CENTER FOR DEVELOPMENT & DISABILITY

Holding Multiple Perspectives: Assessment and Treatment in the Context of Culture, Autism, and Trauma in Young Children

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Early Childhood Evaluation Program

Infant Mental Health
Child-Parent Psychotherapy Program

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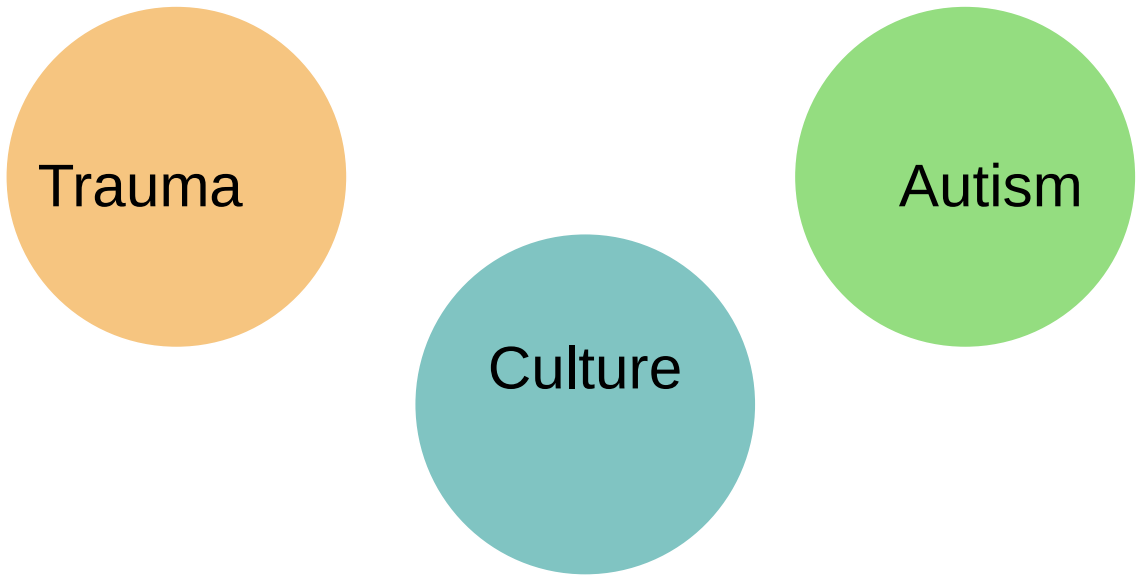
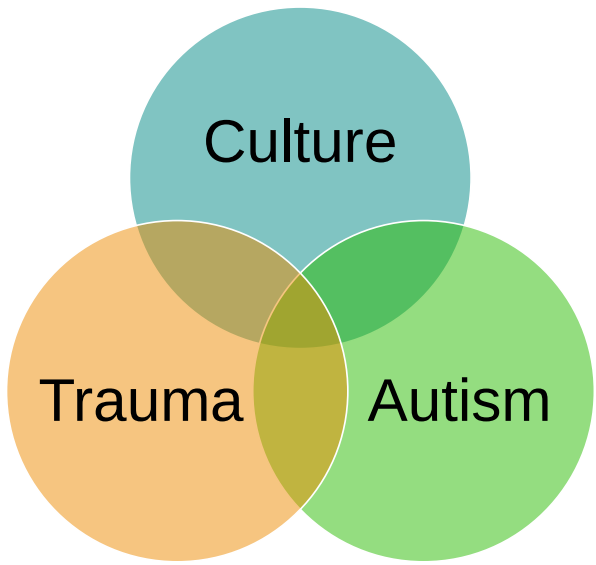
Objectives/ Learning Goals

- Describe 3 major factors contributing to the complex interplay of autism, culture, and trauma, and how these inform approaches to working with families.
- Identify at least 2 specific mental health needs of traumatized young children with autism.
- Describe an Evidence-Based treatment approach to mental health care for this population through a case study.

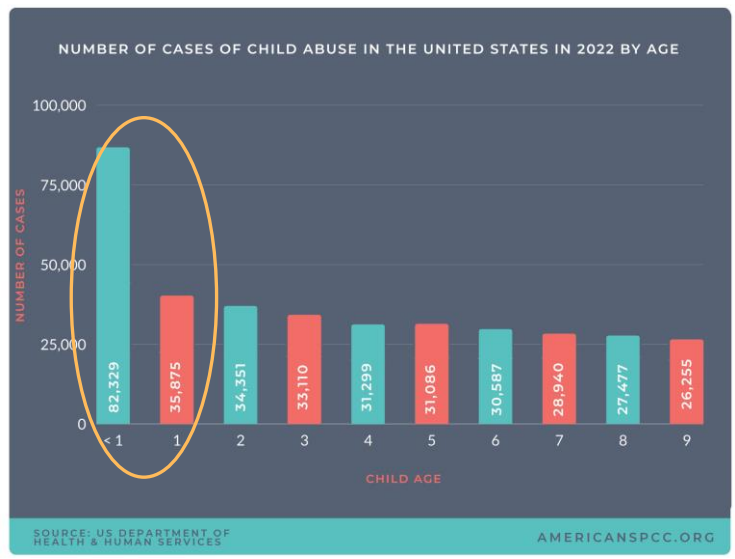

Trauma
Autism
Culture


Culture
Trauma
Autism

Understanding Early Childhood Trauma: Caregivers as the "Protective Shield"

- More than a quarter (27%) of child maltreatment victims are under 2 years old.
- Early exposure to trauma (ACES) linked to later chronic developmental, physical, or behavioral health disorders.
- Trauma experienced within context of primary caregiving relationship is most detrimental (Osofsky, 1995).
  - Impacts developmentally-appropriate belief that parent can provide safety.

https://www.nationalchildrensalliance.org/media-room/national-statistics-on-child-abuse/


NUMBER OF CASES OF CHILD ABUSE IN THE UNITED STATES IN 2022 BY AGE
100,000
75,000
50,000
25,000
0
NUMBER OF CASES
82,329
35,875
34,351
33,110
31,299
31,086
30,587
28,940
27,477
26,255
< 1
1
2
3
4
5
6
7
8
9
CHILD AGE
SOURCE: US DEPARTMENT OF HEALTH & HUMAN SERVICES
AMERICANSPCC.ORG

What Qualifies as a Traumatic Event?

- A “traumatic event is a frightening, dangerous, or violent event experienced or witnessed that is threatening to life or body integrity.”

- A traumatic event is defined by
  - Unpredictability
  - Horror
  - Helplessness
- That overwhelm the capacity to cope
- Trauma is pervasive but usually overlooked
- Perception of what is traumatic is shaped by competencies/resources

Systemic and Contextual Trauma: Current Challenges

- Communities facing increased structural discrimination, oppression, and barriers:
  - Disparities in access to treatment services, increasingly problematic as policies change day to day (e.g., Medical Deferred Action policy discontinued)
  - Families avoiding healthcare and evaluations due to immigration status
  - Funding changes, fear of losing access to insurance or Medicaid
  - Ongoing violence perpetrated on the community (e.g., government separation of immigrant children from their parents at the border)
  - Increasing ICE raids and unclear legal policies across different states
  - Provider fear, lack of efficacy/empowerment, and burnout
  - Talk of “registry” and increased concern about impact of an autism diagnosis; pejorative language (e.g., epidemic, cure, disease)
- **All in the background/foreground during clinical encounters with clients (for ourselves and for clients)**

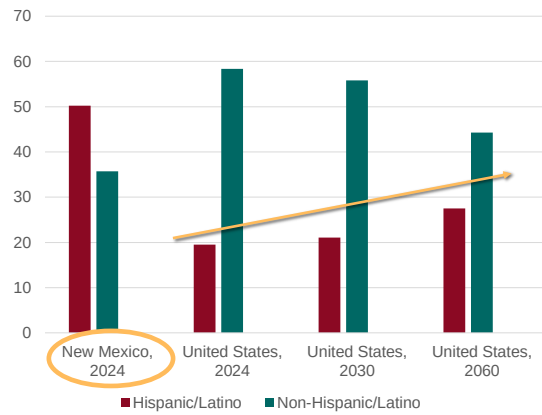
(https://www.nytimes.com/2019/08/29/us/immigrant-medical-treatment-deferred-action.html; Zuckerman et al, 2014; Lopez et al, 2008; CDC, 2022)

Approach to Understanding Cultural Context

- Latinx/Hispanic population is growing in the US and in New Mexico

Data from US Census Bureau; NM State DWS

- Importance of **intersectionality,** or bringing together multiple identities in varied configuration (Crenshaw, 1989).
- Culturally responsive care requires a **cultural humility** approach of ongoing learning (vs. *cultural competence* with an endpoint of something fully learned).



Latine/Hispanics and Trauma

- Higher PTSD prevalence in Hispanic groups, as compared to Caucasians (Hall-Clark et al., 2016).
- Hispanics report higher levels of interpersonal violence (e.g., being a child witness or adult victim of DV, experiencing child abuse) than Caucasians (Alegría, 2013).
- Hispanics underreport psychological symptoms, experience more somatic symptoms (Marshal & Orlando, 2002).
- Hispanics show differences in response during and right after trauma (Pole et al, 2015).
  - Higher rates of avoidance and numbing, serves to maintain PTSD symptoms.

Culture and Treatment Adaptation: Fidelity vs. Fit

Treatment outcomes improve with:

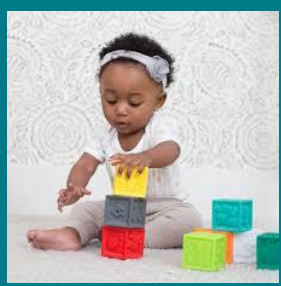
- Use of Evidence Based treatments
- Treatments that align with cultural norms, values, and beliefs of participants

How do we balance ***fidelity*** and ***fit?***

- Goal is appropriate flexibility to achieve fit→
  - Dilemma is how much can we flex treatment for cultural fit AND maintain beneficial outcomes?

(Garcia & Eiff, 2021)

Understanding Autism

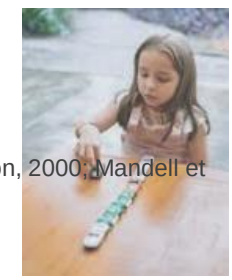


- In 2018, CDC reported 1 in 44 children in US dx with ASD.
  - 1 in 27 boys
  - 1 in 116 girls
- **In 2020, CDC reported 1 in 36 children in US dx with ASD**.
- Improving in identifying autism earlier
  - in 2020, children born in 2016 (4-year-olds) were **1.6 times** as likely as children born in 2012 (8-year-olds) to be identified as having ASD by 48 months of age.
- Boys are nearly 4 times as likely to be identified as girls
- **Approximately 1/3** of children with ASD also had intellectual disability
- In 2020, Black, Hispanic, and Asian or Pacific Islander children had a **higher percentage of ASD** than White children for the **first time**.

Understanding Autism and Culture

- 1 in 36 children in US dx with ASD (CDC, 2020).
- Recent improvement in identifying autism earlier BUT **Spanish speaking families diagnosed with ASD 2.5 years later**.
- In 2020, Hispanic and other BIPOC children had **higher rates of ASD** for the **first time**.
- Children with autism AND children of color are at increased risk for maltreatment and barriers to appropriate services.

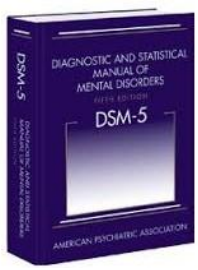
Crosse, Kaye, & Ratnofsky, 1993; Sullivan & Knutson, 2000; Mandell et al., 2005).



DSM-5 Criteria for **Autism Spectrum Disorder**

A. Persistent deficits in social communication and social interaction across multiple contexts

B. Restricted, repetitive patterns of behavior, interests, or activities



Increased Risk for Trauma

Studies on incidence of maltreatment/trauma and Autism:

- Incidence of maltreatment was **1.7 times higher for children with disabilities** than without disabilities (Crosse, Kaye, & Ratnofsky, 1993)
- School-based data showed 9% maltreatment prevalence rate for children without disabilities and **31% for children with disability diagnoses** (Sullivan & Knutson, 2000)
- Children with disabilities tend to be maltreated at younger ages (Sullivan & Knutson, 2000)

Increased Risk for Abuse and Neglect

- **1 in 5 children** treated at community mental health settings for Autism/ASD had experienced **physical abuse** (Mandell et al., 2005)
- **1in 6 children** experienced **sexual abuse** (Mandell et al., 2005)
- Disability may place child at higher risk for abuse/neglect OR maltreatment may cause or exacerbate disability

Why Higher Risk?

CHILD RISK FACTORS

High levels of dependence

Communication problems

Delayed skill development

Difficult to read attachment signals

Difficult to read emotional cues

PARENTAL RISK FACTORS

Psychosocial stressors

Difficulty reading cues

Difficulty reflecting on meaning of child's behavior

Own history of trauma, rejection, harsh discipline

Heightened sensitivity to child distress

Cultural barriers

Breakout Groups

For Providers

Think about the multiple identities of families or individuals with whom you work.

- How can these create barriers (or opportunities)?

In what ways can we create safety for individuals with multiple intersecting identities that bring discrimination or barriers?

For Families and Individuals

Think about your multiple identities, or those of people you know.

- How can these create barriers (or opportunities)?

In what ways have providers created safety for you around identities that can create barriers? Are there ways they can do this better?

Case Discussion

“Mateo” and “Maria”

- Child age: 3 years at evaluation; 3-4 years during treatment
- Language: Monolingual Spanish-speaking
- Ethnicity: Hispanic/Mexican
- Household composition – Mateo, Maria and two older sisters (5 & 10 years old)
- Referred for developmental/autism evaluation, by early intervention team
- Child US citizen, mother undocumented

Developmental Evaluation

- **Interdisciplinary team:** Psychologist, speech therapist, social worker (all bilingual and bicultural)
- **Assessment Measures:**
  - *Developmental Abilities Scale, Second Edition (DAS-II), Spanish* – Low Average
  - Childhood Autism Rating Scale, Second Edition (*CARS-2ST)* – Above cut-off for autism
  - *Vineland Adaptive Behavior Scale, Third Edition* – Delayed Socialization skills
- **Diagnoses:**
  - **Autism Spectrum Disorder** and **Developmental disorder of speech and language, unspecified**
- Following autism assessment, interdisciplinary team recommended additional trauma treatment

Approaches to working therapeutically with Hispanic families

- Appreciation of heterogeneity of culture within and between Hispanic groups
- Respecting cultural values of *Familismo, Simpatia, Respeto,* among others
- Understanding that “disease model” of ASD may not fit with how they see child
- ASD in country of origin may have different meaning and social consequences
- Appreciation of historical and current individual and systemic racism faced by the community (e.g., approaching conversations about documentation status).

National Child Traumatic Stress Network, 2007

Evidenced Based treatment: Child-Parent Psychotherapy (CPP)

"**The child-parent relationship remains the most parsimonious vehicle for improvement** even when the child has a constitutionally based condition such as autism." (Gosh Ippen, Norona, & Lieberman, 2014)

- Trauma-informed, play-based, dyadic intervention for children 0-6
- Addresses trauma, mental health, attachment, behavioral problems
- Can be tailored to address needs of children with ASD and developmental differences
- Emphasis on understanding impact and role of family's cultural context

(Lieberman, Ghosh Ippen, & Van Horn, 2015)

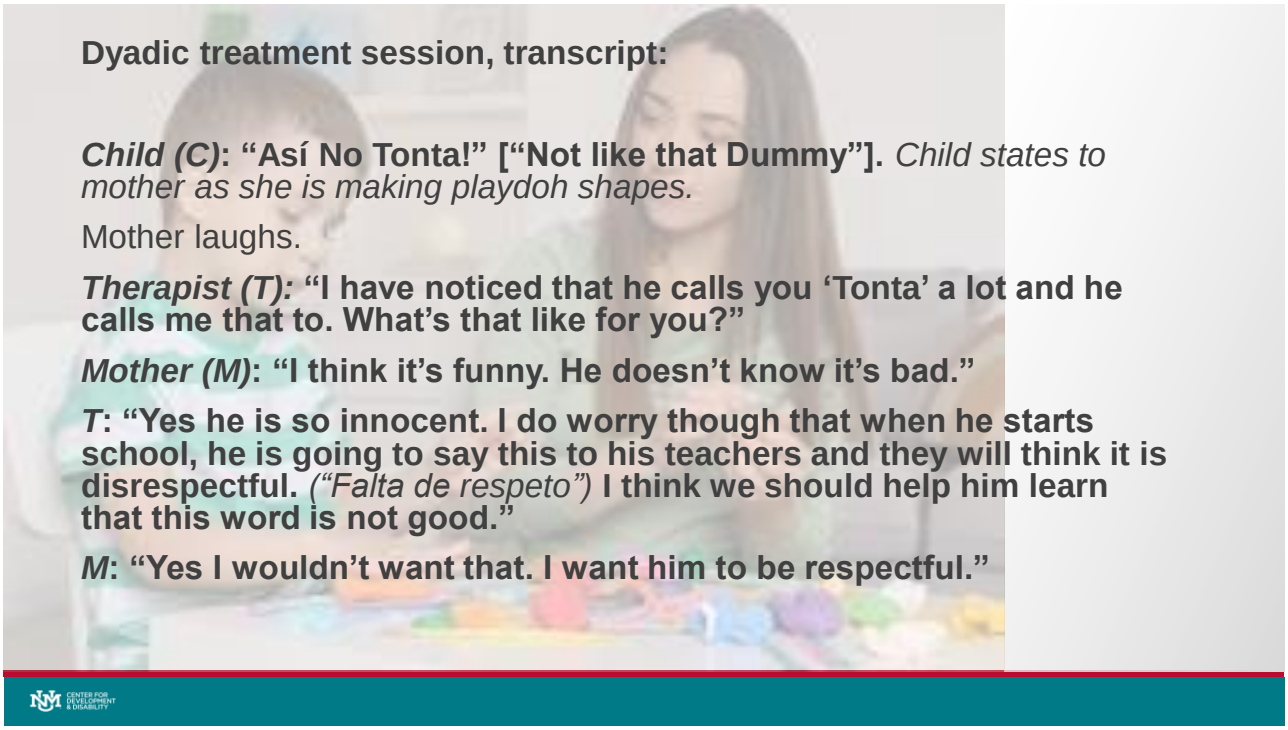
CPP Fidelity Compass: https://childparentpsychotherapy.com/providers/tools-and-resources/fidelity/

Mental Health and Relational Challenges

Child	Mother	Relationship/dyad
• Irritability • Difficulty accepting limits • Frequent tantrums • Aggression towards sibling and mother (verbal and physical) • Separation distress • High activity level and arousal • Limited attention span • Throwing toys	• Experienced ASD diagnosis as traumatic • Overwhelmed with new service systems, child's multiple medical appts • Difficulty reading and responding to child's cues • Difficulty taking child's perspective • Discipline practices tended be punitive • Re-enacting DV dynamics with father, directed to child.	• Parent/child relationship at-risk given history of trauma and ASD symptoms • Mother experienced child's presentation as difficult to manage; shared negative attributions, e.g. "*Enojón*" (angry/irritable boy) • Dyad often interacted as peers or siblings in their ability to manage conflict (e.g., "like an old married couple")

Risk and Trauma History

Mateo's Trauma History	Maria's Trauma History
• Exposure to domestic violence between mother and father (6 mo) • Parents separated - visited father on weekends (6 mo-38 mo) • Father deported to Mexico (39 mo) • Environmental conditions known to create "toxic stress" (0-present)	• Single parent, low wage job, living below poverty line • No family support • Immigrated to US at age 20 • Unexpected death of father (age 26) • Victim of domestic violence (age 27); separation from partner (age 28) • Child received ASD diagnosis (age 30) • Ex-partner deported to Mexico (31)



Dyadic treatment session, transcript:

***Child (C)*: "Así No Tonta!" ["Not like that Dummy"].** *Child states to mother as she is making playdoh shapes.*

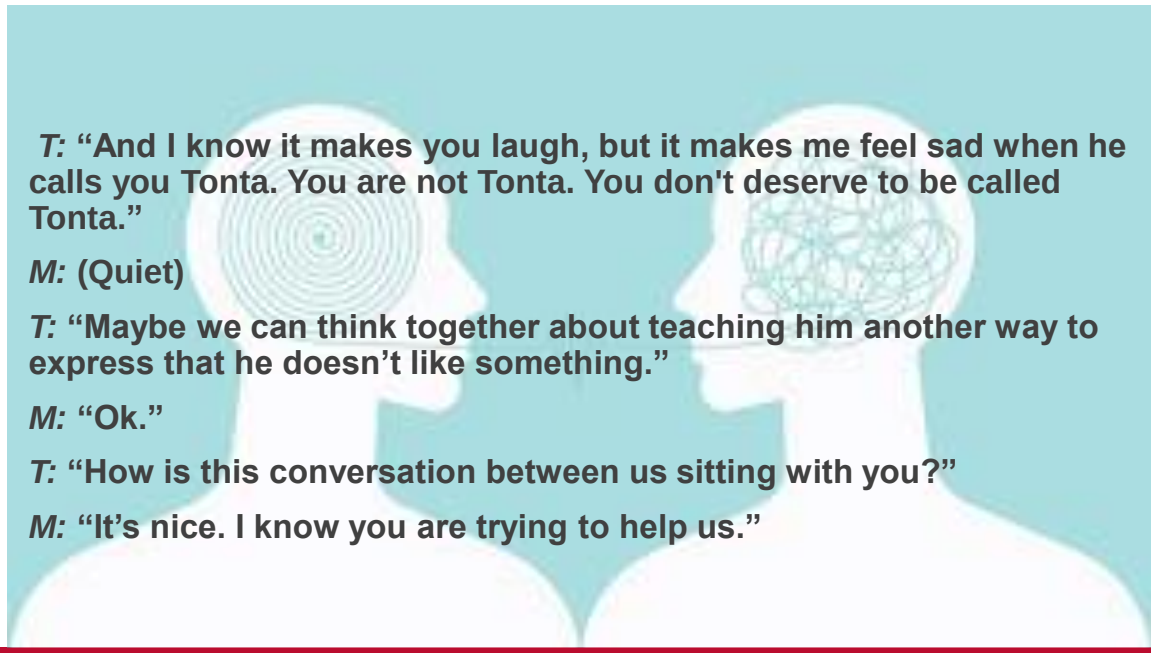
Mother laughs.

***Therapist (T):* "I have noticed that he calls you 'Tonta' a lot and he calls me that to. What's that like for you?"**

***Mother (M)*: "I think it's funny. He doesn't know it's bad."**

***T*: "Yes he is so innocent. I do worry though that when he starts school, he is going to say this to his teachers and they will think it is disrespectful.** *("Falta de respeto")* **I think we should help him learn that this word is not good."**

***M*: "Yes I wouldn't want that. I want him to be respectful."**



T: **"And I know it makes you laugh, but it makes me feel sad when he calls you Tonta. You are not Tonta. You don't deserve to be called Tonta."**

M: **(Quiet)**

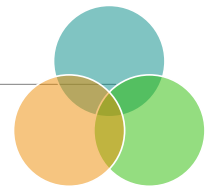
T: **"Maybe we can think together about teaching him another way to express that he doesn't like something."**

M: **"Ok."**

T: **"How is this conversation between us sitting with you?"**

M: **"It's nice. I know you are trying to help us."**

Integrating Theory and Practice



- Reflective Practice– “What is that like for **you**?”
- Trauma Framework – Conceptualized interaction as domestic violence enactment
- Relational and anti-oppressive lens – Collaboratively, “Maybe we can think **together**?”
- Autism and developmental awareness – Could this be an ASD repetitive behavior (RRB)? Speech delay? Teaching replacement behavior and word
- Culturally informed practice - Incorporating value of *respeto*
- Facilitating therapeutic alliance and parental self-efficacy – “What was this conversation like for you?”
- Integration resulted in significant improvements and achievement of tx goals

Bringing it all together- break out groups

What stood out to you about this family?

How is this approach to therapy different (or similar) to what you have experienced/would expect?

What is one thing you want to take away from this presentation?

What is something you want to learn more about?

Thank You

To our interdisciplinary evaluation team collaborators, Cassandra Cerros, PhD, Sylvia Sarmiento, MS, CCC-SLP

To our elders who generously shared their wisdom, Alicia Liberman, PhD, Patricia Van Horn, PhD, Chandra Gosh-Ippen, PhD, and Carmen Norona, LCSW

National CPP Spanish Clinician Consultation Group

To the *familias* who breathe life into theory

Questions?

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NCTSN; https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems/healthcare