

Commentary: Complex Post-Traumatic Stress Disorder. Implications for Individuals with Autism Spectrum Disorders – Part II

Abstract

The term complex post-traumatic stress disorder (CPTSD), (Herman, 1992) describes the clinical presentation of individuals exposed to repeated trauma. Hypotheses regarding the manner in which individuals with autism spectrum disorders (ASDs) with CPTSD may process trauma and the manner and how they might present clinically with this disorder, have been explored (King, 2010). This paper discusses practice-based evidence regarding the treatment of CPTSD in neurotypical individuals and summarizes evidence-based suggestions for the modification of cognitive behavioural therapy (CBT) in individuals with intellectual disabilities (ID). The need to continue to gather evidence-based modifications to CBT to optimize the treatment of CPTSD in individuals with ASDs is highlighted.

Several decades ago, the second son of a Ukrainian speaking couple who had emigrated from Eastern Europe, was born in Israel. At the age of three this child was diagnosed with an autism spectrum disorder (ASD). The family subsequently immigrated to Canada when their child was six years of age, facing linguistic and cultural challenges as they began a life in Canada. Psychometric testing completed on three occasions demonstrated the presence of a mild degree of intellectual disability concurrent with an ASD. Despite his challenges, by grade five, this child was speaking in short but intelligible sentences, was playing the piano with joy, and was proudly described by his father as “quiet and polite.” At age fourteen it was suggested that the child would benefit from a summer program at his high school at the end of grade nine, to allow his social skill repertoire to expand. By June of that year, his mother lamented that “my son’s spirit has left his body, he is broken.” Unsupervised during lunch breaks, this child had been physically, emotionally and sexually assaulted by his peers. Admitted to a tertiary care children’s hospital at age fifteen, he was able to articulate that he was experiencing initial insomnia, and described seeing ghosts and clowns, which were formulated by his mental health team to represent auditory and visual hallucinations. His speech deteriorated, he stopped answering questions and completely withdrew from interactions with others. Jean Vanier, (2005) Canadian Founder of L’Arche, believes

...The danger for individuals, groups, communities and nations is to close themselves off. This happens to the little child when the child feels it is not loved or wanted. Its vulnerable heart is wounded. And because it is so fragile and weak and cannot cope, it closes itself up fearfully behind barriers to protect

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itself; it wants to hurt itself because it feels worthless and guilty, or else wants to hurt others, in revenge for its own inner rage and loneliness." (2005, p. 28)

Hospitalized ten subsequent times, including a four month admission to a tertiary care dual diagnosis service, this child retreated. He was afraid to go to sleep, he covered his eyes and ears, running from the family room of his parents' home when company visited, experienced panic attacks, was noted to demonstrate "odd postures," and engaged in increased stereotypies (which were misinterpreted as pathology rather than a self-survival mechanism). Neurological consultations failed to reveal any abnormalities and metabolic screens, EEGs, CT scans of his head, genetic karyotypes, and a FISH analysis for the number 22q11.2 deletion (DiGeorge) syndrome were unremarkable. His psychiatrists developed a consensus that the provisional diagnosis in this case was schizophrenia, resulting in the prescriptions of Perphenazine, Risperidone, Quetiapine, Olanzapine, Clozapine (which induced neutropenia), Divalproex Sodium, Clonazepam, and Lorazepam. During one admission to hospital this child also received nine treatments of bilateral electroconvulsive therapy.

Some clinicians listened but did not hear. During his first admission to hospital, a month after the swift onset of a significant change in his mental status behaviour, in the absence of the use of alcohol or illicit substances or a family history of psychiatric illness, this child, although mute, wrote on a clipboard that a peer had hit him in the leg and "private parts." The diagnosis remained that of schizophrenia. Shortly thereafter, his parents were informed by the school principal that two fellow students had in fact been arrested for assaulting their son. A referral to an internationally renowned sexual trauma team was recommended but not initiated. In 2002 a psychologist who did listen, heard, and bore witness, wrote "the most parsimonious explanation is that this child is suffering from Post-Traumatic Stress Disorder (PTSD), given the fact that the shift in his presentation followed in close proximity to his victimization at summer camp." A recommendation for psychotherapy was met by resistance by his parents in the context of their increasing frustration, confusion and fearfulness in response to a myriad of medications which had been

prescribed with various adverse effects experienced by their son. They became completely untrusting of a system, which after supporting their child in a group home for four years, determined that he was capable of living on his own with marginal support, only to watch him repeatedly set fires, aggress against his parents, and be apprehended by the police after eloping from a group home. Finally in 2009 this individual was admitted to a state of the art treatment home run collaboratively by a Tertiary Care Psychiatric Facility and a Community Living Association. Unfortunately even in this environment, the child remained aggressive and was charged with sexually assaulting a staff member (grabbing her breasts impulsively) and now awaits court proceedings.

In Peter Levine's book, *Healing Trauma, Pioneering Programs for Restoring the Wisdom of Your Body* (2008), he outlines a twelve-phased healing trauma program, an extension of his exploration into the evolutionary roots of how animals and humans process, and are reunited and heal, or continue to suffer from traumatic experiences (*Walking the Tiger*, 1997). Levine's premise is that "most organisms have an innate capacity to rebound from threatening and stressful events" (2008, p. 30). His careful observations have led him to conclude that "the effects of unresolved trauma can be devastating; it can affect our habits and our outlook on life, leading to addictions and poor decision making. It can take a toll on our own family life and interpersonal relationships. It can trigger real physical pain, symptoms and disease. It can lead to a range of self destructive behaviours." He believes, however, that "the trauma does not have to be a life sentence" (2008, p. 3).

There is hope for the wounded child in our case description. As Levine states, in virtually every spiritual tradition, suffering is seen as a doorway to awaking (p. 4).

If you bring forth that which is within you
Then that which is within you
Will be your salvation
If you do not bring forth
that which is within you
Then that which is within you
will destroy you.

(The Gnostic Gospels, Pagel, E., 1979).

He cites the Four Noble Truths of Buddha.

The **First Noble Truth** is that suffering is part of the human conditioning and that avoiding painful experiences creates the very conditions that promote and perpetuate unnecessary suffering (His Holiness, the Dalai Lama, 2002, p. 41).

Complex post-traumatic stress disorder (CPTSD), a constellation of symptoms was first described by Judith Herman in her groundbreaking work *Trauma and Recovery, the Aftermath of Violence from Domestic Abuse to Political Terror* (1992). Symptoms of this disorder are listed in Table 1.

Table 1. *Signs and Symptoms of Complex Post-Traumatic Stress Disorder*

A. *Alterations in:*

- Regulation of affective responses
- Attention and consciousness
–intrusive symptoms
- Self-perception
- Perception of the perpetrator(s)
- Interpersonal relationships
- Systems of Meaning

B. *History of subjection to totalitarian control over a prolonged period of time*

(Herman, 1992)

These symptoms can present in a variety of ways, leading as they did in our case study to prolonged unnecessary suffering for the survivor and his or her family, despite well-intended but misdirected efforts of many mental health and developmental sector professionals in a system ill-prepared to actually diagnose this condition in individuals with ASD.

The **Second Noble Truth** (His Holiness, the Dalai Lama, 2002, p. 87) suggests that we must discover why we are suffering. Given this child's distorted world view superimposed upon the altered cognitive styles of many individuals with ASD, as well as relative insensitivities to the religious and cultural tenants of the family of the subject of our case study, how was he to begin to understand the suffering

he experienced immediately after being traumatized and more pointedly in the context of the system which denied him psychotherapy, did not listen to his words, and trivialized his behavioural response to the suffering? It is well known that for those suffering from CPTSD it is more closely related to how we deal with the effects of these traumatic events. In this paper we will discuss evidence-based recovery therapies emerging with great promise for neurotypical individuals in this context. We will then review the limited literature regarding modified trauma cognitive behavioural therapy (TCBT) and mindfulness in individuals with intellectual disabilities (ID) noting the complete absence of literature regarding treatment projects for complex PTSD in individuals with ASD.

Research is critically needed to allow the realization of the **Third Noble Truth** (His Holiness, the Dalai Lama, 2002, p. 121) that suffering can be transformed and healed. Finally we will ponder the **Fourth Noble Truth** (His Holiness, the Dalai Lama, 2002, p. 153) that states that once you have identified the cause of the suffering you must find the appropriate path to recapture the simple wonders of life.

This begs the question, in the unique lives of individuals with ASD, particularly in the lives of those who are non-verbal; are we truly able to understand sources of happiness in individuals with ASD, given variations in neuropsychological thinking styles, dysfunctional and altered autonomic nervous systems, and unique hypo and hyper sensitivities? In addition, we are attempting to understand the process of their trauma and methods to assist in healing the lives complicated by an extremely high rate of lifetime prevalence of co-morbid mental health concerns (Bradley & Bryson, 1998; Ghaziuddin, 1998). Levine (2008) suggests that we become traumatized when our ability to respond to a perceived threat is in some way overwhelmed (p. 9). He describes the trauma as a loss of connectiveness to our bodies, families, to others and the world around us.

How do we as mental health professionals measure how much is too much in establishing whether or not a behavioural change in an individual with ASD is compatible with complex PTSD?

The life histories of individuals with ASD and ID are characterized by the following facts:

1. Thirty percent have a friend who is not a family member or a care giver.
2. Ten to fifty percent are homeless.
3. Seventy-seven percent live in poverty.
4. Fifty percent living in the community are prescribed psychotropic medications.
5. Twenty-five percent have unattended dental needs.
6. Forty-three percent have undiagnosed health problems.
7. They age earlier and have higher mortality rates than the general population.
8. The vast majority are living with parents who are aging and becoming increasingly frail and unable to address the support needs of their children. Families on average spend 50–60 hours per week caring for their child with an ID or ASD.
(See Roebuck, 2008, for details about items 1. through 8).
9. As children they are five times more likely to be abused and neurotypical individuals (Mansell & Sobsey, 2001).

How do we respond when the father of an adult child with an ID and co-morbid mental health concerns indicates to a provincial committee on mental health and addictions that “a friend’s son, who was sexually assaulted by a priest, is now labelled a difficult case?” His severe behavioural challenges and medications have led to a weight gain of 125 pounds, with accompanying health problems. The family can find no agency that will support him, so he lives at home with his family, who are also in crisis. How can our system fail individuals so badly? (Johnson, 2009).

As care providers, are we capable of adequately understanding the distortion and already unique world view and self-perception in the life of an individual with an ASD exposed to repeated trauma? This question would resonate with Canadian autism self-advocate Michelle Dawson

who has written in *An Autistic Victory: The True Meaning of the Autistic Decision* (May 2005).

Everything that is said, done, and decided about autism in Canada enriches the lives of autistic Canadians. Daily we live tactical and emotional consequences of having our fate in the hands of non-autistic factions quarrelling over our treatment. (p. 1)

How can we engage families, such as the family described in our case study, when Valerie Paradiz (2002) reminds us that

...professional literature on autism, which I rely on for information about Elijah’s (her son’s) way of life, is impossible to embrace wholeheartedly? Elijah fits the diagnostic picture and yet he is ill-framed by a language that cannot shake its negativities and technicalities, a language so cautiously self-involved with its clinical precision that it overlooks the problem of its own ephemeral standards and presumptuous contentions.” (p. 60)

We begin with three principles expressed by Herman (1992) with respect to the engagement phase of the psychotherapeutic treatment of CPTSD and her work with neurotypical individuals. She stresses the need to address issues sequentially and to assist in the acquisition of therapeutic skills to deal with emotional-laden issues, in a hierarchical order.

Suggested Modifications to the Psychotherapeutic Process in Assessing and Supporting Individuals with ASD and CPTSD

The establishment of emotional stability and safety is deemed essential for successful outcomes, enhancing the individual’s abilities to endure extreme arousal states and enhancing the abilities to master rather than avoid bodily, affective states. Herman also emphasizes the need to identify, if possible, external events triggering intrusive cognitive emotional and physical experiences while providing psycho-education regarding the body’s response to repeated trauma, and increasing an awareness of the sense of self in relational capacities.

Assessment and Diagnosis

Phase 1. Recognizing the uniqueness of the individual.

The potential task of confidently establishing a diagnosis of CPTSD is formidable in neurotypical individuals. This task is further complicated in the lives of individuals with ASD. Formal diagnostic guidelines are not yet in the DSM-IV-TR (American Psychological Association (APA), 2002). Yet the symptom presentation involves the affective, somatoform, obsessive-compulsive behaviours, co-morbid substance abuse issues, and symptoms such as dissociation, an under-recognized symptom of CPTSD. This results in an extreme challenge to the therapist to recognize this disorder in individuals with ASD with severe expressive-communication deficits. Traumatic events often occur during developmentally vulnerable stages in the individual's life, and in this process become intertwined with the child's biopsychosocial development. How easy it would be to dismiss this in a child with an ASD, who by definition is struggling with development of a sense of self, and is uncomfortable in an alien world, even prior to repeated exposure to trauma. Everyday barriers faced by individuals with ASDs, communication difficulties, socialization challenges, executive function deficits, difficulties responding to change and pervasive anxiety, are well documented (Autism Ontario, 2008, Baron-Cohen, 2004; Grandin & Barron, 2005; Berney, T. (2004); Konstantareas, 2005; Thede & Coolidge, 2006; Tonge, Brereton, Gary, & Einfeld, 1999).

Under and over reported symptoms because of the cognitive profile of individuals with ASD (theory of mind, systematizing, alexithymia, lack of central coherence, lack of understanding of emotional vocabulary, poor emotional recall and poor understanding of typical levels of anxiety) all complicate the initial assessment and establishment of the therapeutic alliance in this context (Stoddart, Burke, & King in press). Unfamiliarity with this cognitive and resultant world view has been identified as a barrier to effective assessments of need and optimal provision of psychotherapy (Jahoda, Dagnan, Jarvie, & Kerr, 2006). It is critical for therapists to be aware that many people with

ID and ASD, despite having varying degrees of familiarity with various emotions, have a poor understanding of the relationship between cognitive beliefs and emotion.

Phase 2. Personal empowerment.

The therapist functions as an active, empathic, responsive listener, creating relational conditions in which the client is emotionally validated. Inherent power differences in this relationship must be acknowledged; all attempts at collaboration are optimized.

With reference to individuals with ASD, even prior to exposure to repeated trauma, O'Neill (1999, p. 18) notes that in individuals with ASD

...not all are shy, but all need to feel the calm of their inner experiences. It centres and soothes some of the anxiety that comes from outside confusion. It is comfortable to know that you have a portable sanctuary (your home).

Phase 3. Professional training, ongoing supervision and consultation.

The concepts of readiness to therapy and modifications to therapy, applicable to all forms of psychotherapy, but in particular to trauma CBT (TCBT) and ways to address inherent power inequalities in the relationship between all therapists and an individual with an ASD are the subject of current research. Table 2 depicts methods to prevent an abrupt termination in the early phases of psychotherapy.

In discussing the use of CBT in individuals with ID in general, Gauz argues with strong conviction based on years of clinical practice that it is a myth that individuals with ASD are not capable of psychological insight, or benefiting from any therapeutic relationship to effect change in their lives, or of thinking reflectively about their lives and the future.

Jahoda (2009) offers advice regarding the manner in which CBT can be made meaningful for people with ID. He has also examined the elements of systemic resistance to the provision of psychotherapeutic modalities to individuals with ID and ASD. These include therapeutic disdain—the belief that this group of individu-

Table 2. Methods to Prevent an Abrupt Termination in the Early Phases of Psychotherapy

1. Ensure appointments start and end on time
2. Offer regular appointment times, predictability and sameness, reducing the client's anxiety
3. Reduce the duration of appointments
4. Use humour
5. Use gradient scales as visual aids to gauge degrees of emotion on a gradient
6. Provide written psycho-educational material and/or use pictorial aids
7. Set an agenda in a truly collaborative manner, following the client's lead with a degree of flexibility
8. Have sensory-friendly waiting rooms
9. Provide access to objects or encourage clients to utilize objects of their own as a component of a sensory diet or toolkit directly during psychotherapeutic sessions
10. Allow various seating arrangements
11. Increase the number of therapeutic sessions
12. Engage in and discuss directly the client's areas of interest
13. Gradually introduce emotionally-laden topics

(Stoddart, Burke, & King, in press)

als are "not clever enough." He notes that there has been a very slow paradigm shift from those who have worked in institutional settings but acknowledge an emerging recognition of the person within the individual with ID. In therapists' minds there may still be persistence of social stigma, isolation and resistance to the idea that the individual with ID and ASD do indeed need and want meaning and purpose in their lives. He recognizes that CBT cannot be of assistance to all persons even with optimal modifications he suggests alternative methods of support may not be helpful for:

1. Individuals unable to hold a conversation and tend to delve in social stimuli.
2. Individuals with verbal IQs less than 50 (Willner, 2006).
3. Individuals having significant persistent difficulties linking antecedents to beliefs and consequences.
4. Individuals with specific cognitive or behavioural attributes such as extreme impulsivity.
5. Individuals unable to be taught to recognize and articulate felt emotion.

Jahoda (2010) also emphasizes the importance of distinguishing between cognitive deficits (a lack of cognitive control of emotions and beliefs) and cognitive distortion, the latter being critical thought content to be identified and made explicit to the client in the therapeutic process. He convincingly argues that the use of self-monitoring, pictorial techniques, social problem solving techniques, psycho-education and acknowledgment of verbal self-regulation are helpful in demonstrating that individuals with ID and ASD are indeed capable of altering the way in which they think about the world (challenging underlying cognitive distortions and diminishing automatic negative thoughts leading to distressing emotional feelings). Jahoda et al. (2009a) describe that a collaborative relationship is the cornerstone of successful CBT in individuals with ID, acknowledging the potential for power and inequalities in the client-therapist relationship arising from:

1. Expressive and receptive language difficulties.
2. Client histories with a difference between them and those perceived in power and positions of authority.
3. Concerns regarding passivity, acquiescence, biases and a tendency to say yes to complicated questions.

Using a novel method of interactual analysis in a group of fifteen individuals with borderline to mild degrees of ID, a review of verbatim transcripts of CBT therapy sessions (Jahoda et al., 2009) conclusively demonstrated that a rela-

tive equal power distribution between the client and therapist is achievable; therapists were noted to ask more questions than clients, but clients were confirmed to be able to contribute to the flow of the conversation and play an active role in therapy.

Using a method of interactual analysis developed by Linell, Gustavsson, & Juvonen (1988) and the strategies suggested in *Cognitive Therapy Skills for Psychosis* (Haddock et al., 2001) including a measure of fidelity to the key structural and process elements of CBT (agenda, feedback, understanding, interpersonal effectiveness, collaboration, guided discovery, a focus on key cognitions, the choice of interventions, and the use of homework) Haddock et al. concluded that:

1. CBT therapists were able to achieve high levels of adherence to CBT principles while working with individuals with ID.
2. Were able to establish interpersonal, emphatic, collaborative approaches.
3. Were able to convey understanding through rephrasing and summarizing.
4. Were able to acknowledge the client's point of view as important.
5. Were able to facilitate guided discovery.
6. Asked questions to show interest without being demeaning.
7. Were able to use appropriate questions to reframe the meaning clients attach to events.

Haddock et al. conclude "collaboration does not just mean that the therapist is able to communicate effectively as an expert, but that the client must feel he or she is properly heard and understood." (p. 7). The focus in therapy should be on real life experiences (issues in the here and now).

Interventions in complex TCBT attempt to provide clients with a means of shifting their inner experience of themselves to their sense of interpersonal relationships. The identification that these symptoms of CPTSD (see Table 3) are arising from traumatic events rather than from perceived character flaws, can liberate the client from the paralyzing sense of shame.

Given the immense vulnerability to stigma and discrimination, to which individuals with ASD and histories of repeated trauma undoubtedly are exposed, it is understandable that they engage in experiential avoidance resulting in the constrictive and intrusive symptoms of CPTSD, layered on a pre-existing sense of alienation and disengagement from society.

Intervention

After completing phase one in the therapeutic process as proposed by Herman, the establishment of an active sense of personal and environmental safety and stabilization; phase two, the prolonged exposure to traumatic memories in a gradual way through mindfulness and acceptance strategies combined with exposure exercises, begins the process of explicitly identifying and labelling the signs and symptoms most often present following an exposure to trauma and beginning to address a destabilizing sense of internal shame.

Herman (1992) suggests that the constructive and intrusive symptoms of CPTSD lead to a reduction of normal social and emotional capacities causing a stunting of the development of self esteem, an impairment in daily life routines (so important in the lives of individuals with ASD attempting to modulate pervasive levels of anxiety in a confusing world). In describing children who have been repeatedly abused, Herman (1992) has written

The child faces a formidable task. She must find a way to preserve a sense of trusting people, who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable, power in a state of helplessness. (p. 97)

Herman suggests "it is as if time stops when trauma happens" (p. 37).

Individuals with ASD may also develop CPTSD through what Maria Root (1992) describes as "insidious traumatization which occurs when an individual is repeatedly negatively targeted for some aspect of their identity, resulting in a chronic state of over arousal and stress. A response society often directs towards individuals with ASD, already attempting to modulate chronic states of autonomic nervous system

over arousal through stereotypes, insistence on sameness and predictability, and the utilization of challenging behaviour, to express distress arising from unpredictable changes in their daily life routines.

The third and final stage of therapy proposed by Herman aims to re-establish a connection on many levels between the individual and community. She believes that sharing the traumatic narrative and recreating a grossly distorted chronological personal narrative is a precondition for the reconstitution of a meaningful world, necessary to rebuild a sense of order and pride (and to remove shame, guilt, embarrassment and humiliation). Rather than using power and inequalities in the therapeutic relationship she suggests the therapist cannot take sides or direct the patient's life dreams, but rather "is called upon to bear witness to the trauma." In the third phase of therapy forging a new pathway from disconnection and fear to safety, the victim is faced with the double challenge of rebuilding their own shattered self-assumptions about meaning, order, justice, and finding a way to resolve the differences and free themselves from the adopted beliefs of the perpetrator of repeated abuse.

In sitting with an individual with an ASD who has CPTSD the therapist is called upon to bear witness to the trauma and therefore must spend much time attempting to understand the individual's unique world view. Signs of symptomatic resolution are noted in Table 3.

Table 3. Signs of Symptomatic Resolution

Being able to bear feelings and come to terms with traumatic memories
 Establishing authority and autonomy over traumatic memories
 Bringing symptoms to manageable limits
 Allowing traumatic memories to become a coherent, chronological narrative
 Restoring self-esteem
 Re-establishing interpersonal relationships
 Establishing or recreating a coherent sense of meaning and self

(Herman, 1992)

A number of evidence-based therapies helpful for neurotypical individuals with CPTSD have emerged (Courtois & Ford, 2009). This is comprehensively described in the text *Treating Complex Traumatic Stress Disorders – An Evidence-Based Guide*. These therapies include:

1. TCBT (a combination of CBT, acceptance and commitment therapy).
2. Contextual-based trauma therapy.
3. Experiential and emotion-focused therapy.

We will focus on TCBT given emerging evidence-based practice that with appropriate modifications this particular therapy appears to have value for individuals with ID and ASD. Jahoda (2010) has explored methods of preparing (readiness) clients with ID for therapy through the use of motivational interviewing based on the principles of:

1. Empathic listening.
2. Acceptance without judgement.
3. Avoidance of direct confrontation.
4. The belief that change cannot be forced.
5. Supporting self-efficacy.
6. The essential intervention to create and amplify in the clients mind, a discrepancy between past and present behaviours.
7. Changing the content of therapy—optimizing the fit between client and therapist, involving additional caregivers in portions of the therapy (with written, informed consent from the client) and offering therapy in home-based settings.
8. Modifying therapy—modification would include:
 - a. Using simple language and visual aids.
 - b. Re-scripting the traumatic narrative with happier endings (this correlates well with the documented effectiveness of social stories, narratives and role-playing in therapy involving individuals with ASD (Courtois & Ford, 2009).

It is recommended that clinicians be alert to the need to distinguish between cognitive distortions and cognitive deficits while empathically listening to survivors of complex trauma with ASD. An attempt must be made to address potential deficits in the processing of trauma to which information during the traumatic process has been acquired and now is contributing to the clinical presentation. This may lead to themes contributing to relative reliance in the identification of strengths to highlight and build on. Teaching people to understand emotions, particularly anger, sadness and anxiety, it may be important to identify that events are being appraised as "crazy thoughts." This often becomes an integral part of the social behaviour analysis conducted on the individual suspected of having CPTSD, leading to emotional regulation and skill building as well as adaptive environmental modifications. It is important to recognize that supporting the development of self efficacy, the belief in one's capacity to manage emotional states in an individual with ASD will be occurring in the context of the individual's developmental experiences in which there have been many events in which the individual's views were invalidated or they were exploited. Mettinen, a powerful Canadian self-advocate with ASD, has commented "our society is very quick to judge people's beliefs in all kinds of shallow and totally frivolous manners, but won't even try to understand the origin of these unusual or even unacceptable methods of thinking." (Mettinen, 2006)

The interest in modifying CBT to support individuals with ID, ASD and mental health concerns was highlighted by the establishment of a national network of like-minded professionals, funded by the Dally Thomas Foundation (and the publication in the U.K. of a special edition of the *Journal of Applied Research in Intellectual Disabilities*, 2006). This edition includes both outcomes of evidence-based studies and practice-based evidence. Oathamshaw and Haddock (2006) have stressed the importance of the verbal communication abilities of clients using a task design which demonstrated that potential CBT clients with ID could differentiate between positive and negative feelings. Lindsay et al. (2006) reported that the assessment of individuals with ID, and histories of perpetrated rape and sexual assaults against children showed specific, consistent patterns of cognitive distortions with these offences, and potentially

amenable to reframing and psychotherapy and psycho-education in the context of CBT.

Sams, Collins and Reynolds (2006) developed a novel task which was used to distinguish potential CBT clients based on their abilities to differentiate between thoughts, feelings, and behaviours. Jahoda et al. (2009b) demonstrated that individuals with ID could be identified according to their ability to recognize and label emotions, link events and emotions, and understand the mediating role of cognitions. The editions editor, Willner (2006) has reviewed the existing evidence-based literature including recommendations to increase motivation and address systemic barriers to accessing and engaging individuals with ID and ASD in psychotherapy.

Whitehouse, Tudway, Look and Stenfert Kroese et al. (2006) reviewed, as was discussed previously; the therapeutic need to distinguish between cognitive deficits and distortions. Stenfert Kroese and Thomas (2006) reported in a case study the successful treatment of post-traumatic nightmares using imagery retrieval therapy as a component of CBT. Jahoda et al. (2006) have examined the role of life experiences influencing the self-perception of individuals with ID as follows, the correlated increased vulnerability to depression in this population, the mediating role of cognitions which could be therapeutically identified and reframed in CBT. Dagnan and Jahoda (2006) have used the diagnosis of social phobia to demonstrate the impact of social context on the core thought schema of individuals with ID. An emphasis on the critical need to modify mainstream cognitive models of mental health problems to incorporate issues such as stigma, social-economic status, and self-determination was highlighted.

Methodological challenges to the presentation of CBT were also reviewed including, issues of capacity and consent, the ongoing need to refine and optimize methods of the assessment of presenting psychopathology, and the appropriate role of promoting performance and research studies. In addition, clinical challenges including the need for more opportunities for advanced training for clinicians, the lack of studies addressing the validity and reliability of assessment tools, the lack of stable research and infrastructure funding, and the ability to establish clinical trials to demonstrate with sufficient statistical power the efficacy and effec-

tiveness of CBT in individuals with ID and ASD was openly acknowledged. All of these issues are particularly germane to people with ASD, constituting a spectrum of individuals with core similarities but significant variations in sensory profiles, cognitive strengths and styles, and co-morbid mental health concerns. All of these issues are highlighted in our case study which stresses the need for bio-psychosocial assessments, the need to reformulate the diagnosis if the individual appears treatment refractory, the limitations of support programs primarily based on the use of psychotropic medication and containment, and a relative systemic absence of knowledge regarding the vulnerabilities of abuse experienced by individuals with ASD. Skilled clinicians however have published practice-based evidence regarding the provision of CBT to individuals with ASD to allow passionate and creative skilled clinicians to proceed therapeutically with compassion, while awaiting evidence-based practice. Gauz (2007) has emphasized the need to confirm an individual's acceptance and knowledge of ASD traits as a critical issue to consider before engagement in therapy. She stresses ten key antecedents and perpetuants the clinical presentation of individuals with ASD to be included in both a review of the appropriateness of CBT and combinations in the provisions of CBT as listed in Table 4.

Table 4. Considerations in the Provision of Psychotherapy to Individuals with ASD

Poor social skills and social insight
 A relative inability to understand emotions
 Sensory processing difficulties (seeking or avoiding behaviours)
 Alterations in executive function
 Isocratic learning—information processing styles
 Restrictive and repetitive interests
 Poor fine and/or gross motor skills
 Problems of emotional modulation
 Resistance to change and an inflexible cognitive style
 Difficulties in navigating transitions

(Gauz, 2007)

As therapists witnessing atrocities being perpetuated on the margins of our society with compassion, we need to make a commitment to listen carefully, to acknowledge what we hear and see, and to take action. We need to act with a vision to create a future better than the past and present experienced by those whom we support.

Our vision needs to be informed by the neuro-cognitive styles identified in individuals with ASDs, the impact of hypo and hyper sensory sensitivities on their perception of events, interpersonal relationships, their sense of self and their world views. We also need to honour the uniqueness which characterizes each individual with an ASD despite these commonalities.

There remains a need to embrace the fact that individuals with ASDs are at high statistical risk of developing CPTSD. Research leading to the development of standardized screening and assessment tools is needed to improve diagnostic reliability.

Emerging evidence of successful modifications to CBT in treating individuals with ASD and CPTSD offers the opportunity to conduct randomized trials to identify the essential components of the optimal treatment of this disorder in individuals with ASD.

Key Messages from This Article

Statement for people with disabilities: All citizens have the right to excellent care from people who provide them with support.

Statement for policy makers: Given the dramatically increased incidence of sexual abuse in individuals with Autism Spectrum Disorders, there is a critical need for funded research validating appropriate assessment and treatment approaches for these individuals.

Statement for Professionals: Knowledge of cognitive styles and sensory processing issues in individuals with Autism Spectrum Disorders is invaluable in the assessment of Complex Stress Disorder and modifications to Psychotherapy offered to these individuals.

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