

6

Children with Developmental Disabilities

CHRISTINA A. GROSSO

OVERVIEW OF TF-CBT WITH CHILDREN WITH DEVELOPMENTAL DISABILITIES

As we look at the emerging demographics in society today, we cannot ignore the need for specialized treatment for traumatized children with developmental disabilities. Developmental delays impact one in six children in the United States (Boyle et al., 2011), and these children are up to 10 times more likely to be maltreated than those who are not disabled (Goldson, 2002; Sobsey & Doe, 1991). With the prevalence of trauma in developmentally disabled children and the lack of trained professionals who are able to provide treatment (Charlton, Kliethermes, Tallant, Taverne, & Tisherlman, 2004), we are looking at a crisis in our mental health system. We need to understand how to adapt existing best practice to address the specific needs of the developmentally disabled.

The applications presented in this chapter are a result of the work done over the last 6 years implementing trauma-focused cognitive-behavioral therapy (TF-CBT) in several residential treatment facilities in New York State with children and adolescents with complex trauma and psychopathology (Cohen, Mannarino, & Deblinger, 2006). Of these children, many also suffered from various developmental disabilities, including but not limited to mild mental retardation, learning disabilities, receptive and expressive language disorders, and autism spectrum disorders, namely pervasive developmental disorder. As TF-CBT was initiated,

the challenges of this population emerged as did the need for adaptations that addressed their impairments in cognition, communication, and affect management.

DEVELOPMENTAL DELAYS

The Centers for Disease Control and Prevention (2011) define developmental disabilities as “a diverse group of severe chronic conditions that are due to mental and/or physical impairments. People with developmental disabilities have problems with major life activities such as language, mobility, learning, self-help, and independent living. Developmental disabilities begin anytime during development up to 22 years of age and usually last throughout a person’s lifetime.”

The prevalence of developmental disabilities in children has increased significantly in the last decade. According to a 2008 survey, over 15% of children ages 3–17 have diagnoses of such disabilities, including “attention deficit hyperactivity disorder; intellectual disability; cerebral palsy; autism; seizures; stuttering or stammering; moderate to profound hearing loss; blindness; learning disorders; and/or other developmental delays” compared with 12.84% a decade earlier (Boyle et al., 2011, p. 1034). The occurrence of developmental delays in boys was nearly twice that of girls, with Hispanic children showing significantly less prevalence than white non-Hispanic and black non-Hispanic children. Children with families below the poverty line and children with access to Medicaid or other public health insurance also showed higher rates of developmental disabilities compared with middle-class children with private insurance (Boyle et al., 2011).

Limitations and Challenges

Children with developmental disabilities often have difficulty in areas of cognition, communication, and affective regulation (see Table 6.1). It is important to understand these deficits in order to create adaptations in treatment.

Strengths

As with all children, those with developmental delays also have strengths, a fact that may often be overlooked by caregivers and clinicians as a result of the severity of the developmental challenges. It is imperative that we identify these strengths and use a strengths-based approach to treatment. Children with developmental delays will often have an ability to retain information related to events. They may think in pictures and recall this

TABLE 6.1. Areas of Impairment in Developmentally Disabled Children

Cognition	Communication	Affect dysregulation
<ul style="list-style-type: none"> • May have difficulty with: <ul style="list-style-type: none"> ▪ Abstract thinking ▪ Critical thinking ▪ Sequencing events ▪ Prioritizing ▪ Task breakdown ▪ Ambiguity • Concrete thought process • Fixations • Black-and-white thinking • Think in pictures • Highly focused areas of interest and expertise 	<ul style="list-style-type: none"> • Delays in receptive and expressive language • Idiosyncratic speech • Echolalia • Poor social skills • Engage in one-sided conversation • Difficulty engaging with and responding to others • Lack of boundaries, intrusive behaviors • Trusting of others 	<ul style="list-style-type: none"> • Difficulty identifying emotions in self and others • Difficulty expressing emotion via facial gestures and/or verbal statements • Sensory sensitivity • Impulsive • Easily agitated • More prone to anxiety • More behavioral issues; may be quick to hit, punch, kick when agitated • Tendency for rote behavior when anxious • Difficulty and/or discomfort with change

Note. Based on Charlton, Kliethermes, Tallant, Taverne, and Tisherlman (2004)

information with great clarity and detail. They may also have domains of interest and expertise, with special talents and insights in specific areas such as math, art, and music as well as spatial and mechanical abilities (Grandin, 2010).

TRAUMA AND DEVELOPMENTAL DISABILITIES

Children with disabilities are at higher risk to experience abuse than those without disabilities (Ryan, 1994). According to Sullivan and Knutson (2000), they are 3.79 times as likely to be victims of physical abuse, 3.14 times more likely to be victims of sexual abuse, and 3.76 times more likely to be neglected than their nondisabled cohort. Overall, the literature points to rates of maltreatment among children with disabilities of 1 to 10 times greater than among children without disabilities (Goldson, 2002; Sobsey & Doe, 1991). Studies indicate that 22–70% of abused children have developmental disabilities (National Research Council, 2001). Rates of abuse and maltreatment are thought to be much higher than the statistics just presented as a result of underreporting in this population because of communication issues, reliability of victim reporting, and the judicial system seeing reports as being of questionable credibility (Charlton & Tallant, 2003). Children with developmental disabilities are also more likely to be in out-of-home placement (i.e., residential treatment, day programs, and assisted-living facilities where rates of sexual abuse are

two to seven times higher than in the community) (Overcamp-Martini & Nutton, 2009).

Because of the limitations and challenges discussed earlier, disabled children are at risk for increased victimization. They may not understand what is happening to them and may not have the capacity to communicate effectively with someone who can help. Children with disabilities are often dependent on multiple caregivers for learning and supervision as well as assistance in activities of daily living, including eating, bathing, and toileting, thus increasing exposure to potential boundary violations. They are taught to trust caregivers, adults, and authority figures. As such, they can be easier to manipulate because of decreased capacity for critical thinking and the inability to differentiate safe from unsafe persons and situations. Thus, children with developmental disabilities are more likely to experience trauma, and trauma exposure also increases the likeliness of developmental delays. Severe trauma and neglect can impact children's developing brain and affect problem solving, affect regulation, and comprehension. Prolonged abuse can result in permanent damage to these brain functions. The impact of the trauma on the children may be further compounded by the lack of response and understanding from society (Charlton et al., 2004).

TREATMENT ISSUES AND RECOMMENDATIONS

With the prevalence of trauma in developmentally disabled children, it is probable that clinicians will be finding these children on their caseloads. However, as a result of underreporting, these children may not receive appropriate therapy or may be misdiagnosed (Boyle et al., 2011; Goldson, 2002). Children may exhibit behavioral disruptions that are in reaction to trauma exposure but not report the incident of abuse. This behavior may then be seen as a symptom of the developmental issue alone, and the trauma may go unrecognized and untreated. Compounding this issue further is a twofold problem: (1) a lack of trained professionals who are able to assess for trauma exposure and provide trauma treatment to developmentally disabled children and (2) society's belief that the developmentally disabled do not benefit from verbal psychotherapy (Charlton et al., 2004; Reaven, 2009).

Children with developmental delays present some unique challenges to traditional verbal and cognitive-behavioral therapy (CBT) (Moree & Davis, 2010; Reaven, 2009). Because of their impairments in cognition, language, and emotion, adaptations are needed to help them access the concepts and develop appropriate skills (Moree & Davis, 2010; Wood et al., 2009). Some general strategies include those listed in Table 6.2.

Based on some of these unique challenges that children with developmental disabilities present, CBT offers inherent structure and skill building

TABLE 6.2. Treatment Strategies for Children with Developmental Disabilities

Strategy	Purpose	Examples	Goals
Provide structure, create routines.	Children with developmental delays will often have difficulty and discomfort with change.	<ul style="list-style-type: none"> • Have a consistent meeting day/time. • Create a routine for sessions with opening and closing rituals. • Help family and caregivers create schedules/routines in the home and school (e.g., set times for meals, homework, bed) 	<ul style="list-style-type: none"> • Creates consistency and expectation. • Enhances predictability and comfort. • Increases capacity for autonomy. • Increases opportunity for repetition.
Shorten sessions.	Children with developmental delays will often have shorter attention spans and can be easily agitated.	<ul style="list-style-type: none"> • Adjust session time according to attention span. • Adjust dosage and pacing of gradual exposure. 	<ul style="list-style-type: none"> • Increases sense of competence and success. • Increases capacity for self-control and affect regulation.
Slow down.	Children with developmental delays have difficulty breaking down tasks and interpreting complex and compound messages.	<ul style="list-style-type: none"> • Slow speech down. • Give simple messages. • Present one topic at a time. • Be specific. 	<ul style="list-style-type: none"> • Increases comprehension and competence.
Use art/ visuals.	Children with developmental disabilities are often visual thinkers and "think in pictures."	<ul style="list-style-type: none"> • Provide images to illustrate directions and tasks. • Utilize visual aids when teaching skills. • Encourage children to draw, paint, sculpt their thoughts and feelings. 	<ul style="list-style-type: none"> • Increases comprehension. • Increases ability to communicate.
Use play.	Children with developmental disabilities are visual thinkers and require movement and activation to remain focused.	<ul style="list-style-type: none"> • Use puppets, figurines, sand play, and dollhouses to create stories and metaphor. 	<ul style="list-style-type: none"> • Increases comprehension. • Increases ability to communicate.
Provide repetition.	Children with developmental disabilities have cognitive limitations, including poor comprehension and retention and decreased capacity for generalization.	<ul style="list-style-type: none"> • Repeat skills and concepts in session. • Assign homework to practice skills taught in session. • Use consistent praise and rewards as reinforcement of positive behavior. 	<ul style="list-style-type: none"> • Creates consistency and expectation. • Enhances predictability and comfort. • Increases capacity for autonomy.

(continued)

TABLE 6.2. (continued)

Strategy	Purpose	Examples	Goals
Use interests and fixations.	Children with developmental disabilities often have fixations or special interests.	<ul style="list-style-type: none"> • Ask, discover children's special interests. • Use fixation on favorite character, person, place, thing to teach skill. • Use shared interests to increase socialization. 	<ul style="list-style-type: none"> • Increases engagement in treatment. • Increases communication. • Increases retention of skill. • Increases socialization.

Note. Based on Charlton, Kliethermes, Tallant, Taverne, and Tisherlman (2004); Grandin (2010); and Reaven (2009).

to directly address these needs (Reaven, 2009). CBT has shown to be an effective intervention with children with a variety of functional difficulties because of its capacity to provide structure and self-management strategies. The need for an integrated treatment approach is also emphasized, specifically the use of art therapy and visuals to create concrete, tangible resources to accompany verbal interventions (Moree & Davis, 2010; Oathamshaw & Haddock, 2006; Reaven, 2009; Taylor, Lindsay, & Wilner, 2008; Wahlberg, 1998).

APPLICATIONS OF TF-CBT SKILLS AND TECHNIQUES

As we begin to address these issues in TF-CBT, we must recognize the need to enhance our clinical knowledge and skill in assessing for trauma and developmental delays as well as adapting treatment to fit the needs of our clients. TF-CBT is a highly flexible model and lends itself well to diverse adaptations (Cohen et al., 2006). However, as with any adaptation, it is important to be mindful of the goals of treatment and the purpose of each component so that any alteration is congruent with the philosophy and fidelity of treatment. An effective strategy in achieving this is to ask the question "Why?" Why do we provide psychoeducation to a child who has experienced sexual abuse? Why do we teach grounding and relaxation strategies to survivors of trauma? These questions will help us maintain the fidelity of treatment while creating and adapting our methods/interventions on how to achieve the goals of TF-CBT. Children with developmental disabilities may move through the model more slowly and require more time to understand concepts through repetition and application. Change occurs slowly but does happen. One must be mindful of setting treatment goals to

reflect this incremental progress and provide praise for accomplishments in a specific and immediate manner.

The remainder of this chapter is dedicated to the direct application of skills and techniques for use with children with developmental disabilities. A foundational working knowledge of TF-CBT is assumed and is a prerequisite for fully understanding this discussion, which is built upon original fidelity of the PRACTICE components. Each component is broken down by goal, challenge(s), and skill(s). The goal of each component—the “why”—is delineated as well as the unique challenges of the population and the reason for implementation strategies that are developmentally appropriate. Last, the specific skills and activities utilized to teach each component are discussed. In essence, a “toolbox” of interventions will be accessible to the readers for immediate and direct use with their client population.

Similar to creating a toolbox for the clinician, we also want to create a toolbox of skills for clients. The skills and activities discussed will provide useful and practical tools for the children as they progress through treatment. Clinicians can concretize the toolbox by creating a folder, binder, or box for these materials and use it as a resource and refer back to it to as needed. This will also provide a transitional resource when treatment concludes, to be used by the children at home and school with caregivers.

Assessment

As we know, the role of assessment is extremely important in TF-CBT (see Table 6.3). We need to screen for trauma exposure and symptoms as well as other psychiatric disorders to develop case formulation and treatment goals. At the onset of treatment, we need to determine trauma type and begin to develop a hierarchy of experiences. In addition to psychosocial history, we also complete standardized measures, such as the UCLA PTSD Reaction Index (Steinberg, Brymer, Decker, & Pynoos, 2004) to determine trauma exposure and symptoms and the Child Behavior Checklist (Achenbach, 1991) to reveal behavioral, emotional, and thought problems. Standardized measures are important in rating change over time from pre- to post-treatment. In working with developmentally disabled children, we may also want to consider administering cognitive scales to determine the degree of cognitive impairment and developmental level (Oathamshaw & Haddock, 2006). By completing these various instruments, we can begin to formulate a symptom picture and a differential diagnosis. Some symptoms may overlap across trauma and developmental domains, such as the ability to focus, regulate affect, and control impulses. Are these symptoms a result of avoidance, hyperarousal, and/or hypervigilance resulting from exposure to trauma? Are the symptoms in reaction to an attention-deficit/hyperactivity disorder? Or are these symptoms due to a cognitive delay?

TABLE 6.3. Why Do We Assess Clients?*Goals*

- To assess for trauma, psychiatric disorders, and developmental level in order to develop case formulation and goals for treatment
- To monitor progress over course of treatment

Challenges

Children with developmental disabilities have:

- Overlapping symptoms of trauma and developmental delays
- Difficulty understanding language of assessments
- Limited capacity for sequencing and difficulty understanding frequency
- Difficulty engaging and responding to others

Skills

- Shorten sessions—complete assessment over multiple sessions
- Use visuals to illustrate concepts and aid in communication

Note. Based on Charlton, Kliethermes, Tallant, Taverne, and Tisherlman (2004) and Cohen, Mannarino, and Deblinger (2006).

Standardized measures may present an obstacle to children with developmental issues. They may have difficulty understanding the questions, organizing their thoughts, and communicating their answers (Avrin, Charlton, & Tallant, 1998) and may require one-on-one verbal administration to ensure comprehension. As clinicians, we may need to reframe or explain questions while remaining conscientious in maintaining their integrity. Using behavioral definitions and visuals to illustrate concepts can be helpful. For instance, the clinician can present a drawing of a fire, tornado, flood, or hurricane when asking the child, "Have you ever been in another kind of disaster, like a fire, tornado, flood, or hurricane?" (Pynoos et al., 1998). Children with developmental disabilities may also have difficulty completing an assessment within a standard session. Administering the assessment in sections may help with pacing, maximizing attention and minimizing agitation. The children may also have trouble responding verbally. The clinician should have paper, crayons, colored pencils, or a dry-erase board in the office for children to write responses. This can be a fun, interactive activity that also promotes engagement. Illustrations of people or characters nodding their head and saying "Yes" in a talk bubble or shaking their head and saying "No" can be a useful tool as well.

Completing assessments with intensity ratings and Likert scales, such as the UCLA PTSD Index for DSM-IV (Pynoos et al., 1998), may require additional explanation. Because of issues with sequencing and understanding frequency, children with developmental disabilities may have difficulty with this concept and require visual aids and metaphor. The Rain Cloud Likert Scale, for example (Figure 6.1), uses rain clouds to illustrate this continuum, with a response range of 0, or "none," to 4, or "most" (Grosso, 2011). In

developing a hierarchy of negative stimuli, an illustration of a mountain can be used, with the top of the mountain as the event that “bothers me the most” and the bottom of the mountain as the least distressing event. One should keep in mind that children with developmental disabilities will often have a lower threshold for negative stimuli, and this should be considered when formulating hierarchies (Reaven, 2009).

CASE EXAMPLE

Johnny, a 12-year-old boy with pervasive developmental disorder, mood disorder not otherwise specified, and posttraumatic stress disorder, presented with a history of physical and sexual abuse by his father from age 4 to 7, failed foster care placements, and multiple hospitalizations for highly aggressive behaviors. Johnny had an IQ of 68 and scored a 43 on the UCLA PTSD Index for DSM-IV (Pynoos et al., 1998). Johnny had no contact with his father, who was in prison for his abuse of Johnny, or his mother and siblings. The family moved away when Johnny was placed in foster care and abandoned him, stating that he was “too difficult to care for.” In residential placement, he was often shunned by peers because of his poor social skills and high impulsivity. Johnny would also engage in fantastical game play and appear in “his own world” with little to no awareness of others.

During our first session of TF-CBT, Johnny presented with a fixation on the cartoon *Dragon Ball Z* (Funimation Entertainment, 1999–2003). He discussed this cartoon at length, with particular attention to the character Goku. Johnny described Goku as a boy who knew “karate” and had “superpowers.” Upon further investigation, I also learned that Goku was an odd, monkey-tailed boy who did, in fact, have superhuman strength as he was born from a race of extraterrestrials called the Saiyans, said to be the strongest warriors in the universe. However, Goku was separated from this family as a result of death and ambiguous loss. It became apparent to me that there were many similarities between Johnny and Goku and that Goku

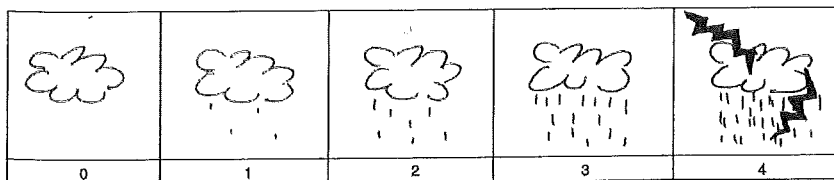


FIGURE 6.1. Rain Cloud Likert Scale (Grosso, 2011). Copyright 2011 by Christina A. Grosso. Reprinted by permission.

represented both an ego ideal and reflection of self for Johnny. His fixation on Goku was a coping strategy because it offered him a relatable figure with a means for self-protection. We began to use Goku in treatment from this moment forward.

Baseline Trauma Assessment

During the baseline trauma assessment, Goku's story served as a foundation for creating narrative. Johnny was able to recite with emotion and interest stories of Goku's adventures. However, Johnny had more difficulty reporting incidents and events from his own day-to-day life with the same intensity. When I asked him to tell me a story about the baseball game he attended a few days earlier, he recalled: "I went to the baseball game with my staff and some kids. The game was long. I ate a hot dog. We came home." When I asked him to tell me more about it and paced him through the story with encouragement to add thoughts and feelings, he added, "It was hot." When asked to tell me a story about his father and the abuse he suffered, he responded, "My dad is like Godzilla. I don't see my dad anymore." When prompted with similar questions, he slammed his fist on the table and stated, "I don't want to talk about it anymore."

After this clinical assessment and in combination with his standardized assessment scores, I realized that Johnny had limited language and cognition to describe what happened to him as well as difficulty identifying and expressing affect. His avoidance of thoughts, feelings, and details related to the trauma were substantiated by his score of a 43 on the UCLA PTSD Index for DSM-IV as well as his decreased detail in his baseline trauma narrative. The level of detail in his baseball story and his ability to tell Goku's story with emotion revealed his ability to complete a trauma narrative with a similar level of detail. However, he required a great deal of emotional and cognitive skill building in order to do so.

Many of the existing skills and activities outlined in TF-CBT for PRAC (Psychoeducation and Parenting, Relaxation, Affect expression and modulation, and Cognitive coping) can be used with children with developmental disabilities because of their highly interactive and visual nature (Cohen et al., 2006). During the PRAC components, children are developing competency and moving from a sense of powerlessness to control. Children with developmental issues are often reliant on caregivers for tasks of daily living and have a sense of diminished autonomy (Charlton et al., 2004). This, coupled with their traumatic experience, can leave children feeling even more dependent and helpless. Therefore, during PRAC it is essential for them to develop mastery and competence through skill-building activities that they can learn in session but then practice and use both in school and at home.

The repetition of these skills will also aid in retention and comfort with the material.

Psychoeducation and Parenting

During psychoeducation, our major goal is to normalize reactions to trauma (see Table 6.4). As with beginning treatment with any child, we want to begin by introducing the goals of therapy, review assessments, and learn more about the child. In working with a child with a developmental disability, we want to pay particular attention to his or her interests and the presence of any fixations because we can utilize this to support the child's learning. Existing strategies in TF-CBT for psychoeducation, such as bibliotherapy and games, are highly effective. Utilizing sources that contain illustrations to describe concepts are most successful, such as the book *A Terrible Thing Happened* (Holmes & Mudlaff, 2000). This book chronicles the behavior of Sherman the raccoon after he experiences "a terrible thing," and captures the raccoon's emotional, cognitive, and behavioral symptoms of trauma through both words and pictures. The "terrible thing" is depicted as a black cloud floating over Sherman's head in a thought bubble and can easily be substituted by the child's index trauma. This book offers a sufficient level of gradual exposure to the trauma through metaphor and provides a direct conduit to the subsequent TF-CBT components. This book can also

TABLE 6.4. Why Do We Provide Psychoeducation to Children Who Have Been Traumatized?

Goals

- To normalize responses to trauma
- To reinforce accurate cognitions

Challenges

Children with developmental disabilities have:

- Poor comprehension and retention
- Decreased capacity for generalization—are black-and-white thinkers
- Fixations or special interests
- Limited attention spans

Skills

- Use visuals to illustrate concepts and aid in communication
- Use favorite characters, cartoons, puppets, figurines, sand play, and dollhouses to create stories and metaphor
- Use active play and games to engage and maintain attention
 - What Do You Know? (Deblinger et al., 2006)
- Bibliotherapy
 - *A Terrible Thing Happened* (Holmes & Mudlaff, 2000)

Note. Based on Charlton, Kliethermes, Tallant, Taverne, and Tisherlman (2004) and Cohen, Mannarino, and Deblinger (2006).

be used to stimulate discussion by pausing at various intervals throughout the story and asking questions such as "What happened to you?" and "Have you ever felt like that?"

During psychoeducation with Johnny, we were able to use Goku as a vehicle for learning. As we discussed results from the assessment and began to review symptoms of trauma, I drew parallels to Goku and asked Johnny questions about some of the reactions Goku might have to scary events. This appeared to interest Johnny because he became engaged in this activity around trauma symptoms that both he and Goku experienced. Playing the What Do You Know? game (Deblinger, Neubauer, Runyon, & Baker, 2006), I asked Johnny, "How can you tell if a child has been sexually abused?" He responded, "You can just tell—you can see it." We were able to discuss further that unlike Goku, who had a monkey tail, we could not see Johnny's trauma. This direct discussion of trauma being invisible appeared to increase his understanding that he could feel and think about his trauma but others did not know or understand his thoughts, feelings, and experiences unless he shared them.

Providing support to parents of children with developmental disabilities is of utmost importance during TF-CBT (see Table 6.5). Research shows that these parents have increased stress because of the cognitive,

TABLE 6.5. Why Do We Provide Parenting Skills?

Goals

- To normalize responses to trauma
- To teach parents strategies for addressing problematic behaviors, including praise, selective attention, time-outs, and contingency reinforcement strategies

Challenges

Parents/caregivers of children with developmental disabilities have:

- Increased stress and feelings of overwhelm as a result of:
 - Increased supervisory demands
 - Lack of education and preparation to deal with disability
 - Lack of appropriate educational and treatment services for their children
 - Lack of response from child to traditional means of discipline and reinforcement

Skills

- Provide structure/ create routine
 - Help family and caregivers create schedules/routines in the home and school (e.g., set times for meals, homework, bed)
- Provide repetition and reinforcement
 - Repeat skills and concepts in session
 - Assign homework to practice skills taught in session
 - Use consistent praise and rewards as reinforcement of positive behavior
- Create supportive family groups

Note. Based on Cohen, Mannarino, and Deblinger (2006) and Hibbard and Desch (2007).

emotional, and behavioral issues presented by their children and a lack of support to effectively address them (Hibbard & Desch, 2007). These developmental issues coupled with the child's emotional, cognitive, and behavioral reactions to trauma creates a significantly stressed, overwhelmed family system. Parents will require creative adaptations to traditional parenting strategies and a flexible and patient clinician to help them after failed attempts. Some basic tenets to focus on with children with developmental disabilities are their need for structure, repetition, and reinforcement. Many children have multiple caregivers because of their increased need for supervision. Treatment may include not only the parents but aides, teachers, and other caregivers to establish safety and increase communication. In essence, the clinician will be working with a multidisciplinary team of individuals who need to understand the impact of the trauma on the children and have consistent skills and strategies to reinforce in their respective roles and environments. It is recommended that the clinician share the children's toolkit with all caregivers, with additional copies made to be kept at home and school.

Relaxation

As we look at the role of relaxation and grounding in trauma treatment (see Table 6.6), we recognize the need to regulate physiological responses, such as increased heart rate, shallow breathing, tension in the body, sweating, stomachaches, and headaches. This regulation is needed in order to manage trauma reminders and later tolerate increased exposure during the trauma narrative. Children with developmental disabilities may have a higher baseline of anxiety and agitation and encounter difficulties remembering and utilizing relaxation strategies (Wood et al., 2009). They may require more repetition of skill with little to no exposure as they learn and practice. Once the skill is acquired, it can be gradually paired with exposure to their negative stimulus hierarchy with support and prompts from both caregivers and therapist.

In order to determine where stress and tension exist in the body, a doll or a drawing of a human figure can be used to have children point to areas of the body that feel activated. The children should be encouraged to use this as a starting point and identify areas on their own body that become dysregulated and then asked, "How does your body feel when you think about scary things?" Relaxation strategies can then be introduced, such as deep breathing using bubbles. Blowing bubbles provides a concrete, focused task for children in that they need to blow the bubble in a slow, steady manner in order to form a full, round bubble that is able to float off the wand. If they blow too hard and fast the bubble will break; and if they blow too slowly the bubble will not form. The therapist can then extend the relax-

TABLE 6.6. Why Do We Teach Relaxation Strategies to Children Who Have Been Traumatized?

Goals

- To reduce physiological symptoms of stress and trauma

Challenges

Children with developmental disabilities have:

- Sensory sensitivity
- Impulsivity
- Agitation and greater proneness to anxiety
- More behavioral issues; may be quick to hit, punch, kick when agitated

Skills

- Relaxation
 - Bubble breathing
 - Goku Squeeze
- Grounding
 - Sensory toolkit
 - Pocket Pal

Note. Based on Charlton, Kliethermes, Tallant, Taverne, and Tisherlman (2004) and Cohen, Mannarino, and Deblinger (2006).

ation exercise to include watching the bubbles float in the air and gently pop on surfaces they contact.

When I began the relaxation phase of treatment with Johnny, some of the exercises, such as squeezing lemons to make lemonade, lost his attention (also note that he appeared confused that lemonade was made from lemons and not from a container of powder). Johnny held a great deal of tension and emotion in his body and would explode with aggression when triggered. In an effort to gain his attention, I created the Goku Squeeze. Goku was able to reach his full superhuman strength when he entered super-Saiyan mode, which he achieved by squeezing his hands into fists and tensing his body. Johnny stated that Goku was strongest then and able to “do good.” Johnny was able to visualize Goku and tense his muscles in his body, beginning with his fists, then moving to his arms, shoulders, face, torso, legs, and feet. He would practice this and hold for a count of 10. He then would release his muscles, and we would reflect on how his body was feeling. He expressed having a sense of calm and that he could “do good” like Goku rather than explode and get into fights.

Grounding

Children with developmental disabilities may also have issues with sensory integration and sensitivity. They may become overwhelmed with loud noises or be soothed by the feeling of cool water on their hands. When working with these children, it is beneficial to explore how they react to various

sensory stimuli and to develop a toolkit with items they find soothing and can use for grounding. Items such as bubble wrap, sandpaper, cotton, felt, Model Magic, playdough, water, and sand can be explored.

People, places, and things can also be used as grounding strategies. Very often, Johnny would rely on his milieu counselor, Pat, to help himself regulate. This worked well when Pat was available but was not an effective strategy when Pat was in a meeting, was off grounds, or had a day off. When Johnny experienced a trigger that was overwhelming, he often relied on Pat to prompt and model the use of a relaxation and/or grounding strategy. As Johnny's autonomy and proficiency in relaxation increased, he still relied on Pat to be present, even though he could do these skills on his own. We soon discovered that Pat himself was a grounding strategy and became part of Johnny's routine when triggered. We wanted to increase Johnny's independence and create a new routine, which prompted us to create a pocket pal, named Pocket Pat. Pocket Pat was a pocket-sized, felt cut-out of a gingerbread-shaped person. Johnny was able to create this during session and fill in the facial features and clothing to resemble those of Pat. On the reverse was his "safety plan": a list of his relaxation and grounding strategies. After completing Pocket Pat, he kept it in his pocket for retrieval whenever he felt triggered or upset to prompt him to use his relaxation strategies. As Johnny used Pocket Pat, his dependence on the real Pat decreased.

Affect Identification and Modulation

As stated earlier, there are many wonderful activities already embedded in TF-CBT that utilize visual and interactive learning that can be used with children with developmental disabilities (Cohen et al., 2006). Affective identification and modulation skills, such as Feeling Faces, Feelings in My Body, and emotional thermometers are highly effective tools to use with developmentally disabled children (see Table 6.7). Additional time may be needed to teach and practice skills to ensure comprehension and retention. Favorite characters, puppets, and cartoons can be used to engage children, and story lines can be created to elicit feelings through metaphor. How would Wally the Whale feel if someone ate his lunch? How would Goku feel if his friend kicked him? Visual aids are also useful to reinforce these concepts. Children can draw their favorite characters with various facial expressions, or images can be downloaded from the Internet on which feelings can be labeled.

During this phase of treatment, Johnny had great difficulty identifying emotion in facial features, a common issue with children with developmental delays. During one session, he became interested in my camera. We proceeded to take many pictures of both him and me making faces. We printed the pictures and labeled them with the corresponding feeling, making a deck of personalized photo feelings cards. As we reviewed the pictures, he would

TABLE 6.7. Why Do We Teach Feeling Identification and Regulation to Children Who Have Experienced Trauma?

Goals

- To help children identify, regulate, and express feelings more effectively
- Decrease avoidance strategies

Challenges

Children with developmental disabilities have:

- Difficulty identifying emotions in self and others
- Difficulty expressing emotion via facial gestures and/or verbal statements
- Sensory sensitivity
- Impulsivity
- Agitation and greater proneness to anxiety
- More behavioral issues; may be quick to hit, punch, kick when agitated

Skills

- Provide repetition and reinforcement
 - Repeat skills and concepts in session
 - Assign homework to practice skills taught in session
 - Use consistent praise and rewards as reinforcement of positive behavior
- Photo feeling cards

Note. Based on Charlton, Kliethermes, Tallant, Taverne, and Tisherlman (2004) and Cohen, Mannarino, and Deblinger E. (2006).

compare his picture with his image in the mirror, name his feeling, shift his gesture, and then rename it with a new feeling. He continued to practice various gestures and then asked me to copy him. Through this activity, he was able to identify and express feelings through both visual and verbal modalities. These cards were also shared with staff and teachers to reinforce with Johnny in the milieu setting.

Cognitive Coping

This component (see Table 6.8) presents one of the most challenging issues in working with developmentally disabled children, namely recognizing and acknowledging internal thoughts (Reaven, 2009). As we begin to teach children how to acknowledge a thought, we need to teach them what a thought is. Very simply, thinking can be described as “talking to ourselves.” We can ask, “What do you say to yourself when you make a mistake?” This self-talk will begin to highlight some of their thought processes and provide the foundation for the intersection among thoughts, feelings, and behaviors (i.e., the cognitive triangle).

Children with developmental disabilities are visual thinkers and require movement and activation to remain focused. In teaching Johnny the cognitive triangle, he and I played “baseball.” I taped a triangle on the floor in my office and labeled each point “thought,” “feeling,” or “behavior.” We then

stood on the thought point and I provided Johnny with a scenario where he walked into the classroom and a fellow student began laughing. I then asked him, "What are you thinking? What are you saying to yourself?" He responded, "He doesn't like me." Next, we moved to the feeling point, and I asked, "How are you feeling?" He responded, "Sad and angry." And then finally we jumped to the behavior point, and I asked, "What do you do?" He responded, "Hit him in the face." We then were able to process why this behavior was not safe and how his thought could be inaccurate and unhelpful. We discussed replacing his original thought, that perhaps his peer did like him and that maybe something funny happened prior to Johnny entering the room. Johnny was then able to state he would feel "curious" and sit down in his seat and begin his classwork.

The cognitive triangle can also be adapted and used as an activity called Bubble People. The clinician helps the child draw numerous pictures of him- or herself or a favorite character (including face and body) on separate sheets of paper, and then they assign a marker color to "thought," "feeling," and "behavior." Similar to the activity described previously, the clinician then describes a scenario. Using the portraits and selected markers, the clinician writes the child's initial thought in a thought bubble next to the head in the drawing using the "thought" marker, adding what feelings would result after having such a thought (and writing them down on the body where the child experienced such feelings). This step is repeated for behav-

TABLE 6.8. Why Do We Teach Cognitive Coping Skills to Traumatized Children?

Goals

- To learn cognitive coping skills
- To acknowledge and share internal dialogue
- To understand the relationship among thoughts, feelings, and behaviors

Challenges

Children with developmental disabilities may have difficulty with:

- Abstract thinking
- Critical thinking
- Sequencing events
- Prioritizing
- Task breakdown
- Ambiguity

Skills

- Cognitive triangle baseball
- Bubble People
- Bibliotherapy
 - *The Little Engine That Could* (Piper, 1990)

Note. Based on Charlton, Kliethermes, Tallant, Taverne, and Tisherlman (2004) and Cohen, Mannarino, and Deblinger (2006).

iors using the appropriate color-coded marker. This is repeated numerous times, changing the thought and then discussing how the resulting feelings and behaviors change as well.

Trauma Narrative and Cognitive Processing

Trauma Narrative

Developing the trauma narrative with developmentally disabled children is a process that requires pacing, structure, and visual storytelling (see Table 6.9). Children have cognitive limitations (see Table 6.8) that will present challenges in creating the narrative in addition to their general trauma symptoms (avoidance and increased arousal in reaction to higher levels of exposure), which are to be expected at this point in treatment. It is important that clinicians be aware of their increased need to move slower and have shorter session times because they may be more reactive to negative stimulus than their nondisabled cohort (Reaven, 2009). They may need support and prompts to use their grounding and relaxation skills as they begin to talk about more distressing events. As they discuss details of the trauma, events may be fragmented and nonsequential. The clinician should begin by

TABLE 6.9. Why Do We Help Traumatized Children Tell Their Story?

Goals

- To unpair thoughts, triggers, and reminders of the trauma from overwhelming negative emotion
- To integrate thoughts and feelings into narrative
- To unify fragments of trauma memory into integrated whole
- To correct inaccurate thoughts
- To process distortions

Challenges

Children with developmental disabilities may have difficulty with:

- Abstract thinking
- Critical thinking
- Sequencing events
- Prioritizing
- Task breakdown
- Ambiguity

Skills

- Visual narrative
- Storyboarding
- Index card trauma timeline
- Bibliotherapy
 - *Please Tell* (Ottenweller, 1991)

Note. Based on Charlton, Kliethermes, Tallant, Taverne and Tisherlman (2004) and Cohen, Mannarino, and Deblinger (2006).

writing each of these "fragments" on index cards. This method of capturing information will allow the children to tell their story first without becoming frustrated trying to capture detail and chronology simultaneously. The cards can be reordered and chronologically sequenced later with pacing and assistance from the therapist.

Another method to assist with the telling of their story is visual narrative. As discussed, children with developmental delays are often visual thinkers and organize their thoughts in images. The therapist can begin by asking the children to draw a picture of what happened to them. This can be done on a single piece of paper or in a cartoon/storyboard approach utilizing multiple frames. This process allows children to capture detail and sequence visually, a method that is more intrinsic to their thought process, thus reducing their risk of increasing anxiety and frustration (Reaven, 2009).

We also want to keep in mind children's responses to the baseline trauma narrative completed at the onset of treatment. How did they respond to the innocuous event narrative? What was their capacity for storytelling? Did they include detail? Was it in chronological order? Did they include thoughts and feelings? How did their innocuous narrative compare with their baseline trauma narrative? We want to guide our expectations for the trauma narrative based on the level of detail ascertained during the baseline narrative of the innocuous event because this highlights their overall developmental level and capacity for storytelling. We cannot expect greater detail for the trauma narrative because it would presumably surpass their capability.

As we revisit the case of Johnny, we recall that he had limited detail in his story of the baseball game and with prompting was able to add feelings. With his account of his abuse he was not able to provide details, thoughts, or feelings and, moreover, became dysregulated, pounding his fist on the table. It was important to remind myself, as I worked with him and encouraged his inclusion of details, that this was congruent to his original baseline presentation. However, he made tremendous progress with identifying feelings and thoughts related to his abuse. He was able to reach this level of verbal communication via the use of visual narrative. Johnny began by drawing a picture of his father, depicted as a fire-breathing Godzilla. With prompting to tell a story about the picture, he began to describe that his father was "mean, angry and hurt" him, just like Godzilla hurt people in the movies. When asked how often this happened, he pointed to the rain cloud that indicated "much" (see Figure 6.1). I then asked him what happened when his father got "mean" and "angry." He responded by drawing a stick figure with a large red mark on its face. I asked him again to tell a story about the picture, and he stated his father would "punch, kick, and push" him. When asked "What happened next?", he drew a bed with two stick figures on it. Again with questioning, Johnny was able to state that after his father physi-

cally abused him, he would push Johnny on the bed and sexually abuse him. With further prompting Johnny was able to state that he felt "angry" and "sad" and that he "never wanted to see Dad again" and was "glad he was in jail." He also stated that he felt "bad" that his family was "gone."

Cognitive Processing

Children with developmental disabilities may have more cognitive distortions related to feelings of blame, guilt, and fear of recurrence compared with nondisabled children (Charlton et al., 2004). Feelings of blame may occur as a result of their limited capacity for critical thinking as well as their poor social skills and ability to communicate effectively with others. Cognitive processing techniques, such as challenging distortions, can be especially difficult because of cognitive and processing delays (Avrin et al., 1998). (See Table 6.9.)

Returning to the case of Johnny, it became clear that some areas of his narrative needed further exploration and processing. As with all children, we want to attend to both explicit and implicit distortions, especially around issues of shame, blame, and guilt. In terms of implicit or hidden distortions, Johnny stated that he felt "bad" that his family was gone, indicating possible feelings of blame and guilt. When I asked why he felt this way, he stated that his family moved away because he was "bad." This issue took a good deal of time to discuss because we needed to break down each feeling and thought one at a time. He had difficulty shifting his thinking, remaining in a state of black-and-white thinking that if he had not told about his abuse his family would still be together. I used a version of the best friend role play, and instead of using a "best friend," which he did not have, I used Goku. Through related story lines focusing on Goku's separation from his family, Johnny was able to begin to shift his thinking and list other possible reasons for his family leaving. We also discussed that if Goku stayed in a home where he was being hurt he would never have been able to become a strong superhero. Johnny was able to develop a list of all the ways in which he became stronger while in residential treatment, including what he learned in TF-CBT. In the final chapter of his narrative, he stated that he wanted to be strong like Goku and help other kids who have been hurt find a safe place.

In Vivo Mastery of Trauma Reminders

Children with developmental disabilities often have a lower threshold for negative stimuli and require special consideration when formulating hierarchies (Reaven, 2009; see Table 6.10). Exposures will need to be paced and have smaller increments of escalating stimuli, and care should be taken

TABLE 6.10. Why Do We Provide *In Vivo* Exposure to Traumatized Children?**Goals**

- To decrease avoidance symptoms of generalized fears

Challenges

- Children with developmental disabilities may have lower threshold for negative stimuli

Skills

- Exposure hierarchies

Note. Based on Cohen, Mannarino, and Deblinger (2006) and Reaven (2009).

not to overwhelm children. Developmentally disabled children also have a tendency for rote behavior when anxious and have difficulty and/or discomfort with change (Avrin et al., 1998). They may become fixated on routines and rituals and have difficulty changing the structure of daily activities and schedules. When generalized fears or avoidant behaviors are noticed, it is imperative to address them as soon as possible so that they do not become further ingrained. It is important to have parents and/or caregivers “actively involved, comfortable, and in agreement with the plan” to offer consistency and reinforcement (Cohen et al., 2006, p. 149).

Conjoint Child-Parent Sessions

The child with developmental disabilities requires repetition of skills and clear structure and routines. As the child progresses through TF-CBT, it is imperative that parents are involved with treatment so they can reinforce skills as they are being used (see Table 6.11). As discussed earlier in the parenting component, the child with developmental disabilities often has multiple caregivers because of increased supervisory demands (Avrin et al., 1998). At various points throughout treatment, it is beneficial to meet with these other caregivers to review PRAC skills and reinforce repetition of learning and practice both at home and in school. Despite this team approach, it is recommended to share the trauma narrative with parents and not with all caregivers so as not to overwhelm the child. Parents may also require individual time to process their own cognitive distortions related to their child's trauma. The therapist should discuss the narrative with the parents before the conjoint session to allow time for these potential cognitions to emerge, prepare them for hearing the narrative, and plan areas of the narrative where they can offer praise and reinforce accurate cognitions. Even though parents need assistance in helping their child recover from trauma, they can also provide a great wealth of information and insight into their child's functioning and progress. Their expertise must be respected.

TABLE 6.11. Why Do We Have Conjoint Sessions?*Goals*

- To increase communication between child and parent
- To increase comfort in talking about trauma

Challenges

- Children with developmental disabilities may:
- Engage in one-sided conversation
- Have difficulty engaging and responding to others

Skills

- Conjoint sessions throughout treatment
- Involve additional caregivers

Note. Based on Charlton, Kliethermes, Tallant, Taverne, and Tisherlman (2004) and Cohen, Mannarino, and Deblinger (2006).

Enhancing Future Safety and Development

As we have discussed throughout this chapter, children with disabilities are at higher risk for experiencing abuse than children without disabilities because of impairment in cognition, communication, and affect regulation (Avrin et al., 1998; Ryan, 1994). They often have limited information regarding sexual education, abuse prevention, and personal safety. Parents and caregivers often view their children as asexual and feel this information is unnecessary (Hibbard & Desch, 2007). However, research shows that sexual interest among children with developmental disabilities often occurs at the same developmental stage as for the rest of the population (Tharinger, 1990, as cited in Charlton et al., 2004). In order to increase awareness and independence and decrease the risk of revictimization in this population, personal safety skills are crucial (see Table 6.12). The content and extent of sexual education should always be discussed with the parents. However, basic safety skills such as recognizing “OK” and “not-OK” touch should be taught to all children.

Children with developmental disabilities often have a lack of boundaries and intrusive behaviors. Couple these tendencies with exposure to interpersonal trauma where body limits were violated, and increased confusion and permeable boundaries emerge. As with the development of PRAC skills already discussed, rehearsal and repetition of skills are important to enhance comprehension and retention.

As Johnny approached the end of treatment, it was essential that he learn practical skills to keep him safe. As with many traumatized and developmentally disabled children, his personal space was often an issue. At times he would hug strangers, and at other times he would not be able to be within talking distance of someone else. Johnny was prompted to ask for a hug or a handshake when he needed physical comfort and to wait for the

TABLE 6.12. Why Do We Provide Safety Planning?*Goals*

- To teach personal safety skills
- To decrease risk of revictimization

Challenges

Children with developmental disabilities:

- May have a lack of boundaries, intrusive behaviors
- May be trained and/or compliant with authority figures
- May have increased dependency on caregivers for physical needs
- Have impaired communication and/or ability to disclose abuse
- Have limited access to sexual education and personal safety skills

Skills

- Repetition and practice
- Experiential learning
 - *Safety Bubble*
 - *No, Go, Tell*

Note. Based on Charlton, Kliethermes, Tallant, Taverne, and Tisherlman (2004); Cohen, Mannarino, and Deblinger (2006); and Hibbard and Desch (2007).

reply. He was also taught to use the Safety Bubble. In this boundary exercise, children stretch their arms out in front of them and imagine being surrounded by an invisible bubble. As they imagine this bubble encompassing their body, they can outstretch their arms in every direction. They are then asked to imagine others with this same bubble. Together with the therapist, they practice walking up to people and maintain the size and shape of their safety bubble. Children are also encouraged to express how comfortable they feel with the distance they are creating between self and other. If their safety bubble becomes invaded, they are prompted to move away and tell the person that he or she is too close. If this person ignores the command, the children are prompted to say "No," go and find help, and tell a safe adult what happened. Children should be encouraged to keep telling until someone listens. Johnny enjoyed this activity and at first required redirection and prompting to maintain the boundary of his invisible bubble. After practice with staff and peers, he made considerable progress maintaining his personal space.

After treatment, Johnny showed considerable improvement. His score on the UCLA PTSD Index for DSM-IV decreased from 43 to 19, indicating that he was no longer meeting criteria for posttraumatic stress disorder (Pynoos et al., 1998). His aggressive behaviors diminished and he was interacting more frequently and positively with peers. Johnny's fantastical play and talents in art making became a method of interaction with peers, who valued his artistic ability and joined him occasionally in game play. He continued to have issues when peers had visitation with family but was now

able to express his feelings of jealousy and sadness in appropriate ways. The discharge plan for Johnny was to continue in residential treatment to address his other mental health needs while case planners investigated a preadoptive foster care family.

As we conclude our discussion of the application of TF-CBT for developmentally disabled children, we can review the progress of treatment and see that our toolbox for both therapist and child is "filling." Many interventions and activities have been introduced, and the expectation is that through future practice this toolbox will continue to expand. There is a growing need for traumatized children with developmental disabilities to receive treatment as well as for trained professionals to provide treatment (Charlton et al., 2004). In an effort to address this problem, we have adapted TF-CBT to fit the needs of this growing population. Traumatized children with developmental delays present some unique challenges to traditional verbal and cognitive-behavioral therapy (Moree & Davis, 2010; Reaven, 2009). Because of their impairments in cognition, language, and emotion, implementation strategies are needed to help children access concepts and develop appropriate skills (Moree & Davis, 2010; Wood et al., 2009). An integrated treatment approach utilizing visuals as resources to accompany verbal interventions was introduced as well as the use of structure, repetition, engagement, and activation strategies. As we have seen through the course of this chapter, these implementation strategies for TF-CBT have been created to increase the sense of mastery and independence in the lives of these children as they recover from trauma.

REFERENCES

- Achenbach, T. M. (1991). *Integrative guide to the 1991 CBCL/4-18, YSR, and TRF profiles*. Burlington: University of Vermont, Department of Psychology.
- Avrin, S., Charlton, M., & Tallant, B. (1998). *Diagnosis and treatment of clients with developmental disabilities*. Unpublished manuscript, Aurora Mental Health Center.
- Boyle, C. A., Boulet, S., Schieve, L. A., Cohen, R. A., Blumberg, S. J., Yeargin-Allsopp, M., et al. (2011). Trends in the prevalence of developmental disabilities in US children, 1997–2008. *Pediatrics*, 127(6), 1034–1043.
- Centers for Disease Control and Prevention. (2011, June 23). *Developmental disabilities increasing in US*. Atlanta, GA: Author. Retrieved from www.cdc.gov/Features/dsDev_Disabilities/index.html.
- Charlton, M., Kliethermes, M., Tallant, B., Taverne, A., & Tisherlman, A. (2004). *Facts on traumatic stress and children with developmental disabilities*. Retrieved from National Child Traumatic Stress Network, www.nctsn.org/products/facts-traumatic-stress-and-children-developmental-disabilities-2004.
- Charlton, M., & Tallant, B. (2003, December). *Trauma treatment with clients who*

- have dual diagnoses: Developmental disabilities and mental illness.* Paper presented at the National Child Traumatic Stress Network Conference, San Diego, CA.
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents.* New York: Guilford Press.
- Deblinger, E., Neubauer, F., Runyon, M., & Baker, D. (2006). *What do you know?* Stratford, NJ: CARES Institute.
- Funimation Entertainment. (1999–2003). *Dragon ball z* [Television series]. Atlanta, GA: Turner Broadcasting.
- Goldson, E. (2002, July). *Maltreatment among children with disabilities.* Paper presented at the 14th International Congress on Child Abuse and Neglect, Denver, CO.
- Grandin, T. (2010). The world needs all types of minds. Retrieved June 21, 2011, from http://blog.ted.com/talks/langlen/temple_grandin_the_world_needs_all_kinds_of_minds.html.
- Grosso, C.A. (2011). *Rain Cloud Likert Scale.* New York: Author.
- Hibbard, R. A., & Desch, L. W. (2007). Maltreatment of children with disabilities. *Pediatrics, 119*(5), 1018–1025.
- Holmes, M. M., & Mudlaff, S. J. (2000). *A terrible thing happened.* Washington, DC: Magination Press.
- Moree, B. N., & Davis, T. E., III. (2010). Cognitive-behavioral therapy for anxiety in children diagnosed with autism spectrum disorders: Modification trends. *Research in Autism Spectrum Disorders, 4*, 346–354.
- National Research Council. (2001). *Crime victims with developmental disabilities: Report of a workshop.* Washington, DC: National Academy Press.
- Oathamshaw, S. C., & Haddock, G. (2006). Do people with intellectual disabilities and psychosis have the cognitive skills required to undertake cognitive behavioral therapy? *Journal of Applied Research in Intellectual Disabilities, 19*, 35–46.
- Ottenweller, J. (1991). *Please tell: A child's story about sexual abuse.* Center City, MN: Hazelden.
- Overcamp-Martini, M. A., & Nutton, J. (2009). CAPTA and the residential placement: A survey of state policy and practice. *Child and Youth Care Forum, 38*(2), 55–68.
- Piper, W. (1990). *The little engine that could.* New York: Platt & Munk.
- Reaven, J. A. (2009). Children with high-functioning autism spectrum disorders and co-occurring anxiety symptoms: Implications for assessment and treatment. *Journal for Specialists in Pediatric Nursing, 14*(3), 192–198.
- Ryan, R. (1994). Posttraumatic stress disorder in persons with developmental disabilities. *Community Mental Health Journal, 30*(1), 45–54.
- Sobsey, D., & Doe, T. (1991). Patterns of sexual abuse and assault. *Sexuality and Disability, 9*(3), 243–259.
- Steinberg, A. M., Brymer, M. J., Decker, K. B., & Pynoos, R. S. (2004). The University of California, Los Angeles Post-traumatic Stress Disorder Reaction Index. *Current Psychiatry Report, 6*, 96–100.
- Sullivan, P. M., & Knutson, J. F. (2000). Maltreatment and disabilities: A population-based epidemiologic study. *Child Abuse and Neglect, 24*, 1257–1273.

- Taylor, J. L., Lindsay, W. R., & Wilner, P. (2008). CBT for people with intellectual disabilities: Emerging evidence cognitive ability and 10 effects. *Behavioural and Cognitive Psychotherapy, 36*, 723-733.
- Wahlberg, T. (1998). Cognitive behavioral modification for children and young children with special problems. *Advances in Special Education, 11*, 223-253.
- Wood, J. J., Drahota, A., Sze, K., Hår, K., Chiu, A., & Langer, D. A. (2009). Cognitive behavioral therapy for anxiety in children with autism spectrum disorders: A randomized controlled trial. *Journal of Child Psychology and Psychiatry, 50*(3), 224-234.