TRI-STATE WEBINAR SERIES

Complex Case Discussion:

Educational Identification of Students Suspected of a Developmental Disability Who May Have Experienced Trauma

Presented by: Susan Hepburn, Ph.D.

Tri-State Autism Spectrum Disorder Webinar Series

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Learner Objectives

1. Describe what trauma is and how it can impact social functioning, communication development, and behavioral flexibility in children

2. Describe what Autism Spectrum Disorder is and how it can impact social functioning, communication development and behavioral flexibility in children

3. Identify 3 assessment practices that can help to determine if a child is presenting with ASD, or with social-emotional challenges associated with trauma, or both

4. List 3 resources that can be helpful for families raising a child with both a developmental disability (like ASD) and a history of trauma.

CHILDHOOD TRAUMA VS. ASD

Definitions, Overlap & Distinctions

DEFINITIONS

TRAUMA

DSM5 (APA, 2013): "exposure to actual or threatened death, serious injury or sexual violence"; also includes witnessing events

APA Presidential Task Force on PTSD & Trauma in Children and Adolescents (2008) adds:

- various forms of maltreatment
- exposure to violence, war, conflict
- family dysfunction
- severe victimization by peers
- pervasive/significant public health problems
- natural disasters/famine/environmental
- extreme poverty
- prolonged/complicated grief

ASD

DSM5 (APA, 2013): "Persistent deficits in social communication and social interaction across multiple contexts

Restricted, repetitive patterns of behavior, interests, or activities

Symptoms must be present in the early developmental period

Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning

Symptoms are present currently or by history"

Etiological Factors (what causes the condition)

TRAUMA

Experience changes the neurobiological infrastructure & significantly impacts development

Acquired (not born with it)

Sometimes, rooted in dysfunctional parent-child relationships

ASD

Neurobiological infrastructure is built differently & significantly impacts development

Congenital (a person is born with it)

Not rooted in dysfunctional parent-child relationships

Biological Findings

TRAUMA

Larger amygdala volumes

Smaller hippocampal volume

Dysfunctions in HPA-axis

Shorter telomere length

Elevated immune system markers

Dysregulated neurotransmitters

See Munger, Loi & Roth, 2018 for review.
Asok et al., 2013; Assogna, Piras & Spalletta, 2020; Cicchetti et al., 2010; Gunnar et al., 2009; Hodel et al., 2015; Tottenham et al.,2010; Tyrka et al., 2015)

ASD

Smaller amygdala volumes; effects related to co-occurring anxiety symptoms

Larger hippocampal volume

Imbalance in excitatory/inhibitory systems

Shorter telomere length

Elevated immune system markers

Dysregulated neurotransmitters

See Gillberg et al., 2019 for review. Herrington et al., 2017; Li et al., 2014; Reinhardt et al., 2020; Rubinstein & Merzenich, 2003; Zerbo et al., 2014)

Moderating Factors (what influences the presentation of the condition)

	DEVELOPMENTAL FUNCTIONING	SEVERITY OF CONDITION	SOCIAL EXPERIENCE	CO-OCCURING CONDITIONS	TEMPERAMENT	AGE	SEX/GENDER	ACCESS TO TREATMENT
AUTISM	☑	☑	☑	☑	☑	☑	☑	☑
TRAUMA	☑	☑	☑	☑	☑	☑	☑	☑

Secondary Factors (How the experience of having the condition impacts behaviors over time)

TRAUMA

History of hurt, mistrust, fear, hypervigilance leads to adaptations that are protective, but may not be so adaptive

- social disinhibition
- withdrawal
- compartmentalizing
- dissociating/disengaging
- masking

ASD

History of being overwhelmed by social and sensory information, without access to communication tools or social intuition leads to adaptations which are protective, but not so adaptive

- insistence on sameness
- withdrawal
- self-stimulating behaviors
- reliance on rules/systems
- masking

Assogna, Piras & Spalletta, 2020;

Evidence-Based Interventions

TRAUMA

Child-Parent Psychotherapy

Trauma-Focused CBT

Parent-Child Interaction Therapy

Circle of Security

Trust-Based Relational Intervention

Theraplay

Stress Management/Coping

(Cohen, Mannarino & Deblinger, 2006; Eyberg, 1988; Focht-New et al., 2008; Jernberg, 1984; Lieberman & van Horn, 2008; Munger, Loi & Roth, 2018; Powell et al., 2014; Purvis & Cross, 2006)

ASD

Pivotal Response Training

Adapted CBT

Parent-Implemented Interventions

Functional Communication Training

Peer-mediated Instruction

Social Narratives

Structured Play Groups

(Amsbary & AFIRM Team, Griffin & AFIRM Team, 2017; Mussey, Dawkins & AFIRM Team, 2017; Sam & AFIRM Team, 2015a; 2015b; Sam, Kucharczyk, Waters, & AFIRM Team, 2018; Suhrheinrich, et al, 2018)

Co-Occurrence of Trauma and ASD

Neurodevelopmental disorders originate in the brain, but can be worsened or improved by psychosocial experiences (Davis, Hoover, & Mion, 2018; Hoover, 2020)

Vulnerabilities associated with having a neurodevelopmental disorder increases risk for physical, verbal, and sexual abuse (Jones et al., 2012)

Children with any neurodevelopmental disorder are 2-7x more likely to experience maltreatment or other violence than same-aged peers (Sullivan & Knutson, 2000)

Children with ASD (with or without IDD) all showed increased risk for maltreatment than same-aged peers from general population and were more likely to be involved in social services reports; substantiated maltreatment was associated with significantly increased rates of aggression, hyperactivity, inattention and temper tantrums (McDonnell et al., 2019)

Overlap in Behavioral Features: Trauma and ASD: Self-Regulation

- Impulsivity
- Poorly regulated arousal
- Inattention
- Sleep problems
- Temper tantrums
- Emotional/behavioral regulation difficulties
- Low frustration tolerance
- Perseverative behaviors

Assogna, Piras, & Spalletta, 2020; Hepburn & Wolff, 2013; Hoover, 2020; Prock & Fogler, 2018)

Distinctions in Behavioral Features: Trauma vs ASD: Self-regulation

TRAUMA

Triggers appear to come from nowhere and dysregulate the child – may see "intermittent explosiveness"; reactive

Hypervigilant to cues

May dissociate when stressed; seems selectively attentive

Perseverative behaviors are often fear-based

May seek basic needs frenetically when stressed (e.g., eating, affection)

Traumatic memories often get somaticized (i.e., body memories)

ASD

Triggers – or antecedents to problem behaviors - are somewhat predictable.

Limited social referencing/vigilance

Problems disengaging attention

Perseverative behaviors are often self-calming

May seek repetition when stressed

Often lacks body awareness

Assogna, Piras, & Spalletta, 2020; Foct-New et al., 2008; Hepburn & Wolff, 2013; Hoover, 2020; Prock & Folger, 2018; Teahan, 2020

Overlap in Behavioral Features: Trauma and ASD: Affect

Irritability

Flat/detached affect

Restricted range of affects

May deny experiencing negative affect

Tendency to remember negative parts of experiences

Difficulty reading affective cues

Difficulty talking about feelings

Difficulty expressing feelings in a healthy way may lead to displacement of distress (e.g., self-harm)

Hepburn & Wolff, 2013; Hoover, 2020; Teahan, 2020

Distinctions in Behavioral Features: Trauma vs ASD: Affect

TRAUMA

Tends to show muted response to big emotional experiences; rarely exuberant

Shows strong reactions to shame
- may lie often/easily to avoid shame
- may overly apologize
- may feel overly responsible

Has nightmares, flashbacks

Shows heightened threat perception; fearful at unexpected times

ASD

May experience exuberance quite often

Less likely to use empathic gestures

Likely to show delayed understanding of shame; unlikely to be pre-occupied with it before teens

Prosody (voice tone, modulation, volume) may not communicate affective state – different than flat – may be sing-songy or mechanical

May not be attentive to the affective tone in the room

Hoover, 2020; Teahan, 2020

Overlap in Behavioral Features: Trauma and ASD: Lack of Social Synchrony

Avoidance/withdrawal may occur at unexpected times

Needs/seeks control

Prone to strident, insistent narratives which may seem out of context

Misreads social cues

May not recognize impact of own behavior on others

Social skills can feel forced or cognitively mediated – not intuitive/free-flowing

Hoover, 2020; Teahan, 2020

Distinctions in Behavioral Features: Trauma vs ASD: Lack of Social Synchrony

TRAUMA	ASD
Attachment problems are often evident.	Attachment problems are rarely evident.
May be particularly attentive to affective cues.	May show diminished attention to faces.
More likely to understand another person's perspective; but has trouble with accurately identifying emotions.	Less likely to understand another person's perspective & feelings
More likely to attempt to mirror/imitate behaviors of others.	Few attempts to mirror behaviors of others
Less likely to use adult's hand like a tool.	Uses adult's hand like a tool
More likely to be overly familiar with strangers; show lack of social boundaries	May treat people as if they are objects.

Hepburn & Wolff, 2013; Hoover, 2020; Teahan, 2020

Often, a child with a trauma history will behave differently with different people –

depending on if they feel safe/can trust the person;

whereas the social difficulties in autism are consistently demonstrated across people and situations.

ASSESSMENT PRACTICES

State of the Research on Assessment of Trauma in Children/Youth who May Have a Neurodevelopmental Disorder (i.e., ASD, IDD, ADHD, SLI)

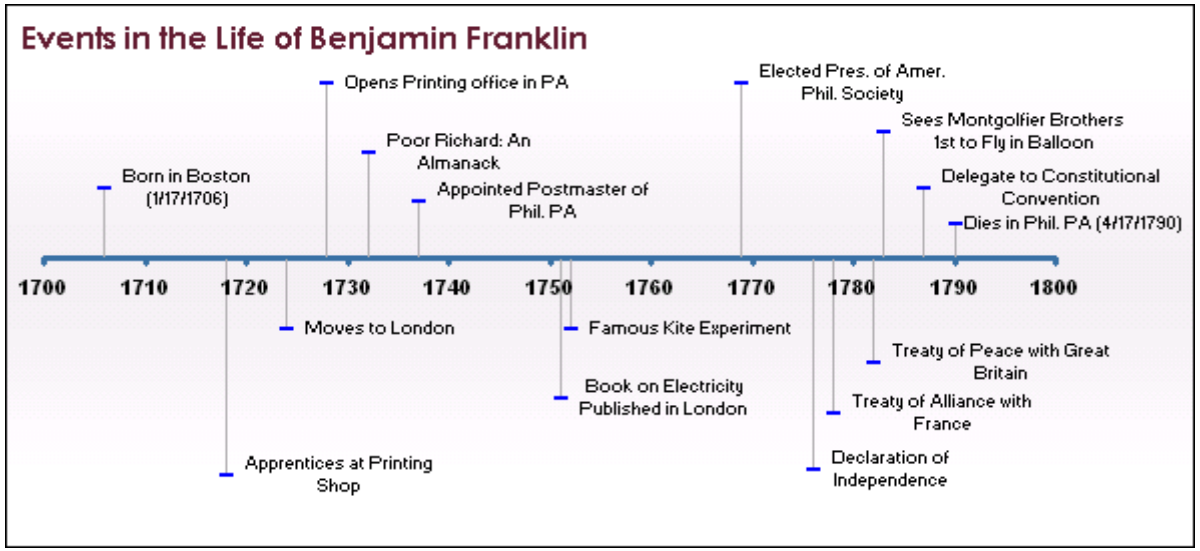
- No measures used in trauma-informed assessment have been validated in persons with neurodevelopmental disorders
- Existing measures may need to be adapted
- The *Interactive Trauma Scale* is under development – web-based, touchscreen application to assess trauma symptoms in youth with ASD (Hoover & Romero, 2019)

(Prock & Fogler, 2018; National Child Traumatic Stress Network, 2020)

1. Map out a timeline of child's history

Include key historical events, such as:

- significant trauma/abuse
- loss of meaningful relationships
- transitions/moves (e.g., to foster home)
- significant changes in family/supports
- potentially re-traumatizing events



- Be sure to ask of the events are ongoing

- Learn more about child's behaviors before and after traumatic event

- Phrase your questions to be specific, clear, objective (i.e., "Has anyone ever hit you and left a mark?" is better than "Have you ever been abused?")

- Examine developmental trajectory

2. Obtain reports from multiple informants – including parent/caregiver, teacher and youth self report

- Youth self-report is very important/unique source of information

- Need to be mindful of potential problems interpreting responses provided by youth with ASD due to:
  - Overly literal interpretation of items
  - Tendency to focus on a detail in the question and may miss main point
  - Tendency to provide more extreme self-report scores on behavioral measures than typically-developing youth
  - Tendency to deny experiencing symptoms that they view as “negative”

Mazefsky, Kao & Oswald, 2011; Stern et al., 2014

3. Include reliable and valid tools to screen for general mental health

- BITSEA: Brief Infant-Toddler Social and Emotional Assessment (Carter & Briggs-Gowan, 2005)
  - Parent & Child care provider versions
  - Ages 1-3 years
  - Assesses relationships, attachment, strengths & competencies
  - Administration time: 5-10 minutes
  - Costs - @ $300 for kit; also includes ITSEA (full version; can do if BITSEA indicates need)
- ASQ: Ages & Stages Questionnaire: Social-Emotional
  - Parent/caregiver report
  - Ages 1-72 months
  - Available in English and Spanish (and some other languages)
  - Administration time: 10-15 items
  - Costs @ $300 for kit: www.brookespublishing.com/resource-center/screening-and-assessment/asq

3. Tools to screen for general mental health (cont.)

- Strengths & Difficulties Questionnaire (Goodman, 1997)
  - Parent, Teacher & Self-Report Versions
  - Ages 2 – 18
  - Includes 5 scales: emotional symptoms, conduct problems, hyperactivity/inattention, peer problems, and prosocial behavior
  - Available in English and Spanish (and some other languages)
  - Administration time: 5 – 10 minutes
  - Free, available via http://www.youthmind.com/

4. Use reliable and valid tools to screen for child trauma and associated features

- See National Child Traumatic Stress Network for measures, including reviews of psychometrics and how to obtain them: www.NCTSN.org

- Life Events Checklist (Gray, Litz, Hsu, & Lombardo, 2004) – caregiver report
- Trauma Symptom Checklist for Young Children (Briere, 2005) – 3-12 years; caregiver report
- Trauma Symptom Checklist for Children (Briere, 1996) – 8-16 years; self-report
- Children's Alexithymia Measure (Way et al., 2010) – 5-17 years; observer report
- Children's Attributions and Perceptions Scale (Mannarino, Cohen & Berman, 1994) – 7-17 years; interview with child/youth

Assessment of Complex Trauma by Parents and Caregivers

Please read the statements below. If you answer yes to two or more, you may want to consider referring your child for a complete assessment for complex trauma. The survey below is a tool to help you decide when you need to seek professional help.

- ○ My child has been exposed to many potentially traumatic experiences.
- ○ My child has difficulty controlling emotions and easily can become sad, angry, or scared.
- ○ My child has trouble controlling behaviors.
- ○ My child often exhibits significant changes in activity level, appearing overactive or agitated sometimes and then calmer, or even quite slowed down at other times.
- ○ My child has trouble remembering, concentrating, and/or focusing. He/she sometimes appears "spacey."
- ○ My child has problems with eating, sleeping, and/or complains about physical symptoms even though doctors find nothing physically wrong to explain these symptoms.
- ○ My child has difficulties in forming and sustaining relationships with other children and adults.
- ○ My child seems to need and seek out more stimulation than other children and/or can be easily distracted by noises, sounds, movements, and other changes in the environment.
- ○ My child has many mental health diagnoses but none of them quite seem to explain his/her problems.
- ○ My child is taking medication (or many medications) for these diagnoses but the medicines are not helping.

Informal Screen from www.NCTSN.org

Southwest Michigan Children's Trauma Assessment Center

NCTSN The National Child Traumatic Stress Network

Trauma Informed System Initiative

Screening Checklist: Identifying Children at Risk
Ages 0-5

Please check each area where the item is known or suspected. If history is positive for exposure and concerns are present in one or more areas, a comprehensive assessment may be helpful in understanding the child's functioning and needs.

1. Are you aware of or do you suspect the child has experienced any of the following:
   _____ Physical abuse
   _____ Suspected neglectful home environment
   _____ Emotional abuse
   _____ Exposure to domestic violence
   _____ Known or suspected exposure to drug activity *aside from parental use*
   _____ Known or suspected exposure to any other violence *not already identified*
   _____ Parental drug use/substance abuse
   _____ Multiple separations from parent or caregiver
   _____ Frequent and multiple moves or homelessness
   _____ Sexual abuse or exposure
   _____ Other _____

If you are not aware of a trauma history, but multiple concerns are present in questions 2, 3, and 4, then there may be a trauma history that has not come to your attention.
Note: Concerns in the following areas do not necessarily indicate trauma; however, there is a strong relationship.

2. Does the child show any of these behaviors:
   _____ Excessive aggression or violence towards self or others
   _____ Repetitive violent and/or sexual play (or maltreatment themes)
   _____ Explosive behavior (excessive and prolonged tantruming)
   _____ Disorganized behavioral states (i.e. attention, play)
   _____ Very withdrawn or excessively shy
   _____ Bossy and demanding behavior with adults and peers
   _____ Sexual behaviors not typical for child's age
   _____ Difficulty with sleeping or eating
   _____ Regressed behaviors (i.e. toileting, play)
   _____ Other _____
3. Does the child exhibit any of the following emotions or moods:
   _____ Chronic sadness, doesn't seem to enjoy any activities.
   Very flat affect or withdrawn behavior

www.NCTSN/Resources/Screening

You'll find 2 measures:

Young Children (0-5 years)
School-aged (6-18 years)

Developed by Henry, Black-Pond,& Richardson, 2010

5. Follow-up on positive screens with a full evaluation

- Overall developmental/intellectual functioning
- Adaptive behaviors across settings
- Executive functioning
- Emotion understanding & regulation
- Temperament/personality
- Problem behaviors
- Social skills
- Communication skills (especially pragmatics)
- Strengths, interests

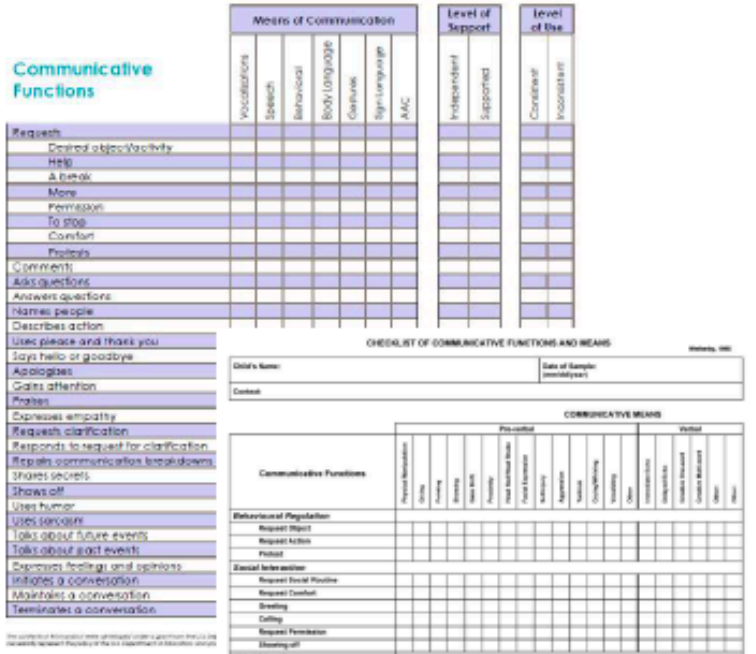
6. Conduct multiple observations in different contexts

- Observe in structured and unstructured settings
- Observe with peers and adults
- Structure your observations to look for signs of autism and signs of possible trauma
- Look at motor behaviors too – autism can have a distinctive gait, posture, motor planning problems are common too and not likely to be associated with trauma

- Can use a tool to guide your observations, such as:
  - Childhood Autism Rating Scale – 2
  - Communication & Symbolic Behavior Scales
  - Functions & Forms Checklist
    - https://www.cde.state.co.us/cdesped/ed_id_part02_

Functions & Forms Checklists

Age: any
Description: captures how a child communicates & why the child communicates
Allows team to set goals on next steps for more conventional forms or expanding current functions



Always look for pragmatic communication behaviors

Pay particular attention to the range of functions and forms of communication you see

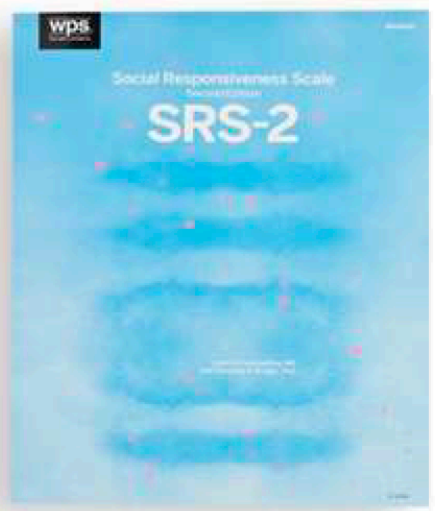
Note how well-integrated verbal and nonverbal behaviors are in different contexts and with different social partners.

7. Use reliable and valid tools to assess autism symptoms

Social Responsiveness Scale-2nd Edition
(can also be used as an ASD screener)

Age: 2.5 to adult
Description: Identifies the presence and severity of socia impairment within the autism spectrum and differentiates it from that which occurs in other disorders.

- Intended to quantify characteristics of ASD and provides subscale scores that correspond to Social Communication and Restricted Interests/Repetitive Behaviors
- Can be challenging for students who are completely non verbal
- Parent and Teacher forms
- Male and female norms

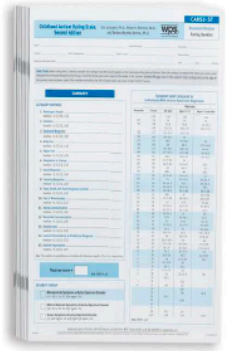


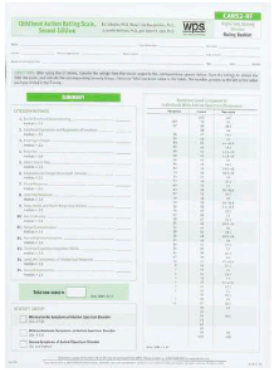
Childhood Autism Rating Scale, 2nd Edition (CARS-2)

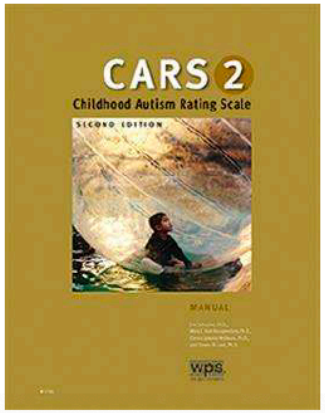
Age: 2+

Description: helps identify children with autism providing quantifiable ratings based on direct behavioral observations.

- 2 Versions
  - High functioning (IQ > 80, green)
  - Standard version (blue)
- Creates an overall score assigned to a severity rating
- Multiple team members can complete it







Autism Spectrum Rating Scales

Age: 2-18

Description: rating scale completed by parents and teachers to evaluate how often specific behaviors were observed.

- Areas include:
  - Socialization
  - Communication
  - Unusual behaviors
  - Behavioral rigidity
  - Sensory sensitivity
  - Self-regulation
  - A short and long form are available
- Multiple options for parent/caregiver
- Computer software available

Autism Diagnostic Observation Schedule, 2nd Edition (ADOS-2)

Age: 12 months

Description: a semi-structured, standardized assessment of communication, social interaction, play, and restricted and repetitive behaviors.

- Recommend at least 2 evaluators

5 MODULES

- **Toddler Module:** 12-30 months of age who do not consistently use phrase speech
- **Module 1:** 31 months and older who do not consistently use phrase speech
- **Module 2:** children of any age who use phrase speech but are not verbally fluent
- **Module 3:** verbally fluent children and young adolescents
- **Module 4:** verbally fluent older adolescents and adults

8. Review data with multidisciplinary team

Consider history, culture, family issues as you summarize and interpret data

Use specific examples of behaviors of concern; be very descriptive

Prior to meeting with the parents, examine your data –

- is there evidence to support that the child has experienced trauma and may qualify under Significant Emotional Disability (SED)?

- is there evidence to support that the child meets criteria for ASD?

If evidence supports both conditions, think about which has the greatest impact on educational functioning

- Consider identifying the other as a secondary condition

9. Present findings to family and decide together on educational eligibility

- When sharing results, be sensitive to parent's feelings/experiences/potential trauma
- Try to be direct, clear, warm, objective, non-judgmental, optimistic
- Present the body of evidence and discuss possible identification categories
- Document concerns, even if they are not reflected in the eligibility category – it's still important for future educational teams to understand what you were concerned about and how you approached the assessment
- Decide together if SED or ASD is a better fit for child's current functioning

Concluding Comments

- This differentiation often involves a comprehensive, multi-disciplinary evaluation.
- Co-occurrence is possible, so don't rule anything out; instead consider which conceptualization is most helpful for understanding the child and selecting interventions
- Focus on developmental history and try to understand when trauma occurred and when concerns about the child's social and communication development first emerged
- ASD is characterized by consistent, persistent problems in social, communication and adaptation to environments; - a child with rich, reciprocal, well-integrated social, emotional and communication behaviors in one setting but not in another is less likely to have ASD

Concluding Comments

- Sometimes a child presents as “autism-like” but social withdrawal has roots in trauma history; if so, developmentally sensitive interventions that target core social relatedness and parent-child interactions are recommended; progress may be faster/different than if child has neurobiologically-based autism

- Even with a trauma history, if the child is showing qualitative differences in social reciprocity, nonverbal communication, and behavioral flexibility, identifying ASD is appropriate

- Remember – your job is to identify current developmental concerns – you don’t need to know how these concerns came to be --- if the child is presenting in a manner that is reflected in the educational definition of ASD, it should be included as either primary or secondary eligibility category

RESOURCES

Resources

National Child Traumatic Stress Network: https://www.nctsn.org/

Specifically:

Child Trauma Toolkit for Educators (2008):
https://www.nctsn.org/resources/child-trauma-toolkit-educators

Screening and Assessment Tools:
https://www.nctsn.org/treatments-and-practices/screening-and-assessment

Resources

Publishers of Tools in this Webinar

- Life Events Checklist: http://www.ptsd.va.gov/PTSD/professional/pages/assessment/assessment-pdf/life-event-checklist-lec
- Ages and Stages: Brookes Publishing
- Childhood Autism Rating Scales – 2 (CARS-2): Western Psychological Services
- Autism Rating Scales – Pearson Assessments
- Social Responsiveness Scale – 2 (SRS-2): Western Psychological Services
- Infant Toddler Checklist/Communication & Symbolic Behavior Scales: Brookes Publishing
- Autism Diagnostic Observation Schedule -2 (ADOS): Western Psychological Services

Resources

AFIRM: Autism Focused Intervention Resources and Modules: https://afirm.fpg.unc.edu/

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Article on the tablet-based assessment of trauma symptoms for children with autism by Hoover, 2019: https://www.kennedykrieger.org/stories/potential-magazine/fallwinter-2019/identifying-trauma-children-autism

Article on trauma and ASD: https://autismawarenesscentre.com/what-is-trauma-a-simple-guide/

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THANK YOU FOR YOUR TIME AND ATTENTION

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