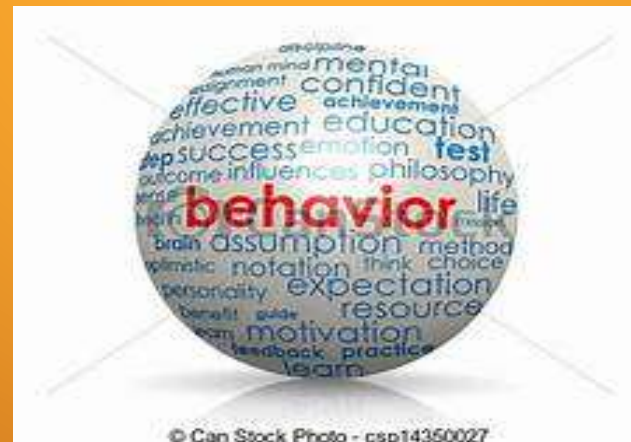


Clinical and Behavioral Effectiveness with Developmental Disabilities

Demystifying Conceptualization and Advancing Positive Behavior Support

Peter Tolisano, Psy.D., ABPP

Board Certified in Clinical Psychology
DDS Director of Psychological Services



Guiding Philosophies

Operationalize our clinical knowledge

Appreciate that disability is a reductionistic term

We can't tell how much an individual can learn and grow by their IQ score

Don't let the presence of developmental disability make us forget everything that we've learned about working with people

A true measure of any society can be found in the way it treats its most vulnerable and marginalized members

Learning Objectives

Setting the conditions to increase clinical-mindedness

Part I

- Better understand the concept of neurodiversity
- Acquire skill in a multi-element behavioral support approach
- Work better with readiness to change
- Facilitate improved behavioral service delivery

Assimilating and Accommodating

Examples of how this training may affect various roles...

- Administrators: Prepare for decisions on risk
- Behaviorists: Develop trauma-informed support plans
- Program Supervisors: Better lead direct care staff to help individuals to feel more valued

Neurotypicality

- Neurotypical is a descriptor that refers to someone who has the brain functions, behaviors, and processing that are considered standard.
- Neurotypical people meet developmental and behavioral milestones at the same time as those of a comparable age.
- They go through life without having to wonder if their brains function in the same way as others and usually never discuss the subject.

Neurodiversity

- A non-medical and umbrella term coined by Judy Singer, an Australian sociologist, in 1998.
- It recognizes how brains develop differently in a categorical ways and work in uniquely in terms of processing information.
- It means that an individual has cognitive strengths and weaknesses from those who develop typically, usually due to a diagnosable medical condition.
- It embraces differences and treats them neutrally. As opposed to viewing them as something bad, wrong, or problematic.

Neurodivergence

- It refers to how the brains work differently in a group of people.
- Originally, it referred specifically to people diagnosed with autism, but usage of the term has significantly broadened over the years (e.g., nonverbal learning disability and dyslexia).
- It manifests on a continuum from very mild signs that most people would never notice to much more pronounced and obvious presentations.
- It recognizes that brain function and behavioral traits are simply indicators of a diverse the human population.

Intellectual Developmental Disorder and Neurodiversity

Intellectual disability is the most common developmental disability

Etiologies based on Behavioral Phenotype:

Genetic syndrome: Down syndrome

Acquired forms: Meningitis, Encephalitis

Neurocognitive Disorder (i.e., loss of ability): Traumatic Brain Injury

Progressive: Rett syndrome

Prenatal: Maternal disease, environmental influences

Perinatal: Labor- and delivery-related

Postnatal: Epilepsy, social deprivation, toxicity

Working Memory Functioning

- Special type of memory housed in frontal lobes.
- I/DD is not Information Deficit Disorder. Low working memory causes difficulty holding information in the mind and using it to guide behavior (i.e., Not a problem of knowing, but rather of doing), which creates *performance disorder*.
- Analogy is GPS in car. Uses images and words.
- Limitations in hindsight, foresight, and initiating and sustaining effort, especially with less rewarding activities.
- Reduce chronological years by 30-percent to find executive functioning/self-regulation age.

Intellectual Developmental Disorder and Neurodiversity

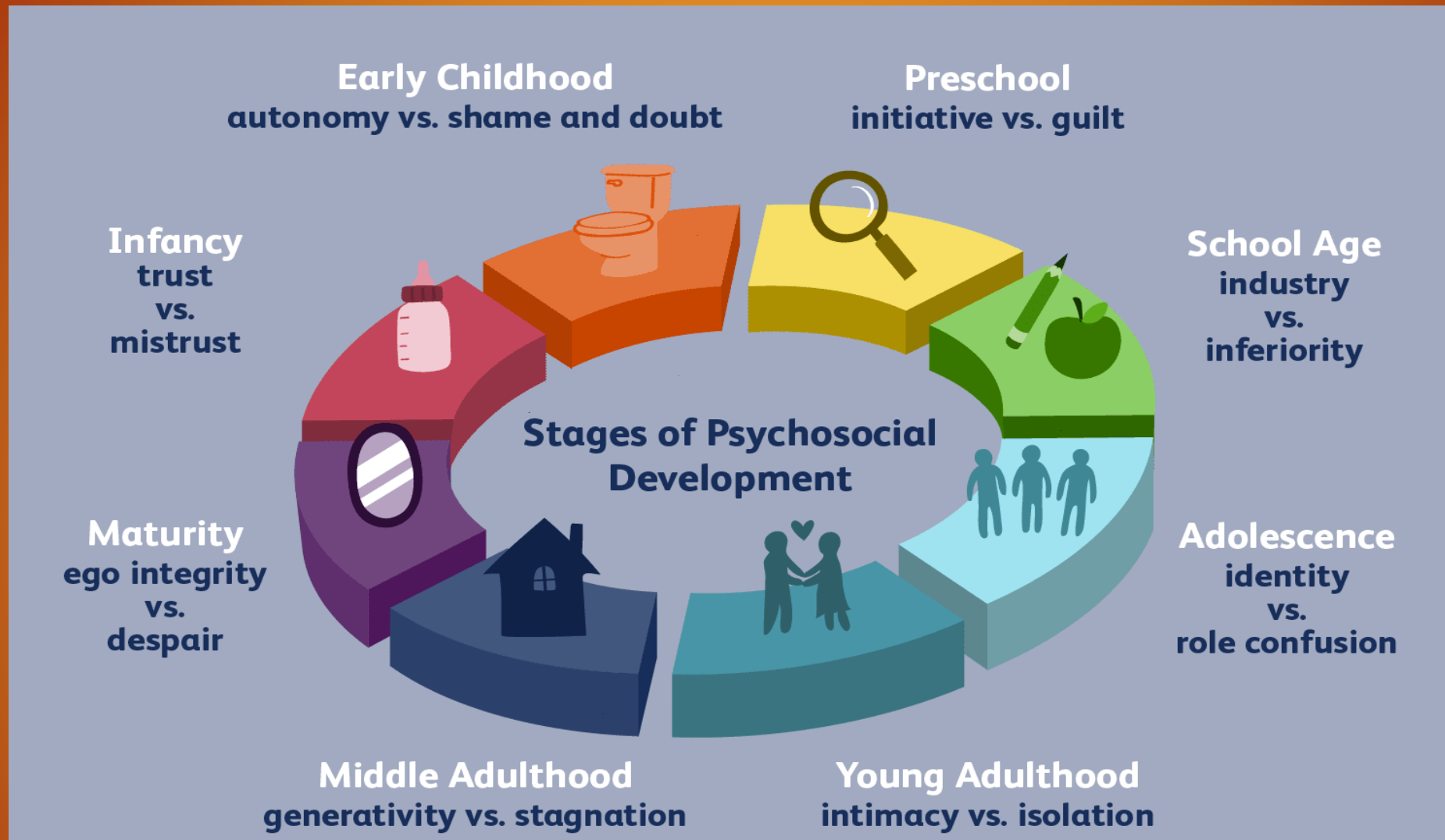
What does it mean to be diagnosed with intellectual disability?

1. Interpret and interact with the world differently

- *General Ability Index*: Verbal Comprehension and Visual-Spatial Abilities tend to be higher scores in the profile.
- *Cognitive Proficiency Index*: Working Memory and Processing Speed are oftentimes the lower scores.
- ❖ While some individuals have globally low cognitive functioning, our goal whenever possible, is to deliver information by accentuating the strengths and minimizing the weaknesses!
- Verbal Comprehension best indicator of potential
- Splinter skills
- Performance Continuum: Capacity → Abilities → Skills

2. Reliance on others

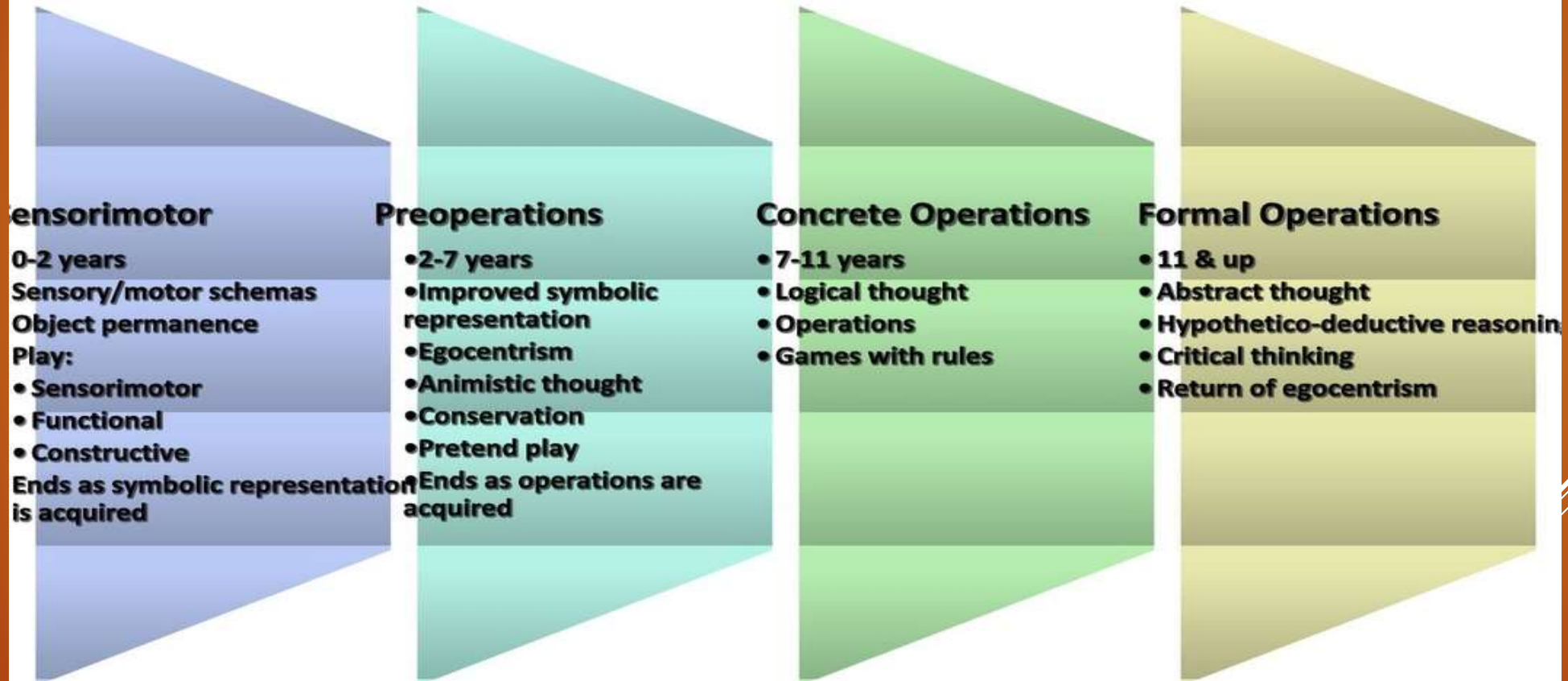
- Adaptive skills deficits often commensurate with cognitive impairment
- Assistance with executive functions (e.g., decision-making)
- Variability across settings differs with supports (e.g., family versus day program)



Most sensitive neuroplastic or critical periods: birth to 18 months and then teenage years;
 Development in senses, motor skills, attachment and social relationships,
 as well as emotional regulation

Piaget's Cognitive Theory

Review of Stages



Concomitant Conditions and Intellectual Developmental Disorder

- The possibility of a co-occurring neurodevelopmental, mental, or physical condition in the context of intellectual disability is *three-to-four times* higher than the general population.
- *Comorbidities that are dispositional to intellectual disability:*
 - Autism spectrum features
 - Communication disorders
 - Motor and sensory integration issues
 - Mood dysregulation
 - Sleep disturbances
 - Attention deficit/hyperactivity traits
 - Impulse control problems

• Continuum: Features  Traits  Full Disorder

Autistic Traits and Neurodiversity

- Common challenges include sensitivity to sensory input, lack of belonging, and an inability to cope.
- “Autistic burnout” is widely accepted concept in neurodivergent communities. That is, under prolonged stress, autistic features lead to physical, emotional, and cognitive depletion (e.g., “afternoon explosion” and performance loops have more effort with less results)
- A 2018 study showed 70-percent of individuals with autism spectrum disorder experience suicidal ideation (versus 33 percent in the general population) and 20-percent meet criteria for generalized anxiety disorder

Neurodivergence and Mental Health

- Underserved population whose needs are often missed and the accessing of supports is most challenging
- Experience negative outcomes:
 - Live in restrictive settings
 - Less educational and vocational opportunities
 - Repeated and lengthy hospitalizations
 - Increased medical and health-related conditions
 - Exposure to polypharmacy and overuse of anti-psychotic medications
 - Intersect with the legal system
 - Experience high rates of victimization and trauma (i.e., peer rejection, bullying, and physical, emotional and sexual abuse).

Improving Behavioral Service Delivery

Contemporary Definition of PBS is an Integration:

- 1) Values that guide the support of individuals with I/DD (i.e., person-centered practice and normalization/inclusion movement)

with the

- 2) Best practices in strategies for behavioral change.

Improving Behavioral Service Delivery

You can't change problem behavior in a problem environment...

- Context is everything!
- Caregivers are the environmental variables that influence (increase or decrease the likelihood) the absence, presence, or maintenance of challenging behaviors. Interactions between staff and the individual-served should make problem behaviors less likely to occur and make effective behaviors more likely to occur (i.e., positive setting events).
- A 2014 study on PBIS revealed that restraints can be reduced by 25-percent by using preventative and data-based approaches along with individualized plans.
- Ross Greene: Collaborative and Proactive Solutions: Primary strategy is preventing students from being distressed. Not modifying behavior, but the problems causing it. Technique: Not life as it is, but as it could be!

PBS Main Principles in Real Life Terms

Creating an Ecology of Support

- It does not focus on the challenging behavior in-and-of itself
- Challenging behavior is learned, so is open to being changed
- Teaching someone an effective behavior, will cause the challenging one to reduce, but it must be more effective than the challenging behavior to be used regularly
- We need to understand the reasons people display challenging behavior, so we can ensure the new behavior is reinforced in the same way
- People often need to increase the ways to achieve what they want, such as developing communication skills. It's acceptable to want attention, need escape, and desire certain things.

PBS Training

What the literature reveals...

- Clinicians and team members with specialized behavioral training in plan writing along with PBS principles are 4 times more likely to produce high-quality behavior support plans, than clinicians with core training in behavioral concepts alone.
- Of importance is foundation training on neurobiology and trauma
- Trainings should be extended from institutional staff to community-based providers
- Higher-level competency in behavioral methods leads to improved staff attitudes and reduced levels of occupational stress
- Support staff are the strongest link toward enhancing the effectiveness of PBS plans.
- *Research about the effectiveness of PBS remains scarce, varied, and controversial after three decades. Perhaps the model is effective, but differences exist across different individuals, situations, staff, and teams.*

PBS Training

For optimal performance in plan implementation, multi-stage trainings should include:

- Begin with a global foundation training for new employees that reviews the basic mission and concepts of PBS and provides examples of treatment plans
- Followed by individual-specific plans conducted by psychologist or developmental specialist that include the following:
 - A summary of the functional assessment
 - Focused proactive and reactive strategies
 - Designated roles in carrying out each component of the plan
 - Plan for monitoring progress and maintaining accountability including regular team meetings, review of data, and fidelity checks to ensure correct implementation of the plan

Why do we need PBS Plans?

- Everyone has different judgments about what is right and wrong, and beliefs about how to respond to behavior based on their own experiences and understanding.
- Using a formalized PBS Plan means that everyone consistently follows the same techniques (i.e., united front) and becomes aware of amendments, rather than everybody “doing their own thing” based on what they think is best.
- If we don’t use behavior support plans, it’s likely behavior will be managed primarily with chemical and/or restrictive interventions (i.e., restraint and seclusion)

Research shows

- ✓ Clinicians with wider focus develop better quality PBS plans
- ✓ Intensively trained staff and caregivers not only remember new information better and feel more confident in their skills but apply the information and skills better.

Develop a PBS Plan in Response to these Occurrences

- Behaviors pose a threat to the health and/or safety of the individual or others
- Behaviors interfere with the attaining goals, community integration, or other personal outcomes identified in the Individual Plan
- Whenever an individual is prescribed more than one psychotropic medication for behavioral control
- When restrictive and/or aversive interventions are used to manage a behavioral crisis

Inappropriate Behaviors of Concern

- Cannot be observed or measured reliably (e.g., mood states)
- Behaviors for which a replacement behavior cannot be taught (e.g., hallucinations)
- Benign behaviors (e.g., self-talk, pacing, telling tales)
- False allegations must be investigated pursuant to DDS policy

Start with the Basic Characteristics:

Behavior is anything that a person does that can be observed and measured

Appearance or Topography:

- What the behavior looks like or what the person did

Frequency:

- How often the behavior occurs

Severity:

- How severe is the impact

Duration:

- How long the behavior lasts

Improving Behavioral Service Delivery

Behavior Plan audits described in the research show these key elements:

- Behavioral Definition*
- Antecedents and predictors*
- Contextual factors*
- Environmental Changes*

- Hypothesized functions(s)*
- Replacement behaviors*
- Proactive teaching strategies*
- Reinforcement tactics*
- Reactive techniques*

- Behavioral objectives and goals*
- Written in understandable language/readability*
- Team communication and responsibilities*
- Service development and coordination*

Are there downsides to PBS?

- Its heavily reliant on resources (e.g., consultation team, qualified staffing, and available funding)
- Its implementation requires careful program design, foundation training, case-specific teaching, and data monitoring.
- Behavior support plans might be “*iatrogenic*,” thereby causing the individual’s behavior to worsen or heightening the caregivers’ struggles (e.g., recommending food as a reinforcer with Prader-Willi syndrome; planned ignoring leading to suicidal ideation)

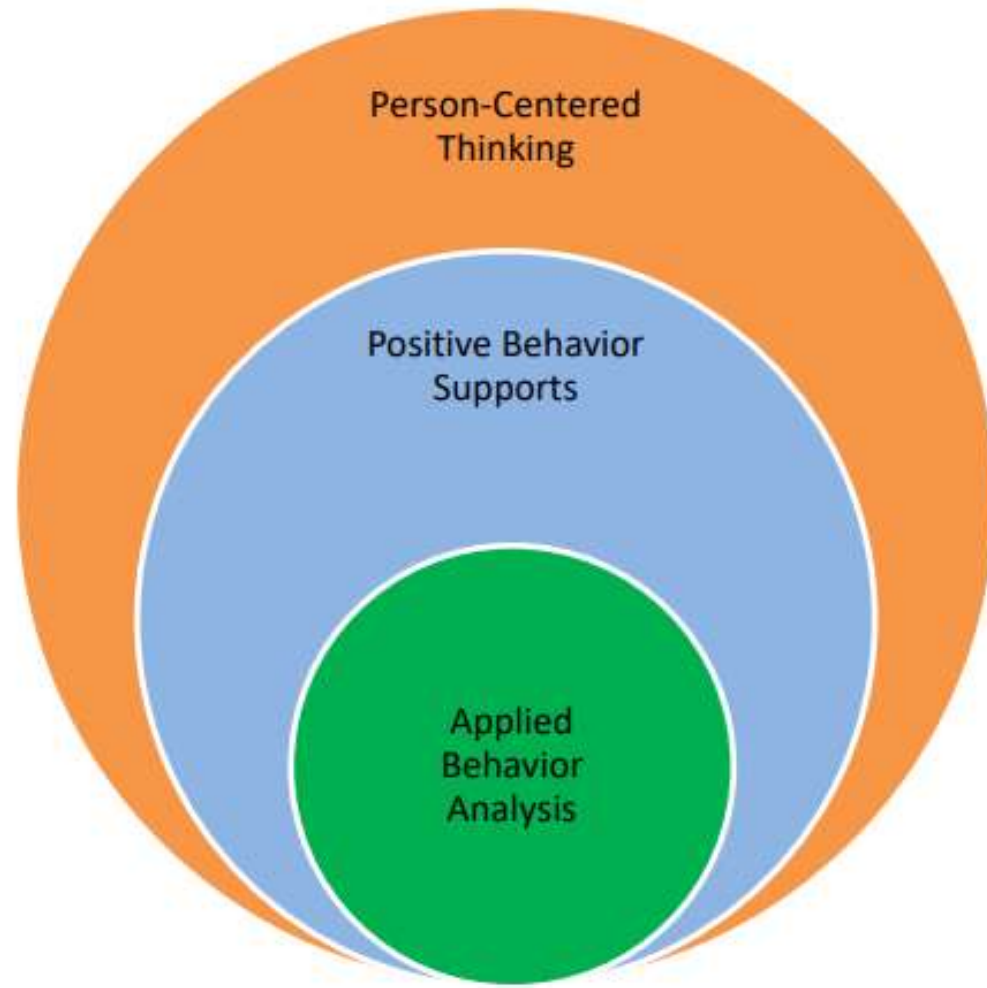
Importance of PBS

- Positive Behavior Support Plans should be living documents. That is, the information in the plan should change to reflect changes in the person's progress and status.
- Plans should be regularly updated. It is important to get feedback and review how effective the strategies are and to reflect about their impact on the person and those caring for them.
- Sometimes there should be a 'contingency' plan with clear guidelines explaining when the main plan should be reviewed more urgently. For example, with increases in self-injury, physical interventions, or PRN medications.
- In highly challenging cases, the goal of adhering to the plan/implementing the protocol may be more appropriate, rather than looking at the outcome (DBT strategy).

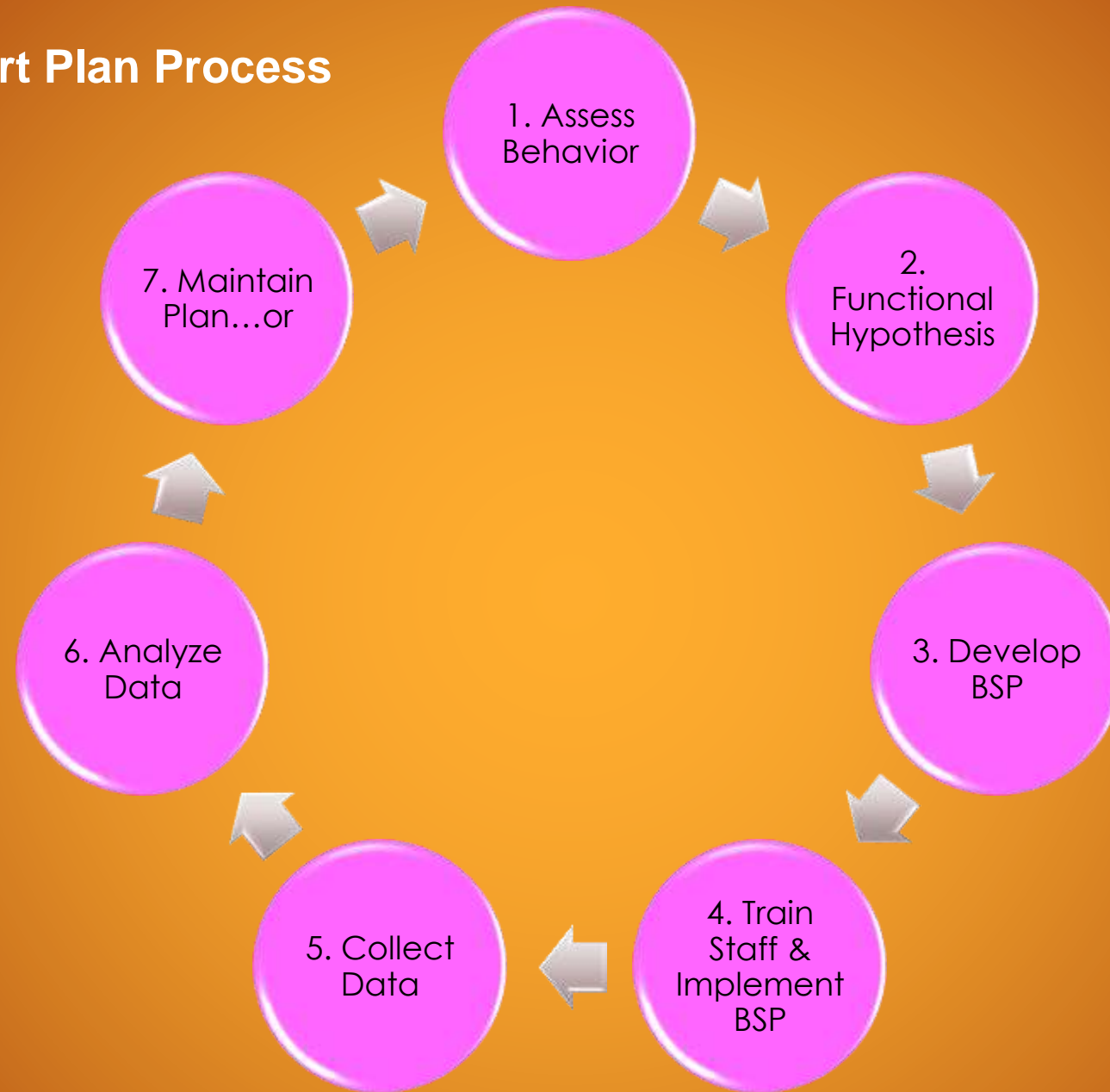
Importance of PBS

A good PBS plan has many more proactive strategies than reactive ones...

- Ensure the plan has proactive strategies that focus not just on the challenging behaviors, but also ways to support the person to have a good life, enable them to learn new skills, and find more effective ways of getting their wants and needs met.
- Reactive strategies are designed to keep the person and those around them safe from harm. They provide a way to gain safe, rapid, and effective control in a situation where the person is distressed, anxious, or engaging in challenging behavior.
- Most common proactive PBS interventions are changing setting events and improving quality of life (McClellan and Grey, 2012).



PBS Behavior Support Plan Process



PBS Roles

Why do we need behavior specialists and consultations?

- Clinical expertise gives a holistic assessment of the individual-referred
- Develop effective guidelines, behavior support *and* crisis intervention plans
- Design data collection procedures
- Train team members
- Monitor and report progress

Multi-Element Model for Behavior Support Plans

Phase 1

Process Records, Observation, Interviews	Content Referral, History, Functional Assessment	Materials Motivators, Preferences and Reinforcers
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Phase 2

Proactive Environmental Changes, Teaching Skills, Prevention	Reactive Situational Management
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Phase 3

Training General, Specific, Adherence	Mediators Natural, Specialized, Professionals
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Phase 4

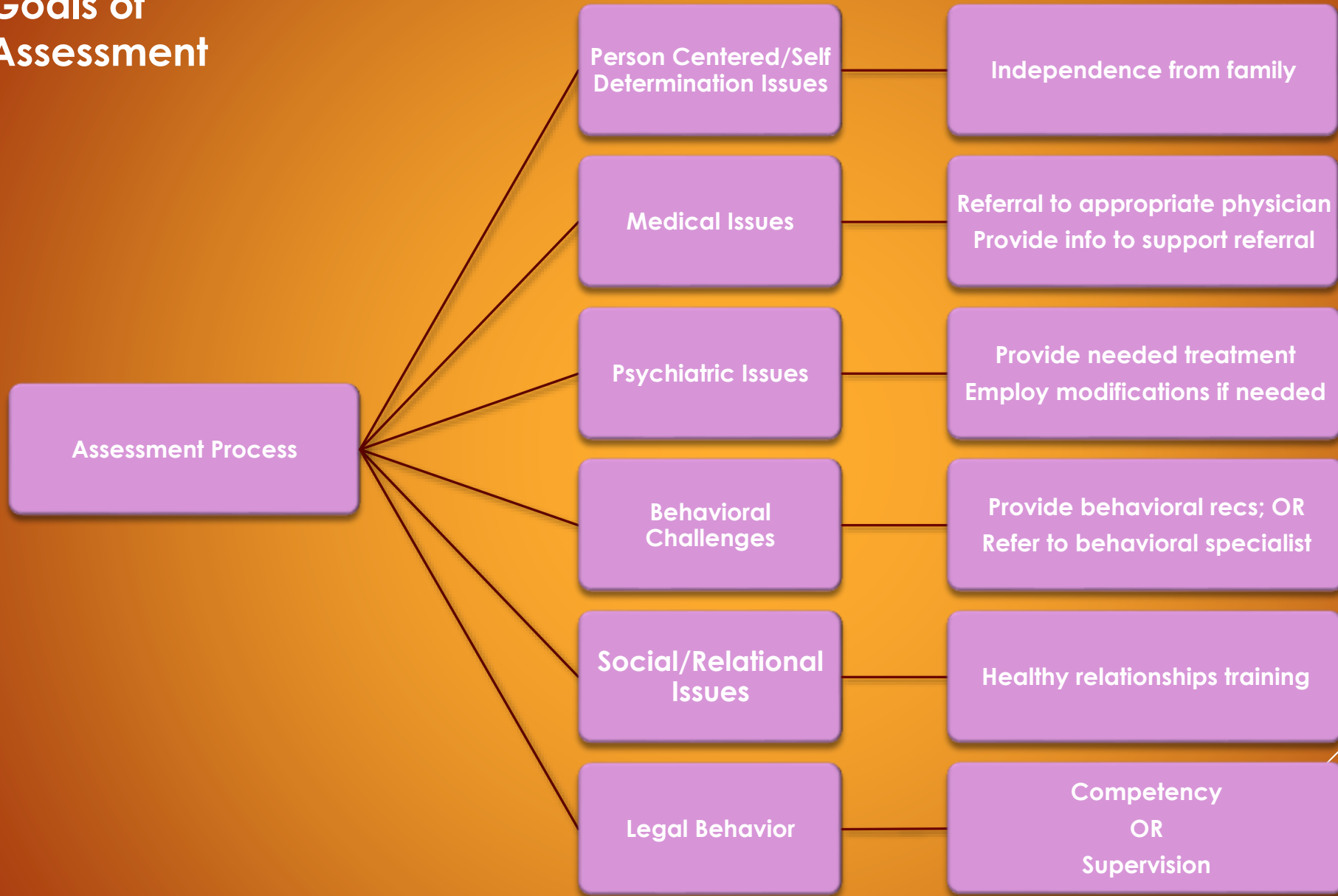
Outcome Measures Control, Quality of Life, Adverse Effects

Clinical Assessment Basics

The intervention is only as good as the assessment that precedes it!

That is, you can't appropriately intervene if you don't properly assess!

Goals of Assessment



Basics of Functional Assessment

- Use of the term *Activating Conditions*

Antecedent Categories:

Events: Bath or bedtime

Circumstances: Noises and crowds

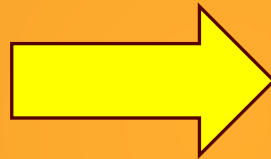
Objects: Lost items

Physical and Emotional Needs: hunger and thirst

Basics of Functional Assessment *Emotional Processing*

Secondary emotions that trigger deeper feelings:

- ▶ Upset
- ▶ Disappointed
- ▶ Frustrated
- ▶ Guiltiness



Primary Core Emotions that are physiologically experienced:

- ▶ Anger
- ▶ Sadness
- ▶ Fear
- ▶ Surprise
- ▶ Disgust
- ▶ Shame (fear of inadequacy and disconnection)

Basics of Functional Assessment *Emotional Processing*

Three Elements to Metabolize Emotions:

- Cognitive label (Dan Siegel: “Name it to tame it”)
- Physiological sensations
- Behavioral/imaginal expression

Recognize that every behavior, perception, and belief serves a function!

Biological Determinants:

- *Genetics*
- *Evolution*
- *Adaptation*

Behaviors, Perceptions and Beliefs:

Hopelessness removes the need to grieve, try, or take positive risks

Evolutionary function of anxiety relates to the fact that sleep is the most vulnerable thing that we do and being hyperaware of our surroundings allowed our ancestors to detect any incoming threats.

Loneliness has a biological protective function in that we need to resecure attachments for safety.

Tantrum functions to learn independence, protest transitions, and test social rules

Codependence makes children responsible for the relationship

Why is aloneness so challenging?

We are alone with our own thoughts and feelings

Behaviors, Perceptions and Beliefs

Repeated Apologies Changes expectations

Grief maintains the relationship (i.e., active attachment)

Splitting function is simplification to reduce complexity and emotionality

Social comparison relates to self-esteem vulnerability and regulation

Anger alerts us to things in the environment that warrant our attention (i.e., expectations for justice or competence are unmet).

Behaviors, Perceptions and Beliefs

Martyring to minimize suffering

Helplessness to receive social support

Depression removes demands or neurologically suppresses anger

Fear of Aging is a fear of dependency and powerlessness

Procrastination/Avoidance as defenses against disappointment and failure

Functional Assessment Expanded: When distressed people may resort to...

- Boredom: Lack of fulfillment/depressive states propels us to fill the space with stimulation
- Communication: Challenges in accessing language leads to needs getting acted-out
- Regret: Template for the future; Orient to what is meaningful
- Familiarity and Tolerance: to gain control and mastery
- Poor Identity: False self to find meaning and purpose
- Unclear Roles: People define themselves behaviorally (e.g., I've been good/bad)
- Connection-seeking (not attention): Overcome fears of abandonment and rejection

Consider that the Function versus the Intent of behavior may differ!

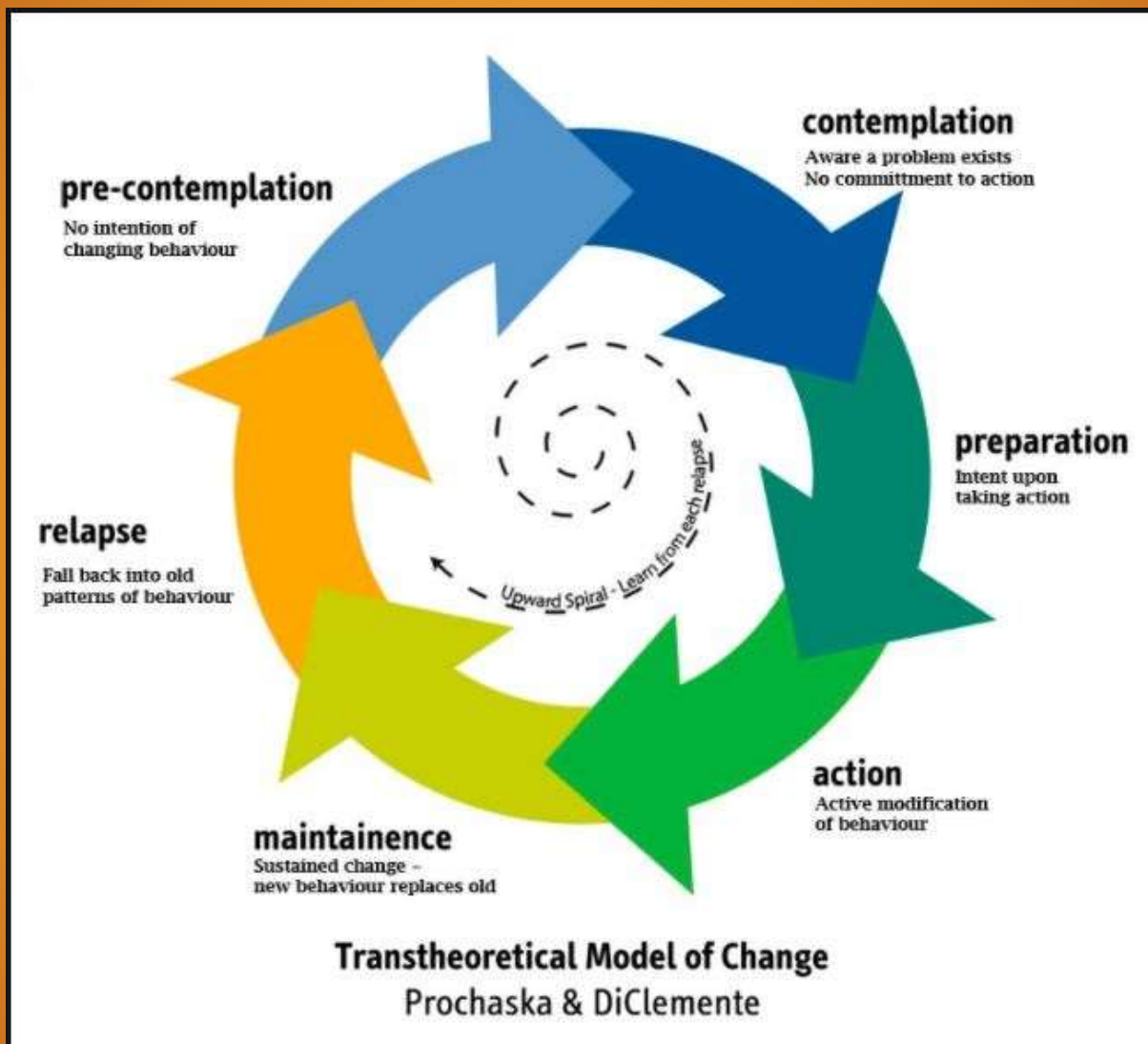
Functional Assessment Expanded: When distressed...

- Gain or avoid intimacy: Push or pull people
- Distraction and avoidance: Momentarily diversion
- Sense of Belonging: Affiliation and Feel part of something
- Reward: Energizing dopamine and norepinephrine to an addictive level
- Regulates internal distress: Endorphin rush
- Control, Mastery, and Power: Counter to fear of others being punitive, controlling, or manipulative

What is the most common function of Applied Behavioral Analysis plans?

Seventy-Seven-Percent of plans show escape as the main function!

“The only way that I could get control was to make things worse!”



Readiness to Change

- *Applies to individuals, families, and systems*
- *Transtheoretical Model: Each stage has early, middle, and end phases*
- *Success isn't linear—it's nonlinear and exponential*
- *Consult Motivational Interviewing strategies*

Readiness to Change

Precontemplation:

- “I can’t/won’t do it!”
- “I don’t see a problem with what I am doing and there’s no reason to change”
- Unmotivated people who are unaware of the problem
 - That is, people who find it difficult to recognize and accept the need for change.
 - Refuse change, unaware of problem, or comfortable with the status quo.
 - Lack insight for their contribution and may externalize blame.
 - Obsess about negative side of change, rather than benefits to gain
- Focus on generating interest and concern about the need to change
- Don’t drive into defensive posture; reframe into understandable situation to reduce stigma (e.g., “I am just asking you to look at your drinking in some different ways.”)

Readiness to Change

Contemplation:

- “I might do it, but I am not sure when.”
- Internal conflict: Is my problematic behavior worthy of change or not?
- Problem takes “center stage” but procrastination is common
- Deceptively look like they will make real changes, but underlyingly have mixed feelings.

- Weigh pros and cons. Deciding to overcome ambivalence.
- Overcome resistance and make choice conscious (e.g., “I know that you have mixed feelings. Let’s give you more information in order to make a good decision.”)
- *Examine function of the behavior that may outweigh consequences!*

Readiness to Change

Preparation:

- “I definitely will try.”
- Inclined to change, but no firm decision about planning and committing.
- Conviction may set in.
- Set it up as an “experiment”
- Identify goals and the associated small next steps toward bigger change.
- Insufficient planning main issue, so line up resources

Action:

- “I am going to do it.” Look for confidence building (self-efficacy)
- Receives the greatest attention. Initial steps to initiating change and applying a plan. Evidences noticeable change in attitude and behavior.
- (e.g., “I am seeing your progress”)
- Go to it too early; 40-percent relapse

Maintenance:

- “I am still doing it!” *Graduating!*
- Successful in making and sustaining change. Avoiding and planning for potential setbacks⁴⁹
- Staying changed until it becomes part of the behavioral repertoire

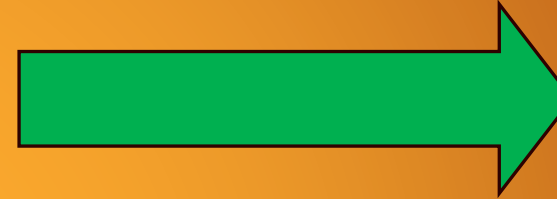
Readiness to Change
Orienting to the Continuum of Change



Against Change

Less receptive
Not problematic
No desire
Increases problem behavior
Arguments against change

**No
Awareness
or Interest**



Toward Change

Raised awareness
Problem recognition
Desire to change
Attitude pro-change
Harm reduction
Abstinence

Readiness to Change

What is the most common therapeutic error?

Recommending an action strategy to someone who is in an earlier stage of change (precontemplation or contemplation)!

When does stage of change model stop applying?

- Carlo DiClemente: Conceptualizing relapse as only occurring when the person gives up the goal of engaging in the change process (whether its in action or maintenance), thereby avoid arbitrary definitions of behavior and instead focus on the broader change process.

Readiness to Change

Other Considerations...

- Treatment relationship (rapport) vs alliance (mutual goals)
- Change attempts are variable and involve the person and their environmental context.
- Black Box Method: Debriefing failure to promote successive approximation learning while recycling through the stages of change. Failure is not a one-off event, and we should review the approach, provider, procedure, support, and system.
- Prospective Hindsight: Ask what could go wrong with the plan before implementation? No abstract thinking; imagine relapse to make it concrete and look for potential faults in the plan.

Readiness to Change

Other Considerations...

- Normalize that multiple change efforts are needed, and that relapse is inevitable. It often takes 3-4 attempts to change.
- Changers are not coerced, but supported
- There's an evolution and recycling through the stages
- Role of a nurturing coach (non-punitive learning) using socratic questions to gain insight

Clinical Assessment

Psychological health is not merely the absence of symptoms (“Dead Man’s Rule”), it’s the positive presence of inner capacities and reserves that allow people to live life with a greater sense of security and possibility.

Clinical Assessment

Basic Tenets...

Do's

- Assure a comprehensive and continuous assessment drives any plan
- Seek diagnostic simplicity
- Work forward from diagnosis to treatment (e.g. medications)
- Converge findings
- Remember most often the IDD is part of the “contextual” issues, not the focus
- *Medical and cognitive causes before behavioral ones!*

Don't make assumptions...

- That someone else has attended to the “easy” stuff
- There is always one “cause” if we could just find it
- That IDD or ASD explain all the symptoms
- That a behavioral presentation is not symptomatic because it's at baseline

THE ELUSIVE PIECE: MEDICAL CONTRIBUTANTS TO "BEHAVIORAL" ISSUES

Clinical Assessment

3P Model

Factors that Contribute to Conditions

Predisposing

- Genetics, temperament, and other stable influences

Precipitating

- Stressful life events, particularly those to which the individual is unable to adjust and adapt
- Cause acuity
- Can be opposite to intent (e.g., Napping and going to bed early exacerbate insomnia)

Perpetuating

- Things that lead to the long-term maintenance (chronicity) of a condition

Clinical Assessment Technical Spheres

Reality Testing: Capacity to distinguish internal vs external reality (e.g., wishes, fears, and beliefs vs. events in the real world). Personal vs. social expectations.



Insight: A deeper understanding beyond awareness. Ability to see what is not evident.

Judgment:

- Based on social constructs. Predicated on awareness/insight.
- Knowing right vs wrong. Reach “reasonable” conclusions (e.g., plea bargain).
- Know what constitutes “appropriate” behavior.
- Correlate prior life experiences to current circumstances.
- Draw realistic conclusions about likely consequences (detailed minutiae)

Clinical Assessment Technical Spheres

Controlling Impulses:

- Neuropsychological capacity to hold aggressive and sexual feelings without acting on them.
- Ties to delay of gratification, frustration tolerance, and toleration of anxiety

Beck (1990): Steps to Impulse Control

- Identify the impulse
- Inhibit the automatic response
- Think through consequences
- Identify alternatives
- Select a response
- Implement Response

Clinical Assessment Technical Spheres

Modulation of Affect: Preventing painful or unacceptable emotional reactions from entering conscious awareness; Management of feelings as to not disrupt emotional equilibrium and social relationships.

Transference/Counter-transference Reactions:

- Treating others as if they were the traumatizing figure.
- Passive-to-active way of healing via control-mastery (Weiss and Sampson)
- van der Kolk's idea that we symbolize and paradoxically seek out mastery over original traumatic events through repetition

Schemas and attributions:

- Internal working models. Templates for our lives.
- Basic rule and cognitive structures that develop over time (e.g., foster care placements relate to abandonment and unlovability)
- Not easily amenable to change. Attributions are meanings attached to events.
- Bridge events and our understanding of them.

Clinical Assessment

The following are important considerations that can interfere with the accurate assessment and recognition of co-occurring mental health needs with I/DD

Diagnostic Overshadowing Bias:

- An assumption that all presentations are due to the I/DD. There must be thorough assessment of these issues prior to any assumed connection.
- Examples:
 - An individual appears to be talking to self or comments are unrelated to current situation, clinician assumes it is due to cognitive challenges without assessing for psychosis.
 - An individual refuses engagement in activities that would seem enjoyable, clinician assumes this is related to skills deficits rather than a sign of anhedonia from depression.

Diagnostic Overshadowing Bias:

“I have spent the past twenty years writing and thinking about diagnostic errors...In medicine, most diagnoses are made through the process of recognition. We see something, recognize it and act on what we see. Most of the time we are right. Most of the time. I’ve asked this patient for a photograph to keep on my desk. A reminder, I hope, that the first diagnosis to come to mind can never be the only one considered.” Dr. Lisa Sanders, New York Times Contributor

Clinical Assessment in I/DD

Cloak of Competency:

- Tendency of individuals with I/DD to minimize or hide their disability. Clinician will need to “test for understanding.” There must be careful wording of questions and how abstract concepts are used.

Assent versus Consent:

- Agreement vs. Informed decision-making. Because individuals diagnosed with ID have problems assessing risk and understanding consequences of their actions and those of others, which requires us to ensure their safety.

Acquiescence Bias:

- Occurs when the individual repeatedly answers yes/no questions in an agreeable fashion. Tells the interviewer what they want to hear. The assessor needs to be mindful of body language presented and balance open- and closed-ended questions.

Baseline Exaggeration:

- When an individual does have some behavioral challenges that worsen when mental health episodes occur. For example, an individual engages in mild self-injurious behavior but when the individual is depressed the behavior worsens.

Clinical Assessment in I/DD

Intellectual Distortion:

- When the individual does present with cognitive limitations that affect their ability to understand the questions, and thus the answers given provide an unclear picture of any behavioral or symptom presentation.

Psychosocial (Autistic) Masking:

- Person conforms to perceived social pressures and environmental factors. They suppress or camouflage signs and symptoms to cope.

Cognitive Disintegration:

- Stresses result in a “disintegration” that looks like a mental health issue when in fact it speaks to the need to build better coping strategies.

Differential Diagnosis with Somatic Concerns

*How do you tell if it's psychophysiological disorder?
Symptoms that have a psychological origin*

- Types of symptoms (e.g., vague)
- Lack of objective findings
- Number of physicians visited
- Level of psychological distress
- Aspects of personality that contribute to symptoms

Does it surprise you that stress and other lifestyle factors can contribute to your symptoms (e.g., pain)?

Pattern Recognition in Clinical Assessment

Genetic conditions associated with I/DD that have characteristic patterns of motor, linguistic, cognitive, behavioral, and social abnormalities:

Examples:

- Angelman: Bouts of laughter, “happy” demeanor, attraction to shiny objects
- Prader-Willi: Insatiable appetite/Overeating
- Fetal Alcohol syndrome: Facial deformities, social skills deficits
- Fragile X: Stereotypies, ataxia
- Williams: Relative language strengths, overly “friendly”

Clinical and Behavioral Effectiveness with Developmental Disabilities

*Demystifying Conceptualization and
Advancing Positive Behavior Supports*

Peter Tolisano, Psy.D., ABPP
Board Certified in Clinical Psychology
DDS Director of Psychological Services

Part II

Learning Objectives

Setting the conditions to increase clinical-mindedness

Part II

- Gain understanding in clinical and risk assessment
- Select behavioral interventions based on zone of regulation
- Acquire nuanced skill in proactive and reactive strategies
- Become proficient in trauma-informed and trauma-sensitive care

Clinical-Behavioral Intervention

Fear Factors:

- Unpredictable, uncontrollable, and chronic duration
- Repeats (Winnicott)
- Countered by exposure (real or imaginal desensitization)

Anxiety Factors:

- Rigidity: Executive dysfunction help them find alternatives

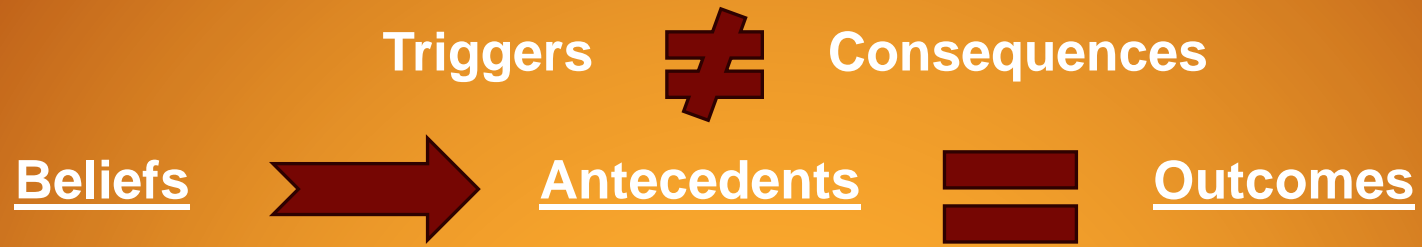
Four Anxiety Distortions (Mind over Mood curriculum):

- Overestimate threat (e.g., catastrophizing: possibility versus probability)
- Overestimate bad outcome (i.e., worse scenario)
- Underestimate own coping
- Underestimate available supports and resources

Adaptation Stresses

Source	What it sounds like?	Adaptive or Empowered Response
Identity Distress	<ul style="list-style-type: none"> • “I can’t do things” • “I hate myself” • “I’m good because I’ve been behaving” 	<ul style="list-style-type: none"> • Better understand strengths and weaknesses • Know positive attributes • Self-expression
Emotional Distress	<ul style="list-style-type: none"> • “I don’t know how to feel” • “I get so angry I don’t know what to do” 	<ul style="list-style-type: none"> • Protect sense of self
Systemic Stress	<ul style="list-style-type: none"> • “I can’t get what I need” • “It’s unfair how they treat me” 	<ul style="list-style-type: none"> • Active coping
Interpersonal Stress	<ul style="list-style-type: none"> • “People don’t accept me. They only judge me” 	<ul style="list-style-type: none"> • Prolonged coping • Feel trusted, respected, and secure by changing the environment • True to self

Clinical-Behavioral Intervention



Most common cognitive biases:

- Distortion: Extremes
- Deletion: Leave out positives
- Generalizations: Always

Achieving adaptive cognitions: *Catch, Check, and Change*

- Relabel
- Reattribute
- Refocus
- Revalue

The success of CBT is based on the experiential behavioral component!

Risk Management

General Principles

- *The best predictor of future behavior is past behavior*
- *Probability versus Possibility trap*
- *It's not about the odds, it's about the stakes!*
- An integrated and proactive approach:
 - ✓ Early detection
 - ✓ Evaluation
 - ✓ Mitigation
 - ✓ Management
- Foreseeable Risk: What is reasonable to anticipate given the circumstances
- *Give it the "Hartford Courant Test!"*

Risk Management

General Principles

- Why is identifying risk important? It's essential to wellbeing and purpose
- In context of developmental disability, risk has three general categories:
 - Health (e.g., disease prevention)
 - Behavioral (e.g., decision-making)
 - Safety and Environmental (e.g., abuse and exploitation)
- ***Aggravating versus Mitigating*** factors

Clinical Risk Assessment for Psychosis

Critical Indicators of psychosis in prodromal stage of illness (attenuated symptoms usually before age of 30)

- Changes in perception, such as hearing things others do not
- Interested in new religious/philosophical beliefs
- Intolerant or complaining about common things or daily life
- Withdrawing and isolating from others
- Mistrusting
- Unusual beliefs or strange, suspicious thoughts
- Ideas or preoccupations that are difficult to understand
- Loss of interest or motivation
- Changes in eating, sleeping, or appearance (negative symptoms)
- Personality alterations

When to pursue a Psychosexual Risk Assessment?

Who could benefit from these assessments?

It assists the legal system (attorneys and courts), social service agencies, foster care placements, schools, detention facilities, congregate and residential settings that work with the following:

- sexually reactive children
- adolescents who have engaged in inappropriate sexual behavior
- adults who have displayed in unsafe or illegal sexual behavior
- Individuals charged with sex crimes

When to pursue a Psychosexual Risk Assessment?

Factors to explore regarding the nature, extent, and intensity of paraphilia (Pattern of illicit {unusual and unacceptable} sexual interests or practices)

- Developmental History
- Psychosocial History
- Mental status
- Sexual interests
- Sexual self-regulation
- Values, attitudes, and beliefs supportive of sexual abuse or assault
- Treatment targets
- History of sexual functioning
- Psychiatric Diagnoses
- Collateral Information
- Sexual knowledge and development
- Level of denial, deception, evasion of responsibility
- Victimology

Static or Treatable Risk Factors in Psychosexual Cases

- Under age 35
- Aggression or violence after age of 15
- Impulsiveness or recklessness
- Major mental illness
- Substance abuse or dependency
- History of sexual trauma
- Prior conviction for a sexual offense
- History of grooming a sexual victim
- Antisocial influences or affiliations
- Poor school performance and disciplinary issues
- Past incarceration

Dynamic or Modifiable Risk Factors in Psychosexual Cases

- Unstable major mental illness (mood, psychosis, personality)
- Poor emotional regulation or impulse control
- Low insight
- Untreated substance abuse or dependency
- *Emotional congruence with children*
- Attitudes supporting sexual offending
- Loneliness or social rejection
- Problems developing and/or maintaining prosocial relationships
- Failure to recognize risk to re-offend
- Exploitative or lacking concern for others
- Rejection of supervision

Protective Factors in Psychosexual Cases

- Over age 40
- No early life history of physical, emotional, or sexual abuse
- No school disciplinary problems
- No significant mental health issues
- No impulsivity or violence crimes
- No substance abuse or maintaining sobriety
- Positive attitudes toward treatment and supervision
- Prosocial relationships and recreational activities

Suicide Assessment

- In 2021, 12 million adults reported seriously considering suicide; rate in US dropped during pandemic.
- Individuals with a diagnosis of intellectual disability and co-occurring mental health disorders are at higher risk for suicide. Thus, screening for suicidal ideation is essential, especially because their lack of awareness of risk and danger can relate to attempts and subsequent accidental injury (i.e., parasuicidality)

*Warning signs for suicide fall into three categories:
Talk, Behavior, and Mood*

- Suicidal ideation/ambivalence can be protective, as part of the person wants to live.
- Behavior markedly changing in unusual or uncharacteristic ways
- Mood becomes reactive or inactive; Resignation

Suicide Assessment

- Contemplation can be prolonged, but impulse in 40% of cases occurs in the 30 minutes that elapses between deciding to attempt suicide to carrying out action
- Help to demystify it by appreciating that suicidal behavior is often crisis-oriented and acute in nature
- Best acute safety intervention point is removing access to means, rather than focusing on intent or plan.
- Safety, no-harm, and no-suicide contracts are contraindicated, ineffective, and a lightning rod for litigation
- Leaving family member responsible for a suicidal person could be considered negligent.

Guiding Principles in Risk Assessment of Harm to Self and Suicide

Theorists include Klott, Joiner, and Jobes

- Don't strip away maladaptive behavior that works for coping because it's preventative
- It's a myth that asking about suicidal ideation will activate it
- Identify the locus of the individuals suffering
- Look for idiosyncratic dynamics including complicated mental status

Ask about Unmet needs!

- ❖ *Weighted factors: Hopeless, Aloneness, Self-Dislike, Inability to Cope, and Anger*
- ❖ *Interpersonal Theory: Perceived burdensomeness, thwarted belonging, and fearlessness*
- ❖ *Reasons to Live versus Die usually provides insight into underlying factors (Nietche: Why and how)*
- ❖ *Impulsivity correlates like gambling, overeating, and hair pulling*
- ❖ *Social cohesion/Isolative (e.g., don't let people close) increases risk*
- ❖ *Neurologically: Under-Developed prefrontal cortex (e.g., intellectual disability, adolescents, and dementia)*

Best Practice Considerations for Suicide Risk Assessment and Safety Planning Interventions

- Motivational Interviewing favorable
- Importance of a nonjudgmental and direct approach (past negative reactions from friends, family, and providers might be barriers)
- Safety planning is a collaboration between clinician and individual to identify onset of warning signs to crisis, articulate coping skills, identify social supports, and access professional services
- Malpractice concerns about liability lead providers to an over-reliance on Emergency Departments and Inpatient Hospitalization. However, these approaches have limited benefit because they are typically brief, don't involve suicide specific interventions, and may leave individuals hopeless upon discharge.
- Other Important questions: Previous attempts, family history of suicide, social isolation, perceived burdensomeness, and precipitating events prior to crisis
- Additional risk assessment points: Duration and intensity of ideation, worse-point ideation, gradient of coping strategies, and stigma reduction

Guiding Principles in Risk Assessment of Harm to Self and Suicide

- Suicide Measures (e.g., Columbia): Not standard of care
- If don't document, then you didn't do it
- Don't pathologize suicide (e.g., guilt-tripping) by telling them the emotional pain they would cause others
- Post-Attempts:
 - Ask: Why are you still alive?
 - Interruptions: Accidental, Self, and Potency of Means
 - Risk after an attempt increases exponentially!
- Resolution Phases:
 1. Safety
 2. Soothe emotional pain
 3. Foster hope (what influences the future?)
 4. Cultivate meaning

Hypothetical Safety Plan Worksheet (Gradient Format)

1. Warning Signs (thoughts, images, mood, behaviors that crisis is developing)
2. Internal Coping Strategies (relaxation, activities)
3. People and Social Settings that are Positive Distractions
4. People to Ask for Help
5. Reasons for Living
6. Making the Environment Safe
7. Professional or Agencies to Contact during Crisis

Always Ask: On a scale of 0-100, how confident are you that _____ strategy will help or work?

Proactive Strategies

Aspirational Philosophy:

The objective of Positive Behavior Supports is not just to define and eliminate undesirable behaviors, rather to understand the function of the behaviors so we can teach more effective alternative behaviors, modify the environment, and promote supports to make the challenging behavior less likely to occur.

Actual Improvements in Quality of Life:

- Assist in communicating wants and needs effectively (e.g., Do you want to be heard or helped?)
- Change the atmosphere (e.g., increasing space)
- Offer opportunities for choice and control I.e., availability of preferred items and activities)

Proactive Strategies are designed to meet the person's wants and needs without them needing to rely on challenging behavior to achieve them!

Helping Working Memory

Cognitive

- Match expectations to actual capacity.
- Represent all information (lists, digital recordings, sticky notes, cue cards, pictures sequences with arrows for routines, and journals) **physically**
- Encourage self-talk and imagery during tasks
- Rehearse when-then plans to prime recall of what to do next . They have difficulty keeping in mind what you ask them to do.
- Accommodations need to be “at the point of performance” (i.e., natural setting where the knowledge is utilized)
- Skills training often doesn’t help because it relies on conveying knowledge. Better to use scaffolding to help them recall and use what they know
- Keep instructions short and business-like
- Only focus on important chores, tasks, and directives. Eliminate trivial battles

Behavioral

- Help them **anticipate** problem situations (e.g., restaurants, church, visitations, and phone calls)
- Encourage positive alternatives. That is, think about a challenging behavior and what positive options could be done instead (to override low working memory in the moment)
- Arrange positive feedback and rewards

Reactive Strategies: Key Points

- *Do you want to be correct or effective?*
- Avoid discussing the fallacy of fairness
- Art of validation is in getting the person to change the circumstances to help themselves to de-escalate (“How did we get here today?”)
- Slow down the process by using transparency, transference, and awakening somatic awareness.

Debriefing:

Becoming behavioral detectives to learn from crises

- Debriefing is necessary as a solution- and problem-focused approach
- It helps to avoid superficial and pejorative labels (i.e., attention seeking and manipulative), and to understand antecedents, functions of behavior, and alternative ways to cope
- It includes stakeholders for consistency
- Allows us to practice responses
- Creates safe space to share and create

Reactive Strategies: Key Points

Behavior correction is nearly impossible during dysregulation.
When escalation starts, we need to prompt coping strategies that are *proactively planned and rehearsed* to lower the intensity.

Effective reactive strategies are contingent on working in a Window of Tolerance (Dan Siegel, 1999). Optimal zone in nervous system arousal where you can respond effectively to emotions and sensations.

Faux window is the temporary management without fully resolving the underlying physiological imbalance.

Reactive Strategies: Dialogue

- The ideal approach depends on the person and the context (e.g., For anxiety, using an internal-focus on relaxation versus external-focus with grounding)
- Being present and attuned matters most. *How can I meet your needs? No assumptions--* Empathically ask permission to “help, hear, or hug.”
- Research suggests that a powerful way to soothe a person’s feelings is to converse, as temporal lobe functioning centers on language and emotion.
- Most effective “I understand why you feel that way.” Recognize things will improve and seeing new perspectives. In the short-term validation is often best “I can imagine that was difficult.”
- Try to see both sides of situations “I want you to feel independent. But in this situation, you might be going against that goal.”
- Listen to the cues as the person discusses the problem. “They don’t care about me” needs validation. Saying they wish they felt differently or can’t solve a problem is asking for help.

Reactive Strategies: Dialogue

- Telling people, they shouldn't feel that way makes it worse, such as "calm down" and "relax" makes people angrier. These strategies backfire because they imply the other person's feelings are inappropriate or too intense. Telling someone they are overreacting paradoxically makes them more emotional.
- Research shows people are much more receptive to advice if they feel emotionally validated and supported. Then ease into problem solving. Watch projecting your own preferences.
- Validation = acknowledgement (not agreement or acceptance)
- Coach them into a problem-solving or self-resolving mindset
- Challenging perspectives needs to be couched in an explanation of how much you care otherwise it's just confrontational.

Reactive Strategies: Reflective Listening

Learning to reflect not repeat...What's the theme in the message, rather than just the words or phrases.

Statement	Repetition	Reflection
"I don't want to go day program. It's a waste of time."	"You don't want to go to the day program."	<i>"It's not something that you think will help. You don't think it's worth your time."</i>
"It's not my fault. My roommate is the reason things happened."	"You don't think it's your fault but his."	<i>"People are blaming you, but that's not where you think it belongs."</i>

Reactive Strategies: *Why can they be problematic?*

Historically, challenging behaviors in people with intellectual disability have been subjected to punishment and aversive techniques.

Punishment and aversive techniques will suppress undesirable behavior -but only temporarily- because they don't teach new skills or provide proactive strategies to prevent the behaviors from occurring in the first place.

Positive behavior supports is an approach that is more respectful and more effective for producing lasting behavior change.

Discipline and consequences can shut down negative and positive behaviors!

Reactive Strategies: What doesn't work!

Perceived as Punishers:

- Verbal reprimand
- Planned ignoring
- Response interruption
- Time-out
- Removing a privilege
- Suspensions
- Order with authority (e.g., “You need to calm down”)
- Imperatives (e.g., Should, Must, Have, and Don't)

The side effects of punishment clearly outweigh the potential benefits:

- Potentially breach human and civil rights
- Endanger safety of those receiving and providing support
- Adversely affect the ongoing relationship between the individual and support staff
- Reactive aggression
- Avoidance of the person/setting delivering punishment
- Suppression of behaviors similar to the target behavior but appropriate
- Teaches the person to use punishment to others

Selecting Behavioral Interventions

Based on Zones of Regulation and consistent with a Trauma-Informed approach

- Traffic light analogy
- Format helps staff to identify when they should intervene

Green: Typical or baseline behavior when calm

Amber: Anxious or agitated precursors. Challenging behavior about to occur.

Red: Behaviors of Concern themselves

Blue: After the incident tension reduction and learning to return to green

Green Strategies

- Aimed at reducing the chances of challenging behavior
- Avoid “no and don’t” communication
- Proactively set expectations for upcoming events
- Be enthusiastic about the individual (mirroring in attachment)
- Be consistent between staff
- Give reminders of rules, routines, and structures
- Provide choices with two or three options
- Praise adaptive behavior
- Change the environment to suit them
- Use exercise and activity to reset the limbic system

Amber Phase

- Early warning signs before the challenging behavior
- Behavior described might be viewed as spontaneous, but precursors are often unrecognized or there's a failure to change staff behavior
- Look for subtle, but observable changes in body language (e.g., pacing, pressured vocalizations, and intense facial expressions)
- Amber strategies are de-escalation designed to get individual back into the green phase
 - Minimize or eliminate the triggers
 - Divert or distract
 - Change staff roles
 - Inquire about distress
- *Caveats:*
 - ❖ *Ignoring the behavior might be perceived as disapproving of the person*
 - ❖ *Only encourage expression of emotion in the context of adequate impulse control, otherwise the person might act on the anger!*

Red Phase

- The behavioral crisis itself
- Respond with reactive strategies to establish safety
 - Use low arousal approaches (e.g., calm voice, supportive stance, create space, and avoid demands)
 - Distraction and diversion
 - Redirection
 - Restrictive interventions only as a last resort!

Blue Strategies

- Recover and return to their baseline
- Careful as biological responses could re-escalate

- Check for injuries when safe
- Don't remind the person about the behavior (e.g., tell them off)
- Be familiar with signs of quieting

- Make no demands
- Move to different setting or give space
- Engage in an activity

- Staff reflect on incident in private
- Document for team

Principle of Differential Reinforcement

PICA Example

- It is important to include training and planning for positive alternative behaviors because failing to replace the maladaptive behavior after removing the desired item may unknowingly reinforce the craving for the pica item.
- Prompt and encourage him to exchange a found food item or inedible object for a preferred food item. This will help him to discriminate between edible and inedible items and shape successive approximations of appropriate behavior.
- Use positive practice intervention and overcorrection. This will occur when he is instructed to discard the found item by stating to him “Where does it belong? Put it in the trash receptacle.” Offer verbal praise with his compliance or physical assistance with non-compliance. This represents a naturally corrective action for pica.
- Safe items can be placed in a “Pica Box,” which should be easily accessible to him when he feels like engaging in Pica.

Principle of Inadvertent Reinforcement

- Human behavior is learned
 - No behavior occurs “out of the blue”
 - Behaviors continue to occur because they are effective
 - Behavior is ultimately controlled by its consequences
-
- ❖ Positive Reinforcement increases behavior by the addition of a desirable event when the behavior occurs (e.g., praise, money)
 - ❖ Negative Reinforcement increases behavior by the removal of an aversive event when the behavior occurs (e.g., excuse from chores, escape from crowd)

Susan lives in a CLA with two housemates. At dinner, all three individuals go to the kitchen table. A staff member serves food to a peer before serving Susan. As a result, Susan begins to scream and pull her own hair. The staff member then quickly gives Susan a food serving, and Susan relaxes.

James has supported employment in an office, in which he does several tasks. When he is given the task of shredding papers, which he dislikes, he always makes a mess. When he becomes messy, James is removed from the task he dislikes.

Best Practices Approach to Selecting Interventions

Which Interventions...

- Correspond to the function of the behavior? *Poor quality behavior plans conceptualize one way and then intervene in another!*
- Produce few negative side effects?
- Are the least intrusive?
- Produce more positive outcomes?
- Teach alternative adaptive behavior?
- Receive the most support?

Best Practices

Research and experience finds these to be obstacles in successful behavior supports...

- Behavior weakly defined
- Inadequate data collection to inform practice and prescribing
- Failure to consider underlying issues (e.g., medical, trauma, personality, and mood)
- No replacement behaviors identified and taught
- No collaboration and consistency between settings
- Poor identification of preferences and dislikes
- Caregiver training incomplete (i.e., staff unable to demonstrate competent skill performance)
- No monitoring or periodic retraining (leading to staff drift).

Trauma Facts and Effects

- Definition:
 - Anything life altering and/or less than nurturing
 - Passive trauma versus Circumscribed, discrete, or catastrophic trauma
- Cost of ignoring trauma is that it amplifies anxiety/emotions and “carry over” hinders the quality of life.
- Get stuck in hypervigilance. No internal compass to detect harm and safety.
- Somatic symptoms: sleep problems, digestive issues, fibromyalgia, migraines, chronic fatigue are in part substitutes for the body’s repressed internal cries for help.
- The “after effect” of trauma (i.e., après coup) when perceptions and development catch-up to what has happened.

Developmental or Formative Trauma

The internal logic has yet to be revealed!

- Trauma of Invalidation
- Disenfranchised grief (Can't get back time)
- We don't escape or overpower it, but endure it (Levine)
- Imprinting and "Reminiscence Bump"
- Current trauma reactivates or awakens the multisystem effects of earlier trauma, such as codependency, capacity to trust, manage conflict, select partners, reality test, misplaced anger, and fragmented self

Developmental or Formative Trauma

The internal logic has yet to be revealed!

- Relationships that inadvertently reinforce the same are selected, as an attempt at healing via control and mastery.
- What schema is activated? Abandonment, emotional deprivation, defectiveness/shame, helplessness/unmet needs, or enmeshment
- In terms of grief, developmental disability is an ambiguous loss (there physically, but not cognitively and/or emotionally)

Examples:

- *Caregiver was unavailable and neglectful. Result: “My needs don’t matter. I am unlovable and worthless.”*
- *Child feels undeserving: Unresolved pain is passed on (Intergenerational Transmission)*

Trauma Sensitivity

Being trauma sensitive--not just trauma-informed
Understand it and then act accordingly

Prefrontal cortex is critical for planning, judgment, and decision making—it keeps the emotional part of the brain (limbic) in check.

When distressed the balance shifts and the amygdala that identifies threat takes over.

Hebb: *Neurons that fire together, wire together (memory themes {"I-Statements"}) look like a venn diagram)*

Our bodies react the same way whether the threat is external (disappointing others) or internal (fear of failure).

Trauma Sensitivity

Function of Survival Responses

- **Social Engagement (parasympathetic) to co-regulate**
- **Flight or flight (sympathetic) to mobilize**
- **Freeze or collapse (vagal) by immobilizing to conserve energy and protect (turtling)**

Safety, Connection and Problem-Solving



Survival State

BRAIN STEM

The Survival State represents the primal brain and asks the question, "Am I safe?" The only way to soothe the Survival State is through the creation of *Safety*.



Emotional State

LIMBIC SYSTEM

This Brain State represents mid-level functionality and asks the question, "Am I loved?" The only way to soothe an upset emotional state is through *Connection*.



Executive State

PREFRONTAL LOBES

The Executive State represents the optimal state for problem-solving and learning. This Brain State asks the question, "What can I learn from this?"

Triune Brain

Top
Down

Cortex

- Speech
- Logic
- Higher Thinking
- Academics
- Memory



Bottom
Up

Limbic System

- Security
- Emotion
- Desire

Brain Stem

- Fight or Flight
- Instinct
- Survival
- Safety

Trauma Sensitivity

- Amygdala is oriented to negative events and responds to actual or perceived threat. Evolutionary function to get out of harm's way is programmed in our genes and passed to the next generation.
- Amygdala is mature at birth, but neural pathways can't support it; therefore, we need sensitive and attuned caregiving.
- Fear conditioning is fast and long-lasting. It never fully extinguishes. We can make progress and then fear gets re-evoked even by minor triggers. Half second of delay for information to get to cortex. Anger and fear can be experienced without conscious mind.
- Amygdala activation during trauma undermines the ability of the hippocampus to lay down memories, thus causing fragmentation. Laying down memory is shaped by past experiences. Myelination is needed for explicit and episodic memory.

Trauma Sensitivity

- Individuals with intellectual/developmental disability are more limbically reliant, particularly due to lower functioning of the cortex.
- Also, those diagnosed with I/DD are most susceptible to “Sanctuary Harm.”
- Neuroception (Porges): The autonomic nervous system unconsciously (below awareness) searches for cues of safety and danger (e.g., tension in face, hip movements, or angle of neck). Our bodies adjust to what we detect.
- The ANS is shaped by early relationships and continues to be influenced by experiences. Protection (fight flight) or disconnection (freeze) over connection.
- Behaviors reflect strategies used from young age within relationships. Habitual responses!
- Episodic Memory → Semantic Memory → Procedural Memory (Sandler)

Trauma Sensitivity

- We get trauma-triggered and the adaptive child—the things we learn to do as a kid because of emotional neglect and aggression—part comes in and takes over. It wants to preserve itself.
- When we repeat the same adaptive child moves, then we develop a dysfunctional relational stance (e.g., controlling, retaliating, or withdrawing)
- *We generally don't reenact the experience of trauma itself. Instead, we act out the coping strategy that we evolved to deal with it. Transform an internal conflict into an interpersonal one.*
- *Most common: Avoidance, Surrender, or Over-Compensation*
- Patterns are anchored in developmental trauma. Current circumstances mirror earlier conflicts. For example, trauma bond cycle involving abuse followed by reconciliation and nurturance (love and fear).

Trauma Recovery Model

Our goal is to help those that we serve stay in the Window of Tolerance!

<p>Hyperarousal: (Fight or flight) Intense anger, reactivity, panic, sleepless, poor concentration, vigilant, or overwhelmed</p>	<p><i>Precursor dysregulation:</i> Irritable, anxious, or agitated</p>	<p>Window of Tolerance: Optimal; Comfort, access reason and emotion, alert, engaged, grounded, present, relaxed, sociable, flexible, and caring</p>	<p><i>Precursor dysregulation:</i> Shutting down, discomfort, poor sense of time, or problems concentrating</p>	<p>Hypoarousal: (Freeze) Depressed, numb, constricted, unavailable, dissociated, detached, or rigid</p>
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Persecutor

Rescuer



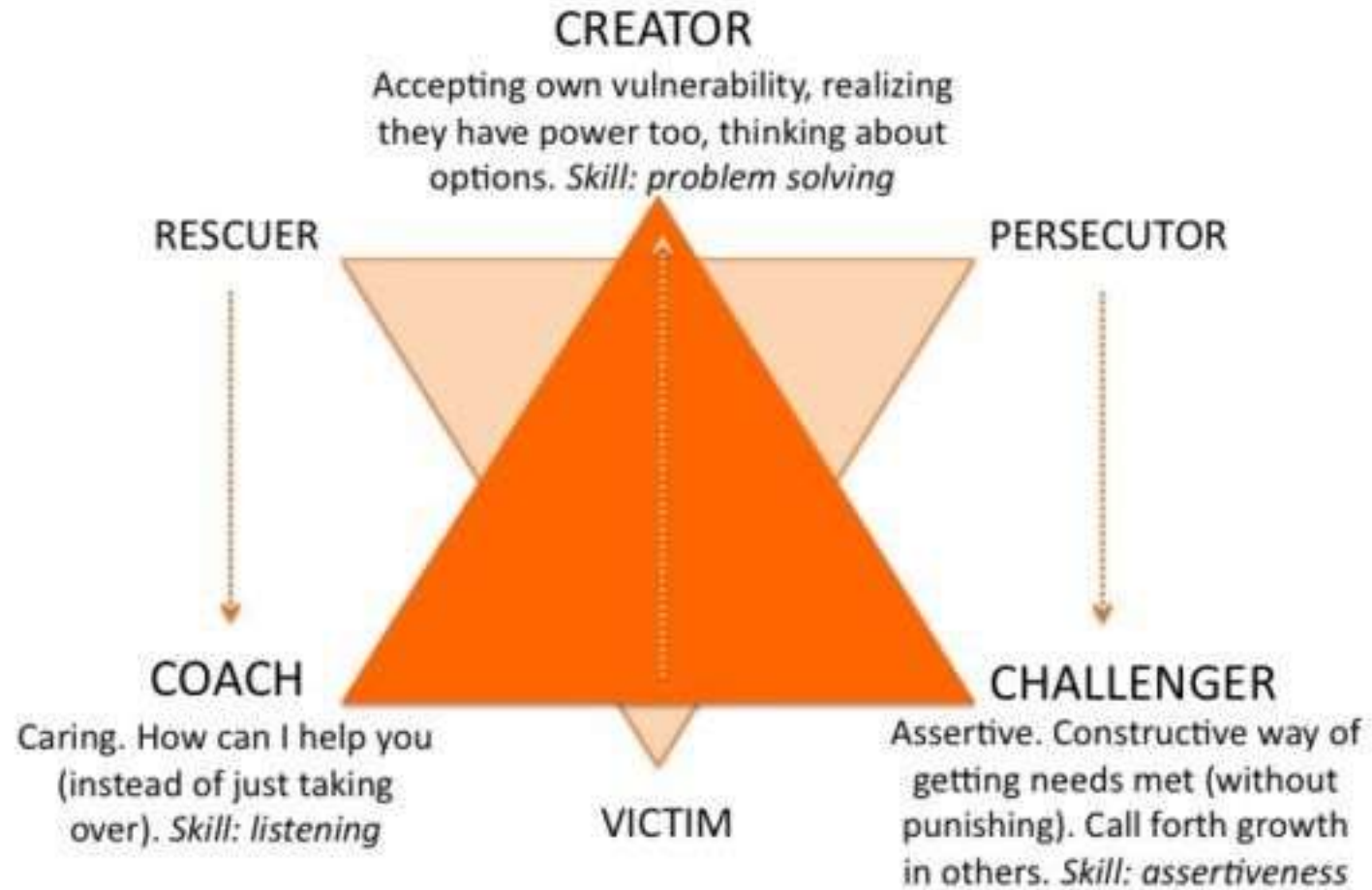
The Drama Triangle

Victim

- Identification with the Aggressor
- Angrier at the third party (protector, bystander)

EMPOWERMENT TRIANGLE

KEY = SELF-AWARENESS



Enhancing Resiliency

What's wrong with you? to What happened to you?

- **Those with developmental disabilities (especially ASD) are at increased risk for Adverse Childhood Experiences (Anda and Felitti, 1995), which increases their risk for mental, somatic, and psychosocial health comorbidities.**
- **Protective factors include:**
 - **Investment and belief**
 - **Social and emotional competence of the caregivers**
 - **Parental knowledge of child development**
 - **Determination, motivation and hope**
 - **Effective school environments**
 - **Social connections and specific help in times of need**
- **Iacoviello and Charney (2014): Optimism, cognitive flexibility, active coping, social supports, physical wellness, and a moral compass**

Transforming Interactions

Key Points

- Teach Dialogue (e.g., Reciprocal validation “your side versus my side”)
- Remedial Empathy: How does the individual perceive what I am saying?
- Correct/Right versus Effective (objective versus subjective reality)
- Intent versus Impact
- Guilt versus Shame (Bradshaw; “Making a mistake” versus “Being a mistake”)
- The individuals we serve have a lifetime of exposure to “service systems” and a feeling that people are trying to “fix” them. This often results in an over focus on the “disability and weakness,” rather than “needs and strengths.”

Transforming Interactions

Key Points

- *Implicit memory and state-dependent retrieval: Our original memories are encoded and get enacted unconsciously!*
- Don't intervene or interpret during heightened affect to avoid reinforcing trauma. Look for soothing, safety, and empathic attunement to quiet implicit memory
- Working with highly challenging behaviors: Due diligence and fidelity to the plan, rather than focusing on outcome.

Problem Interactions

Fear-based authoritarian staff cause myriad negative outcomes, such as increased risk for anxiety and depression, low self-esteem, and exhibit more disruptive behavior.

Conditional regard leads to resentment and poor self-regulation.

Exerting psychological control (e.g., “You didn’t follow directions so you’re bad” or “If you really cared then you would be good and follow directions”). This causes identity to be centered on behavior, rather than attributes.

Caregivers are “intervening variables” to outcome. How do we help to liberate others from the reactive brain?

(French and Alexander) “Corrective emotional experience”

Areas to help Caregivers

Antecedent-Based:

- Training of Program Supervisors
- Allocation of Responsibility to Trainees
- Prompting

Consequence-Based:

- Monitoring
- Feedback

Ensuring Buy-In

Empowerment is associated with these concepts:

- Knowledge on how principles align with procedures
- Self-efficacy (“I can make an impact”)
- Creating understandable and feasible protocols
- Coaching for fidelity
- Refine capturing of idiosyncratic variables and overlapping functions
- Better understand caregiver motivations
- *In practice, simply teaching skills (“train and hope”) is insufficient to fully engage caregivers in implementation, even when given the most effective and contextually relevant strategies.*

Healing ourselves helps us to heal others

Ways to avoid burnout and cope with adversity

- ✓ *See the humanity behind the behaviors of others*
- ✓ Acceptance (things are inevitable, especially with longevity)
- ✓ Humility (limitations)
- ✓ Gratitude (Emmons) Counting our blessings
- ✓ Journaling to slow thinking
- ✓ Support system (mentoring)
- ✓ Life beyond work (identity)

Special Topic: Assistive, Adaptive, and Rehabilitative Technology

Incorporate Devices and Services into Behavior Support Plans

- Any item, equipment, or product used to maintain or improve functional capabilities.
- Initiatives started in 1960s
- Areas may include communication, learning, and mobility
- Low, medium and high-tech tools
- Examples include self-care aids, reminder devices, voice recognition, accessibility software, and medication dispensing.
- Benefits: Easier lifestyle, independence, and less institutional costs
- Can be coupled with physical and occupational therapy
- Patricia.cymbala@ct.gov or Amy.Blazawski@ct.gov

In Summary...

Look for ways to improve behavioral delivery systems:

- **Change policy and leadership agenda**
- **External review and debriefing**
- **Data to inform practice**

- **Person-centered planning and rights**
- **Family and stakeholder involvement**
- **Consult with those who have lived experience**
- **Trauma-informed and sensitive-care**

- **Increased staff training**
- **Prevention tools (sensory modulation techniques)**
- **Empathy and cultural awareness**

Conclusion

Remember I/DD is a neurological and genetic disability, not a choice. We need to use understanding, compassion, and willingness to make accommodations to lower the effects of impairments.

“There’s no such thing as an individual. We co-regulate each other’s nervous systems. We need to shift from a control model to a collaborative and humble one. We’re not above the system, we’re in it.”
Terrance Real, LCSW