Adapting Trauma Focused Cognitive Behavior Therapy TF-CBT

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Breaking the Barriers: Forming Cross System Partnerships to Effectively Serve Individuals With Mental Illness and Intellectual Disabilities.

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Intercept Center

- Collaborative program between Aurora Public Schools and Aurora Mental Health
- Focused on meeting the mental health needs of People (6-21) with developmental disabilities
- Day treatment and intensive child and family outpatient services
- In addition to a major mental illness, virtually all clients receiving services at Intercept have a history of trauma

Adapted Trauma Treatment Work Group

- Subgroup for Deaf and Hard of Hearing
- Subgroup for Developmental Disabilities

Goals for the Subgroups

- Develop a paper outlining known facts about treating each underserved population.
- Develop general guidelines for adapting trauma treatment.
- Adapt specific trauma treatment tools for use by special populations.

Goals: Participants will

- Understand the special vulnerabilities of this population to developing mental illnesses
- Be able to describe the recommended methods of adapting mental health treatment to make it accessible
- Develop and practice skills for the implementation of DBT-SP, an adapted model of Dialectical Behavior Therapy
- Develop and practice skills for the implementation of Adapted Trauma Focused Cognitive Behavior Therapy

Cultural Considerations

- People with developmental disabilities represent a significant minority population for which we have a responsibility to provide treatment
- About 2% of the population meets the criteria for having a developmental disability

Cultural Considerations: Continued

- We are just beginning to develop evidence based adapted treatments for people with developmental disabilities
- Research is not yet available on the interaction of ethnic minority status with developmental disability

Developmental Disabilities

- The concept of disability or lack of certain desirable characteristics is interwoven throughout the definition of the population and the nature of most treatment recommendations.
- The population is defined externally, by caregivers and treatment providers, rather than the people involved.

Isolation vs. Inclusion

- Many think of people with developmental disabilities living with their families in relative isolation or living in institutions.
- Today most people with developmental disabilities are part of a community, participating in:
  - Educational opportunities through public schools
  - Vocational and residential opportunities through their Community Centered Boards
  - Recreational activities through groups like Special Olympics
  - Advocacy activities with their local ARC groups

What are the Cultural Norms for this Population

- As inclusion in groups with similar interests and needs increases, cultural norms and expectations are developing in a variety of areas:
  - Educational
  - Social
  - Vocational
  - Residential
  - Recreational

Prevalence of Developmental Disabilities

- 1.8% of the population of the United States.
- With a 2001 population of 285 million people we estimate 5 million people in the US have developmental disabilities.
- In any large scale disaster, nearly 2% of the population may require adapted trauma treatment.

Experiences of People with DD in the Community

- Higher rates of maltreatment than the general population.
- Perpetrators perceptions:
  - Ideal victims
  - Lack credibility
  - Unable to report

Abuse and Developmental Disability

- 3 to 6% of maltreated People have a permanent developmental disability as a result of abuse or neglect
- Child maltreatment is a factor in 10 to 25% of all developmental disabilities

Sobsey, 1994

Vulnerabilities

- Higher level of assistance from caregivers
- For longer periods of time
- For invasive daily functions
- Higher level of stress on the family
- People are less able to meet parental expectations

Charlton, Kliethermes, Tallant, Taverne, & Tishelman (2004)

Vulnerabilities

- Cognitive disability interferes with:
  - The ability to predict high-risk situations
  - Understand what is happening in an abusive situation
- Barriers to reporting:
  - Mobility challenges
  - Restricted ability to communicate

Charlton, Kliethermes, Tallant, Taverne, & Tishelman (2004)

Vulnerabilities

- Trained to be compliant to authority figures (Valenti-Hein & Schwartz, 1995)
- 44% had a relationship with their abuser directly related to their disability (Davis, 2004)

Vulnerabilities

- Increased responsiveness to attention and affection may make them easier to manipulate.
- Less likely to be provided with general sex education or any type of training around human sexuality.
- Caregiver's assumption that they are not developing sexually.
- Society's tendency to label people who are different as bad.

Trauma May Take Many Forms

- Natural disasters
- Accidents
- Invasive medical procedures
- Physical abuse
- Emotional abuse
- Sexual abuse

Myths

- People with developmental disabilities do not have the same response to trauma as people in the general population (Charlton et al., 2004)
- People with developmental disabilities cannot benefit from therapy (Mansell et al., 1998)

Facts

- People with developmental disabilities suffer from the same difficulties in life that the rest of the population encounters
  - Anxiety and depression
  - Grief and trauma
  - Job stress, etc.

Charlton et al., 2004; Butz et al., 2000; Nezu & Nezu, 1994

Facts

- Many different types of therapy have been found to be effective in treating people with developmental disabilities.
- Although it generally takes longer for people with developmental challenges to make changes, those changes are stable once made.
- People with developmental disabilities are less likely to recover spontaneously from trauma without treatment.

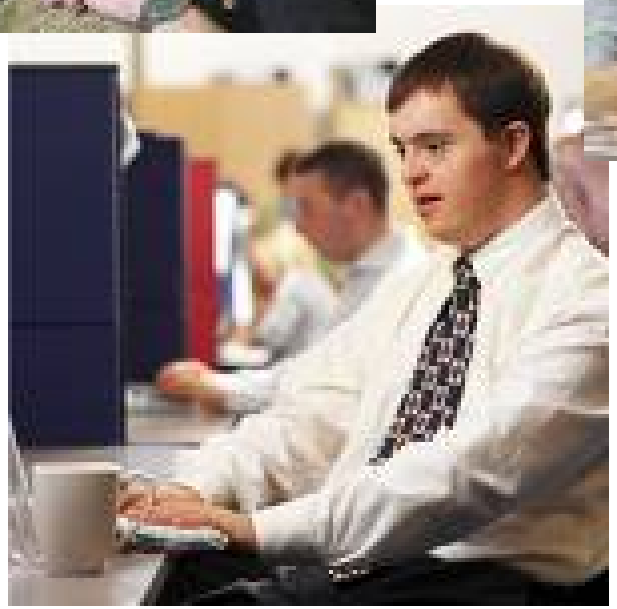
The need for adapted treatment

People with developmental disabilities are more likely to be impacted by abuse due to a variety of factors that impair their resilience or ability to spontaneously recover their former level of functioning following an abusive incident.

Charlton et al., 2004; Burrows & Kochurka, 1995; and Mansell, Sobsey, & Moskal, 1998

Community Realities

- Few professionals are trained to meet the needs of People with developmental disabilities
- We don’t have adequate research on how best to adapt trauma treatment for this population



Adapting Trauma Focused Cognitive Behavior Therapy

Caution

- The current presentation is based on Cohen, Mannarino and Deblinger's model of Trauma Focused Cognitive Behavior Therapy (TF-CBT)
- The information in this presentation is a blend of standard TF-CBT training, original thought and modification of TF-CBT material for special populations.
- This work is not intended to replace standard TF-CBT training.
- The material presented here should not be used by those unfamiliar with TF-CBT.

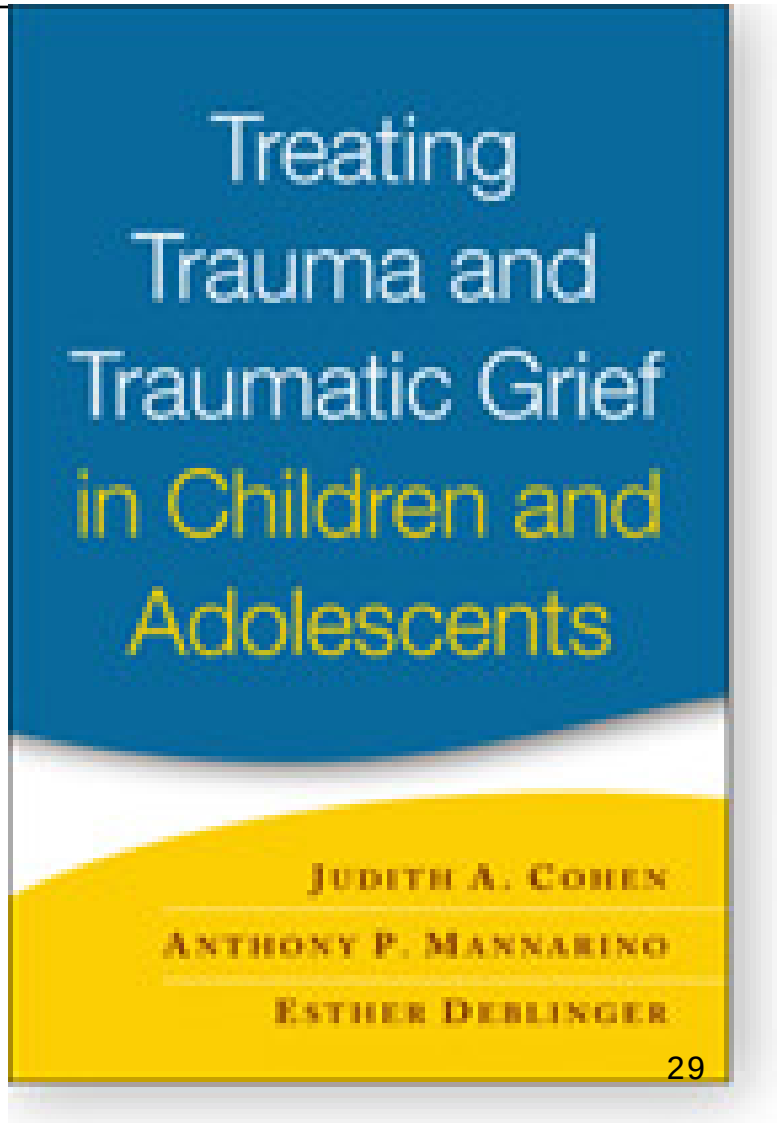
Training Resource

- Those who wish to use this adaptation should first participate in standard TF-CBT training
- A free web-based training for TF-CBT is now available at:

  http://tfcbt.musc.edu/

Other TF-CBT Training Resources

Cohen, J.A., Mannarino, A.P., & Deblinger, E. (2006). Treating Trauma and Traumatic Grief in Children and Adolescents. New York: The Guilford Press.



Why should we adapt TF-CBT for people with developmental disabilities?

- People with developmental disabilities are more likely to be exposed to trauma than those in the general population
- They are more likely to experience negative effects on their mental health as a result of their exposure to trauma

Trauma Information

- It is important that normal trauma responses not be attributed to the person's developmental disability or pre-existing mental illness.
- People with developmental disabilities generally have the same types of symptoms following trauma that anyone else would: sleep disturbance, startle response, numbing, emotional constriction, disrupted sense of safety, shattered self-identity, etc.
- Trauma responses generally represent a change from the person's normal level of functioning.

When is trauma treatment needed?

- When time has passed after a trauma and the person has not returned to their prior level of functioning.
- When the remaining symptoms of trauma are significantly impairing the person's ability to function.

Normal Response to Trauma—Responses that abate over time

- Loss of control during the event.
- After the event:
  - Intrusion of material from the event
  - Numbing
  - Emotional constriction
  - Intense efforts to control experiences that might elicit memories
  - Dissociative splitting off or aspects of the experience
  - Hypervigilance (enhanced startle response and sleep distrubance)
  - Shattered sense of safety
  - Disruption of self-identity

Trauma Symptoms—Responses that continue to be problematic long after the event

- Sleep disturbance
- Exaggerated startle response
- Numbing
- Emotional constriction
- Disrupted sense of safety
- Shattered self-identity
- Trauma responses represent a significantchange from the person's normal level of functioning.

Why should TF-CBT work for People with Developmental Disabilities?

- It is a strength based approach
- It focuses on development of competency skills
- It uses cognitive behavioral treatment techniques which are relatively easy to adapt for people at different developmental levels
- It has already been structured for use across a wide range of developmental levels

Additional Reason for Adaptation

- One of the reasons that trauma has such a negative impact on people with developmental disabilities is their impaired resilience
- TF-CBT focuses on developing skills that are associated with greater resilience
  - Strong self-esteem
  - Ability to self-sooth
  - Feelings of competency to deal with challenging situations

Adapting Psychotherapy for People with Developmental Disabilities

- Slow down your speech
- Use language that is comprehensible to the client
- Present information one item at a time
- Take frequent pauses during the session to check comprehension

Charlton & Tallant, 2003

Additional Adaptations

- Use multisensory input
- Make specific suggestions for change
- Allow time to practice new skills
- Do not assume that information will generalize to new situations

Charlton & Tallant, 2003

Format for TF-CBT

- Family Therapy Model
- Session is generally divided between
  - Time with client
  - Time with caregivers
  - Time working with everyone together
- In the non-adapted model a 90 minute session is generally used, although people with developmental disabilities may need a shorter session
- Sessions always end with time to do something fun together to allow the person to re-center before leaving therapy.

Who can act as the Coach in this model

- Parent
- Group home staff member
- Teacher
- Advocate
- Any caregiver that is involved with the client and willing to commit to regularly attending sessions with the client (even by phone)

Adaptations for People with Developmental Disabilities

- Be sure to include all significant caretakers—there are often several
- Assess for secondary trauma due to societal or community response:
  - Assumptions that because of the developmental disability the client has not been impacted by the trauma
  - Assumptions that the client cannot benefit from therapy
  - Lack of availability of appropriately adapted treatment that has resulted in significant delays in providing assistance

Adaptations for People with Developmental Disabilities

- Be sure that all members of the treatment team are using the same type of language to address the trauma
- Simplify training techniques to increase comprehension
- Work explicitly on generalization to other environments
- Allow more time for the client to learn the skills
- Use more repetition
- Don’t assume that the material is too complex for the client to understand

Components of treatment

- Assessment
- Address safety issues
- Psychoeducation
- Skills Development
- Trauma Narrative
- Trauma Processing
- Reintegration

Assessment

- Baseline Trauma Assessment
- Assessment of severity of trauma symptoms
  - UCLA-PTSD Index
  - Trauma Symptom Checklist

NCTSN
The National Child
Traumatic Stress Network

Baseline Assessment/Renew

Client Name: _____ Client Number: _____

Trauma Information

For each trauma that the child has experienced, please complete the following information.

Trauma Type	Has child experienced	When was this trauma revealed/known?	Frequency of experience	Type(s) of experience	Setting(s) of experience	Perpetrator(s)	Was serious injury/death inflicted on anyone?	Additional questi
1. Sexual maltreatment/abuse: ***(actual or attempted sexual molestation, exploitation, or coercion by a caregiver):***	☐ No ☐ Yes ☐ Suspected ☐ Unknown	☐ Baseline ☐ Other, please provide date: __/__/____	☐ One time event ☐ Repeated exposure ☐ Unknown	☐ Experienced ☐ Witnessed ☐ Vicarious ☐ Unknown	☐ Home ☐ School ☐ Community ☐ Other, specify: _____ ☐ Unknown	☐ Parent ☐ Other adult relative ☐ Unrelated adult (but identifiable) ☐ Sibling ☐ Other Youth ☐ Stranger ☐ Unknown	☐ No ☐ Yes—To Whom ☐ Child ☐ Parent ☐ Other adult relative ☐ Unrelated (but identifiable) adult ☐ Sibling ☐ Other youth ☐ Other, specify: _____ ☐ Unknown	**Was a report filed (Police, Child Protective Services)** ☐ No ☐ Yes ☐ Unknown
2. Sexual assault/rape: ***(Actual or attempted sexual molestation, exploitation, or coercion not recorded as sexual abuse)***	☐ No ☐ Yes ☐ Suspected ☐ Unknown	☐ Baseline ☐ Other, please provide date: __/__/____	☐ One time event ☐ Repeated exposure ☐ Unknown	☐ Experienced ☐ Witnessed ☐ Vicarious ☐ Unknown	☐ Home ☐ School ☐ Community ☐ Other, specify: _____ ☐ Unknown	☐ Parent ☐ Other adult relative ☐ Unrelated adult (but identifiable) ☐ Sibling ☐ Other Youth ☐ Stranger ☐ Unknown	☐ No ☐ Yes—To Whom ☐ Child ☐ Parent ☐ Other adult relative ☐ Unrelated (but identifiable) adult ☐ Sibling ☐ Other youth ☐ Other, specify: _____ ☐ Unknown	**Was a weapon used?** ☐ No ☐ Yes ☐ Unknown **Was a report filed (Police, Child Protective Services)?** ☐ No ☐ Yes ☐ Unknown
3. Physical maltreatment/abuse ***(actual or attempted infliction of physical pain or bodily injury by a caregiver):***	☐ No ☐ Yes ☐ Suspected ☐ Unknown	☐ Baseline ☐ Other, please provide date: __/__/____	☐ One time event ☐ Repeated exposure ☐ Unknown	☐ Experienced ☐ Witnessed ☐ Vicarious ☐ Unknown	☐ Home ☐ School ☐ Community ☐ Other, specify: _____ ☐ Unknown	☐ Parent ☐ Other adult relative ☐ Unrelated adult (but identifiable) ☐ Sibling ☐ Other Youth ☐ Stranger ☐ Unknown	☐ No ☐ Yes—To Whom ☐ Child ☐ Parent ☐ Other adult relative ☐ Unrelated (but identifiable) adult ☐ Sibling ☐ Other youth ☐ Other, specify: _____	**Was a weapon used?** ☐ No ☐ Yes ☐ Unknown **Was a report filed (Police, Child Protective Services)?** ☐ No ☐ Yes ☐ Unknown

Trauma Information

21. Primary focus of current treatment? (select only one)

- ☐ Sexual maltreatment/abuse
- ☐ Sexual assault/rape
- ☐ Physical maltreatment/abuse
- ☐ Physical assault
- ☐ Emotional abuse/Psychological Maltreatment
- ☐ Neglect
- ☐ Domestic violence
- ☐ War/Terrorism/Political Violence inside the U.S.
- ☐ War/Terrorism/Political Violence outside the U.S.
- ☐ Illness/Medical
- ☐ Serious Injury/Accident
- ☐ Natural Disaster
- ☐ Kidnapping
- ☐ Traumatic loss or bereavement
- ☐ Forced displacement
- ☐ Impaired Caregiver
- ☐ Extreme Interpersonal Violence (not reported elsewhere)
- ☐ Community Violence (not reported elsewhere)
- ☐ School Violence (not reported elsewhere)
- ☐ Other Trauma (not reported elsewhere)

Trauma Type Experienced by the Child:	**When was this type of trauma experienced? Age in years: (Check all ages that apply)**																		
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**Unkn**

Name _____; Center Number ☐☐☐☐; Subject I.D. Number ☐☐☐☐☐☐; Age ☐☐;
Sex: ☐Male ☐Female; Today's Date (**write month, day and year**) ☐☐/☐☐/☐☐; Week of Treatment: ☐☐☐☐

Here is a list of problems people sometimes have after very bad things happen. Please **THINK** about the bad thing that happened t you. Then, **READ** each problem on the list carefully. **CIRCLE ONE** of the numbers (0, 1, 2, 3 or 4) that tells how often the problem has happened to you **in the past month**. Use the **Rating Sheet** on Page 3 to help you decide how often the problem has happened in the past month.

PLEASE BE SURE TO ANSWER ALL QUESTIONS

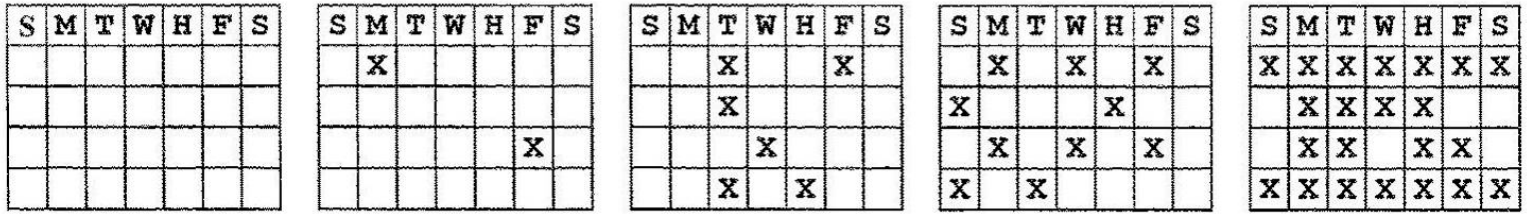
HOW MUCH OF THE TIME DURING THE PAST MONTH	None	Little	Some	Much	Most
1_{D4} I watch out for danger or things that I am afraid of.	0	1	2	3	4
2_{B4} When something reminds me of what happened, I get very upset, afraid or sad.	0	1	2	3	4
3_{B1} I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I do not want them to.	0	1	2	3	4
4_{D2} I feel grouchy, angry or mad.	0	1	2	3	4
5_{B2} I have dreams about what happened or other bad dreams.	0	1	2	3	4
6_{B3} I feel like I am back at the time when the bad thing happened, living through it again.	0	1	2	3	4
7_{C4} I feel like staying by myself and not being with my friends.	0	1	2	3	4
8_{C5} I feel alone inside and not close to other people.	0	1	2	3	4
9_{C1} I try not to talk about, think about, or have feelings about what happened.	0	1	2	3	4
10_{C6} I have trouble feeling happiness or love.	0	1	2	3	4

Contact: UCLA Trauma Psychiatry Service
300 UCLA Medical Plaza, Ste 2232
Los Angeles, CA 90095-6968
EMAIL: rpynoos@mednet.ucla.edu

FREQUENCY RATING SHEET

HOW OFTEN OR HOW MUCH OF THE TIME
DURING THE PAST MONTH, THAT IS SINCE _____,
DOES THE PROBLEM HAPPEN?

0	1	2	3	4
NONE	LITTLE	SOME	MUCH	MOST
NEVER	TWO TIMES A MONTH	1-2 TIMES A WEEK	2-3 TIMES EACH WEEK	ALMOST EVERY DAY



Small Group Discussion

- Discuss how to introduce these tools to your client (and caregiver)
- Reassure them that you won't talk about details of the trauma until skills for managing stress are developed

Checklist for TF-CBT
Intercept Center—Aurora Mental Health
Date

Psychoeducation

_____ Describe the model including:
- Short-term, trauma focused treatment model
- Phases that will be covered in treatment

_____ Discuss structure of treatment, including:
- Duration of sessions
- Format of sessions
- Stress the importance of consistency in treatment

_____ Address the client's sense of safety and correct any misperceptions

_____ Baseline trauma assessment; UCLA-PTSD Index

_____ Provide psychoeducation regarding normal responses to trauma

_____ Provide specific information regarding the specific type(s) of trauma experienced by the client

Skills Development

Date _____

_____ Teach feelings identification

_____ Teach a method of identifying the intensity of feelings: numerical scale, line, arms

_____ Provide deep (belly) breathing training

_____ Teach deep muscle relaxation through analogy (cooked or uncooked spaghetti) or progressive muscle relaxation techniques

_____ Teach thought stopping—client has control of their thoughts (remote control to stop and replace whatever is "playing")

_____ Teach positive self talk

_____ Teach the cognitive triangle—connection between thoughts, feelings and behavior—run through a series of scenarios, working toward more accurate or helpful thoughts

Narrating Trauma

Date _____

_____ Provide information about the benefits of gradual exposure interventions

_____ Review the feelings intensity scale and decide with the client when they want help reducing intensity

_____ Develop a signal for when help is needed to reduce feeling intensity

_____ Decide how the trauma narrative will be developed: pictures, writing, dance, song, etc.

_____ Begin the trauma narrative with a first chapter that describes the client—All about Me

_____ Do a second chapter on a relatively non threatening "trauma." Use the baseline trauma assessment to direct progress through the narrative.

Note additional dates spent on basic trauma narrative:

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Processing Trauma

Date

_____ Work through the trauma narrative with the client adding thoughts and feelings

_____ Assist the client in critically examining and appropriately modifying cognitive distortions (be aware of issues around causality or responsibility for the event)

_____ Ask the client to describe the worst moment and be sure this is included in the narrative

Integrating Trauma work

Date_____

_____ Have the client read the whole narrative to caregiver

_____ Help the client to listen to the caregiver's feedback (not your fault, good job, etc)

_____ Discuss what was learned in the course of treatment

_____ Add what was learned to the end of the narrative

_____ Process termination of treatment with client

_____ Process termination of treatment with caregiver

Components of treatment

- ✓ **Assessment**
- Address safety issues
- Psychoeducation
- Skills Development
- Trauma Narrative
- Trauma Processing
- Reintegration

Safety

- Is the client currently in a safe environment?
- What is the risk for re-traumatization?
- Does the client need extra help dealing with ongoing environmental stressors? (dealing with provocative peers, teasing at school, etc.)
- Are there cognitive distortions that increase the current perception of danger

Components of treatment

- ✓ **Assessment**
- ✓ **Address safety issues**
- ○ Psychoeducation
- ○ Skills Development
- ○ Trauma Narrative
- ○ Trauma Processing
- ○ Reintegration

Psychoeducation

- Provide general education about the impact of trauma on normal functioning
- Provide specific information about the trauma the client experienced in language that is accessible
- Risk Reduction
  - Identify “Red Flag” situations
  - Develop a safety plan
  - Develop appropriate assertiveness skills

Psychoeducation Issues: Sexual Abuse Basic Information

- Sexual abuse is confusing
- You may be confused about whether or not you've been abused
- Sexual abuse is when someone touches or rubs your private parts without your permission
- Sometimes the person asks you to touch their private parts.
- The person who does this is a sex offender
- The person may make you do these things by being mean and hurting you
- The person may pretend it's just a game and give you money or something you want
- The person can be someone you know, like your relative or a close friend
- The person could be a complete stranger
- Sexual abuse is always wrong
- Sexual abuse is not your fault

Psychoeducation Issues: Sexual Abuse Who is sexually abused?

- Sexual abuse happens to a lot of people
- Anyone can be sexually abused
- It happens to people of all different ages
- It happens to people who are rich or poor
- The important thing to remember is that being sexually abused is not your fault
- It is not about what you look like
- It is not about anything that you did
- It is always the perpetrator's fault

Psychoeducation Issues: Sexual Abuse Who sexually abuses?

- It is hard to understand why anyone would be a sexual abuser
- There are lost of reasons--Some people have sexual feelings for people who are younger or less able than they are
- Most people don't have this kind of feeling
- Some people choose to sexually abuse someone else even though they know it is wrong
- Some offenders even use tricks or make people scared so they can abuse them
- Most offenders are men, but sometimes women sexually abuse
- You can't tell offenders by the way they look or act or dress
- Some people sexually abuse others, but there are MANY more people who do not

Psychoeducation Issues: Sexual Abuse How do people feel after abuse?

- The feelings can be hard to understand
- Sometimes the sexual touching feels good
- Sometimes the sexual touching feels bad or hurts
- You may like or love the person who did this to you
- You may hate or be scared of the person who did this to you
- You may be really mad at the person
- It's OK to have lots of different feelings about the abuse
- Some people even feel like what happened is their fault
- Sometimes all these feelings affect how people behave
  - Don't want to be alone or sleep alone
  - Feel mad a lot and get into lots of fights
  - Feel sad and just want to cry all the time
- It really helps to talk about all of these feelings

Psychoeducation Issues: Sexual Abuse Why don't people tell about being abused?

- Sometimes people don’t tell anyone that they have been abuse
- Sometimes it's hard for other people to understand why you didn’t tell
- There are lots of reasons why people don't tell.
  - Sometimes, the person who did the abuse says that it's 'a secret,' and ‘don’t tell anybody.’
  - Sometimes the person makes threats and says things like 'if you tell anyone, I'll hurt you, or I'll hurt your mom.'
  - The person who hurt you may even tell you that if you tell, no-one will believe you.
  - Sometimes, people don't tell because they're ashamed or embarrassed or afraid that they'll get in trouble.“
- It’s OK if it took you a long time to be able to tell what happened
- It’s important that you are talking now and people are helping you

Practice

- Pick one of the pieces of psychoeducation information
  - Normal response to trauma
  - Describe TF-CBT model and phases
  - Sexual abuse
  - Assessment tools
- Work together and role play introducing material, making information concrete
- Pick a spokesperson to share your suggestions with the group.

Components of treatment

- ✓ **Assessment**
- ✓ **Address safety issues**
- ✓ **Psychoeducation**
- ○ Skills Development
- ○ Trauma Narrative
- ○ Trauma Processing
- ○ Reintegration

TF-CBT

Skills Development

Select the skills to teach

- Not every person needs every skill
- Introduce skills development as a time for deciding which skills work best for you
- Explore what skills have been learned previously
- Be sure that by the end of this phase the person feels the ability to control symptoms in some way

Feelings identification and affect modulation

- Restrict the number of different emotions that you will work with
- Pick emotions that are likely to be familiar to your clients
- Use lots of repetition in creative ways
  - Role play
  - Feelings bingo
- Use visual and verbal cues—thermometer for assessing intensity of affect
- Rate affect before and after use of relaxation skills

Use a sample list of feelings

Scared

Sad

Happy

Angry

Embarrassed

Personalized relaxation skills

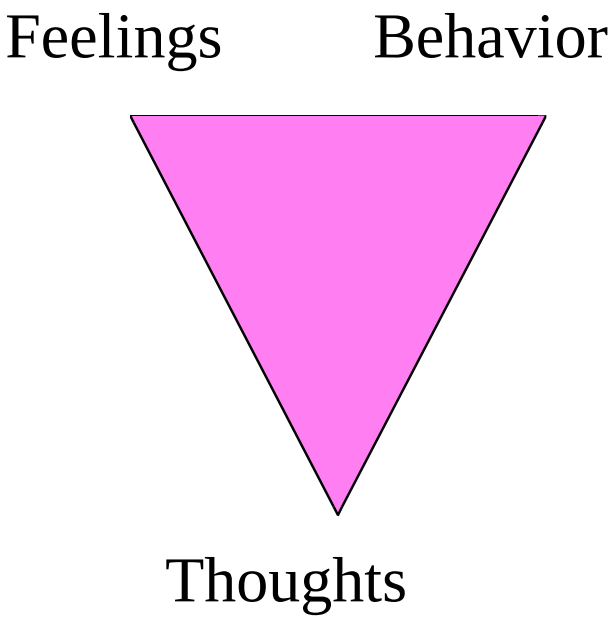
- Make modifications that not only address developmental, but chronological age
- Cooked spaghetti or belly breathing works well with younger people, but adults may be uncomfortable with these approaches
- Isometrics often work better than other types of tension/release exercises
- Teach deep breathing with simplified language
- Allow time for more repetitions over a longer period of time
- Involve caregivers in helping with practice sessions, but avoid setting up power struggles

Positive self talk

- Because of their concreteness, many people with developmental disabilities do not a have a clear way of discussing or understanding their own self talk
- Start by developing a vocabulary
- Use lots of examples related to the client's day to day life
- Don't become frustrated if the client doesn't get the idea right away—continue to present the information in different ways
- It often works well to combine presentation of positive self-talk with cognitive coping

Cognitive Coping

- The Cognitive Triangle: Recognize the relationship between:
  - Feelings and Thoughts
  - Thoughts and Behavior
  - Feelings and Behavior
- Understand the effect of
  - Inaccurate thoughts
  - Unhelpful thoughts



Cognitive Coping

- Practice a lot of different examples of how a thought might effect a feeling or action
- Talk about how positive self talk has a different effect than negative self talk
- Use drawings to illustrate the points that you are making verbally—white board works well for this

Thought stopping

- The idea that they can control their thoughts is likely to be a new one
- Because of their concrete approach to many things, people with developmental disabilities may view their thoughts as something that just happens, not something under their own control
- As the client becomes conscious of the self talk that is occurring, it is easier to introduce the idea that you can stop a negative thought or replace it with a positive one

Practice Session

- In your groups, role play introducing one of the skills to a client.
- Practice using adaption's to the model, i.e., simple language, short statements, opportunities for feedback
- Share insights with your group.

Break for Lunch