TREATING TRAUMA OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES USING THOUGHT FIELD THERAPY

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Individuals with Intellectual and Developmental Disabilities

Are children and adults who have disabilities that began before the age of 18 and usually include these disabilities: Intellectual disability Cerebral palsy Epilepsy Autism And other neurological conditions that effect their cognitive and communication abilities

Lanterman Act, 1969
Individuals with Intellectual and Developmental Disabilities

These individuals are likely to experience abuse of all types at rates far higher than generic children and adults. For children, the known rate of abuse for girls is 85% and for boys 58%. For adults the known rate is generally about 80% or more. For most, however, their abuse experiences have never been specifically identified, nor has treatment for the abuse been provided. In most cases, if abuse treatment has been authorized it is provided by interns in public clinics, using cognitive methods (CBT)... for people with cognitive disabilities.
Individuals with intellectual and developmental disabilities

In fact, frequent approaches are to identify the difficulties the individual is experiencing (aggression, depression, irritability, etc.) which I interpret as signs of abuse, but the functional behavior analysts identify as problem behaviors to be eliminated using behavior modification techniques. This is often considered “therapy” by disability specialists, while ignoring the emotional pain the person is experiencing.

Other responses are to send the rape victim for sex education services.
Or to conclude that no therapy will help because the individual is non-verbal or has a cognitive disabiity.
Myths and stereotypes

These interfere with clear thinking about the psychological and physical needs of children and adults with developmental disabilities. For example, it is widely believed that they:

Do not have emotional feelings like their age counterparts.
Do not experience physical or emotional pain, as do others.
They do not understand the importance of abuse or it’s implications.
They do not experience shame or embarrassment in the same way.
Since many require personal care (bathing, toileting), it is thought they cannot/do not understand or feel the invasion of sexual abuse by carers.
Some believe they are all dangerous and marauding sex fiends, and should not be allowed to roam loose in the neighborhood.
Some believe that they have a mental illness (which most do not, except PTSD)
Many believe that they cannot benefit from any therapy, or only child-like therapies like play therapy.
People with disabilities

Represent about 20% of the population

PEOPLE WITH **DEVELOPMENTAL DISABILITIES** REPRESENT ABOUT 3% OF THE POPULATION

Some diagnostic syndromes are more well-known than others, although their actual representation in the population does not mirror that. Examples include:

<table>
<thead>
<tr>
<th><strong>Most well-recognized</strong></th>
<th><strong>Less well-recognized</strong></th>
<th><strong>Others</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Down Syndrome</td>
<td>FASD (Fetal Alcohol Spectrum Disorder)</td>
<td>Fragile X</td>
</tr>
<tr>
<td>Syndrome</td>
<td></td>
<td></td>
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<tr>
<td>Autism</td>
<td>William’s Syndrome</td>
<td>Arthrogryposis</td>
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<tr>
<td>Asperger’s</td>
<td>Angelman Syndrome</td>
<td>Frederick’s ataxia</td>
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<tr>
<td>Cerebral Palsy</td>
<td>PKU</td>
<td>FAE/FAS</td>
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<tr>
<td>Epilepsy</td>
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INTELLECTUAL DISABILITY

THIS IS THE NEW TERM REPLACING “MENTAL RETARDATION”.

SINCE THE DIAGNOSIS BECAME AN EPITHET, IT WAS DECIDED A NEW TERM WAS NEEDED. “THEY” CAME UP WITH “INTELLECTUAL DISABILITY” WHICH, WHILE GENERIC, LITERALLY ALSO INCLUDES THOSE WITH DEMENTIA, ALZHEIMER’S AND ACQUIRED BRAIN INJURY/TRAUMATIC BRAIN INJURY...IMHO

AUTISM SPECTRUM DISORDERS used to ENCOMPASS ASPERGER’S SYNDROME, WHICH HAS NOW BEEN DELETED FROM DSM 5.

WHAT EVER TERM IS USED, “Intellectual and developmental disabilities” (I/DD) REFERS TO SLOWER LEARNING THAN OTHERS. NOT NO LEARNING.

MANY WITH AUTISM ARE THOUGHT TO HAVE AN INTELLECTUAL DISABILITY, BUT OFTEN THEY DO NOT. HOWEVER, BECAUSE OF HIGH SENSORY SENSITIVITY, AND REACTIONS OF DISTRESS TO LOUD NOISE/LIGHT/AIR ETC, THEY ARE OFTEN THOUGHT TO BE UNABLE TO MANAGE THEIR CONDUCT WHEN IN FACT THEY ARE IN PAIN, RESPONDING AS ANYONE WOULD, TO GET AWAY FROM THE PAIN.
# INTELLECTUAL DISABILITY

<table>
<thead>
<tr>
<th>LEVEL DESIGNATION</th>
<th>IQ SCORE</th>
<th>EDUCATIONAL LEVEL</th>
<th>DIFFERENT OUTCOMES FOR SAME IQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borderline</td>
<td>70-85</td>
<td>GENERAL ED.</td>
<td>Parental attitudes and expectations. Some with mild I/D function as if they have borderline level, some with severe I/D have skills of much higher levels. Expectation and education have strong impact on outcome</td>
</tr>
<tr>
<td>Mild</td>
<td>55-69</td>
<td>SPECIAL ED – GEN ED CLASSES + RESOURCE ROOM AND PULL OUT FOR SPEECH, OCCUPATIONAL AND OTHER THERAPIES</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>40-54</td>
<td>SPECIAL ED – SPECIALIZED INSTRUCTION, SMALLER CLASS SIZE, TEACHING AIDES PRESENT OFTEN SEGREGATED AREA OR BUNGALOW. PRACTICE OF PHYSICAL RERAINT.</td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>25-39</td>
<td>SPECIAL ED – GEN ED CLASSES + RESOURCE ROOM AND PULL OUT FOR SPEECH, OCCUPATIONAL AND OTHER THERAPIES</td>
<td></td>
</tr>
<tr>
<td>Profound</td>
<td>5-24</td>
<td>SPECIAL ED – SPECIALIZED INSTRUCTION, SMALLER CLASS SIZE, TEACHING AIDES PRESENT OFTEN SEGREGATED AREA OR BUNGALOW. PRACTICE OF PHYSICAL RERAINT.</td>
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http://www.healthofchildren.com/M/Mental-Retardation.html
Intellectual Disability

Most common causes of intellectual disability (descending order):
- fragile x syndrome (x chromosome)
- down syndrome (trisomy of 21st chromosome)
- pku – phenylketonuria (INBORN ERROR OF METABOLISM)
- fas/FASD – FETAL ALCOHOL SYNDROME / FAE – FETAL ALCOHOL EFFECTS
- cmv – CYTOMEGALOVIRUS OR OTHER MATERNAL INFECTION

FIVE PERCENT OF I/D CAUSED BY GENETIC FACTORS
OTHER CAUSES: ILLNESSES AND INJURIES IN CHILDHOOD, ENVIRONMENTAL CAUSES (EXPOSURE TO TOXINS SUCH AS LEAD; BIRTH TRAUMA; LACK OF ATTENTION AND CARE IN INFANCY, LACK OF FOOD AND WATER. OVER 75% CAUSE IS UNKNOWN
There’s a great motto about autism: “when you’ve met one person with autism, you’ve met one person with autism”

Although certain characteristics may be shared...they are expressed in different ways!
These include:

Most notable and negative: meltdowns
Originally thought of as tantrums (volitional), these are responses to overload – sensory, emotional, intellectual, mood, trauma-rebounds. The individual goes into a classic flight-fright-freeze mode, but since it is “autism” and not an in-the-moment trauma, often not recognized as the impact on the individual that it is. If treated in the moment with energy psychology treatments, the individual can recover relatively quickly.
Autism

Aspects of life that distinguish a person with autism (ABBREVIATED LIST) AND NOT APPLICABLE FOR ALL PERSONS WITH AUTISM:

Communication
- non verbal, low verbal, verbal til 18 months then non-verbal

Eye contact

Physical distancing

Single focus of attention or interest

Physical hand flapping, flicking or other movement (to calm)

Conduct similar to adhd

Many have extremely high iq’s

Many have intellectual disabilities.

May have one or more areas of interest and expertise

Social anxiety

Relationship building difficulties
Autism

Range of personalities as in general population
Difficulty learning social verbal and physical interaction skills
Extremely perceptive
Many are gifted in memory, art, technology, deep understanding of topics

Troubles with:
Anxiety
Depression
History of abuse (all types)
Sexual boundaries DUE TO LACK OF TRAINING AND INFORMATION PROVIDED TO THEM
OTHER DISABILITIES INCLUDED IN DEVELOPMENTAL DISABILITIES

THERE ARE LITERALLY HUNDREDS EVEN THOUSANDS OF developmental DISABILITIES

DEVELOPMENTAL DISABILITIES OCCUR PRIOR TO THE AGE OF 18 (CA) OR 21 (FED. DEFINITION) AND CAUSE DIFFICULTIES IN LEARNING, ADAPTIVE SKILLS MASTERY, AND SELF SUFFICIENCY.

ALTHOUGH DEFINED IN LAW, THE ESSENCE IS A DIFFERENCE IN ABILITY TO LEARN, SOCIALIZE, CONDUCT SELF-CARE ACTIVITIES, AND COMMUNICATE. SOME DISABILITIES CAUSE DIFFICULTIES IN CONDUCT INCLUDING AGGRESSIVE BEHAVIORS.

“DEVELOPMENTAL DISABILITY” REFERS TO CONDITIONS THAT OCCURRED DURING THE DEVELOPMENTAL YEARS AND NEGATIVELY IMPACTED DEVELOPMENTAL PROGRESS. THUS IF A TRAUMATIC BRAIN INJURY OCCURS BEFORE ONE’S 18TH BIRTHDAY (CA) OR 21 (FED. DEFINITION), THEY CAN QUALIFY AS HAVING A DEVELOPMENTAL DISABILITY. HOWEVER, THE SAME ACCIDENT OCCURRING ONE DAY AFTER THE BIRTHDATE, WOULD NOT BE CONSIDERED DEVELOPMENTAL BUT A DISABILITY.
TFT and Intellectual Disability

Thought field therapy is a unique therapy

Using no or few words, emotional healing can be accomplished

TFT is not an intellectually based therapy (as opposed to most commonly used conventional therapies such as “cbt” cognitive-behavioral therapy)

TFT also is not a skill-building therapy, nor is it a long drawn-out therapy such as play therapies, art therapies, in which play, for example is conducted and interpreted by the therapist.
A word on approaches currently used on individuals with I/DD

Assessments:

1. Whole Person assessment: These are conducted by regional centers, service agencies in california serving people with I/dd. Annual or triennial assessments are conducted to serve as a foundation for services that are needed/desired by the individual and incorporated into the individual program plan (IPP).

2. Functional Behavior Analysis: this is an assessment conducted by a behaviorist to identify difficult behaviors, their cause, and recommend behavioral interventions to stop them. Rarely are these clinicians. Rarely is any attribution for a behavior identified other than “seeking attention.” Why the person may be seeking attention is not explored. (in my experience)
Applied Behavioral Analysis

Although this is identified by some as “therapy” the practitioners are often not therapists, but training in behavior modification, now re-identified as applied behavioral analysis, likely due to the “bad name” behavior modification gained.

However, the practices are identical:
Identified wanted/unwanted behavior
Conduct behavioral rehearsal, rewarding for accomplishment of the former and punishing for unwanted behavior.
Often the punishing is withholding a desired object or activity (at this time, although some practice “aversives” which may be noxious or painful experiences.

As in the functional behavior analysis, specific unwanted/wanted behaviors are identified, and plans created and implemented to behavior mod the subject into behaving / not behaving in identified ways.
Example of ABA for Traumatized Woman

Jane (pseudonym) was raped by the boyfriend of the owner of the group home in which she lived. Jane had down syndrome and moderate intellectual disability. Following the rape, she exhibited a number of changes, including sadness, depression, nightmares, fears, anxieties. On the outside (what the behaviorists see) she ”refused” to change into nightclothes but now slept in her day clothes; she was angry, irritable, would not obey the staff; she began to engage in sexualized conduct with strangers who came to the house (males only). She had changes in her eating habits, work productivity, socialization. She no longer liked things she had enjoyed before. She was morose. SHE BEGAN TO FABRICATE (LIE).

After one year of ABA “treatment” many of these external problem behaviors were extinguished. However, ten years later they all came flooding back. She was referred to me for therapy, as in trauma therapy for sexual assault victims. This is just an informational bullet on the difference between therapy and behavioral intervention. ABA does not recognize trauma or internal triggers of prior traumas or internal emotional or psychological functions.
TFT and Intellectual Disability

Conducting therapy should be done choosing a therapeutic modality that best matches the client’s need.

In working with folks with intellectual disabilities, it has been my experience that focusing on the presenting problem immediately yields the best results.

The presenting problem usually is that someone feels horrible, due to x. This could be the death of someone or a loss of a friendship or relationship (staff change) but individual’s feelings have been overlooked/ignored, and their grief/sadness is interpreted as non-compliance, or attention-seeking behavior (note: seeking attention is by far the #1 supposed cause of difficult behavior. Behaviorists fail to discern any other reason for conduct. One could say, ok, a function of their conduct is they get attention (negative attention from staff) when what they need is solace, conversation, inclusion in grief activities such as wakes, funerals.
Thought field therapy is the tapping upon specific meridian points in a particular order while the client focuses on the traumatic or problem experience. Tapping is done by the individual upon him/herself, while the practitioner taps upon him/herself as a model of instruction. Prior to the tapping therapy the client is asked to rate how bad x feels. This can be done with numbers, on a paper with faces indicating happiness to sadness, stretching the hands to indicate how much or measuring from the ground. Some will not be able to rate, so this step can be skipped.

If the client is completely unable to give a rating, you can determine the rating through muscle testing, and continue this until the person is at a one or zero.
TFT and Disability

Adjustments:

Some people are not able to tap the points on their body, due to their disability. In such a case, some approximate the points, and I allow them to do this knowing that their intention takes care of any physical errors. This is common with autistics.

For those with neurological difficulties, many are able to tap most points but cannot execute the 9g treatment, thus for them I tap the gamut spot while they do the nine steps.

For those who are blind, I make no adjustments at all, even with the eye movements and they can do them even though they cannot see.

For those who are deaf, one must be sure that the person can easily see you and the interpreter easily, so be sure to place yourself facing the light/window, and the interpreter is placed near you and easily visible. Prior to the first set of instructions say we will do ten taps for each step, so close your eyes for 10 taps, then open for ten taps, etc.

For others unable to tap I ask a surrogate, usually a parent, to hold hands with their child and tap upon themselves on behalf of the client, which works very well.
TFT and Disability

Adjustments:

In order to help anchor the psychological reversal treatment of tapping upon the side of the hand, I encourage my patients to tap the sides of both hands on a table, while saying, “boom boom boom boom,” in a rhythm, repeated four times. To keep attention while tapping under the arm make “monkey” noises.

I also teach what I call “instant valium” for calming: tap on the gamut spot, look down at your nose, slowly raise your eyes to the ceiling, then slowly back down. Usually they are able to do this on their own.

If the individual is unable to reach x location for the tapping, they can use an implement (pen, incense stick, ruler) to gently tap.

For those with a physical disability, an alternative is for the person to focus on the problem (hand pain example) and mentally conduct the tapping process rather than doing so physically. This works just as well.
Case examples
Serving Individuals with Developmental Disabilities – in California

Contact your local regional center (there are 21) according to your address.

Request and submit an application to become a “vendor”, that is an authorized provider of services for the regional center. This will include your proposed rate.

You can also submit a vendor application to make presentations to regional center clients and parents, to teach them about trauma (and other) treatments that can help them.
Questions and answers

• Discussion!!!!!!!
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