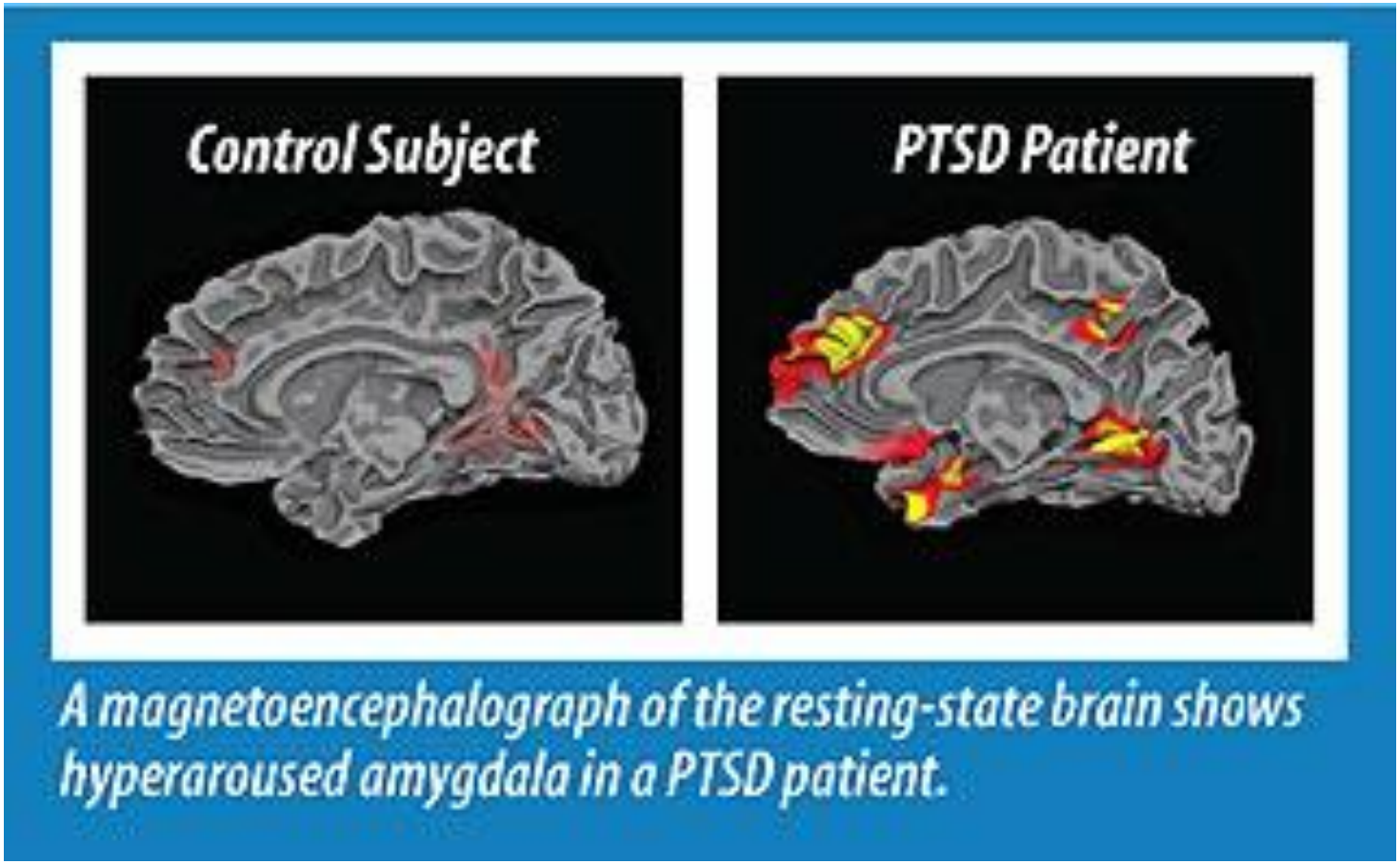

Axon
Synapse
Dendrites
Cell Nucleus
Axon Terminals
Cell Body


A
NORMAL
B
STRESSED

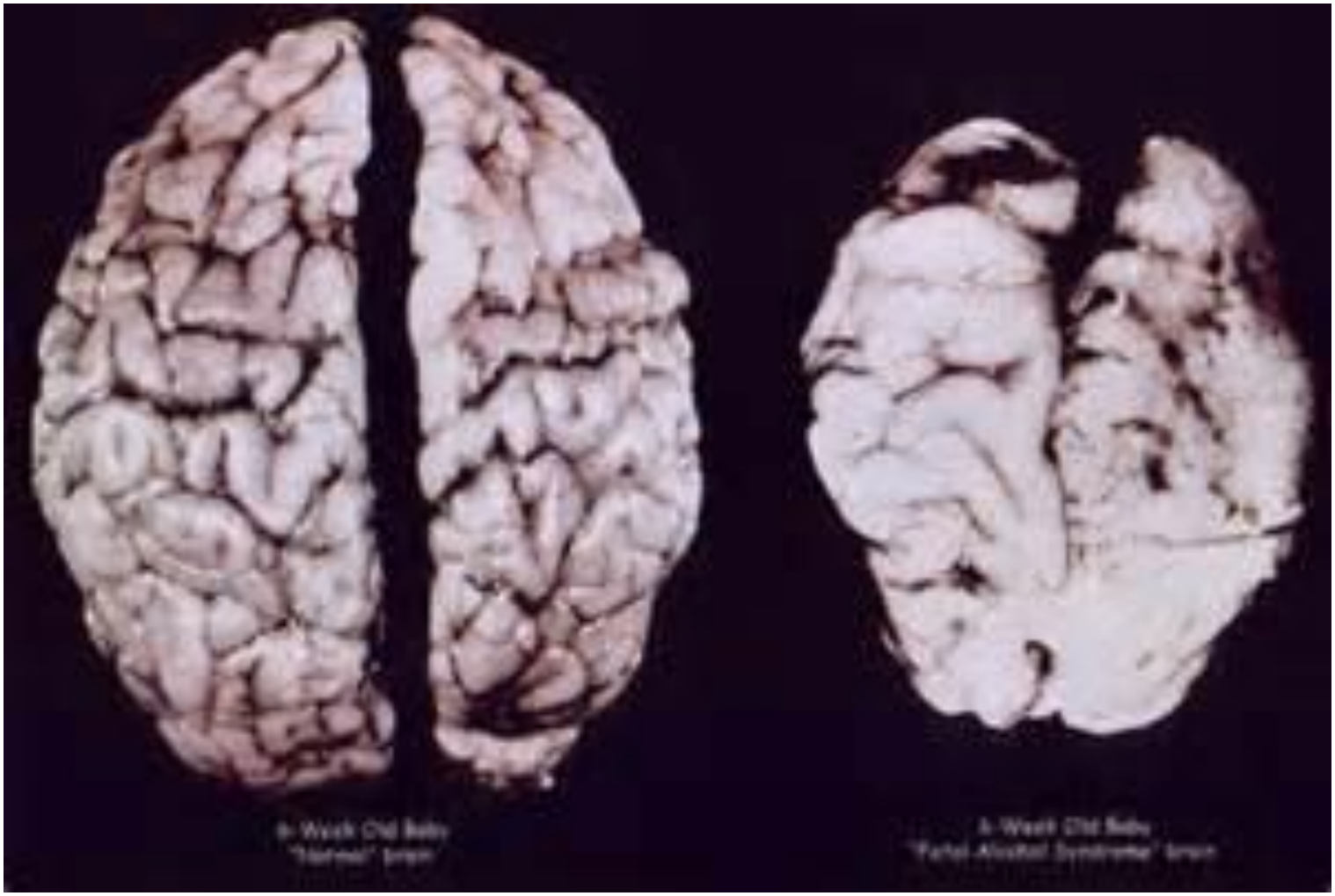



Normal Brain
Anxiety Disorder


NORMAL
DEPRESSED



A magnetoencephalograph of the resting-state brain shows hyperaroused amygdala in a PTSD patient.

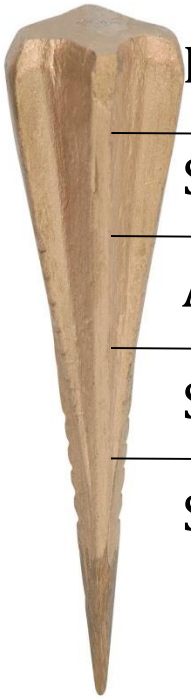


Traumatic Event

Stone

Iron-Nickel Meteorite

Petrified Wood



Physical Survival

Safety

Affiliation – Belonging

Self-esteem

Self-Actualization (Direction)

DSM-5

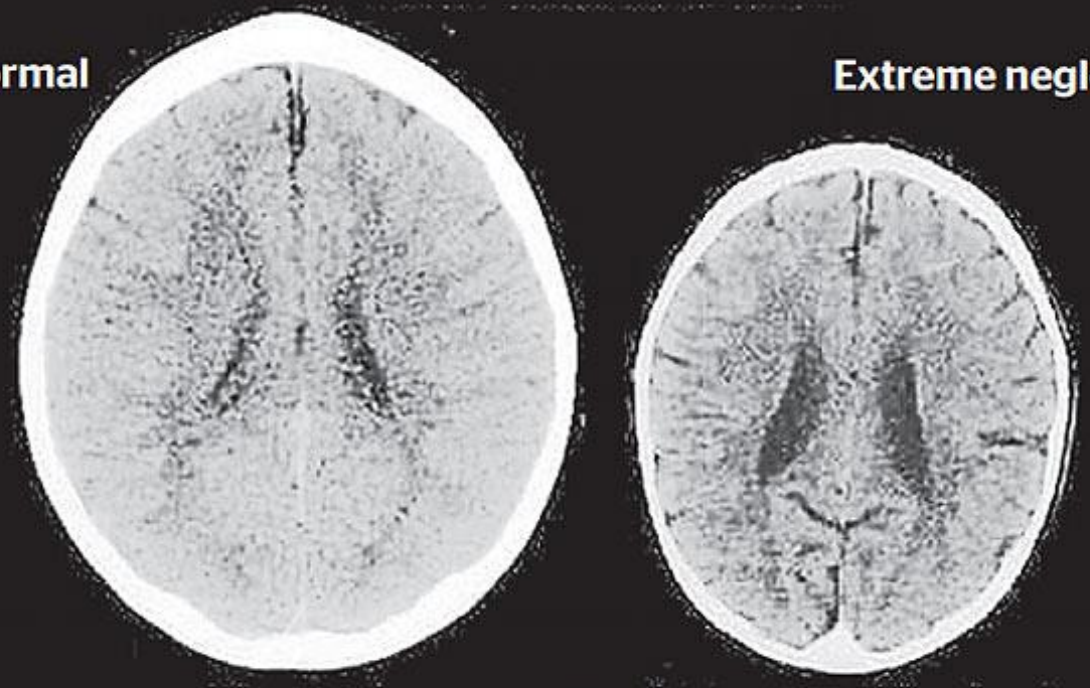
- Trauma-and- Stressor-Related Disorders
  - Reactive Attachment Disorder
  - Disinhibited Social Engagement Disorder
  - Posttraumatic Stress Disorder
  - Acute Stress Disorder
  - Adjustment Disorders

Other Things Affected by Trauma

- Alcohol and drug use
- Depression
- Somatic symptom amplification
- Other risk behaviors (e.g., carrying a weapon)
- Organic disorders related to head injury, toxic exposure, etc.
- Exacerbation of pre-existing chronic mental illness

HOW STRESS CHANGES A CHILD'S BRAIN

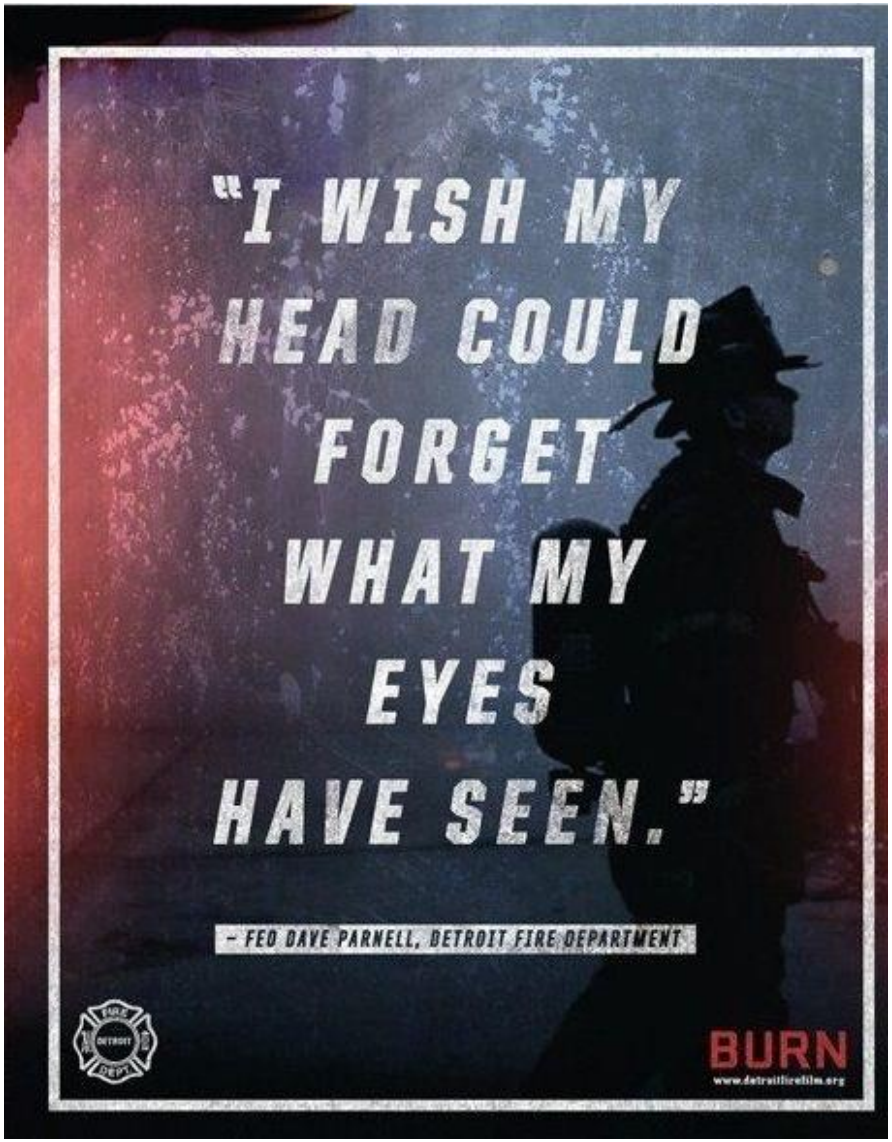
3-YEAR-OLD CHILDREN



- Prolonged exposure to trauma triggers physiological changes in the brain.
- Neural circuits are disrupted, causing changes in the hippocampus, the brain's memory and emotional centre.
- This can cause brain shrinkage, problems with memory, learning and behaviour.
- A child does not learn to regulate emotions when living in state of constant stress.
- Associated with greater risk of chronic disease and mental health problems in adulthood.

PTSD

- Does not imply any pre-existing condition or predisposition
- Exposure may lead to developing PTSD
- Clinical presentation is a function of the person's characteristics


"I WISH MY HEAD COULD FORGET WHAT MY EYES HAVE SEEN."
– FEO DAVE PARNELL, DETROIT FIRE DEPARTMENT
BURN

DSM-5

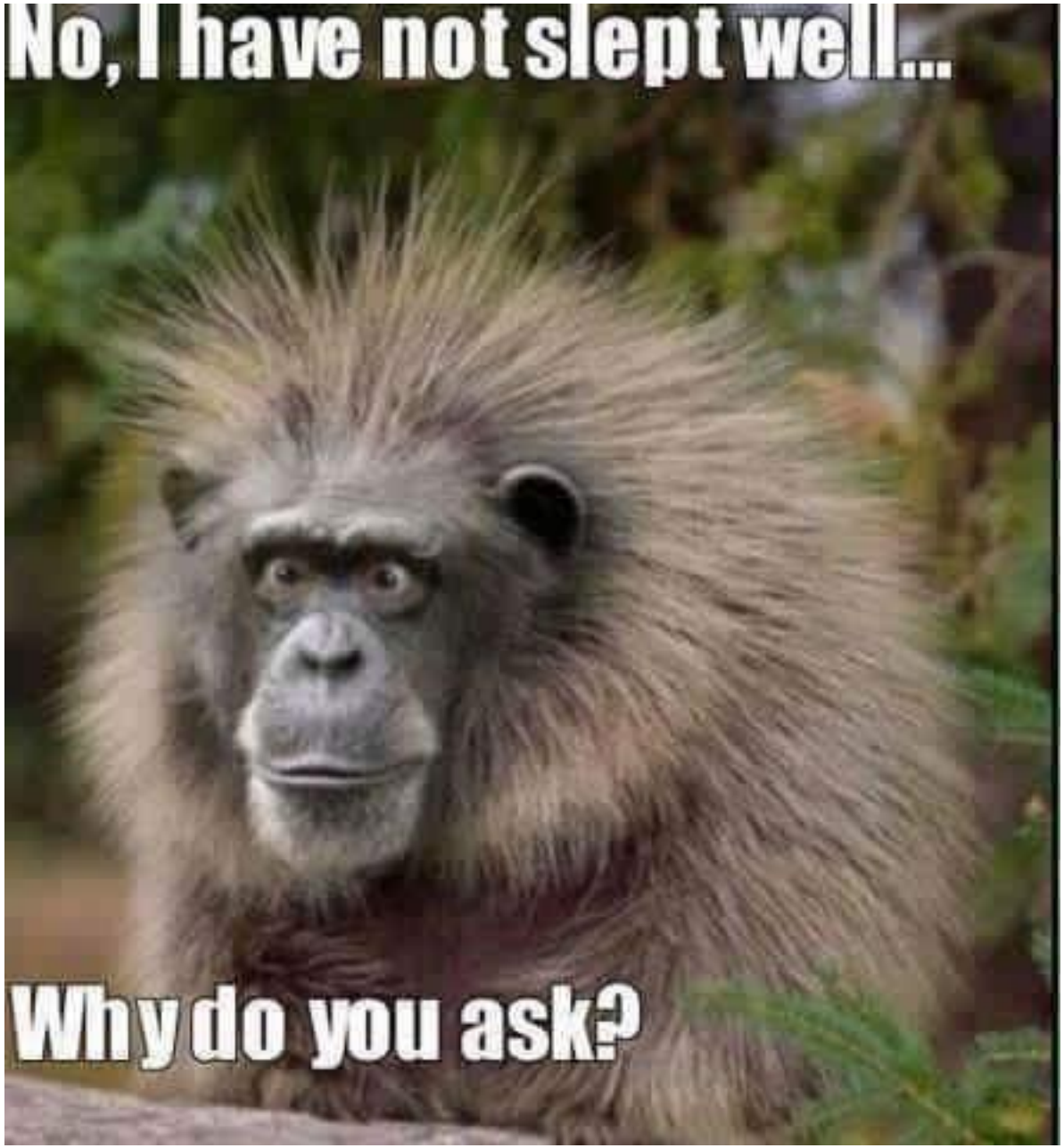
- Essential Features:
  - Exposure to an identifiable event (s)
  - After the event, intrusive symptoms develop:
    - Intrusive memories
    - Distressing dreams
    - Dissociative reactions
    - Intense or prolonged psychological distress with presence of trigger
    - Marked psychological reactions to triggers

DSM-5

- Essential Features:
  - Negative alteration in Mood or Cognition:
    - Inability to remember important aspects of event
    - Persistent negative beliefs / expectations re: self or others
    - Persistent distorted perceptions re: cause or consequences of event

DSM-5

- Essential Features:
  - Negative alteration in Mood or Cognition:
    - Persistent negative emotional state
    - Marked decreased participation in significant activities
    - Feelings of estrangement


No, I have not slept well...
Why do you ask?

DSM-5

- Essential Features:
  - Marked change in arousal & reactivity
    - Begins or worsens after the event
    - Irritable or explosive behavior
    - Reckless or self-destructive behavior
    - Hyper vigilance
    - Exaggerated startle reflex
    - Problems with concentration
    - Sleep disturbance


"I HEARD THUNDER"

DSM-5

- Essential Features:
  - Duration: more than 1 month
  - Clinically significant distress or impairment
    - Social
    - Occupational / Educational
    - Other important areas of functioning

DSM-5

- Note:
  - Fear, Helplessness, Horror (Emotional Reaction) is no longer required

Prevalence

- 12-month - 3.5% of adults in US
- 75 yoa - 8.7% of adults in US

Prevalence

- Individuals with Intellectual Disabilities are:
  - > 4 times as likely to be crime victims *(Sobsey, 1996)*.
  - 2-to-10 times more likely to be sexually abused *(Westat Ind., 1993)*.

Prevalence

- Individuals with Intellectual Disabilities are:
  - 4 to 10 times higher risk of being physically or sexually assaulted
  - 80% have been abused sexually and/or physically, neglected, or mistreated in a variety of ways.

99% of perpetrators are well known to, and trusted by both the child and the child's care providers

(Baladerian, 1991).

Myth

- Low IQ protects you from "understanding" what happened
- You don't have to "understand" to be traumatized
- Most victims do not "understand" the traumatic – They know how it affected them.

Intellectual Disabilities Vulnerabilities

- The less language ability you have – The more likely you will be abused
  - (and the harder it is to report abuse!)
- Trained to obey (cooperate with)
- Not given sexual education, information

Intellectual Disabilities Vulnerabilities

- Isolation & not feeling part of their age group – makes susceptible to manipulation because attention is given
- Delayed processing interferes with judgment
- Naïve

Intellectual Disabilities Vulnerabilities

- Personal care may require others to touch in intimate areas

- Myths held by others:
  - "feel no pain" myth
  - "dehumanization" or "damaged goods" myth
  - "helplessness" myth

PTSD in Intellectual Disabilities

- Symptoms appear directly related to the Intellectual Disability:
  - Acting out when distressed
  - Difficulty describing emotional state
  - Difficulty understanding causality

PTSD in Intellectual Disabilities

- Symptoms appear directly related to the Intellectual Disability:
  - Difficulty understanding effects of his / her behavior and treatment of others
  - Difficulty learning
  - Distorted self-concept

PTSD in Intellectual Disabilities

- Exposure to a traumatic event may Exacerbate person's pre-existing tendencies *(with or without ID)*

- The person's developmental level affects his / her ability (capacity) to use coping skills and adapt

PTSD in Intellectual Disabilities

- Presenting complaint (reason for referral):
  - Will emphasize behavior

(Everyone's symptoms are behavioral)

PTSD in Intellectual Disabilities

- Presenting complaint (reason for referral):
  - Will be a change from perceived Baseline
- Your task:
  - Get an accurate, detailed description of perceived changes
  - Assess how the person feels about his / her symptoms
  - Discover the event (s)
  - Get an accurate, detailed description of baseline
  - Contrast reported symptoms against baseline

Special considerations for interviewing people with developmental disabilities

- Slow down the pace
- Allow ample time to respond
  - 30 seconds or more
- Desire to please overrides
  - Ask yes and no questions both ways
- Short attention span
  - Use visuals/hands-on examples
- Behavior *is* communication

Beware diagnostic overshadowing!

What are we looking for?

- Besides trauma, it's the big three:
  - Intrusive symptoms
  - Avoidance
  - Arousal

PTSD in Intellectual Disabilities

- Common Presenting Complaints:
  - Non-compliance:
    - Not cooperating with or combative with personal care
    - Refusing to complete ADL's
    - Refusing to get up, do chores, get through routine tasks on time
    - Refusing medication

PTSD in Intellectual Disabilities

- Common Presenting Complaints:
  - Irritability:
    - May be situational (affective) or state steady (mood)
    - Agitation – on the edge, can't get comfortable
    - Restlessness – can't sit still, can't relax
    - Increases in
      - Somatic complaints
      - Seeking constant human interaction (especially caregiver)
      - Self-soothing behaviors (including self-stimulating)
      - Isolating / withdrawing

PTSD in Intellectual Disabilities

- Common Presenting Complaints:
  - Angry outbursts:
    - May be a change in frequency, duration, intensity or form *(e.g., now directed at people not things)*

PTSD in Intellectual Disabilities

- Common Presenting Complaints:
  - Angry outbursts:
    - May be described as:
      - "Out of the blue" – No identifiable antecedents
      - Attacking someone he / she would never target before
      - Clusters around specific times, activities, locations – especially if forced to go / participate
      - Destroying beloved possessions

PTSD in Intellectual Disabilities

- Common Presenting Complaints:
  - Self-injury:
    - May be due to obsessively pursuing self-stimulation or specific acts designed to cause injury

PTSD in Intellectual Disabilities

- Common Presenting Complaints:
  - Self-injury:
    - May be described as:
      - Increased rocking
      - Increased head banging
      - Head banging to split the skin open
      - Biting that include breaking the skin
      - Nose picking to the point of bleeding

PTSD in Intellectual Disabilities

- Common Presenting Complaints:
  - Self-injury:
    - May be described as: *(cont.)*
      - Reopening wounds
      - Breaking things to get sharps to cut self
      - Masturbating to the point of damage
      - Including object in the masturbation
      - Gorging on water, air, or food
      - Increase in Pica behaviors

PTSD in Intellectual Disabilities

- How do these behaviors indicate PTSD?
  - Non-compliance:
    - Attempt to avoid situations that look / feel like the traumatic situation
    - Attempt to avoid people who remind of the personnel associated with the traumatic event
    - Attempt to isolate
    - Demonstration of irritability / irritable mood
    - Demonstrates over reactivity

PTSD in Intellectual Disabilities

- How do these behaviors indicate PTSD?
  - Angry outbursts:
    - Effective way to avoid situations that look / feel like the traumatic situation
    - Attempt to avoid people who remind of the personnel associated with the traumatic event
    - Results from agitation caused by increased arousal
    - Demonstration of irritability / irritable mood
    - Demonstrates over reactivity
    - Attempt to achieve isolation (stimulus reduction)

PTSD in Intellectual Disabilities

- How do these behaviors indicate PTSD?
  - Self-injury:
    - Distract one's self from intrusive memories or reliving the event
    - Attempt to localize anxiety, irritability
    - Attempt to remind self the body is real
    - Switch to a stimulus he / she may control

PTSD in Intellectual Disabilities

- How do these behaviors indicate PTSD?
  - Self-injury:
    - To communicate:
      - Pain
      - Irritability
      - Vulnerability
      - Obsessional qualities
      - Something serious has occurred

PTSD in Intellectual Disabilities

- How do these behaviors indicate PTSD?
  - Self-injury:
    - Attempt to again help / nurturance from others
    - Results from agitation caused by increased arousal
    - Attempt to exert external control over internal stress

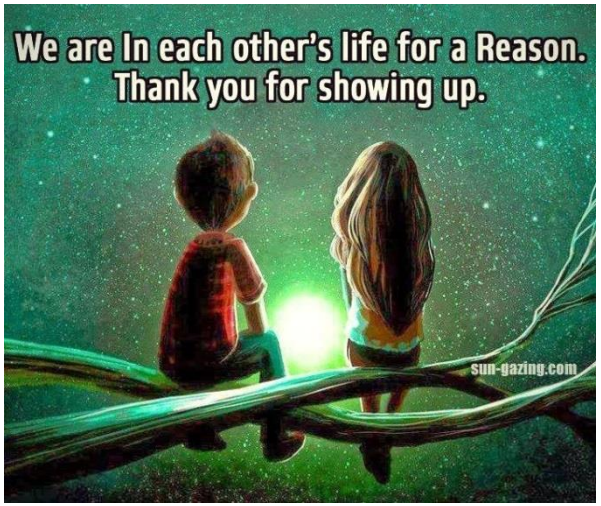
PTSD Treatment Considerations: Intellectual Disabilities

- Above all else:

Do No Harm

PTSD Treatment Considerations: Intellectual Disabilities

- People who feel they have little control
  - Seek the familiar
  - Seek controlled environment
  - Attempt to restore "normal"



PTSD Treatment Considerations: Intellectual Disabilities

- Re-establish Normalcy:
  - Boundaries:
    - You
    - Me
    - Them
    - Word

Reinforce the integrity of the SELF

Re-establish differentiation between SELF and the world

Bolster object permanence of SELF

PTSD Treatment Considerations: Intellectual Disabilities

- Re-establish Normalcy:
  - Make interactions predictable & consistent
    - Use scripts
      - Verbal
      - Choice making
      - Timing
      - Behavioral

Attitude: Be understanding, project confidence and calm

Preparation: Remember behavior is communication – asking for reassurance

Timing: In the moment

Behavior: Remain calm, interactive, but matter-of-fact, address concern directly

PTSD Treatment Considerations: Intellectual Disabilities

- Re-establish Normalcy:
  - Use the weight of familiar routine
    - Segment day into routines
      - Arise
      - Morning
      - Mid-day
      - Evening
      - Bedtime

Use environmental cues

Use sequence cues

Use "First _____ then _____"

Emphasize the natural reinforcement of "feeling normal"

"Behavior first, feelings follow"

Crowd out negative thoughts

PTSD Treatment Considerations: Intellectual Disabilities

- Re-establish Normalcy:
  - Supports:
    - Use natural supports
    - Emphasize boundaries
    - Here & now focus
    - Encourage skill use
    - Expect up's & down's

Demonstrate being present in the moment

Provide safe opportunities to learn & use skills

Practice, practice, practice

Everyone uses the scripts

May have to use formal social conventions


WHEN A FLOWER
DOESN'T BLOOM YOU
FIX THE ENVIRONMENT
IN WHICH IT GROWS,
NOT THE FLOWER.
THEVIBRANTMIND

PTSD Treatment Considerations: Intellectual Disabilities

- Things to anticipate:
  - Critical periods
    - Time of day
    - Location
    - Types of people
    - Environment
    - Anniversaries

Who, what, when, & where's of the event need to be understood

Contrast with here and now

Used to anticipate and plan

for accommodation

for modification

for skill training

for support needs

PTSD Treatment Considerations: Intellectual Disabilities

- Build resiliency:
  - Ways to deal with unexpected stimuli:
    - Noise
    - Changes
    - Touches
    - Smells
    - Feelings
    - Persons
    - Etc.
  - Ways to handle over-stimulation

What can she / he do?

Where can she / he go?

How can she / he get help?

How can she / he remain in control?

What skills, scripts can she / he use?

PTSD Treatment Considerations: Intellectual Disabilities

- Approach dispositions:
  - Individual is a Person
  - Put the person on equal standing
  - Use collaborative approach
  - Tell the person what you are going to do before you do it

Behavioral reactions are communication –
Not attempts to manipulate

PTSD Treatment Considerations: Intellectual Disabilities

- Contextualize Event:
  - Use a life-line (time line)
  - Use visuals
    - Time lines
    - "Me" boxes
    - "Secret Gardens"

Re-establishing boundaries to place things in context

PTSD Treatment Considerations: Intellectual Disabilities

- Contextualize Event:
  - Recognize, differentiate & understand bodily sensations
    - Build affective vocabulary
    - Coordinate affective vocabulary with body state
    - Use visuals
      - Drawings
      - Collage
      - Pictures
    - Progressive relaxation

Grounding self – Mastering physical self

PTSD Treatment Considerations: Intellectual Disabilities

- Trigger Management:
  - Identify triggers
  - Define triggering qualities
  - Inventory his / her responses to those qualities
  - Develop alternatives
    - Avoidance
    - Accommodations
    - Desensitization
    - Mastery

Grounding self in the environment – Mastering the environment

PTSD Treatment Considerations: Intellectual Disabilities

- Group Therapy:
  - "I am not alone" – decrease isolation
  - "Others have survived" – build hope / future
  - Emphasize Role Play & Social Skill training
    - Observe strengths and needs in the interactions
    - Individual becomes aware of personal social behaviors
    - Opportunities to practice

Grounding self in group – Mastering self in groups

PTSD Treatment Considerations: Intellectual Disabilities

- Motivation:
  - Identify the emotion (s) driving his / her actions
  - Help him / her see the effects of his / her actions
  - Align verbal interactions with client's stated goals

    "I know you're the type of person who wants _____ . What can you do to help you get that?"

Grounding purpose – Mastering self-determinism

PTSD Treatment : Intellectual Disabilities

- Evidence Based Treatments:
  - Cognitive Behavioral Therapy (CBT)
  - Trauma Focused – Cognitive Behavioral Therapy (TF-CBT)
  - Dialectical Behavioral Therapy (DBT)
  - Skill Streaming

PTSD Treatment : Intellectual Disabilities

- Medical Treatments:
  - Anxiolytics
  - Antidepressants
  - Mood stabilizers
  - Sleep agents
  - Upper GI treatments

What if someone reports abuse to me?

- We're all mandated reports (24/7), but how to go about reporting depends on your role…
  - Direct caregiver: listen, document, and report to your supervisor
    - Stay with them (this is not a time to abandon)
    - Avoid interviewing them; just listen
  - Supervisors, therapists, medical staff, etc.: listen, document, and follow procedures
    - Avoid leading questions