Trauma-Focused CBT for Children with Autism:

A Treatment Manual

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Traumatic events such as abuse, bullying, and exposure to violence are commonplace among typically developing children and occur at least as often among those with autism spectrum disorder (ASD), though there is growing evidence that children with ASD are exposed to a variety of adverse childhood experiences at a higher rate than others (Berg et al., 2016; Hoover, 2015; Kerns, Newshaffer, & Berkowitz, 2015; Rigles, 2017). The majority of youth in the U.S. are exposed to at least one potentially traumatizing event in childhood, according to recent surveys (Kessler et al., 2009; Kessler et al., 2012). The most common among children and adolescents are the unexpected death of a loved one, man-made/natural disasters, and witnessing death or serious injury (McLaughlin, 2013). Child abuse and neglect occur at relatively high rates as well. The most recent estimate based on nationally gathered statistics suggests approximately 9.1 children per thousand in the U.S. experience at least one form of maltreatment each year (Child Trends Databank, 2015). While the rates of substantiated child abuse and neglect appear to be declining slightly, concerns about the number of unreported cases persist, suggesting that we may never know the absolute number of children exposed to maltreatment (Fallon et al., 2010).

Bullying, or peer aggression such as physical assault, threats, intimidation, ostracizing, teasing, or cyber-bullying (Wang et al., 2009) is another potentially traumatic experience for many youth. Recent estimates based on student reports suggest that between 10-33% of school-aged children have been victims of bullying (Hymel & Swearer, 2015). Bullying may be a particularly prevalent form of maltreatment for children with ASD. Prevalence estimates vary depending on time frames and reporters, but by all reports, children with ASD are bullied more often than peers with other disabilities and more often than non-disabled peers (Sreckovic, Brunsting, & Able, 2014), those with intellectual disabilities alone (Zeedyk et al. 2014), and their

typically developing siblings (Nowell, Brewton, & Goin-Kochel, 2014). One estimate summarizing data from a variety of studies (Storch et al., 2012) indicates that broad-scale parent and youth surveys report 44-77% of ASD youth being bullied within a one-month period, as compared to a rate of 2-17% in self-report surveys of typically developing youth (van Roekel, Scholte, & Didden, 2010).

Posttraumatic stress disorder (PTSD) is described in the DSM-5 as a syndrome arising from witnessing, directly experiencing, or being otherwise exposed to serious physical or sexual violence, threats to bodily integrity, or death of family members (American Psychiatric Association, 2013). The central symptom pattern comprises the following symptoms specifically related to the traumatic events: a) re-experiencing of traumatic thoughts or images through memories, dreams, or intrusive thoughts; b) avoidance of reminders or stimuli associated with the events; c) negative cognition and mood states; and d) alteration of physical arousal. Other types of adjustment difficulties, including impairment of relationships and attachment, persistent complex bereavement, or other culturally-related syndromes may fall in the DSM-5 Other Specified Trauma-and-Stressor-Related Disorder category while not meeting full criteria for PTSD (Goenjian et al., 1995; Perkonigg et al., 2005).

Trauma affects children differently at each stage of development and can interfere with the acquisition of developmental milestones (Lieberman, Chu, van Horn, & Harris, 2011; Trickett, Noll, & Putnam, 2011). Broad and long-lasting negative health effects have also been found in those exposed to trauma in childhood (Felitti et al., 1998). While males and females are exposed to violence and abuse at about the same rate (U.S. Department of Health and Human Services, 2015), there are gender differences in the expression of trauma-related symptoms. Males on average tend to display more externalizing behavior, and females tend to display more

internalizing behavior with heightened susceptibility to PTSD especially following sexual abuse (Darves-Bornoz, Choquet, Ledoux, Gasquet, & Manfredi, 1998; Evans, Davies, & Delillo, 2013; Walker et al., 2004).

Among those youth exposed to trauma or abuse, a minority develop trauma-related symptoms or full-blown PTSD. In a thorough review of well-conducted studies employing multiple informants, Alisic et al. (2014) estimated a full-PTSD diagnosis rate of 15.9% among youth exposed to traumatic events. This number varied based on gender and type of trauma. Least at risk for PTSD were males exposed to non-interpersonal trauma, while girls exposed to interpersonal trauma were found to be at highest risk for PTSD. Victims of bullying have also been shown to have a variety of negative short- and long-term psychosocial outcomes (McDougall & Valliancourt, 2015; Nanser et al., 2001) including suicidal ideation and attempts (Borowsky et al., 2013; Litwiller & Brausch, 2013; Pan & Spittal, 2013).

Trauma in ASD

Given the high percentage of traumatic exposures among youth, it is likely that a significant proportion of those with ASD have been exposed to potentially traumatizing events with resulting symptoms. Several factors may contribute to vulnerability for traumatization. Studies have found that children with ASD are more socially isolated, less accepted and liked by peers, and more often excluded and ridiculed (Carter, 2009; Rotheram-Fuller, Kasari, Chamberlain, & Locke, 2010). Children with ASD often lack the social support networks that have been shown to protect or buffer children from the effects of peer bullying (Bauminger & Kasari, 2000; Estell et al., 2009). They have been shown to become more angry and upset in response to bullying than typically developing children, which could lead to more targeted aggression directed toward them (Rieffe, Camodeca, Pouw, Lange, & Stockmann, 2012). This

response pattern is consistent with findings that ASD is commonly associated with general emotional dysregulation (Mayes et al., 2012; Samson et al., 2015). While some may question their awareness of ostracism or other types of social bullying, there is evidence to suggest that they are often keenly aware, but that higher functioning youth may be affected proportionally more than lower functioning youth (Loveland et al., 2001; Rowley et al., 2012; Shtayermman, 2007). Perhaps because of these developmental vulnerabilities, they show high rates of co-morbid anxiety and other emotional and behavioral problems (Konst & Matson, 2014; Simonoff, et al., 2015; Vasa et al., 2014). They may therefore be expected to have more significant emotional reactions to traumatic events.

There is some evidence that children with ASD show a higher incidence of PTSD and related symptoms in response to potentially traumatic events than their typically developing peers. For example, one study looking at the differences between children with and without ASD in an outpatient clinic found that children with ASD were exposed to fewer overall instances of traumatic events (26%) than has been reported in typically developing samples. However, the proportion of individuals diagnosable with trauma-related symptoms was considerably higher than the 20% range usually reported in the trauma literature (e.g., Copeland et al., 2007); as high as 100% among those who were multiply traumatized (Mehtar & Mukaddes, 2012). Children with ASD have been shown to have more suicidal ideation when teased and bullied (Mayes et al., 2013), and to display more depressive symptoms than non-ASD youth with similar levels of trauma exposure (Bleil Walters et al., 2013). In a recent review, children with ASD were shown across studies to respond to bullying with significant symptoms of anxiety, depression, suicidality, and severe anger. Those exposed to other forms of maltreatment and trauma were

found to have symptoms of PTSD, suicidal thoughts, and regression in adaptive functioning (Hoover, 2015).

Trauma Informed Treatment for Children with ASD

Joseph is a 12 year old boy who was diagnosed with ASD when he was a kindergarten student. He lives with his mother, stepfather, and two younger half-sisters in a large Midwestern city. Joseph has always been a cheerful boy who has positive relationships with his family members and a lifelong preoccupation with train engines, diesel trucks, and large machinery. He speaks in a very quiet tone and often fails to respond verbally when questioned about anything other than his special interests. Joseph has been known to have occasional tantrums and "meltdowns" when frustrated or surprised by changes to his routine. His usual bright demeanor has changed since an incident on the school bus, in which he was sexually fondled by three older boys over a period of several days. Since the incident, Joseph has been increasingly isolated, refuses to leave his home or go to school, has been wetting the bed at night, and his episodes of angry blow-ups have increased to a daily basis. It is only with great difficulty that his parents have been able to get Joseph to an outpatient clinic to receive evaluation and treatment for his trauma.*

Potential obstacles. Treatment strategies are needed to address trauma in the population of children dually diagnosed with ASD and PTSD. But this can be difficult. Not only do children with ASD respond differently, perhaps with more sensitivity to trauma than typically developing children, but they respond differently to treatment as well. One can expect that the youngster in the preceding vignette will have difficulty talking about what happened to him, may respond to evaluation measures with a different perspective or type of self-reporting than most typically

developing children, and may need more help with his conceptual understanding of trauma. His response to treatment will likely follow from and be consistent with core symptoms of autism.

DSM-5 (APA, 2013) ASD criteria are as follows:

Social Communication Symptoms (persistent deficits in all three of the following):

- Deficits in social-emotional reciprocity
- Deficits in nonverbal communicative behaviors used for social interaction, including difficulty understanding and using gestures and recognizing facial and other nonverbal cues
- Deficits in developing, maintaining, and sustaining relationships

Restricted Repetitive Behaviors (deficits in at least 2 of the following are required for diagnosis in addition to the Social Communication symptoms above):

- Stereotyped or repetitive behavior
- Insistence on sameness, inflexible adherence to routines, including extreme distress at small changes
- Highly restricted, fixated interests that are abnormal in intensity or focus
- Hyper-or hyporeactivity to sensory input

These symptoms are persistent, pervasive, and present from an early age, and impair everyday functioning (APA, 2013). Children and youth with ASD are much more prone to co-morbid psychiatric symptoms than those without ASD (Joshi et al., 2010). The most typical of these are sleep disturbance, specific phobias, agoraphobia, obsessive-compulsive disorder, depression, and ADHD (Mannion & Leader, 2013). According to the CDC study in 2008, approximately 40% of

ASD cases in childhood have co-occurring intellectual disabilities. Among those youth with both conditions, problem behavior is particularly common.

Language delays may get in the way of reporting abuse or expressing reactions to trauma (Cook, Kieffer, Charak, & Leventhal, 1993). Verbal expression and processing form a key part of most therapies for trauma in children, but may be difficult or impossible for children with ASD (Howlin & Clements, 1995). Some children with ASD are entirely non-verbal or lack receptive language comprehension. Those with intellectual or language delays may have limited ability to understand the concepts taught in evidence-based trauma treatments such as Trauma-Focused Cognitive Behavior Therapy (TF-CBT).

Strengths and resources of families with ASD. While there are particular challenges to treating children on the autism spectrum, these authors have found that it can be very successful as children and families with ASD often have unique strengths that lend themselves well to trauma treatment. There is solid evidence that these children respond well to CBT interventions for general anxiety; with some speculation that these interventions might be the best tolerated due to the rule-oriented, logical nature of ASD thinking (e.g., Chalfant, Rapee, & Carroll, 2006; Reaven et al., 2009).

In our clinical experience, the need for rigid routines and "sameness" may be helpful qualities for making use of treatment. Once children overcome initial resistance to a new setting or therapist, they build treatment into their routine and participate regularly. They easily go along with a pattern of providing "updates" about the previous week, move into treatment activities, and enjoy spending a few minutes at the end of the session relaxing or engaging with the therapist in activities related to their special interests. Such interests can also be a powerful motivator and enhancer of therapeutic interventions as long as they are not allowed to "hijack"

sessions excessively. For example, special interests and preoccupations can be used to make therapy concepts come alive for children with ASD and can reinforce their involvement. This pattern lies at the core of such interventions as Power Cards (Gagnon & Myles 2016) and Real Life Heroes (Kagan, 2017). Another treatment-related strength is the natural tendency of many children with ASD to take seriously and adhere strongly to written rules and schedules. We often find that children with ASD stick rigidly to expectations and carry out "homework" assignments more readily than do many typically developing youth. Furthermore, we have found that involving caregivers in treatment of children with ASD supports their learning inside and outside of session.

Adapting Treatment

The core deficits and associated features of autism make it important to adapt trauma-informed treatment models to make them effective for children with ASD (Moree & Davis, 2009). While no evidence-based treatment model specifically for children with ASD who have trauma-related symptoms has been developed, recommendations for adjusting TF-CBT for children with developmental disabilities have been discussed. Grosso (2012) highlights the need for sensitive assessment procedures using drawings, a "Rain Cloud Likert Scale," and support for completing standard scales such as the UCLA-PTSD Index. The TF-CBT treatment steps are discussed in detail with accompanying suggestions for adapting them for use with children who have a variety of disabilities. Also, Tallant (2010) makes many excellent recommendations for work with children who have ASD. Many of these ideas will be incorporated in this manual.

Another source of adaptations for use with trauma treatment can be obtained from models designed to treat children and youth on the autism spectrum who have general anxiety problems. PTSD has been assigned its own diagnostic category in the DSM-5, but its symptomatology

shares much with anxiety disorders. Evidence-based packages with documented efficacy for treating anxiety in children with ASD include:

- Coping Cat (McNally et al., 2012)
- Cool Kids (Chalfant et al., 2007)
- Facing Your Fears (Reaven et al., 2012)
- Behavioral Interventions for Anxiety in Children with Autism (BIACA; Storch et al., 2013)
- Building Confidence (Wood et al., 2009)

All of these packaged interventions are based on a CBT model of change and have many similarities. They all explicitly speak to the adjustments that are necessary to apply established treatment approaches to work with children on the autism spectrum. Summarizing the active ingredients of several of these approaches, Moree and Davis (2009) specified: a) the creation of disorder-specific hierarchies of goals and treatment, b) the use of concrete, visual tactics, c) incorporating the child's "special interests" or preoccupations, and d) parent involvement. This treatment manual incorporates many of these adaptations to work with traumatized children.

Trauma-Focused CBT

TF-CBT is a 12-16-session intervention designed for children ages 3-18 and their non-offending caregivers. It is arguably the most widely used and best validated treatment model for addressing childhood trauma. The model is built largely on a gradual exposure approach to reducing anxiety. Throughout the intervention clients are aided in developing skills for relaxation and coping as they prepare for and eventually face memories of their trauma (Cohen et al., 2006).

During the initial phase of treatment, the therapist provides psychoeducation about trauma exposure and traumatic stress and teaches a variety of stress-reduction skills such as deep breathing, muscle-tension relaxation, emotion identification and regulation, and cognitive coping. Caregivers also receive education and guidance on effective parenting skills and behavior management. A central component of TF-CBT —the trauma narrative— is implemented following the child's successful incorporation of the stress-reduction skills. The trauma narrative functions as a means of therapeutic exposure and facilitates emotional and cognitive processing of the event. The narrative involves identifying thoughts and feelings related to the event and correcting distorted beliefs or perceptions. After completion of the trauma narrative, the therapist helps prepare the child and caregiver to maintain future safety and healthy coping, and then initiates treatment termination.

The efficacy of TF-CBT has been demonstrated in a number of randomized controlled trials and has been deemed "supported and efficacious" based on current standards (Cohen et al., 2010). Significantly greater improvements in PTSD, internalizing symptoms, dissociation, sexualized behavior, and social competence in sexually abused children have been observed in children who received TF-CBT compared to wait-list controls and child-centered therapies (Cohen & Mannarino, 2015). Moreover, therapeutic effects of TF-CBT for sexual abuse have been maintained over 6, 12, and 24 month time periods (Deblinger et al., 1999; Deblinger et al., 2006). TF-CBT has also demonstrated effectiveness with children exposed to intimate partner violence of their caregivers (Cohen et al., 2011). A culturally adapted, group TF-CBT intervention proved beneficial for treating child soldiers and other war-affected boys in the Democratic Republic of the Congo (McMullen et al., 2013).

The model has proven efficacious even without the narrative component and at different treatment lengths (Deblinger et al., 2011). It appears that the full-length non-narrative variation allows for greater focus on parenting skills and may be most helpful for children with severe behavioral regulation problems.

TF-CBT has been successfully applied in a variety of contexts including community-based samples (Webb et al., 2014), and with Native American tribal populations (Bigfoot, 2010). Scheeringa et al. (2011) demonstrated in random controlled trials that the model can successfully ameliorate trauma related symptoms in children ages 3-6 years. Special accommodations have also been recommended for using TF-CBT with military families (Cohen & Cozza, 2012). Despite its proven usefulness in many areas and natural extensions for those with ASD, no clinical trials have been done to support its efficacy with this group.

Manualized Trauma Treatment for Children with ASD

The purpose of this treatment manual is to provide a standard set of adaptations to TF-CBT for children with autism as a basis for high fidelity intervention and clinician training. The adaptations are based on a combination of clinical recommendations (e.g., Grosso, 2012) and proven methods for treating anxiety disorders in children with ASD. This will allow the model to be tested empirically as a beginning to an evidence base that currently does not exist.

Development of this intervention started at the Center for Child and Family Traumatic Stress at Kennedy Krieger Institute (CCFTS), a pediatric outpatient treatment center specializing in trauma-informed care for the largely urban population of Baltimore City. The Horizons clinic was established at CCFTS comprising a group of social workers, licensed professional counselors, and psychologists who provide trauma-informed care to children identified as having

intellectual and developmental disorders. TF-CBT is a foundation intervention both at CCFTS and within the Horizons clinic.

To organize an effort to adapt TF-CBT to work with this population, a matrix table was formed with the steps of TF-CBT on one axis and core needs and deficits of ASD on the other axis. The resulting cells were completed based on clinical experience, literature review, and supporting audiovisual, activity suggestions, educational aids, and other materials obtained from sources designed to help children with ASD. The matrix forms the backbone of this treatment model and is continually being updated as materials are added from the ever-growing ASD literature.

The manual will proceed following the steps of TF-CBT, at each step describing commonly encountered challenges unique to ASD and recommended interventions and materials to address these. Many of the points in the intervention portion of this manual are very much consistent with what is done in TF-CBT with typically developing children and families. In order to apply the steps to children with ASD, it needs to be made more explicit and stepwise. At each step, the clinician must assess how the client's disability impacts the ability to make use of the TF-CBT intervention being considered. The intervention options provided in the manual range from specific (e.g., particular worksheet from an evidence-based packaged intervention) to general (e.g., the use of general behavioral principles), and they are to be used at the clinician's discretion based on their knowledge, experience, and understanding of their individual patient's developmental level and needs. At each step accommodations are needed to fit each client's unique sensitivities, preferred learning modalities, and conceptual capabilities, thus the clinician must be flexible in their approach to implementing these interventions. Further, we cannot assume that the child with ASD will intuitively understand and volunteer to participate in what is

being asked of them, and extra motivational aids are often needed to sustain cooperation in a difficult treatment process.

This manual is not meant to replace formal training in TF-CBT. Practitioners should first receive training and achieve some proficiency in the overall model before attempting to apply these adaptations for a specialized population. A free online course is available at www.musc.edu/tfcbt that can provide a beginning; further training can be accessed through local and regional training initiatives associated with the National Child Traumatic Stress Network www.nctsn.org and the CARES Institute www.caresinstitute.org/education.

Assessment of trauma in children with ASD

Maya is an 8-year-old girl of Latino heritage who has been diagnosed with ASD as well as a moderate range intellectual disability. She has significant speech articulation impairments making verbal communication almost impossible for most people who try to engage her in conversation. Her mother is able to understand her and often serves as an "interpreter." Maya witnessed several instances of violence when the family emigrated to the U.S. from a Central American country. In one episode, she was present when a close family member was robbed and shot. Maya has always displayed considerable anxiety and tended to avoid talking with people outside of her family. Since the shooting, she has become more anxious and hypervigilant. She worries about her mother's safety when she goes to work. Maya also reports having auditory hallucinations that began after the shooting episode. She does not speak openly about the potentially traumatic event.

In Maya's case, questions arise about whether and to what degree her symptoms are related to trauma or are due to her longstanding developmental delays and associated anxiety or

changes in her environment. Assessing trauma symptoms can be a challenge in ASD. Differential diagnosis is difficult because of confounding aspects of the developmental disability itself and other comorbid mental health problems. Language impairments, limited emotional expression, and a concrete thinking style may render the usual methods and measures useless or invalid. It is important to avoid the tendency for "diagnostic overshadowing," in which symptoms are overly attributed to the developmental disability rather than to real-life concerns or problems that arise from other sources (Levitan & Reiss, 1983; Meera et al., 2013). However, measurement of comorbidity is complicated. Some assessment instruments have been shown to successfully differentiate associated psychological syndromes in ASD. These generally consist of structured psychiatric interviews administered to parents and caregivers and include the K-SADS (Hepburn et al. 2014)) and the Anxiety Disorders Interview Scale (ADIS; Kerns et al., 2016). Using the K-SADS-E, Joshi and colleagues (2010) identified several cases of PTSD among a sample of children previously diagnosed with ASD. The ADIS has promise for other forms of anxiety assessment in this sample, but is not known to have been used for PTSD.

Other standardized questionnaire-based measures have proven useful for assessing trauma symptoms in a typically developing population, but these have not been applied particularly to children with ASD. These include but are not limited to the UCLA-PTSD Reaction Index (Pynoos & Steinberg, 2013) and Trauma Symptom Checklist (Briere, 1996). As with all measures, it is important to obtain input from a variety of sources. Most studies have concentrated on parent reports, which can provide valuable data, but it is particularly important to obtain children's own reports of their experiences, which are highly correlated with internalizing symptoms in ways that are not captured as well through caregiver reports (Adams et al., 2014; Becker et al., 2004). Children on the autism spectrum do not always respond in

predictable ways, may avoid specifically referencing trauma or feelings, and may need multi-modal inputs and opportunities for expression. They do tend to respond well to electronic devices and tablet-based teaching and assessment tools, which have been demonstrated to be effective with children who have ASD (van der Meer et al., 2012).

One engaging self-report instrument currently in development is a mobile app: The Interactive Trauma Scale for Children (ITS). The app is a diagnostic tool that is presented in a multi-modal, interactive format, administered by tablet or smart phone. Children of most developmental levels, beginning at approximately age 6, are prompted to create an "avatar" of themselves, and then given a series of True-False trauma exposure questions (e.g., "Were you bullied?" "Did you have someone bigger or older than you touch your private parts?" etc.). The child is then asked which experience troubles them the most. They are then led through a series of symptom-based questions (e.g., "I have bad dreams," "I feel angry," "I blame myself for what happened," etc.) to which they respond in a Likert scale format: "Never," "A little," "Sometimes," "A lot," "Always" by sliding a thermometer-like scale up and down. The items are displayed in picture form, in writing, and spoken aloud by the app. The responses are scored based on DSM-5 criteria -- re-experiencing, arousal, negative emotion, avoidance, dissociation, and overall trauma response. It is recommended that the UCLA-PTSD RI-5 parent report and ITS will be administered at the beginning of treatment, following the Narrative stage, and at the end of treatment to gage progress.

Using assessment to match the treatment to the client. Assessment is an ongoing process, not just a tool for initially diagnosing either developmental disability or trauma-related symptoms. For each TF-CBT step, the therapist is first asked to assess the degree to which adaptations are needed for the child and family. The amount or type of adaptation will vary

across the TF-CBT steps depending on the clients' personal strengths and difficulties. For some higher functioning children and youth, very little adaptation may be needed, or at least little adaptation at some steps, in order to make progress through that stage. For other children and families, much adaptation may be needed. As the clinician approaches each TF-CBT step, referencing past intellectual and other testing combined with careful observation, questioning, and accumulating experience with the family will inform a flexible clinical assessment of the client's skills and motivation. The specific accommodation or intervention follows from this assessment and further assessment is informed by the way the client and family responded to previous steps.

For example, in the case of Maya, the 8-year-old with ASD and intellectual delays described above, the therapist's review of her cognitive testing and difficulty discussing and understanding information at the Psychoeducation stage, suggests that she will have trouble identifying thoughts and feelings at the Affect Regulation stage. The therapist should approach Affect Regulation using concrete visual prompts about feelings in specific situations she often encounters (struggles with homework; going to bed at night) and designing a "toolbox" of affective coping skills tailored to her special interests.

ASD-MODIFIED TF-CBT

General principles. A few guiding principles which will be evident across all of the TF-CBT steps are needed to orient to working with children on the autism spectrum.

1. **Order and routine.** Children with ASD tend to thrive on schedules and routine, and often have difficulty with change. The clinician will observe that some children are resistant to coming to therapy sessions at first, and then after getting used to the therapist, setting, and

treatment structure, have no difficulty at all. They may have trouble terminating therapy for the same reason. The therapist can make use of the child's need for structure by building a routine within sessions and homework assignments. Families with a child who has ASD may be more likely to complete assignments sent home, than "neurotypical" clients for that reason.

It is helpful for sessions to follow a standard routine, fitted to the child and family's needs. The following is a sample session plan that works for many families:

i. Meet together with child and caregiver – start with "updates" of events or homework since the last session.

ii. Refer to visual schedule of the session with approximate timeframes for each aspect of the session.

iii. Move into TF-CBT step-specific work for the session, including use of workbooks, other therapy materials, and discussion of trauma-related material.

iv. Finish with a game, special interest activity, or relaxation activity of the child's choosing for the last few minutes of the session. This is the part of the session that can typically be done without the caregiver present.

2. **Generalization.** There is much evidence that children with ASD have difficulty generalizing skills gained in treatment sessions to novel situations outside of sessions (Radley et al. 2014). Clinical experience suggests that they have a hard time recognizing when to use the skills in the real world outside of the session. For example, after being taught to use sensory calming strategies for example, the child with ASD may not be aware enough of internal anxiety cues that would signal that it is time to use the strategies. Some teaching methods such as video modeling, have been shown to increase generalization in this population, precisely because it

aids generalization (Smith et al. 2016). At the Horizons clinic, we strongly encourage caregivers to attend all sessions for generalization purposes, to help kids with the concepts, and for integrating it with their own experience.

3. Language and perspective-taking. Children on the spectrum may not understand certain concepts. They may better understand if information is presented as non-interpersonal or in visual or multi-modal ways. Deblinger and colleagues (2011) suggest that the treatment provider slow down speech, use language that is comprehensible to the client, and present information one item at a time. Further, Attwood and Scarpa (2013) recommend the following to help with the language aspects of treatment:

- Understanding of concepts and strategies used in CBT may be improved by inclusion of relevant literature. When reading a text, there are no interpersonal skills involved.
- Use computer programs, demonstration, observation, and visual imagery.
- Due to difficulties with communicating inner thoughts and feelings, try using a communication system other than face-to-face conversation, such as email or text message during session.
- Use music or lyrics to explain inner thoughts and emotions, or create a drawing, cartoon, or collage.
- Provide very concrete examples and reduce the amount of abstract material (Wood & McLeod, 2008).
- Take frequent pauses during the session to check for understanding.
- Use visual aids to supplement verbal instruction.
- Use role playing and real-life practice assignments with hands-on learning.

4. Motivation and willingness. Researchers have discovered that people with ASD often have a tendency for focusing on proximal details rather than seeing the big picture, called the "weak central coherence" model (Olu-Lafe et al., 2014; Happe & Frith, 2006). This explains one reason why people with autism often have trouble seeing "the forest for the trees." They do not always immediately grasp the big-picture reasons for engaging in treatment or implications of not engaging. Also, they are less motivated by a desire to please parents or others. They many times need some motivational support to engage in therapy. Use of material reinforcers such as points, stickers, and a reward schedule can help them to stay engaged in the treatment work. They may only be able to tolerate relatively short sessions due to difficulty sustaining treatment interactions (Attwood & Scarpa, 2013). They may also be more successful if introspection is de-emphasized and the focus is placed on skill building (Deblinger et al., 2011).

5. Special interests. Most children with ASD have preoccupations with certain interests such as superheroes, videogames, electronics, or more esoteric interests like dinosaurs, U.S. presidents, weather patterns, road maps, etc. This focus on special interests has both pros and cons. On the downside, when a child discovers that the therapist will show an interest or willingness to listen, they may strike off into a litany of discussion about the interest. This has the potential to derail treatment sessions. The therapist has to learn how to respectfully and firmly help the child return to the subject of treatment. On the upside, special interests can be a highly motivating tool for engaging children in treatment. They can be used as reinforcers (i.e., time spent in therapy leads to time spent discussing or exploring the interest) or as a teaching tool. An example of the latter is psychoeducation about trauma using the language of the special interest (i.e., Thomas the Tank Engine lost his mother). The hard work is to make sure there is balance between use of the interest and putting it away and focusing on other things.

I. Steps of TF-CBT

The following steps match specific recommendations above with stages of TF-CBT to provide an adapted treatment. At each stage, the "clients" are considered to be both the child and caregiver(s), as adaptations may need to be made for either or both in treatment.

Psychoeducation and Parent Training

This step combines education of both the caregiver and child about trauma and its effects on the child and other family members. This begins the process of gradual desensitization of the child to the issue of trauma without going into the details of traumatic experiences. Caregivers may be just as traumatized by events as children and therefore may also need information and support as part of this gradual exposure practice. It is recommended that caregivers and children be seen together for psychoeducation, at least initially. This allows the caregiver to be exposed to the same concepts and educational materials as the child, thus increasing mutual understanding about trauma and reinforcing the value of skills practice later on. It is often valuable to follow up in individual work with the child, either in each session, or at strategic points in the therapy in order to provide the needed repetition and internalization of knowledge and skills.

Parent training sessions, usually conducted with the caregiver(s) alone, focus on improving the caregivers' understanding of behavioral principles as applied to their child who has both autism and trauma. Behavior problems may arise from experiences of trauma and are often the most disturbing aspect of a child's trauma response. Children with autism have been shown to respond in many cases to antecedent-based approaches rather than purely consequence-driven behavior modification methods. That is, an analysis of antecedents and setting events associated

with the behavior and designing interventions to take antecedents into account, can help decrease rigid, repetitive and challenging behavior (Stichter et al. 2009).

Petie was repeatedly physically bullied by older peers at his elementary school. He reported fear of being re-traumatized and would put up a verbal defense by approaching peers in an overly talkative, anxiety-driven manner, often reminding them of the rules of the school and classroom. Though he was usually correct in his identification of school rules, the behavior generally had the effect of increasing rejection and teasing by peers. Functional behavior analysis suggested that his over-talkativeness was based on anxiety about being the victim of further bullying as well as loneliness and desire to "bond with other kids." In treatment with Petie and his mother, he was taught to "read the signs" of peers who were likely to be friends and to focus his attention on them, while decreasing his volume of speech on the school bus. His mother was coached to remind him of this and provided a device with music and earbuds for him to listen on the bus. This effectively reduced the amount of his talking, confrontation, and negative attention he received from peers, and hence he had fewer angry disruptive episodes.

ASSESS:

a. Receptive and/or expressive verbal, and visual-spatial abilities.

- Do the clients know key terms inherent in this step (e.g., "trauma," "trigger," "physical, sexual, psychological abuse," "rewards and reinforcement")?
- Will the clients benefit from pictures and other visual and activity-based illustrations of trauma, its effects, and parenting skills?

b. Conceptual understanding.

- Do the clients understand the connection between having traumatic experiences and the signs and symptoms present in the child?
- Do the clients understand how the child's trauma might impact adult caregivers?
- Do the clients have good conceptual connections between descriptions and actual experiences and events (i.e., grasping concepts related to trauma and potential feelings, consequences, outcomes, interpersonal implications)?
- How much do the clients know and understand specific behavioral interventions, including Functional Behavior Analysis (FBA), use of antecedents, behavioral intervention plans, and social skills training?

c. Generalization skills.

- Are the clients able to recognize potentially traumatic situations or reminders of past traumas?
- Can the clients remember information that was presented in the Psychoeducation step?
- How able are caregivers to implement recommendations for parenting skills, including consistently tracking, reminding, and rewarding child's behavior?

d. Willingness and motivation.

- How willing and motivated are the clients to engage in therapy with an unfamiliar adult?
- How willing is the child to stop, think, and use relaxation skills before, during, or after a stressful trigger?
- What is the level of the caregivers' willingness to change parenting styles if needed?

INTERVENE:

a. IF verbal or visual-spatial skills require support:

- Modify vocabulary, teach key words with flashcards ("trauma," "trigger," etc.).
- Use books and stories in conceptual range (e.g., *A Terrible Thing Happened*; Holmes & Mudlaff, 2000*).*
- Use videos to illustrate parenting skills (e.g., time-out, calm voice, consistency).
- Use illustrations of trauma's impact on brain and body.

b. IF conceptual understanding requires support:

- Clearly explain the concepts of FBA and antecedents (i.e., behavioral triggers) to caregivers.
- Use third-party descriptions, stories, animal analogies, and apps.
- Directly address secondary trauma due to societal or community response (i.e., assumptions that because of the developmental disability the client has not been impacted by 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; Tallant, 2010).
- Be sure that all members of the treatment team are using the same language to address the trauma (Tallant, 2010).
- Caregiver's knowledge of ASD specific skills:
    - Provide psychoeducation about ASD and related behavior problems (e.g., rigidity, need for routine and structure, impaired social perspective taking and how that impacts child's willingness to follow rules and instructions;

executive functioning ability, receptive and expressive language contributions).

- Provide psychoeducation about antecedent (trigger-based) analysis. Identify with caregiver triggers and safety signals that are particularly relevant to child.
- Help design behavior intervention plan based on child's unique sensitivities, ASD related meltdowns, and misunderstandings.
- Introduce Carol Gray Social Stories (Gray, 2016) as a way of educating child about expected behavior in a variety of circumstances.
- Teach the Circles Curriculum using the Circles App (www.circlesapp.com) to help reinforce appropriate boundaries for a child who is sexually or physically acting out.

c. IF generalization skills require support:

- Use contingency charts and reminder charts that can be checked off and returned in following sessions. Therapist may need to have parallel charts; one for caregiver and one for therapist in case of loss or losing track.
- Offer a coping call, text, or e-mail during the week.
- Inform other support systems of the caregiver and encourage follow-up on parenting plan.
- Provide reinforcement for caregiver and enhance the parental role for example, by encouraging the caregiver to review the skills at home as if he/she were the therapist at home.
- Refer caregiver to a parent support group.

d. IF willingness and motivation require support:

- Move slowly into a warm-up stage: use activities and games to facilitate comfort in therapy setting. The therapist may consider incorporating the child's restricted interest, as long as the interest does not "hijack" the rest of the session.
- Show the steps of therapy on visual handout and check off the stages as you go.
- Stay in same therapy office each session; set up routine and consistency.
- Set up reinforcement contingencies: identify interests and activities that can be earned by participation in each session (e.g., time to view a video, play a game, have snack, do some physical activity) consistent with the child's interests.
- Use a point system or sticker chart.
- Refer caregiver to own treatment.

Relaxation

ASSESS:

a. Receptive and/or expressive verbal, and visual-spatial abilities.

- Do the clients understand key terms inherent in this step (e.g., "deep breathing," "relaxation," "tense," "stressed," and "breath")?
- Are the clients able to name parts of the body that might experience tension and identify how tension or body states "feel"?
- Will the clients benefit from pictures and other visual and activity-based illustrations of tension and relaxation?

b. Conceptual understanding.

- Do the clients understand the connection between relaxation and reduced feelings of stress and anxiety?

c. Generalization skills.

- Do the clients have the ability to remember skills taught in session?
- Do the clients have the ability to read cues that it is time to use relaxation?
- What is the caregiver's ability to remember, remind, prompt, and carry out thoughts-based plans at home and in the community?

d. Willingness and motivation.

- How willing is the caregiver to teach and reinforce relaxation skills at home and in the community?
- How willing is the child to stop, think, and use relaxation skills before, during, or after a stressful trigger?

INTERVENE:

a. IF verbal or visual-spatial skills require support:

- Use flashcards to teach key terms (e.g., "deep breathing," "breath," "relaxation," "tension, " "stress").
- Show pictures, illustrations, video examples of deep breathing and relaxation.
- Use cartoon face pictures before and after relaxation.
- Help the child watch the physical changes in his/her face during relaxation by using a mirror.

b. IF conceptual understanding requires support:

- Involve the parent (Tallant, 2010).
- Focus on day-to-day examples and do not become frustrated if the client does not understand right away (Tallant, 2010).
- Teach about the physiological symptoms associated with anxiety (e.g., racing heart, sweaty hands, etc.) instead of relying on the subjective emotional feeling, in order to help the child concretely identify when he or she is feeling anxious (Attwood & Scarpa, 2013).
- Demonstrate and lead a deep breathing exercise at the beginning of every session.
- Engage the child in "pizza breathing" (i.e., pretend you are using your breath to cool down a hot pizza).
- Teach progressive muscle relaxation for children.
- Identify sensory aids to relaxation (e.g., deep muscle massage, gross muscle movement, stress/Koosh balls, sound, smells, etc.) and/or set up sensory area.
- Create a "calming caddy" (e.g., a box full of coping skill objects, such as a stress ball, coloring utensils and coloring book, bubbles, etc.) .
- Create a sensory kit for relaxation (e.g., homemade stress balls, glitter jar, smooth worry stones).
- Worksheets and Books:
    - "Things I Like to do to Relax" worksheet from Facing your Fears (Reaven et al., 2011, p. 48).
    - Normalize worrying with "How I React When I Worry" worksheet from Facing your Fears (Reaven et al., 2011, p. 9).
    - Me Moves Program (thinkingmoves.com).

- Ursula unwinds her anger (Sargent, 2014).
- Use Lazy 8 breathing and Six Sides of Breathing from Zones of Regulation (Kuypers, 2011).
- Use the Calming Sequence from Zones of Regulation (Kuypers, 2011).
- The survival guide for kids with ASD (and their parents) (Verdick & Reed, 2012).
- Create a relaxation flip book.
- Use a relaxation script.

- Apps and Vidoes:
  - Younger children: Elmo Belly Breathe video.
  - Younger children: "Breathe, Think, Do with Sesame" by Sesame Street Workshop Apps.

c. IF generalization skills require support:

- Use Schedule for Calming and/or Relaxing Activities from Facing your Fears (Reaven et al., 2011 p. 68).
- Create a reminder chart with both the child and caregiver.
- Create a visual schedule of reminders for use of relaxation skills.
- Find out how the child relaxes currently (e.g., TV, video games, physical activity) and discuss how it might apply to situations where those strategies are not available.
- Switch item from pocket to pocket to count how many times relaxation is used. For example, decide with the child that he/she will practice a relaxation skills 5 times per day. To keep track, start the day with 5 pennies in his/her left pocket.

Each time she practices the relaxation skill, she moves one penny into her right pocket.

- Create a home routine for meditation, yoga poses, prayer, and/or breathing. For example, upon arrival home from school or just before bedtime.
- Schedule a text check-in between the clients and clinician during week.

d. IF willingness and motivation require support:

- Remind the clients how little time the strategy actually takes (Reaven et al., 2011).
- Reinforce relaxation time with points and rewards.
- Reinforce use of relaxation when upset to calm down.
- Engage the caregiver in relaxation activities of their choosing for the purpose of modeling for the child.
- Schedule caregiver-only sessions to practice relaxation and gain commitment
- Refer the child and/or caregiver to yoga and/or mindfulness classes.
- Refer the caregiver to a local support group.

Affect Expression and Modulation

ASSESS:

a. Receptive and/or expressive verbal, and visual-spatial abilities.

- Do the clients understand central key terms including names of feelings (happy, sad, disappointed, scared, etc.)?
- Would the clients be helped by visual illustrations of emotions and emotion management?

b. Sensory differences.

- Do the clients have hyper- or hypo-sensitivity to sensory inputs that need to be considered in designing interventions?
- Do the clients have preferred ways to manage sensory issues if they exist?

c. Conceptual understanding.

- How well do the clients identify feelings in themselves and others?
- What are the clients' understanding of emotional expression, emotional response, body response, and the positive effects of managing one's emotions?

d. Generalization skills.

- How able are the clients to remember affect regulation skills?
- What is the client's' ability to apply techniques to manage self when they may believe that their response is justified or impossible to manage, or they are so sensitive to emotional input that it overwhelms thought and coping response?
- What is the level of the caregiver's ability to remember, remind, prompt, and carry out affect regulation plans at home and in the community?

e. Willingness and Motivation.

a. How willing are the caregivers to teach and reinforce relaxation skills at home and in the community?
b. How willing is the child to stop, think, and use relaxation skills before, during, or after a stressful trigger?

INTERVENE:

a. IF verbal or visual-spatial skills require support:

- Improve emotional vocabulary (Attwood & Scarpa, 2013).

- Remark about the child's intellectual abilities and logical thinking abilities (Attwood & Scarpa, 2013).
- Use concrete visual tactics with emotional statements, social stories, and role-plays (Wood & McCleod, 2008) (e.g., www.wrongplanet.net).
- Make a physical emotional coping skills toolbox. For example, pull out a "hammer" with an emotional coping strategy on it, and a "screwdriver" with another strategy (Wood & McCleod, 2008).
- Use video modeling.
- Use computer-assisted programs to help children to learn facial expressions (Silver & Oaks, 2001; Tenaka et al., 2010; Beaumont & Sofronoff, 2013) (e.g. Barron Cohen "The Transporters" for age 6 and below).
- "Words for Worry Word Search" worksheet from Facing your Fears (Reaven et al., 2011, p.4).
- Quantify the degree of expression using a thermometer (e.g., "Steps to Success: Finding my Target" worksheet from Facing your Fears; Reaven et al. 2011).
- Make a scrapbook of thoughts and feelings (DeMars, 2011).
- "Check your Engine" from the Alert Program (Williams & Shellenberger, 1996).
- Create an anger map.
- Apply steps above to caregiver (i.e., concrete visual tactics, computer-assisted programs, quantification by thermometer, associate feelings with tangible objects, Alert Program).

b. If sensory differences require support:

- Obtain consultation from an occupational therapist about sensory hyper- and hyposensitivity.
- Use sensory aids to cope with immediate affective reactions, such as squeezing a stress ball, touch, deep massage, physical activities, and aromatherapy.
- Implement sensory breaks to separate from overwhelming inputs such as noise, bright lights, and interpersonal inputs.
- Examine sensory "triggers" to affect regulation problems through use of FBA for antecedents of blow-ups and meltdowns.

c. IF conceptual understanding requires support:

- Younger children: Sesame Street Exploring Feelings videos.
- Younger children: "Breathe, Think, Do with Sesame" by Sesame Street Workshop Apps.
- Play Feelings Bingo.
- Create a bracelet with emotional coping skills on it (Wood & McLeod, 2008).
- Stress-o-Meter worksheet from Facing your Fears (Reaven et al., 2011).
- Create a visual reminder on a school binder (Wood & McLeod, 2008).
- Provide examples of scripting with fill in the blanks to improve communication (e.g., "When I …(yell), I am feeling…(angry), I need…(to be alone)." Or "When I…(cry), I am feeling ...(sad), I need…(a hug).").
- Use social stories (Gray, 2016).
- The Incredible 5-Point Scale: Assisting students in understanding social interactions and controlling their emotional responses (Buron & Curtis, 2012).

- Use a metaphor to make ideas more concrete, such as the metaphor of a toolbox full of tools to "repair" feelings or numerical rating to indicate the emotional intensity (Attwood & Scarpa, 2013).
- Zones of Regulation (Kuypers, 2011).
- The survival guide for kids with ASD (and their parents) (Williams & Shellenberger, 1996).
- "Check your engine" from the Alert Program (Williams & Shellenberger, 1996).
- Cool Kids ASD Program: Therapist manual and parent and child workbooks, which are designed for children (Grade 1- 6) who have anxiety and autism spectrum disorder (Chalfant et al., 2011).
- Use distraction-based substitution through a competing response.

d. IF generalization requires support:

- Visual prompts for caregiver (e.g., Boardmaker, visual schedule, phone reminders).
- Engage caregiver in relaxation activities of their choosing. Consider conducting caregiver-only sessions to practice relaxation and gain commitment.
- Refer child and/or caregiver to yoga or mindfulness classes.
- Mindfulness Based Stress Reduction caregiver group (e.g., Bazzano, et al., 2013).
- Use trackers or text check-in with clinician between sessions.

e. IF motivation and willingness require support:

- Help the child to identify with superheroes or models for managing affect. For example, Harry Potter can provide an illustration of how a perceived hero copes

with adversity, becoming a model of how to cope with feelings, such as anger, when being bullied or tormented by peers (Attwood & Scarpa, 2013).

- Use the child's special interests to motivate and teach. For example, if the special interest is weather systems, his emotions may be expressed as a weather report. If the special interest is trains, have the child conduct a project or field study to visit a station and observe the emotions of passengers saying farewell, greeting friends and relatives, and waiting for a ticket. If special interest is cars, create a "Feelings Parking Lot" using little cars as they pull into each "parking space" that has an emotion or coping skill written in it (Attwood & Scarpa, 2013).
- Use colored candies to represent emotions and coping skills (e.g., M&M's: red is angry, brown to show how to breathe when feeling angry, green to show one calming activity, yellow to say one thing that makes you excited, blue to say one poor choice you made when you were angry and what you could have done differently, orange to say a good choice you made when you were angry).

Cognitive Coping

ASSESS:

a. Receptive and/or expressive verbal and visual-spatial abilities.

- Do the clients understand key terms inherent in this step ("thoughts vs. feelings," "mind," "brain," "thought glitches," "thought challenging," "negative thoughts," "positive thoughts")?
- Will the clients respond best to verbal explanations, visual illustrations, or a combination of both?

b. Conceptual understanding.

- At what level do the child and caregiver understand the connection between thoughts, feelings, and the purposes of cognitive coping?
- What are the clients' awareness of their own thoughts?
- What are the clients' understanding of the relationship between thoughts, feelings, and actions?
- How accurately can the clients understand Theory of Mind concepts (e.g., accuracy of self-reflection about thoughts; Baron-Cohen, 1989)?
- What are the clients' abilities to challenge their own thought process?

c. Generalization skills.

- What are the clients' abilities to remember skills taught in session?
- What are the clients' abilities to read cues that it is time to use cognitive techniques?
- What is the caregiver's ability to remember, remind, prompt, and carry out thoughts-related plans at home and in the community?

d. Willingness and motivation.

- How able is the caregiver to teach and reinforce cognitive coping skills at home?
- How willing is the child to "stop and think"?
- Are there impulse control problems that preclude cognitive reflection in the moment?

INTERVENE:

a. IF verbal or visual-spatial abilities require support:

- Define and practice key terms using Boardmaker or flash cards (e.g., “thoughts,” “feelings,” “brain,” “mind,” “thought glitches,” “thought challenges,” “negative thoughts,” “positive thoughts”).
- Use thought bubbles to illustrate types of thoughts.

b. IF conceptual understanding requires support:

- Use cognitive-behavioral triangle (i.e., thoughts, feelings, actions) with visual illustrations of each point.
- Use cognitive-behavioral diamond or cross-bun model (i.e., thoughts, feelings, physiological changes, actions) with visual illustrations of each point
- For a hands-on activity, create a baseball diamond using the cognitive-behavioral diamond. Each base is labeled with one of the concepts (i.e., thoughts, feelings, physiological changes, actions), and use example scenarios to provide opportunities for the child to determine which “base” to move toward.
- Make a game of “truth or fiction.”
- Use the “TF-CBT Triangle of Life” app Allegheny Health Network.
- Create characters to represent healthy and unhealthy thinking. For example, use the “The ‘What are you Thinking?’ Team” and “Healthy Thinking Team” worksheets (https://apsac.memberclicks.net/assets/documents/2014institutehandouts/institute%203%20take%20two%20cognitive%20processing%20advanced%20clinical%20strategies.cognitive%20work.pdf).
- Create poison-antidote thought bubbles.
- CBT Animals: https://www.teacherspayteachers.com/Product/Filtering-Fish-CBT-Animals-Freebie-Cognitive-Distortions-2002023.

- Make a physical cognitive-coping toolbox to pull out a “hammer” with a cognitive coping strategy on it, and a “”screwdriver”” with another strategy (Wood & McLeod, 2008).
- Create a Jacob’s Ladder and write down positive self-talk on sticky notes, then place under the ribbon on one side of the ladder, and put negative self-talk on sticky notes on the other side.
- Make thought bubbles using materials to take the focus off of abstract concepts (Wood & McLeod, 2008).
- Create cartoon scenarios to show cognitions (Wood & McLeod, 2008).
- Teach clients to “mind read,” which is the ability to read the nonverbal cues that indicate the emotions or intentions of others (Attwood & Scarpa, 2013).
- Use the concept of Worry Bugs to develop the idea of smashing or “not feeding” the worry bugs (Irvine & Green, 2014).
- Develop Helper Bugs to externalize worries and anxiety from Facing Your Fears worksheets (Reaven et al., 2011).
- Use worksheets from various sessions of Facing your Fears (e.g., session 3, 5 & 6; Reaven et al., 2011).
- Instead of anticipating the child to generate spontaneous solutions, encourage flexible thinking, such as by asking, “what else could you do?” and providing multiple-choice options (Attwood & Scarpa, 2013).
- Provide suggestions for helpful thoughts and calming activities (e.g., Facing your Fears; Reaven et al., 2011).

- Promote understanding of the thought/reality distinction (i.e., just because we have thoughts does not mean they are "real" or "true").

c. IF generalization skills require support:

- Create a cognition/brain wall chart for home.
- Provide opportunities for "stop and think" practice and role plays.
- Use visual reminders for "stop and think," such as drawing or printing a red stop sign and securing it to a pencil.
- Use the "Incredible 5-point Scale" to promote flexible thinking in real-world situations and reflect after incidents of concrete or "sticky" thinking (Buron & Curtis, 2012).

d. IF willingness and motivation require support:

- Use the child's special interests (e.g., Power Cards; Gagnon, 2001, visualize a hero using cognitive coping to solve an emotional problem).
- Use video modeling (Charlop-Christy, Le, & Freeman, 2000; Bellini & Akullian, 2007).

Therapeutic Trauma Narrative

ASSESS:

a. Receptive and/or expressive verbal vs. visual-spatial abilities.
    - Will the client be better able to complete a narrative in verbal or visual format?
    - What kinds of support will the client require to complete a narrative (e.g., translator, keyboard, art materials, breaking task into small pieces)?

- Is the client able to tell a personal story?

b. Conceptual understanding.

- Do the clients understand the purpose and helpfulness of producing a trauma narrative?

c. Willingness and motivation.

- Does the caregiver support the idea of the narrative and encourage the child to do this step in treatment?
- Does the caregiver have personal trauma or other issues that reduce willingness to support or listen to the narrative?

INTERVENE:

a. IF verbal or visual-spatial abilities require support:

- Work at a slow pace and take breaks. Try one sentence at a time.
- Have the child dictate the narrative to the therapist or use recorder if writing skills require support.
- Get creative. Create songs, raps, drawings, painting, coloring, chapter books, PowerPoint presentations, video, photos, collages, etc.
- Make the narrative into the child's autobiography and use a template to prompt for information (e.g., my name is... when I was in X grade a bad thing happened...). Try www.lifestoryworks.org for examples and templates.
- Trauma Narrative may not be necessary for treatment progress. For example, consider not doing narrative if child is non-verbal or unable to understand or respond to the concept of narrative (Deblinger et al. 2011).

b. IF conceptual understanding requires support:

- Use books or examples of narratives to teach the concept to client and caregiver. These might include: A Terrible Thing Happened; templates and ideas from Lifestory Works.

c. IF willingness and motivation require support:

- Use Power Cards to facilitate creating the narrative or refer to other heroes or interests, (e.g., Harry Potter and his traumatic story, Batman's early childhood loss).
- Work with the caregiver or refer for own treatment to address resistance to the narrative.

In-Vivo Desensitization

ASSESS:

a. Receptive and/or expressive verbal and visual-spatial abilities.

- Do the clients understand key terms inherent in this step (e.g., "fear," "worry," "anxiety," "exposure," "face your fears")?
- Will the clients best respond to visual explanations, diagrams, prompts?

b. Conceptual understanding of desensitization.

- Do the clients readily understand the applicability of gradual exposure?
- Do the clients understand the distinction between reality and fantasy?
- Do the clients understand the difference between thoughts and feelings?

c. Generalization skills.

- Do the clients remember to carry out "homework" assignments?

- Will the clients remember and respond to visual schedules, calendars, and prompts?

d. Willingness and motivation.

- Are the clients able to see the "big picture" about how in-vivo practice might be helpful?
- How does the child respond to reinforcers?
- How able is the caregiver to reinforce the child's follow-through on difficult in-vivo practice?

INTERVENE:

a. IF verbal or visual spatial abilities need support:

- Define and practice key terms using Boardmaker or flash cards (e.g., "anxiety," "triggers," "avoid," "face your fears").
- Use roller coaster visual analogy for anxiety gradient.
- Provide concrete example of a fear hierarchy, such as a ladder (e.g., Reaven et al., 2011).

b. IF conceptual understanding of In-Vivo needs support:

- Use roller coaster explanation or comparable explanations depending on the child's interests (e.g., Spiderman's fear of heights, Thomas going up steep hills, video game overcoming difficult levels).
- Use Stress-o-Meter (Reaven et al., 2011).

- Use live or video modeling. Make the In-Vivo practice into the child's own movie for video feedback (e.g., Facing your Fears session 7, which provides an example script; Reaven et al., 2011).

c. IF generalization skills need support:

- Build desensitization hierarchies outside of the office (e.g., school, home, community).
- Create a homework checklist or practice calendar/schedule.
- Coach caregiver in the importance of in-vivo practice.
- Use tech-based reminders – phone, text, etc.
- Use negative reinforcement (i.e., one of the child's chores is removed if he completes his therapy homework).
- Use the Premack Principle, or "Grandma's Rule." For example, "If you complete your homework, then you can have time to play videogames."

d. IF willingness and motivation need support:

- Use a point-based positive reinforcement system based on successful steps of the In-Vivo process.
- Explore caregiver's motivation and understanding of In-Vivo practice.
- Use the child's special interest. For example, use Power Cards, stories of interest or hero engaging in in-vivo (e.g., Spiderman swinging from trees first before moving to tall buildings).
- Use video and live modeling.

Enhancing Safety Skills

ASSESS:

a. Receptive and/or expressive verbal and visual-spatial abilities.
    - Do the clients understand key words inherent in this step (e.g., “safe,” “tell someone,” “danger,” “boundaries,” etc.)?
    - Are the clients able to read written safety signals in the environment (e.g., stop signs)?
    - Will these clients remember and respond to visual schedules, calendars, reminders, and prompts?
b. Conceptual understanding of safety.
    - Are the clients able to recognize unsafe environments (e.g., situations in which re-victimization might occur) and the difference between safe and unsafe?
    - Do clients recognize the need to promote safety?
    - Do clients expose themselves to unsafe situations through behavior?
    - Are clients able to anticipate possible unsafe situations before they have happened?
    - Are the clients able to identify safe and unsafe people?
c. Generalization skills.
    - Do the clients remember psycho-education?
    - Will the clients make use of charts and reminders?
    - Will the clients recognize situations outside of therapy that require the use of coping skills?
d. Willingness and motivation.

- Do the clients believe that it is important to maintain safety?
- How motivated are the clients to improve their situation or their child's situation?

INTERVENE:

a. IF verbal or visual-spatial abilities require support:
    - Define terms using Boardmaker or flash cards (e.g., "safe," "unsafe," "stranger danger," etc).
    - Use visual cues as reminders for safety (e.g., Boardmaker).
b. IF conceptual understanding needs support:
    - Use Let's Talk About Taking Care of You (Stauffer & Deblinger, 2005) book and handouts.
    - Read No-No and the Secret Touch: The Gentle Story of a Little Seal who Learns to Stay Safe, Say "No," and Tell! (Patterson et al. 1993).
    - Use the Circles Curriculum for teaching personal boundaries.
    - Use the Red Flag Green Flag Personal Safety Curriculum (Rape and Abuse Crisis Center, 2008).
    - Use Social Stories (Gray, 2016) about safety.
    - Use Comic Book Conversations (Gray, 1994) about safety.
c. IF generalization skills need support:
    - Construct home and school reminders.
    - Implement daily check-ins at home about safety skills.
    - Use safety skills check-off lists and/or written safety plans.
    - Use video modeling of people ignoring safety signals.

d. IF willingness and motivation need support:

- Use Power Cards to promote social skills of children with ASD by capitalizing on their special interests.
- Use reinforcement contingencies established for following the safety plan.

RECOMMENDED SUPPLEMENTAL THERAPY MATERIALS

Books:
A Terrible Thing Happened
Let's Talk books (http://hffbooks.com/Lets_Talk_Book_Information.html)
ASD and Me
NoNo and the Secret Touch
The survival guide for kids with Autism Spectrum Disorders (and their parents)
Ursala Unwinds Her Anger

Apps and Device/Computer Based Materials:
Boardmaker www.boardmakeronline.com
Lifestory Works www.lifestoryworks.org
Secret Agency Society www.sst-institute.net
Triangle of Life app

Programs:
Alert Program (www.alertprogram.com)
CBT Animals: Stories and Worksheets to Teach Children about Cognitive Distortions.
Circles Curriculum (www.stanfield.com/product/circles-curriculum-bundle-w1037-3/;www.circlesapp.com)
Comic Book Conversations
Cool Kids (https://shop.centreforemotionalhealth.com.au/product/cool-kids-asd-program/)
Facing Your Fears
Power Cards
Real Life Heroes (www.reallifeheroes.net)
The Incredible 5-Point Scale
Social Stories
Superflex (www.thinksocial.com)
Worry Bugs. Irvine, J. & Green, A. (2014). Helping young worriers beat the worry bug: A practical and fun-filled guide of therapeutic ideas and activities. USA: Monsters in My Head, LLC.
Zones of Regulation (www.zonesofregulation.com)

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TF-CBT Component	DSM-5 ASD symptoms & related concerns		
	Persistent deficits in social communication and interaction	**Restricted, repetitive patterns of behavior, interests, or activities**	**Other Concerns Typically Experienced by Children with ASD (e.g., Executive Functioning, Anxiety, Poor Handwriting, etc.)**
General Recommendations for all TF-CBT Components	• Include relevant literature[DH1]. • Use computer programs, demonstration, observation, and visual imagery • Email or text message for communication[DH2] • Use music or lyrics • Create a drawing, cartoon, or collage • Reduce the amount of abstract material • Take frequent pauses to check for understanding • Use visual aids • Role plays • Real-life practice assignments • Hands-on learning • Provide cues to cut off tangents[DH3] • Shorten sessions • De-emphasize introspection and focus on skill building • Slow down your speech and use language that is comprehensible to the client • Present information one item at a time	• Use the Suppression Method[DH4] • ABA-related strategies • Referral for ABA services • Habit Reversal Training[DH5] • Role plays • Behavioral rehearsal • Practice in real-life situations • Social story[DH6] • Use a specific schedule of activities for the session • Use a frequent schedule of reinforcement and rewards (e.g., Token economy with stickers, points, stars, coins, for following rules and completing activities • Use Premack Principle to reinforce non-preferred with preferred activities • Incorporate special interests • Use interests and talent to improve motivation, attention, and conceptualization • Power Cards[DH7]* • Lighting may need to be dimmed • Smells, such as perfumes or deodorants, may need to be minimized • If snacks are provided, texture and taste need to be considered • Ask before engaging in any physical gestures • Calming music or sounds for clients who are oversensitive to auditory stimulation • Use a fidget toy • Use multisensory input	• Referral for medication • Highlighting material • Graphics or visual aids • Clearly posting rules • Repeat instructions and material • Provide visual schedule • Regularly monitor and give feedback to maintain attention • Minimize environmental distractions • Allow time to practice new skills • Do not assume that information will generalize to new situations, work explicitly on generalization to other environments • Encourage any suggestion without criticism • Adopt a positive approach about mistakes, "we learn more from our mistakes than our successes." • Remark about the child's intellectual abilities and logical thinking abilities • Use video modeling[DH8] • When using a workbook, the clinician can be the scribe • Set aside time at the end of each session to exchange information with the parents regarding the child's responses and abilities during session, explain the project, seek information • Encourage family members to respond positively and appropriately to the child's new abilities

Psychoeducation / Parenting	• Provide psychoeducation regarding social skills to parents to practice at home • Refer to Parent Support Group • Teach caregiver mindfulness skills • Teach caregiver to "resist worry" instead of anticipating what could go wrong • Use concrete examples to show how much time someone spends worrying (Facing your Fears p.14-18) • A Terrible Thing Happened* • What Do You Know Game* •Assess for secondary trauma due to societal or community response • Use consistent trauma-related language across all members of the treatment team		• Parents are often more aware of the child's anxiety than the child is, so helping the parent understand the impact of their own feelings would be beneficial, specifically helping them understand that parental stress lowers parental confidence.
Relaxation	• Visual imagery • Teach child about the physical symptoms associated with anxiety • The survival guide for kids with ASD (and their parents[DH9]) • Ursula unwinds her anger[DH10] • Normalize worrying (Facing your Fears "How I React When I Worry," p.9) • Use day-to-day examples • Don't become frustrated if the client does not understand right away • Involve the parent • Relaxation flip books	• Deep breathing • Muscle relaxation • Positive self-talk • "Schedule for Calming and/or Relaxing Activities" (Facing your Fears, p.30) • Make a Calming Caddy • Sensory kit for relaxation	• Externalize the worry and name the anxiety as something else in order to become the boss of it • You Are The Boss of Your Worry Workbook[DH11] • "Worry Bug" and "Helper Bug" (Facing your Fears, p. 20-22)

Affect Regulation	• Computer-assisted programs to help children to learn facial expressions • Improve emotional vocabulary (Facing your Fears "Words for Worry Word Search," p.4) • Quantify the degree of expression using a thermometer (Facing your Fears "Steps to Success: Finding my Target," p. 34) • Use a metaphor to make ideas more concrete, such as the metaphor of a toolbox full of tools to "repair" feelings or numerical rating to indicate the emotional intensity • Zones of Regulation[DH12] • The survival guide for kids with ASD (and their parents[DH13]) "Check your engine" (p. 196-200[DH14]) • Use social stories • Associate feelings with tangible objects (e.g., scrapbook of thoughts and feelings) • The Incredible 5-Point Scale[DH15] • "Check your Engine[DH16]" • Anger Map visual[DH17]	• Distraction-based substitution • Use competing response • Provide examples of scripting with fill in the blanks to improve communication (e.g., "When I …(yell), I am feeling…(angry), I need…(to be alone) or (e.g., "When I…(cry), I am feeling ...(sad), I need..(a hug). • Harry Potter can provide an illustration of how a perceived hero copes with adversity, • If the special interest is weather systems, his emotions may be expressed as a weather report •If the special interest is trains, have the child conduct a project or field study to visit a station and observe the emotions of passengers saying farewell, greeting friends and relatives, and waiting for a ticket • If special interest is car, create a "Feelings Parking Lot" using little cars as they pull into each "parking space" that has an emotion or coping skill written in it • Use colored candies to represent emotions and coping skills (e.g., M&M's: red- angry, brown- show how to breathe when you're angry, green- show one calm down activity, yellow- say one thing that makes you excited, blue- say one poor choice you made when you were angry and what you could have done differently, orange- say a good choice you made when you were angry.)	• Use concrete visual tactics with emotional statements, social stories, and role-plays (e.g., wrongplanet.net) • Make a physical toolbox with various tools inside labeled with different emotional coping strategies • Remark about the child's intellectual abilities and logical thinking abilities • Video modeling[DH18] • Create a bracelet with emotional coping skills on it • Create a visual reminder on a binder • Cool Kids ASD Program therapist manual, parent workbook and child workbook[DH19]

Cognitive Coping	• Teach to "mind read" or the ability to read nonverbal cues of emotions or intentions • Facing your Fears (sessions 5 & 6) • Make thought bubbles • Use cartoon scenarios to show cognitions • Use a Jacob's Ladder with positive and negative self-talk on sticky notes • "Triangle of Life" App*	• Cognitive picture rehearsal • Encourage flexible thinking: "what else could you do?" and provide multiple-choice options rather than anticipate the generation of spontaneous alternatives • Provide suggestions for helpful thoughts and calming activities (Facing your Fears p.53) • Use characters to represent healthy and unhealthy thinking (see "The Thinking Team" handout) • The Little Engine That Could* - examples of positive self-talk • Incorporate special interests	• Use social stories about cognitive restructuring (e.g., wrongplanet.net) • Make a physical toolbox with various tools inside labeled with different cognitive coping strategies • Create a bracelet with cognitive coping skills on it • Create a visual reminder on a binder
Trauma Narrative	• Determine if Trauma Narrative is necessary • Get creative (create songs, raps, drawings, chapter books, PowerPoint presentations) • Work at a slow-pace and take breaks • Try 1 sentence at a time • Make the narrative into the child's autobiography (www.lifestoryworks.org for examples and templates)	• May utilize a reinforcement system • Use Power Cards to facilitate creating the narrative[DH20]	• Make the narrative into the child's own movie for video feedback • Have the child dictate the narrative to the therapist • Use drawings • Make up a song • Go at a slow pace
In Vivo Desensitization	• Provide concrete example of a fear hierarchy (e.g., ladder, see Facing your Fears p.54-55)	• Provide a specific schedule, plan, and reinforcement systemt • Facing your Fears (session 7) • "Facing Fears Rating Sheet," (Facing your Fears, p.59)	• Use concrete examples of social phobia hierarchy • Provide social coaching by school staff, teacher, or parent • Make the In Vivo practice into the child's own movie for video feedback (e.g., Facing your Fears session 7)
Cognitive Processing	• "Triangle of Life" App*		

Enhancing Safety / Social Skills	• Training in conversational turn-taking • SuperFlex… A Superhero Social Thinking Curriculum[DH21] • You Are a Social Detective[DH22] • SSGRIN HFA (Social Skills GRoup INtervention for children with High Functioning Autism[DH23]) • The Survival Guide for Kids with ASD (And their parents[DH24]) • Circles Curriculum for teaching personal boundaries* • Red Flag Green Flag • Use a game like Simon Says to identify body parts • A Workbook About Taking Care of Me[DH25] • NoNo and the Secret Touch[DH26] • Thinking about you thinking about me[DH27] • ASD and me[DH28]	• Power Cards[DH29]	• Facing your Fears • Building Confidence Model[DH30]