SAFEST KID (A Sexual Assault Framework in Education to Support Trauma in Kids with Intellectual Disability): Delphi Study Development of a Model and Utilization

Ashley M. Hudson
SAFEST KID (A Sexual Assault Framework in Education to Support Trauma in Kids with Intellectual Disability): Delphi Study Development of a Model and Utilization

Abstract
There is a grave need for additions to the school psychologist’s toolbox to support students with intellectual disability (ID) and sexual trauma. These children are especially vulnerable to adverse life experiences overall and are at a particularly high risk of experiencing sexual abuse and resulting trauma. Children with ID are less likely to have their trauma symptoms identified by those around them, as symptoms do not always present in the same way as their neurotypical peers and trauma symptoms are more likely to be grouped into the rest of their disability through diagnostic overshadowing. Additionally, individuals with ID are at risk both from abuse perpetrated by individuals without ID and from other individuals with ID as well. New childhood trauma cases cost the US upwards of $124 billion per year, and the estimated cost of the total burden of untreated trauma is over $500 billion. This highlights the need for accessible sexual health and healthy relationship education within school systems to help intervene in this trauma cycle and ensure that children with ID are taught the necessary skills to understand interpersonal boundaries, consent, advocacy, and sexual rights, as well as how to form and maintain healthy relationships. For the population of children with ID, schools remain the place where they are most likely to have their mental health needs met, and schools are the place where they are most likely to receive any form of sexual health education. The epidemic of sexual abuse among the population of individuals with ID has recently come to light, and many of these individuals are at risk of suffering from resulting sexual trauma. Looking at systems-level change, preventative measures, and targeted adapted interventions, the model of SAFEST KID aggregates these components into one framework that provides guidelines for the transition to trauma-informed schools, integrated and developmentally tailored healthy relationship curricula, and a targeted individual intervention for use by school psychologists to support students with ID and sexual trauma. Manuscript Two showcases the results of the Delphi study regarding the viability of the SAFEST KID model, aggregating real-world knowledge and experience from a panel of experts. The Delphi study was conducted to collect input and insight from individuals with expertise in ID, childhood sexual trauma, and school systems to enhance the SAFEST KID model by incorporating both extensive existing topical research as well as the lived experience of professionals and practitioners in the field. A panel of experts was recruited and given multiple rounds of iterative questionnaires, generating consensus on a list of concepts that were used to answer the research questions, create a set of guidelines for adapting interventions for use with children with ID and sexual trauma, and augment the SAFEST KID model. The Delphi study investigated the research questions of how the SAFEST KID model is likely to be used, what are predicted barriers to implementation, and what realistic adjustments to its components are necessary. To conclude, Manuscripts One and Two highlight the overarching need within school systems to apply trauma-informed trainings across districts that consider developmental differences in child trauma presentations, to implement social-emotional learning and healthy relationship curricula across grade levels, and to have therapeutic evidence-based intervention tools ready for use by school psychologists to support the well-being of students with ID and sexual trauma.

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SAFEST KID (A SEXUAL ASSAULT FRAMEWORK IN EDUCATION TO SUPPORT TRAUMA IN KIDS WITH INTELLECTUAL DISABILITY): DELPHI STUDY DEVELOPMENT OF A MODEL AND UTILIZATION

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ABSTRACT

There is a grave need for additions to the school psychologist’s toolbox to support students with intellectual disability (ID) and sexual trauma. These children are especially vulnerable to adverse life experiences overall and are at a particularly high risk of experiencing sexual abuse and resulting trauma. Children with ID are less likely to have their trauma symptoms identified by those around them, as symptoms do not always present in the same way as their neurotypical peers and trauma symptoms are more likely to be grouped into the rest of their disability through diagnostic overshadowing. Additionally, individuals with ID are at risk both from abuse perpetrated by individuals without ID and from other individuals with ID as well. New childhood trauma cases cost the US upwards of $124 billion per year, and the estimated cost of the total burden of untreated trauma is over $500 billion. This highlights the need for accessible sexual health and healthy relationship education within school systems to help intervene in this trauma cycle and ensure that children with ID are taught the necessary skills to understand interpersonal boundaries, consent, advocacy, and sexual rights, as well as how to form and maintain healthy relationships. For the population of children with ID, schools remain the place where they are most likely to have their mental health needs met, and schools are the place where they are most likely to receive any form of sexual health education. The epidemic of sexual abuse among the population of individuals with ID.
ID has recently come to light, and many of these individuals are at risk of suffering from resulting sexual trauma. Looking at systems-level change, preventative measures, and targeted adapted interventions, the model of SAFEST KID aggregates these components into one framework that provides guidelines for the transition to trauma-informed schools, integrated and developmentally tailored healthy relationship curricula, and a targeted individual intervention for use by school psychologists to support students with ID and sexual trauma. Manuscript Two showcases the results of the Delphi study regarding the viability of the SAFEST KID model, aggregating real-world knowledge and experience from a panel of experts. The Delphi study was conducted to collect input and insight from individuals with expertise in ID, childhood sexual trauma, and school systems to enhance the SAFEST KID model by incorporating both extensive existing topical research as well as the lived experience of professionals and practitioners in the field. A panel of experts was recruited and given multiple rounds of iterative questionnaires, generating consensus on a list of concepts that were used to answer the research questions, create a set of guidelines for adapting interventions for use with children with ID and sexual trauma, and augment the SAFEST KID model. The Delphi study investigated the research questions of how the SAFEST KID model is likely to be used, what are predicted barriers to implementation, and what realistic adjustments to its components are necessary. To conclude, Manuscripts One and Two highlight the overarching need within school systems to apply trauma-informed trainings across districts that consider developmental differences in child trauma presentations, to implement social-emotional learning and healthy relationship curricula across grade
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### ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ADL</td>
<td>Activities of Daily Living</td>
</tr>
<tr>
<td>ASD</td>
<td>Autism Spectrum Disorder</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behavioral Therapy</td>
</tr>
<tr>
<td>CBITS</td>
<td>Cognitive Behavioral Intervention for Trauma in Schools</td>
</tr>
<tr>
<td>CSA</td>
<td>Child Sexual Assault</td>
</tr>
<tr>
<td>DBT</td>
<td>Dialectical Behavioral Therapy</td>
</tr>
<tr>
<td>EBP</td>
<td>Evidence-based practice</td>
</tr>
<tr>
<td>EMDR</td>
<td>Eye-Moment Desensitization and Reprocessing</td>
</tr>
<tr>
<td>FASD</td>
<td>Fetal Alcohol Spectrum Disorders</td>
</tr>
<tr>
<td>ID</td>
<td>Intellectual Disability</td>
</tr>
<tr>
<td>IDEA</td>
<td>Individuals with Disabilities Education Act</td>
</tr>
<tr>
<td>IDST</td>
<td>Individuals with Intellectual Disability who have experienced sexual trauma</td>
</tr>
<tr>
<td>IEP</td>
<td>Individualized Education Program</td>
</tr>
<tr>
<td>MATCH-ADTC</td>
<td>Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Problems</td>
</tr>
<tr>
<td>MTSS</td>
<td>Multi-tiered system of support</td>
</tr>
<tr>
<td>NASP</td>
<td>National Association of School Psychologists</td>
</tr>
<tr>
<td>NSES</td>
<td>National Sexual Education Standards</td>
</tr>
<tr>
<td>PKU</td>
<td>Phenylketonuria</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-Traumatic Stress Disorder</td>
</tr>
<tr>
<td>SAFEST KID</td>
<td>Sexual Assault Framework in Education to Support Trauma in Kids with Intellectual Disability</td>
</tr>
<tr>
<td>SWPBIS</td>
<td>School-wide Positive Behavior Interventions and Supports</td>
</tr>
<tr>
<td>TBI</td>
<td>Traumatic Brain Injury</td>
</tr>
<tr>
<td>TF-CBT</td>
<td>Trauma-Focused Cognitive Behavioral Therapy</td>
</tr>
<tr>
<td>TFC/TTMM</td>
<td>Trauma-Focused Coping in Schools/Multimodality Trauma Treatment</td>
</tr>
<tr>
<td>TIC</td>
<td>Trauma Informed Care</td>
</tr>
</tbody>
</table>
OPENING COMMENTARY

In the United States, public schools continue to be the place where children are most likely to have their mental health needs met. This is done through the efforts of various mental health professionals who work in school settings, including school psychologists, school-based therapists, school social workers, and school counselors (National Association of School Psychologists [NASP], 2016). Among today’s youth, almost half of them are likely to experience a traumatic event in their lifetime before the age of 18 (Saunders & Adams, 2014). Considering these trauma statistics and the barriers faced when accessing community mental health services such as cost, access to transportation, mental health stigma, and availability of resources and providers, schools continue to be the most accessible way for children to receive targeted mental health care. Trauma, especially when left untreated, puts individuals at higher risk for a host of negative long-term life consequences (Dye, 2018; Springer et al., 2003). Providing therapeutic supports within school settings has been shown to significantly reduce this increased risk as well as the barriers to accessing mental health supports.

Access to mental health care is limited for the general population, and it is estimated that up to half of youth who would benefit from treatment for mental health difficulties do not receive care (Whitney & Peterson, 2019). Among children who have an intellectual disability (ID), this number is even higher. Students with ID can be excluded from general educational experiences by being placed in self-contained
classrooms and, despite often having access to sexual health and general health education curricula, often are not checked for their understanding in these areas and do not absorb the full spectrum of information (Rowe & Wright, 2017). These exclusions, both explicit and implicit, are in part due to the belief that children with ID are unable to benefit from settings of traditional learning in a significant way and that adapting material for this population is too difficult. Together, these elements contribute to an “ignored curriculum” for this population, which conceptualizes the knowledge gained through incidental learning through social interactions and experiences beyond classrooms (Gougeon, 2009; Moljord, 2018; Rowe & Wright, 2017). Further, these stigmatized beliefs transfer over into the treatment options available to individuals with ID when they experience trauma. The lack of knowledge checks and learning opportunities combined with residual stigma towards ID results in a more limited selection of resources available, especially ones that have been specifically designed with this population in mind.

Trauma is wide-ranging, idiosyncratic, and potentially devastating. It has the power to derail the trajectory of one’s life, forever change one’s outlook on the world, and reshape one’s core identity. Many different types of experiences can be considered traumatic, and though all deserve attention and investigation, this dissertation focuses specifically on sexual trauma. Sexual trauma is unique in that it holds its own form of stigma, retaining an aura of taboo in Western culture that creates additional barriers to treatment (Byrne, 2017; Martinello, 2015; Treacy et al., 2017). Among children with ID, the risk of experiencing sexual trauma is significantly higher due to the specific vulnerabilities of this population, and the risk of this trauma going untreated is
significantly higher due to the lack of targeted resources available to them. Though Western society is beginning to reckon with the debilitating, and at times seemingly ubiquitous, nature of sexual trauma, it has yet to reckon with the lesser-known side of this epidemic: sexual abuse among individuals with ID.

Rates of sexual abuse among individuals with ID are elevated and the current data is likely an underrepresentation of the true prevalence of the abuse due to multiple factors (Eastgate et al., 2011; Frawley & Wilson, 2016; Rowe & Wright, 2017). These factors include the taboo topic of sexual abuse generally, the widespread nature of under-reporting across survivors of sexual abuse, diagnostic overshadowing within the ID population, communication difficulties within the ID population, and the stigma of ID (Byrne, 2017; Keesler, 2014b). Current evidence-based treatment options for sexual abuse and trauma available for the neurotypical population include variations of cognitive behavioral therapy (CBT), such as trauma-focused cognitive behavioral therapy (TF-CBT), dialectical behavioral therapy (DBT) and Cognitive Behavioral Intervention for Trauma in Schools (CBITS), Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC), Trauma-Focused Coping in Schools (TFC)/Multimodality Trauma Treatment (MMTT), play therapy, art therapy, medications, and various crisis intervention services such as PREPaRE and Psychological First Aid (Chafouleas et al., 2019; Brock et al., 2016; Hanson & Wallace, 2018; Hoover, 2019; Perfect et al., 2016). Treatment outcomes for youth able to access services are promising, though treatment options for addressing sexual abuse within the ID population remain limited (Hanreddy & Östlundb, 2019; Rowe & Wright, 2017; Treacy et al., 2017).
Because of the cognitive limitations inherent in the disability, there is an outdated belief that modalities designed for the neurotypical population cannot be adapted for individuals with ID (Taylor et al., 2008). The historical beliefs that individuals with ID do not have sexual rights, do not deserve to be full members of society, should not hold jobs, should not have families, and are not entitled to a free and appropriate public education still linger within the stigma when it comes to designing targeted therapeutic treatments for these very real and complex individuals (Byrne, 2018). There is a need for therapeutic interventions to address the devastating nature of sexual abuse within the population of individuals with ID, as having lower cognitive and adaptive scores do not strip away a person’s humanity. This “Silent Epidemic” has gone on for far too long (Shapiro, 2018), and it is beyond time for new forms of treatment to attempt to address this suffering.

This dissertation is a two-manuscript work that lives at the intersection of ID, sexual trauma, and therapeutic treatment in school settings. Manuscript One reviews the current literature surrounding these themes, weaving them into a cohesive narrative that highlights the current gaps in the treatment of trauma for youth with ID. It aims to fill one of these gaps by using the available literature to create an augmented treatment model specifically designed for students with ID who have experienced sexual trauma. By building on knowledge regarding how students with ID best learn, characteristics of ID itself, sexual trauma symptoms, and the baseline structures of the best available treatments for sexual trauma, this first chapter pulls these pieces together to create a new targeted model in the form of SAFEST KID: A Sexual Assault Framework in Education to Support Trauma in Kids with Intellectual Disability.
Manuscript Two is devoted to the design and analysis of a Delphi study for the SAFEST KID model. As there is currently limited research regarding the treatment of children with ID and sexual trauma in school settings, the Delphi method was an ideal methodology to use for this inquiry. The Delphi method asks recruited experts to complete iterative rounds of questioning, pulling from their lived experience and expertise, to generate group consensus and answer the study’s research questions (Iqbal & Pipon-Young, 2009; Keeney et al., 2001). This study consisted of a multiple-round analysis incorporating the review of experts in school psychology and mental health professionals who work with youth with ID and youth who have experienced sexual trauma. Professionals from the field were solicited who had expertise in ID and schools, ID and sexual trauma, and ID and both schools and sexual trauma. The experts were given the iterative surveys to complete over several months, and lists of concepts and themes were generated through structural coding and thematic analysis based on the survey results. The concepts were fed back to the experts through iterative surveys until a consensus on the concepts was achieved. These concepts and themes were used to answer the three research questions of the Delphi study: how can the SAFEST KID model become viable for school-based practitioners, how could school-based practitioners adhere to the pillars and principles of TIC when working with children with ID and sexual trauma in schools, and what are the barriers to school-based implementation of a therapeutic intervention for children with ID and sexual trauma? Additionally, the results of the study were used to create a set of guidelines for adapting interventions for use with children with ID and sexual trauma and used to enhance the SAFEST KID model that
was proposed in Manuscript One. Taken as a whole, this dissertation describes the current landscape of sexual trauma as it relates to youth with ID. It presents the case for why this form of targeted treatment is needed and proposes a way to help close this gap in treatment and services for this vulnerable population.
Intellectual Disability (ID) is the most common type of developmental disability, with 1-3% of the US population meeting the criteria for ID, or 6.5 million people; around 545,000 of those individuals are school-aged, between 6-21 years old (American Academy of Pediatrics, 2019; Gentile et al., 2019). As of 2019, just under 130,000 children were receiving school-based services through an Individualized Education Program (IEP) for Multiple disabilities (qualifying for ID and another disability category), and just under 420,000 children were receiving IEP services in schools for ID; 200,000 children were receiving services under Developmental Delay, and 720,000 children were receiving services under autism spectrum disorder (ASD; Office of Special Education Programs, 2021). Having a label of developmental delay or ASD does not inherently mean the child has an ID, however, there is overlap among these diagnoses and these numbers indicate that there is a small but significant number of children in the United States who could benefit from school-based services designed for ID.

Among individuals with ID, the risk of experiencing trauma is significantly higher than for the general population in both childhood and adulthood (McNally et al., 2021).
This includes various types of abuse, adverse life events, and traumatic experiences that are wide-ranging, and experiences of childhood abuse have been causally linked to poorer outcomes in both mental and physical health, though actual statistics rates vary significantly (Norman et al., 2012; Hughes et al., 2017). Sexual abuse in particular is a grave concern for this population as it is currently estimated that one-third of individuals with ID will experience sexual abuse at some point in their lives, and the most frequent kind of perpetrator is often a peer with ID or a person without ID who has frequent contact with the individual (Tomsa et al., 2021).

When trauma goes untreated, it has the power to negatively impact the life of the individual and the rest of their relationships (American Psychological Association, 2004), as well as set in motion generational cycles of trauma – most significantly when trauma comes via sexual abuse (Coyle, 2014). Risk for abuse within this population stems from peers who may have been abused themselves or who have not learned appropriate interpersonal skills as well as neurotypical individuals in their vicinity who may choose to abuse their power (Martinello, 2015). This indicates that proper education and trauma supports are needed to stop cycles of trauma within the population of those with ID, as well as to enhance self-protective skills and interpersonal boundaries generally.

Guiding Frameworks

Two key theoretical frameworks are to be considered: an ecological systems framework and a trauma-informed care (TIC) framework. The ecological systems framework shares the understanding that no individual functions in isolation but rather is an amalgamation of all the moving parts surrounding them and is a product of the society
in which they develop (Bronfenbrenner, 1992). As such, a child with ID who has experienced trauma must be viewed in connection with the other main characters in their life, the different levels of their community, the time in which they live, and the relationships between the moving pieces of their world. An ecological systems framework takes into consideration the individual as well as the microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Bronfenbrenner, 2005; Darling, 2007). As outlined by Bronfenbrenner, the microsystem consists of the individual’s close environment, such as their family and peers, school, and common daily activities and interactions. The mesosystem consists of the interaction between the factors in the child’s microsystem, and how these components relate to one another. The exosystem consists of the extended environment such as the government, media, social systems, finances, and extended family. The macrosystem consists of general ideas that permeate the culture at large, and more subtle influences of society. The chronosystem consists of the time in which the individual is developing, and the changes that are likely to occur over the individual’s lifetime. Combined, the layers of the ecological system create a more fully informed picture of the various components influencing the life of an individual and providing keystone points for possible interventions.

The second framework of importance, TIC, operates with the understanding that many individuals have experienced trauma in their lives, and so fostering environments that promote recovery and protect against revictimization is imperative; trauma is not a one-time event, but an experience that likely continues to shape the individual’s ongoing present experience and functioning (Butler et al., 2011). According to the tenets of TIC,
TIC includes the four pillars of realize, recognize, respond, and resist revictimization, and the guiding six principles that follow (Talapatra et al., 2020): safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment voice and choice; and cultural, historical, and gender issues (Purkey et al., 2018). The pillar of realize represents the necessity of individuals who work with populations that experience high rates of trauma to understand this relationship and its influence; recognize highlights the need for people to be able to identify signs of trauma in others; respond indicates the action steps needed in the form of appropriate targeted interventions for trauma across levels of need; resist revictimization represents the need for trauma prevention efforts to be put in place (Talapatra et al., 2020). Under the umbrella of the TIC framework, existing systems and trainings are re-evaluated with these considerations of possible trauma history in mind, priority is given to trauma education for all relevant individuals, and there is a continual process of reassessment for the presence of trauma symptoms among individuals in the focal community (Butler et al., 2011). The six guiding principles of TIC are woven throughout the four pillars and are constructed to foster individual safety, support physical and psychological needs, and strengthen relationships with others (Talapatra et al., 2020). They consider the impact of trauma on an individual by making space for choice where possible so the individual’s voice to be heard, highlighting the strengths the individual has, and focusing on how to educate the individual to be aware of their situation and potential future, and what skills can be learned, and keeping in mind intergenerational trauma and cultural influences (Butler et al., 2011; Purkey et al., 2018).
These two frameworks offer parameters to help view a child with ID as well as the available supportive systems in a realistic way. They offer a way to move forward with the understanding that there are many levels in which to intervene in the cycle of trauma, and there are numerous factors to consider when striving for long-lasting changes that stretch far beyond the individual survivor. Even an intervention that targets the individual and their immediate environment must consider the other layers in their life, and the history of experiences that continue to impact the present day. Change is more possible when the full landscape of the situation is considered. Intervening in cycles of abuse is more possible when awareness has been established and trauma education and systems of response and prevention follow.

**Intellectual Disability**

To better understand the population for whom this manuscript is targeted to support, this section will discuss ID terminology and context. IDs are a subset of neurodevelopmental disorders that result in deficits in an individual’s cognitive and adaptive functioning, beginning within the individual’s developmental period before the age of 18 (American Psychiatric Association, 2013; Katz & Lazcano-Ponce, 2008; National Council on Disability, 2018). ID is a disorder often represented by limitations in executive functioning in the individual, as well as in the understanding of abstract concepts, reasoning ability, learning, and practical and interpersonal functioning (Katz & Lazcano-Ponce, 2008; Tassé et al., 2012). A cognitive assessment, an adaptive functioning assessment, and clinical judgment are needed to diagnose ID in an individual.
(American Psychiatric Association, 2013). Despite these vulnerabilities and a history of marginalization, individuals with ID are complex and real people with unique strengths who have many of the same hopes and dreams as people without ID.

**Diagnostic Characteristics**

Almost 3% of newborn babies qualify for the label of ID, with 0.5% falling within the category Severe ID, the lowest range (Gilissen et al., 2014; Reichenberg et al., 2016). Between 1-3% of the Western population is currently estimated to qualify for ID (Emerson, 2012; Karam et al., 2015; Malik et al., 2011; Westerinen et al., 2007). ID is divided into the four main categories of Mild ID, Moderate ID, Severe ID, and Profound ID, often beginning below the score of 70 IQ points on a standard cognitive assessment, or two standard deviations below an average score (Reichenberg et al, 2016). Table 1 offers a breakdown of the ID population.

**Table 1**

*Categories of ID*

<table>
<thead>
<tr>
<th></th>
<th>Mild ID</th>
<th>Moderate ID</th>
<th>Severe ID</th>
<th>Profound ID</th>
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<tbody>
<tr>
<td><strong>Proportion</strong></td>
<td>85% of individuals with ID</td>
<td>10% of individuals with ID</td>
<td>4% of individuals with ID</td>
<td>1% of individuals with ID</td>
</tr>
<tr>
<td><strong>IQ Range</strong></td>
<td>50-70 points</td>
<td>35-50 points</td>
<td>20-35 points</td>
<td>&lt;20 points</td>
</tr>
<tr>
<td><strong>Supports</strong></td>
<td>Often can live independently sans substantial supports</td>
<td>Often can live independently with supports, such as in group arrangements</td>
<td>Often need support for ADLs and often cannot</td>
<td>Often require full-time care</td>
</tr>
</tbody>
</table>
To meet the criteria for ID, individuals likely have an IQ score that falls two standard deviations below average and have impaired adaptive skills within one of the three categories of practical, social, or conceptual skills (American Psychiatric Association, 2013; Individuals with Disabilities Education Act (IDEA), 2004; Katz & Lazcano-Ponce, 2008). Adaptive skills refer to activities of daily living and other practical skills used throughout one’s day that help enable an individual to navigate their life independently (Tassé et al., 2012). They are functional skills that tend to be learned implicitly through life, though for individuals with cognitive impairments or learning differences, these skills often need to be taught explicitly instead (Gougeon, 2009; Räty et al., 2016). Adaptive skills are relevant in all areas of life and can provide important intervention points for the development of targeted supports for an individual with ID (Tassé et al., 2016). Gaps in these skills are often directly related to the details of the individual’s specific diagnosis and personal traits, and the opportunities they have been exposed to during their life.

Genetic and chromosomal conditions resulting in intellectual disability include Down syndrome, William’s syndrome, Fragile X syndrome, Lesch-Nyhan syndrome, Rett syndrome, DiGeorge syndrome, Niemman-Pick disease, Hunter disease, Hurler disease, Hartnup disease, galactosemia, homocystinuria, maple syrup urine disease, Soto’s Syndrome and Phenylketonuria (PKU) among others (Karam et al., 2015; Katz & Lazcano-Ponce, 2008; Lee et al., 2020; Roy et al., 2012). ASD, though it may be
comorbid with ID, does not cause ID (Thurm et al., 2019; Thompson et al., 2019). Down syndrome is considered the most common chromosomal cause of ID (Katz & Lazcano-Ponce, 2008; Lee et al., 2020). The consumption of alcohol during pregnancy may lead to Fetal Alcohol Spectrum Disorders (FASD) in the child, and FASD is currently the most common cause of ID that is considered preventable (Lee et al., 2020; O’Leary et al., 2013; Williams et al., 2015). The factors that lead to the manifestation of ID are numerous and encompass both environmental and genetic factors. Despite the wide variety of potential causes, children who meet the criteria for ID require additional supports and adapted interventions to reach their full potential in life.

ID is a lifelong condition that impacts individuals at similar rates across cultures and demographics when looking into the statistics of Moderate, Severe, and Profound categories of ID (Boat & Wu, 2015; Gentile et al., 2019). Poverty, sex, and poor prenatal care are risk factors for Mild ID, as Moderate, Severe, and Profound forms of ID are more heavily biologically influenced and may have an etiology separate from Mild ID (Lee et al., 2020). Within the Mild ID category, more males than females are often identified with ID, as well as more Black children (2x) and Hispanic children (1.5x) being identified than White children (Boat & Wu, 2015; Lee et al., 2020). Even controlling for SES, test administration bias and the cognitive tests themselves used to identify ID appear to impact the rates of ID identification (Boat & Wu, 2015). This indicates that there are likely issues of systemic bias occurring within larger society as well as within the ID assessment process itself that beg to be addressed.
Strengths and Vulnerabilities

Though having ID results in significant life impacts across one’s cognitive, practical, and interpersonal functioning, there are many supports in place in schools and society now available to help support the developmental trajectory of these individuals. Many people with ID live full and meaningful lives, benefit from public education, hold gainful employment, have long-term relationships, maintain deep friendships, expand the worldview and empathy of others, and deserve to benefit from the full impact of their human and societal rights.

Individuals with ID have a significantly higher risk than the non-ID population of being taken advantage of by others. In terms of abuse and neglect, individuals with ID are significantly more likely to experience these traumatic events than individuals without ID as they are less likely to accurately assess risk and are more likely to be dependent on others (Martinello, 2013; McGlivery, 2018). These risks continue to increase if the individual identifies as female or is still a child. In youth with ID who are placed in residential treatment facilities, the risk of abuse and neglect rises, sexual abuse in particular (Euser et al., 2015).

Individuals with ID have vulnerabilities stemming from their condition that do not apply to the general population to the same extent. Beyond limitations in cognitive capacity, individuals with ID are likely to have difficulties in interpersonal relationships due to a lack of awareness and compliance, as well as difficulties in risk assessment and judgment of consequences (American Psychiatric Association, 2013). Furthermore, it is often the case that learning structures such as assessments and curricula are not often
designed with this population in mind. Though individuals with ID are currently legally protected to receive a free and appropriate public education (FAPE; IDEA, 2004), it is often the case that they are not always afforded the same level of opportunities, support, education, and resources due to persistent stigma and beliefs of what ID entails, lack of understanding from others, and a dearth of targeted resources for this population (Scior et al., 2020). Due to these vulnerabilities, individuals with ID are at greater risk of not learning the necessary skills to take care of themselves in life. These include emotional regulation skills, daily functioning skills, and basic academic skills to maintain steady employment, make meaningful relationships, and protect and advocate for themselves in the world.

Children with ID are more likely than children without ID to communicate affection to others physically, and this tendency to use touch as a predominant means of expression can put them at risk of various forms of abuse since their personal boundaries may not be as firm as children who are not used to communicating through physical contact as often (Wissink et al., 2018). Though the affectionate and friendly nature of many children with ID is one of their most beloved tendencies, this can simultaneously put them at risk as they are less likely to hold firm interpersonal boundaries or be able to accurately identify risky scenarios which can put them in situations where others can easily take advantage of their friendly nature (Martinello, 2013, McNally et al., 2021). Complicating this matter further is that in schools, children with ID are not necessarily given the same educational supports to help develop their social, emotional, and personal awareness in the same manner as other students without ID. Having ID does not make a
child stop wanting to be loved and accepted by others, and this powerful need needs to be buffered by protective education on proper social boundaries, norms, and ways to protect themselves from people with less pure intentions.

**Historical Residue**

Historically, individuals with ID were not recognized as citizens, were not viewed as having sexual rights, were not entitled to an education, were not entitled to healthcare, and were not able to obtain employment (Conrad, 2018; Byrne, 2018). In the 20th century, individuals with ID were often isolated from society, whether placed in institutions or sequestered in their homes (Burghardt, 2015). As the century progressed and the popularity of eugenics rose, individuals with ID were often forcibly sterilized and stripped of their rights to reproduce (Roy et al., 2012). In 1907 and in the name of eugenics, Indiana became the first state to legalize the sterilization of individuals with ID who lived in state institutions; the law stood until 1974 (Reilly, 2015). Though rights for individuals with ID have progressed significantly in the past decades, this area continues to be a battleground. Individuals with ID continue to represent how society conceptualizes humanity, and how society regards what kind of people are deserving of a full life.

**Challenges Today**

Today, the rates of abuse among the ID population vary due to underreporting from decreased self-report and recognition of abuse. Population characteristics such as dependency on others, cognitive limitations, and susceptibility to manipulation all serve
to place individuals with ID in vulnerable positions (Keesler et al., 2014; Pestka & Wendt, 2014). The grouping of data in various studies into general abuse categories instead of specific abuse categories (e.g., sexual abuse or physical abuse) further undermines the crisis as it relates to sexual abuse as it makes it difficult to streamline data collection across studies (Byrne, 2018). Qualities related to the disability, such as memory lapses or mistakes, can lead to individuals’ reports of abuse being doubted, and there is often a lack of interest in these cases from judicial bodies (Martinet & Legry, 2014). In addition to this increased likelihood of individuals with ID suffering from adverse life experiences, the difficulty of diagnosing the impact of trauma contributes to the normalization of trauma effects on behavior. This inability to separate symptoms of trauma from characteristics of ID decreases the likelihood that these trauma symptoms will be treated, and the general lack of training among staff in distinguishing between mental illness and symptoms of ID helps to maintain the ubiquity of diagnostic overshadowing and uphold barriers in treatment (Keesler et al., 2014).

A further area of complication is that individuals with ID are also at a higher risk of perpetuating abuse than individuals without ID (Asscher et al., 2012; van der Put et al., 2014). A significant portion of this higher rate may be due to a lack of education surrounding healthy relationships, counterfeit deviancy, increased likelihood of being manipulated, or not understanding appropriate boundaries (Keesler, 2014a; Martinello, 2015; McNally et al., 2021). It also highlights the need for interventions in this area to address the consequences of the dearth of resources for youth with ID, as individuals who experience abuse during youth are more likely to perpetrate abuse as they age. The
deficits of note in the offending individuals with ID are more likely to be related to deficits in emotional regulation and interpersonal skills (Asscher et al., 2012).

Individuals with ID face many barriers. They are more likely to suffer adverse life experiences such as abuse and trauma, have to contend with historical inequalities and residual stigma, and are often not the population in mind for evidence-based interventions. Yet, they are complex individuals fully deserving to live a complete and intricate life.

**Childhood Trauma**

Trauma occurs when a child experiences or witnesses a threatening event that overwhelms their capacity to process (The National Child Traumatic Stress Network [NCTSN], 2003). A traumatic experience is unique to the individual, and though there are situations that most individuals would consider traumatic, trauma is a subjective experience that can only be decided by the individual. While abuse and trauma are separate entities, with abuse being objective improper treatment and trauma being a subjective individual experience, both are intertwined by their nature. A situation can be abusive yet not traumatic, and trauma can stem from situations that are not abusive. Childhood trauma often is rooted in various forms of interpersonal abuse, such as physical abuse, emotional or psychological abuse, sexual abuse, and neglect, though it can also stem from medical procedures, community violence, natural disasters, grief, bullying, and war or persecution (Chafouleas et al., 2019; NCTSN, 2021). Two-thirds of
children will likely be exposed to at least one traumatic experience before they reach adulthood (Overstreet & Chafouleas, 2016).

Knowledge of the causes and effects of trauma is continuing to grow, and in recent years has become a popular subject of study. As the types of interpersonal abuse such as physical, emotional, sexual abuse and neglect often occur in the home or other private spaces, signs for these types of trauma can be difficult to identify in children. There is a movement to increase the level of trauma-informed care (TIC) in professionals who work with children, to increase the identification of traumatic experiences and for adults to understand signs and symptoms of trauma to look for in youth, particularly in school settings (Maynard et al., 2019; Record-Lemon & Buchanan, 2017; Ridgard et al., 2015; Wiest-Stevenson & Lee, 2016).

The impact of trauma on the lives of children can be lifelong if untreated (Afifi et al., 2016; Child Welfare Information Gateway, 2019; Monnat & Chandler, 2015; Widom et al., 2012). Lifelong effects can include academic difficulties and learning problems (Bick & Nelson, 2016), behavioral difficulties (Herrenkohl et al., 2017), mental health struggles (Choi et al., 2017; Fuller-Thomson et al., 2016), increased risk for involvement in the juvenile justice system (Herrenkohl et al., 2017; National Institute of Justice, 2017), and chronic health problems (Afifi et al., 2016; Child Welfare Information Gateway, 2019; Monnat & Chandler, 2015; Widom et al., 2012). Trauma greatly increases the risk for substance use disorders generally as well (Thompson et al., 2017). It is important for school professionals who work with children to be able to identify the signs when they are present, as trauma has the power to continue generational cycles of
trauma and alter the lives of not only the individual affected but all of society, which bears the cost of child abuse reaching into the billions (Child Welfare Information Gateway, 2019). It is important to understand these types of childhood trauma and their impact and treatment generally. It is also important to understand how these areas look different for a child with disabilities like ID who search for support within the most accessible settings - schools.

**Interpersonal Childhood Abuse**

During childhood, multiple types of trauma can occur. Beyond the traditional grouping of trauma into the categories of emotional abuse, physical abuse, sexual abuse and neglect, there are the forms of community violence, bullying, natural disasters, refugee trauma, medical trauma, traumatic grief, terrorism and violence, early childhood trauma, and complex trauma to consider (NCTSN, 2016). While many of these potential catalysts for trauma occur out in the open, or can easily be identified in the community, instances of interpersonal child abuse are often more difficult to identify.

Childhood physical abuse, emotional abuse, sexual abuse, and neglect are specific kinds of experiences that can be isolated instances or repeated experiences and are often tied to the child’s home or private life. The type, frequency, severity, and duration of the abuse matters, as well as when it occurred during the child’s developmental trajectory (Child Welfare Information Gateway, 2019). Due to their likelihood of being deeply intertwined in the reality of the child’s quotidian existence, the increased difficulty of identification, and the potentially disruptive effects of treatment, interpersonal forms of
childhood abuse in particular can lead to long-term negative life impacts from this kind of trauma.

**Childhood Neglect**

Neglect is one of the most common forms of abuse a child can experience (De Bellis, 2005), and it can come in the form of both physical and emotional neglect (Herzog & Schmahl, 2018). At its core, neglect is the consistent inability or desire to meet the basic needs of a child, or acting in a way that either indirectly causes harm to the child or is a failure to act to prevent the child from risk or harm (Child Welfare Information Gateway, 2019a). Child neglect increases the individual’s chances of experiencing diabetes and poor pulmonary, visual, and oral health (Child Welfare Information Gateway, 2019b), and increases the risk generally that the individual will experience both physical as well as mental health problems later in life.

**Childhood Physical Abuse**

Child physical abuse occurs when someone uses intentional force against a child that harms their overall health, dignity, life, or development (Christian, 2012; Butchart et al., 2006). What constitutes child physical abuse varies by culture, and as such instances of what may be considered violence in some cultures are considered appropriate punishments in other cultures (Christian, 2012). Physical abuse can lead to traumatic brain injuries and changes in cognitive and emotional functioning, as well as the cyclic perpetuation of physical abuse, and can increase the individual’s chances of later experiencing diabetes and malnutrition (Child Welfare Information Gateway, 2019b; Monnat & Chandler, 2015; Widom et al., 2012).
**Childhood Psychological Abuse**

Childhood psychological or emotional abuse describes behaviors and patterns that harm the child’s sense of self-worth and personal development. It often comes in the form of verbal abuse, rejection, manipulation, and threats while simultaneously discarding support and love (Child Welfare Information Gateway, 2021). Similar to other kinds of abuse, psychological abuse can lead to difficulty with interpersonal relationships and an increase in antisocial behaviors. Children who experience psychological abuse are more likely to feel rejected by their peers as adults, and this perceived rejection may lead to increased feelings of real or perceived isolation (Shevlin et al., 2015b). This combination of factors results in an overall increased risk for adult mental health disorders, revictimization, and continued isolation in the “loneliness loop,” or the cycle of hypervigilance and cognitive biases that feed into one another (Hawkley & Cacioppo, 2010; Shevlin et al., 2015b).

**Childhood Sexual Abuse**

Though all forms of abuse have negative impacts on children, sexual abuse can be particularly devastating. Statistics vary due to under-reporting, study measures, and definitions of sexual abuse, yet it is estimated that 20% of women and 10% of men experienced a form of sexual abuse as a child (Pittenger et al., 2019; Shevlin et al., 2015b). Due to the intimate nature of sexual abuse and the remaining stigma surrounding it in society, individuals are less likely to report this type of abuse than others, and it is more likely to go untreated (London et al., 2005). Studies that delve into this area often utilize different definitions of what constitutes sexual trauma and abuse and frequently
fail to include diverse measures related to sex and gender diversity. Further, individuals are not likely to report their sexual abuse as children and often do not disclose their experiences on their own until later in life. These components combined make it difficult to gather accurate prevalence statistics, and rates often have a wide range of estimates of the true prevalence of childhood sexual abuse. Many statistics likely underrepresent the rates of childhood sexual abuse, yet it is clear that any instances of it have profound implications for the survivor.

Though there are no pre-determined outcomes for children who have survived sexual abuse, experiencing one instance of sexual abuse as a child increases the risk that the individual will experience revictimization, or another instance, leading to additional sexual trauma later in life (Pittenger et al., 2019). Qualities and behaviors in survivors of sexual abuse that can contribute to the risk for revictimization include heightened sexual activity, multiple sexual partners, substance use, distorted views of healthy intimate relationships, lowered self-esteem, decreased control of affect or emotional regulation, feelings of guilt, self-blame and shame, increased submissiveness, decreased likelihood of utilizing coping skills, and significant post-traumatic stress disorder (PTSD) symptoms (Child Welfare Information Gateway, 2019; Pittenger et al., 2019). Additionally, individuals who experienced sexual abuse as a child are more likely to perpetuate this abuse themselves later on in their lives, though the majority of children who experienced abuse do not go on to become abusers themselves (Yang et al., 2018). Overall, experiencing childhood sexual abuse and living with this type of untreated trauma greatly increases the chances that the individual will go on to experience significantly more
adverse experiences in life (Child Welfare Information Gateway, 2019). These heightened risks convey the need for interventions that properly address sexual trauma early on to intervene in this terrible cycle, as trauma will remain and continue to interfere in life in various ways if left untreated (van der Kolk, 2014).

**Childhood Interpersonal Abuse and ID**

Children with ID are three to six times more likely to become victims of neglect and emotional, physical, and sexual abuse than those without disabilities (Keesler et al., 2014). They are at an increased risk for experiencing interpersonal abuse due to a variety of factors, related to the qualities of their ID as well as the environments they are more likely to be in (Wissink et al, 2018). Further, a large concern for youth with ID who experience this type of trauma is the phenomenon of diagnostic overshadowing. Because many professionals who work with children are not familiar with trauma symptoms in youth, with symptoms of ID, or with both when they are combined, youth with ID who experience trauma are at a much higher risk of having their trauma symptoms grouped in with their disability, and thereby are less likely to receive needed care as their trauma continues to go unnoticed (Keesler et al., 2014). Trauma symptoms often manifest differently in an individual with ID, and this lack of alignment with traditional trauma symptoms decreases the chances of them being accurately identified for what they are (Talapatra et al., 2020). Despite studies demonstrating an increased risk for experiencing trauma among youth with ID, this population is also at a greater risk for not having their trauma identified, at a greater risk for experiencing adverse life effects, and less likely to
receive targeted treatment that can help relieve their symptoms and improve their long-term life outcomes.

**Childhood Neglect and ID**

Children with ID often require additional care and scaffolding than children without ID. Though the effects of neglect and other forms of abuse are often grouped together as all lead to an increased risk for both physical and mental health struggles (Wigham & Emerson 2015), instances of neglect can leave a child with ID without the support needed to reach their full potential; synaptic connections that could have formed are not able to, skills that may have been mastered become much harder to learn (Perry, 2002). Neglect can be both physical and emotional, and though both are detrimental to the development of the child, for a child with ID physical neglect can put them at risk of physical injury or premature death (Herzog & Schmahl, 2018). Neglect can hinder the individual’s ability to transition into adulthood successfully and render one further limited unnecessarily due to their lack of support throughout childhood (Wigham & Emerson, 2015). This can further lead to increased risk for struggles with housing, poverty, and isolation, as well as the likelihood of engaging in dangerous interpersonal acts in the absence of positive learned skills.

**Childhood Physical Abuse and ID**

Physical abuse has been shown to increase the risk of suicidality in individuals with ID, especially when the trauma history is also significant for sexual abuse, (Merrick et al., 2006). As with other types of abuse, physical abuse is related to decreased levels of both mental and physical health in individuals with ID (Hughes et al., 2019). In some
instances, physical abuse is what leads to the ID through the manifestation of a traumatic brain injury (TBI).

**Childhood Psychological Abuse and ID**

Psychological abuse among children with ID has been shown to predict levels of psychological distress, increased both in part due to the ID and to the experience of this kind of abuse (Weiss et al., 2011). Emotional abuse has the power to accrue over the life of the individual, compounding its weight if left untreated (Robinson, 2010). When experienced during childhood, this kind of treatment can form the baseline for the type of treatment that is to be expected in adulthood. Youth with ID are less likely to learn implicitly from others, and this vulnerability increases the chance of being taken advantage of by other individuals who treat them similarly to their early abuser.

**Childhood Sexual Abuse and ID**

Despite the high rates of trauma that impact all children, sexual abuse in particular has plagued individuals with ID: there is an epidemic of sexual abuse amongst this population and individuals with ID are up to 10 times more likely to experience sexual abuse than individuals without disabilities, though rates widely vary (Blaustein, 2013; Chafouleas et al., 2019; Shapiro, 2018; Talapatra et al., 2020). Individuals, both children and adults, with ID are at a greater risk than individuals without ID to suffer from sexual abuse (Byrne, 2018), yet children with ID are at a four times greater risk of experiencing sexual abuse than children without ID, and are also the most at risk for extreme and repeated forms of sexual abuse out of all groups of children with disabilities, (Wissink et al., 2018). Children with ID are at risk both from perpetration by individuals without ID
as well as other individuals with ID (Martinello, 2015), indicating a strong need for better education for this population surrounding healthy relationships, interpersonal boundaries, and consent, and for better training in symptom identification for those who work with this population.

Additional factors complicate the intersection of children with ID experiencing sexual abuse. Youth with ID tend to develop faster physically than cognitively, socially, or emotionally, and this discrepancy leaves them vulnerable, especially in the absence of targeted educational resources to support their interpersonal growth (Rowe & Wright, 2017; Wissink et al., 2018). Youth with ID are in charge of a sexually mature body without explicitly being given the tools or resources to navigate it more mature world. Further complicating matters, individuals with ID are less likely to be taken seriously if they do come forward to report abuse, as qualities related to ID such as memory lapses or mistakes can result in the reports being doubted and less likely to see their reports receive a judicial response (Martinet & Legry, 2014). As individuals with ID are more likely to depend on help from caregivers than individuals without ID, especially during childhood, this puts them at risk for abuse from individuals without ID due to their increased trust in familiar individuals and increased likelihood of command compliance (Wissink et al., 2018). The epidemic of sexual abuse among individuals with ID touches upon issues of human rights, human decency, access to care, and what type of treatment society will accept for its marginalized members. Childhood sexual abuse is devastating, and too many children with ID have had to experience it.
Symptoms of Childhood Trauma

Symptoms of trauma can vary significantly among individuals, which contributes to the difficulty of trauma identification in children. Across the range of trauma symptoms, common ones include changes in mood, sleep difficulties, changes in appetite or weight, changes in social functioning, an increase in emotional outbursts and reactivity, inappropriate reactions in situations, blunted affect, difficulty with sustained attention, a loss of interest in activities, avoidance of reminders of the trauma, dissociation, and lowered self-esteem (Child Welfare Information Gateway, 2019). Children who experience abuse are likely to act out some of these experiences with other children or in public settings, and identification of this kind of behavior should be met with concern and investigation instead of immediate punishment only, and sexual knowledge beyond what is appropriate for the child’s developmental level should be considered a potential signal of abuse (Wissink et al., 2015). For all children, signs of physical bruising, blood, difficulty walking, and repeated infections are signs that abuse is occurring and further investigation is warranted. Furthermore, experiencing a single traumatic event increases the risk that that individual will experience another traumatic event in their lifetime (Sacks & Murphey, 2018). Children who have experienced trauma are at risk for a range of debilitating conditions, including mood disorders, substance use disorders, and post-traumatic stress disorder (PTSD), as well as chronic health conditions such as heart disease, elevated stress levels, risky behaviors, and decreased lifespan (Afifi et al., 2016; Child Welfare Information Gateway, 2019; Monnat & Chandler, 2015; Sege et al., 2017; Widom et al., 2012).
Signs of Interpersonal Abuse in Schools

Signs of trauma can vary based on developmental age in children (NCTSN, 2003). Preschool children may experience an increase in nightmares, crying, screaming, separation anxiety from caregivers, and difficulty eating. Children of elementary school age may exhibit increased anxious or fearful behaviors, may have difficulty concentrating and sleeping, and may feel sensations of shame and guilt. Youth of middle and high school age may experience feelings of isolation or depression and may struggle with self-harm, substance use, eating disorders, and sexual promiscuity (Choi et al., 2017; Fuller-Thomson et al., 2016; Thompson et al., 2017).

In terms of academic performance, abused children are likely to struggle with learning and attention, and overall productivity (Bick & Nelson, 2016). They are more likely to experience internalizing and externalizing behavioral disorders, and struggle with cognitive flexibility, working memory, and self-control (Herrenkohl et al., 2017). Schools are uniquely posed to identify signs of abuse in students, as school personnel are likely to have repeated and frequent contact with children over multiple years. School staff and students can benefit from being trained in the identification of abuse symptoms and what next steps to take, as it takes a community to end these wide-reaching cycles of trauma.

Signs of Interpersonal Abuse in Schools in Children with ID

Children with ID may show symptoms of trauma in ways that can differ from those of students without ID. Their specific vulnerabilities put them at greater risk for experiencing interpersonal abuse, and their cognitive limitations do not serve as a
protective factor against the pain that this trauma can cause. Taken together, it is imperative to highlight the ways that symptoms can manifest differently when ID is involved. Similar to children without ID, in the aftermath of trauma, children with ID are likely to show an increase in behavioral incidents or an increase in the severity of incidents, emotional volatility, isolation, self-harm, and avoidance, and additional symptoms are likely to learn more heavily towards the somatic including changes in appetite, energy, and digestion (Talapatra et al., 2020; Wissink et al., 2018). Depending on the individual and the extent of the ID, some of these trauma symptoms can easily be grouped into branches of the disability, however, it is possible that they really are cries for help. To experience trauma is to undergo a fundamental change in one’s worldview; for children with ID, this change can take longer to process but changes in typical functioning for the individual should always spark an inquiry from others.

**Treating Childhood Trauma**

When it comes to helping others, many systems focus on how they can help the greatest number of people in the most effective manner, and it is a common theme in school psychology to acknowledge that most supports are designed for individuals who fall in the middle of the bell curve (Qu, 2015). It is an admirable cause to focus on helping as many people as possible, however, this mentality often leaves out people in need who fall within the minority. There is a common theme throughout educational, disability, and psychological literature that research on tools for use with individuals with ID is beginning to take off (McNally et al., 2021); as awareness about the trauma-related
needs of this population grows, the call for more resources gets louder. The potential for positive impact is high, especially considering the rates of abuse present among children with ID.

Despite the varied rates in trauma statistics for individuals with ID, it is generally agreed that the rates are higher than those of the general population. When a neurotypical child suffers from abuse or trauma, research shows that the risk increases for the individual to experience phenomena such as eating disorders, substance abuse struggles, physical illness, and additional complex mental health disorders, especially when the trauma is untreated (Aas et al., 2016; Lloyd, 2020; Mulvihill, 2005). Because of this knowledge, there is a plethora of resources to lean on for an individual without ID who experiences different types of trauma, yet research is only beginning to empirically validate tools for use within the ID population (McNally et al., 2021).

Currently, select screener measures that have been validated for use within the ID population include the Posttraumatic Stress Checklist (PCL-5; Karatzias et al., 2019; Mason-Roberts et al., 2018), the Impact of Events Scale-Intellectual Disability (IES-ID; Hall et al., 2014), the Bangor Life Events Scale for Intellectual Disability (BLESID; Rittmansberger et al., 2020; Wigham et al., 2014), the Psychiatric Assessment of Adults with Developmental Disabilities (PAS-ADD; Moss et al., 1997), and the Lancaster and Northgate Trauma Scales for Intellectual Disabilities (LANTS; Wigham et al., 2011), with support emerging in particular for use of the LANTS in terms of predicting PTSD symptoms in an individual with ID (Rittmansberger et al., 2020). The forms of therapy that have been used successfully with individuals with ID include EMDR, CBT, TF-
CBT, imagery rehearsal therapy, and general psychoeducation (Karatzias et al., 2019; Kroese et al., 2016; Lemmon & Mizes, 2002; McNally et al., 2021). As research shows that increases in problematic, avoidant, and aggressive behaviors and decreases in adaptive skills are likely if the trauma of an individual with ID goes untreated (Clark et al., 2016; Kildahl et al., 2020b; Lemmon & Mizes, 2002; Mason-Roberts et al., 2018; McNally et al., 2021), it is important to treat trauma in individuals with ID in the same way that it is important to treat trauma in individuals without ID.

Treatments for trauma in the neurotypical population have entered the mainstream in recent years. It is now common to see models of TIC present in school mental health offerings and staff trainings, as well as being a popular element added to the general therapist’s toolbox (Maynard et al., 2019; Record-Lemon & Buchanan, 2017; Ridgard et al., 2015; Wiest-Stevenson & Lee, 2016). There are numerous models of standard trauma treatment available and designed for the neurotypical population, such as CBT and its offshoots including dialectical behavioral therapy (DBT), Cognitive Behavioral Intervention for Trauma in Schools (CBITS) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), as well as play therapy, art therapy, eye movement desensitization and reprocessing (EMDR) Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC), and Trauma-Focused Coping in Schools/Multimodality Trauma Treatment (TFC/TTMM) (Chafouleas et al., 2019; Jaycox et al., 2012; Malchiodi, 2003). While there exist many more models of intervention posed to address childhood trauma, there is a core repertoire to choose from,
often based on the CBT framework. For an overview of first-line childhood trauma interventions, see Table 2.

Table 2

*First-Line Childhood Trauma Interventions*

<table>
<thead>
<tr>
<th>Name of Intervention</th>
<th>Length of Time</th>
<th>Applied Settings</th>
<th>Targeted Treatment &amp; Associated Disorders</th>
<th>Intended Age Range (Years)</th>
<th>Used with ID</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Verbal Therapies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Art Therapy</td>
<td>Variable</td>
<td>Variable</td>
<td>Trauma and abuse, PTSD, anxiety, depression</td>
<td>All</td>
<td>Yes</td>
</tr>
<tr>
<td>Play Therapy</td>
<td>20 sessions</td>
<td>Variable</td>
<td>Trauma, anxiety, depression, behavioral disorders, interpersonal struggles</td>
<td>3-12</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Cognitive-Behavioral Focused Therapies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBT</td>
<td>5-20 sessions</td>
<td>Variable</td>
<td>Anxiety, depression, eating disorders, substance use disorders, interpersonal disorders</td>
<td>4+</td>
<td>Yes</td>
</tr>
<tr>
<td>CBITS</td>
<td>10 sessions</td>
<td>Schools, mental health</td>
<td>PTSD, behavior disorders, depression</td>
<td>11-18</td>
<td>Yes</td>
</tr>
<tr>
<td>Therapy</td>
<td>Duration</td>
<td>Clinical Setting</td>
<td>Description</td>
<td>Length</td>
<td>Use</td>
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<tr>
<td>DBT</td>
<td>12-15 weeks</td>
<td>Often clinical settings</td>
<td>Mood disorders, eating disorders, personality disorders, substance use disorders</td>
<td>7+ Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Trauma Focused Therapies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>EMDR</td>
<td>6-12 sessions</td>
<td>Often clinical</td>
<td>Trauma</td>
<td>4+ Yes</td>
<td></td>
</tr>
<tr>
<td>MATCH-ADTC</td>
<td>Variable sessions</td>
<td>Often clinical</td>
<td>Anxiety, depression, trauma, behavioral disorders</td>
<td>8-13 No</td>
<td></td>
</tr>
<tr>
<td>TF-CBT</td>
<td>8-25 sessions</td>
<td>Variable</td>
<td>Trauma, abuse, complex trauma, emotional and behavioral struggles</td>
<td>3+ Yes</td>
<td></td>
</tr>
<tr>
<td>TFC/TMM</td>
<td>14 sessions</td>
<td>Schools, clinics, residential, group settings</td>
<td>PTSD, depression, anxiety, anger</td>
<td>6-18 No</td>
<td></td>
</tr>
</tbody>
</table>

**Non-Verbal Therapies**

There are many types of therapies to choose from currently, and a selection of therapies that have been used historically and continue to be used today includes non-verbal therapies. These therapies do not require a child to not have verbal communication skills but can be used with an individual who does not have strong language capabilities.
A primary selection of non-verbal therapies described here includes art therapy and play therapy.

**Art Therapy**

Art therapy is a mode of treatment that incorporates various forms of art and creativity to navigate psychological complexities, trauma, and personal struggles. As a technique, it has faced significant criticism based on the lack of standardization, heavy use of subjective interpretation, and low rate of objective measures. However, it also offers a mode of communication outside of verbal or written expression that can be very useful particularly when beginning to work with trauma survivors as well as individuals with communication difficulties, and can be combined with additional models of therapy (Malchiodi, 2003; Blaustein & Kinniburgh, 2010). It is effective as a starting point of expression and an aid to communicating emotions and experiences when words are insufficient or not possible at the time. Survivors of trauma often struggle to verbally communicate their experiences, and their memories are often visual. Because of this, art therapy can be a helpful tool to lean on when this occurs and provide an additional multi-modal avenue of expression (Pifaldo, 2007). Art therapy has frequently been combined with CBT and provided over a multi-week treatment model to target various struggles such as depression, anxiety, PTSD, trauma, and emotional dysregulation with success (Pifaldo, 2006; Pretorious & Pfeifer, 2010). Art therapy can be helpful for trauma survivors, particularly ones dealing with sexual trauma, as it provides a safe way to engage in posttraumatic play or recreate the trauma events through play, though it is important to keep in mind that different materials in art therapy may be individually
triggering to some based on their experiences (Malchiodi, 2003). Art therapy can be used as an individual or group intervention, and one of its most valuable features is its ability to help individuals process their experiences without requiring them to utilize verbal expression (Pretorious & Pfeifer, 2010). Beyond the therapeutic structures that can be combined with art therapy, allowing a child to engage in art experiences can reintroduce joy and novel experiences into their life, which can lead to more positivity in other areas of their life in the aftermath of trauma (Malchiodi, 2003).

Play Therapy

Play therapy is a tool for children ages 3-12 that currently has a mixed base of efficacy in terms of therapeutic validity despite its presence in the therapeutic toolkit since the early 1900s (Bratton et al., 2005; Mora et al., 2018). Play is a natural part of a child’s life and has the potential to serve as a vehicle for communication when traditional talk therapy techniques are not possible, such as in the absence of verbal communication, underdeveloped abstract thought, and lack of a mature cognition (Bratton et al., 2005; LaBauve et al., 2001). Much of the debate stems from the heavy focus on the interpretation of the child’s play by the play therapy provider due to its lack of standardization and consistency and its still nascent evidence base (Phillips, 2010; Porter et al., 2009). Though research supports the use of toys to help aid in the expression of communication, emotions, past experiences, and social development generally, particularly with children with communication difficulties (Astramovich et al., 2015), play therapy’s overall efficacy as a stand-alone modality is still uncertain (Baggerly & Bratton, 2010; Bratton et al., 2005; Phillips, 2010).
Non-Verbal Therapies and ID

Though not structured enough to be used on its own for children with ID who have survived trauma, elements of art therapy may be useful to incorporate in a targeted model for this specific population in school settings (McDonald & StJ Drey, 2018). Art therapy techniques can be utilized when the individual struggles with verbal or social communication and can provide a means for expression and connection when the individual is unable to translate their feelings or experiences into words (Aguilar, 2019). Art therapy can offer an alternative mode of treatment for individuals with ID when talk-therapy-based methods are less successful and can provide a tool for rapport building between the mental health provider and the child. For individuals with ID, art therapy can help open the channels of emotional expression and may help stabilize behavior (Ho et al., 2020).

Play therapy techniques have been used with children with ID successfully, despite a historical belief that children with ID do not engage in play (Astramovich et al., 2015; Mora et al., 2018). Despite play therapy’s mixed evidence base, play itself is an integral part of child development that teaches the individual a wide range of personal and interpersonal skills throughout their growth. For children with ID, engagement with play therapy can help foster these social skills and increase their competencies in prosocial behaviors, decrease pressure on family life, help manage emotional and behavioral difficulties, and help lower anxiety and aggression (Astramovich et al., 2015; Mora et al., 2018). Through play therapy, children with ID can increase their social skills in group play settings which can lead to stronger friendship skills and decreased
loneliness later in life (Astramovich et al., 2015). It is more likely that children with ID will need to be taught play and social skills more explicitly than children without ID, as without intervention childhood struggles are likely to continue into adulthood (Mora et al., 2018).

Overall, non-verbal therapies such as art therapy and play therapy have supportive elements to offer children with ID who are seeking therapy. Their strongest pieces surround their strategies that can navigate the non-verbal space, and as there is a wide range of capabilities and verbal fluency levels among the population of children with ID, these therapies offer resources to draw from when talk-based approaches fall short. When a child with ID requires trauma-processing and more extensive targeted therapy, these non-verbal therapies are not as effective as ones based on CBT frameworks or trauma-processing frameworks. However, they are helpful to keep in mind when surveying potential resources for this population, as they can be applied to work with a wide variety of individuals.

**Cognitive-Behavioral Focused Therapies**

Thinking more specifically about therapy modalities, CBT and its offshoots are some of the most well-researched and most commonly used therapies today within the neurotypical population. These include CBT, CBITS, and DBT. They have proven to be effective in treating anxiety and depressive disorders, substance abuse and eating disorders, relationship problems, and mental illness within the neurotypical population (American Psychological Association, 2019). Despite the high rates of adverse life experiences occurring within the population of ID, research on the use of CBT with this
population is still in its infancy (Taylor et al., 2008). There is limited research on the effectiveness of using versions of CBT with individuals with ID in part due to the historical reluctance of therapists to engage with this population, and due to the stigmatized belief that individuals with ID lack the cognitive requirements to benefit from CBT (Taylor et al., 2008). Furthermore, there is an additional layer of stigma present within this population in the form of the outdated belief that individuals with ID do not have sexual rights (Byrne, 2017). Despite this history, there is growing support behind the usage of variations of CBT with this population.

Due to CBT’s baseline focus on cognitive components, practitioners have been wary of implementing this intervention with the ID population. There is a growing segment of research that supports the use of CBT for individuals with ID, especially in the area of emotional regulation and executive functioning (Unwin et al., 2015). Poor emotional regulation has long resulted in increased rates of institutionalization and prescriptions of behavior-controlling drugs for individuals with ID, yet interventions focused on regulation for those with ID can halt the cascade effect of those negative repercussions and increase overall quality of life (Taylor et al., 2008).

**CBT**

CBT is one of the most researched and strongest evidence-based treatments for addressing mental health disorders generally, and has been effective in treating anxiety, depression, trauma, substance use and eating disorders, and interpersonal relationship struggles for a wide range of individuals (American Psychological Association, 2019). The general structure of CBT as a time-limited and problem-focused approach involves
parsing apart the relationship between emotions, behaviors, and thoughts over 5-20 sessions, and requires strong rapport between client and therapist; it has been shown to effectively address a wide range of disorders in individuals of all ages (Mevissen-Renckens, 2017; Skinner & Wrycraft, 2014).

**CBITS**

Another branch of CBT that is set to benefit students specifically is Cognitive Behavioral Intervention for Trauma in Schools (CBITS), which has taken the core elements of CBT and adapted them for use within a school setting (Chafouleas et al., 2019). Elements of both TF-CBT and CBITS stand to serve students well and have been combined into the school-based intervention Bounce Back. Bounce Back is an intervention designed to treat trauma in elementary school students and pulls from both TF-CBT and CBITS to involve caregivers, trauma narratives, and CBT core skills that can be used in schools in individual or group settings (Distel et al., 2019; Langley et al., 2015). This intervention is a promising baseline to use when considering measures to adapt for students with ID, as it already includes the important elements of caregiver support, viability within a school setting, and trauma focus.

Rooted in cognitive behavioral therapy, CBITS is a 10-session version of CBT that has been adapted for use specifically in school settings with a focus on addressing trauma (NCTSN, 2012b). Following in the lines of CBT’s prominence, CBITS is one of the strongest interventions for childhood trauma available for ready use within schools (Chafouleas et al., 2019; Hoover, 2019). Incorporating elements in the treatment that specifically target trauma, CBITS aligns elements of psychoeducation and trauma
processing with cultural sensitivity and adaptation while striving to help youth generalize skills and integrate their trauma experiences in a school-based group setting (Chafouleas et al., 2019; Morsette et al., 2009).

One targeted manualized therapeutic intervention based on CBITS is Bounce Back. Bounce Back is a school-based intervention based on CBT principles that takes TF-CBT and CBITS and combines them into one modality for school-based group intervention for younger children (Chafouleas et al., 2019; Langley et al., 2015). Both TF-CBT and CBITS are first-line interventions to target youth trauma, and incorporate practical elements of use within school settings, caregiver involvement, structured sessions, and room for flexibility and adaptation (Cohen et al., 2017; Langley et al., 2015; Morsette et al., 2009; NCTSN, 2012b). Bounce Back incorporates two of the most promising trauma treatments for youth and makes them applicable for use within a school setting while incorporating parent involvement, group support, psychoeducation, and generalizable content (Chafouleas et al., 2019). Both CBITS and TF-CBT contain elements that are likely to be beneficial to treating youth with ID (Chafouleas et al., 2019; Langley et al., 2015). Bounce Back presents a tool ready to be used in schools, as it is targeted for younger students, contains components from developmentally tailororable therapeutic modalities, and its parent therapies contain guidelines for developmental adaptations (Idusohan-Moizer et al., 2015; Skinner & Wrycraft, 2014; Stenfert Kroese et al., 2016). As Bounce Back was adapted for use with younger children at its onset, yet pulls from modalities that cover a wide age range, it naturally incorporates developmental scaffolding and support (Chafouleas et al., 2019).
**DBT**

Dialectical Behavioral Therapy (DBT) is a specific kind of CBT that was developed originally to aid in the treatment of individuals diagnosed with borderline personality disorder (Rathus & Miller, 2015). Currently, it is most often used to treat adolescents suffering from various mood disorders, including types of anxiety and depression, as well as suicidal ideation, substance abuse, and self-harm behaviors. Many individuals are introduced to DBT when they are at an acute stage of suffering or are exhibiting significantly distressing behaviors (Rathus & Miller, 2015).

DBT’s components are divided into four main modules Mindfulness, Distress Tolerance, Walking the Middle Path, and Emotional Regulation (Rathus & Miller, 2015). It is intended to be delivered in a group therapy format, with both adolescents and their caregivers participating in learning and practicing the skills individually and together across a 12-16 week period. The overall message communicated during DBT therapy is that it is possible and even likely for two seemingly opposite things to be true at once.

**Cognitive-Behavioral Focused Therapies and ID**

Due to CBT’s focus on cognitive components, practitioners have been wary to implement this intervention with the ID population, but considering CBT has been effectively used with children, indicating that a full and mature cognition is not a precursor for benefiting, it is likely that benefits similar to those gained by the general population can be obtained (Taylor et al. 2008). There is a growing segment of research that supports the use of CBT for individuals with ID, especially in the area of emotional regulation and executive functioning (Byrne, 2020; Unwin et al., 2015), particularly
through mindfulness-based CBT (Idusohan-Moizer et al., 2015). There is growing support that an adapted and simplified version of CBT can positively impact those with ID (Taylor et al., 2008), and as CBT is the first-line evidence-based treatment for a wide spectrum of disorders including anxiety, depression, and trauma, its flexibility and room for necessary adaptations make it a strong choice for use with ID (Byrne, 2020). To successfully be used with youth with ID, significant adaptations are required as this is a cognitively-based therapy, yet despite the lingering stigma surrounding the use of CBT and ID, positive outcomes are possible (Byrne, 2017; Taylor et al., 2008). CBT and its offshoots are only beginning to be used with the population of youth with ID, but targeted adaptations are becoming increasingly common.

CBITS, the school-based offshoot of CBT, offers a twist in the form of a manualized school-based intervention grounded in the CBT framework that also has incorporated culturally relevant adaptations based on its current population of focus (Morsette et al., 2009). As it is rooted in the CBT framework, designed to be used in schools and create spaces for necessary adaptations and flexibility, it is posed to work well with students with ID. As CBITS focuses on trauma from the child’s perspective and includes multiple parent and teacher education sessions in its model (NCTSN, 2012b), its structure is posed to benefit youth with ID who are likely to see more positive treatment outcomes when important caregivers are involved (Kerig et al., 2010; Talapatra et al., 2020).

In contrast to CBT and CBITS, while there is some evidence to show that individuals with ID can benefit from DBT, its intricate nature and fast pace requires
significant adaption (Lew et al., 2006). Adapted DBT may indeed benefit individuals with ID if administered intentionally, however, DBT is most helpful for a tangential set of disorders outside of sexual trauma. It is focused more directly on mood disorders and problematic behaviors, and uses reframing, mindfulness, and behavioral activation to address these mental health needs (Rathus & Miller, 2015). It is less focused on actively processing trauma and working through past specific experiences. For this reason, it is not the preferred therapeutic model to use as a foundation for use with students with ID and sexual trauma, but may be useful for helping to address additional internalizing or externalizing behaviors of concern.

Overall, cognitive-behavioral-based therapies are posed to benefit individuals with ID if adaptations are made to tailor the intervention to the individual’s developmental level. Despite the historical stigma and lingering biases, individuals with ID are capable of gaining from cognitive-based interventions, and emerging research continues to highlight this. While each intervention will need to be considered for use in light of the situational context and individual needs of the child, CBT and CBITs offer potential frameworks to use as adaptive models for an intervention targeted to children with ID.

**Trauma Focused Therapies**

Additional therapies that are often first-choice interventions fall into the category of trauma-focused therapies. These therapies include TF-CBT, EMDR, MATCH-ADTC, and TFC/TTMM. While TF-CBT is also rooted within the CBT framework, these
therapies have the key focus of addressing trauma in others through various interventions at the individual and systems level.

**TF-CBT**

There is a clear need for validated and intentionally designed therapeutic tools to use when working with this population, and a version of CBT that is primed to succeed at this intersection is TF-CBT. CBT’s trauma-informed counterpart was created in response to the need for therapeutic interventions that not only acknowledge the role trauma plays but were designed with it in mind. Though TF-CBT was originally designed to target PTSD symptoms relating to sexual abuse within the neurotypical population, it operates via a short-term model that incorporates family members and trusted adults into the therapeutic process (TF-CBT National Therapist Certification Program, 2020).

TF-CBT for children and adolescents was created by Drs. Judith A. Cohen, Anthony P. Mannarino, and Esther Deblinger, and has been in use for over twenty-five years. It is one of the most empirically supported methods of treating trauma and resulting emotional and behavioral difficulties in youth with PTSD amongst survivors of sexual trauma (Cohen et al., 2017). It is both highly adaptable without compromising its structure and able to be individualized to fit the needs of various populations. Additionally, it is a time-structured treatment approach that incorporates family in the therapeutic process and is effective in treating various types of trauma in children as young preschoolers, particularly sexual trauma (Cohen et al., 2017).

**EMDR**
EMDR is a psychotherapeutic treatment with a controversial history that has continued to be empirically validated over the past 30 years (Davison & Parker, 2001; de Jongh et al., 2019; Valiente-Gómez et al., 2017). It offers trauma treatment with a focus on addressing PTSD symptoms through its eight-phase structure and its exposure-based foundation, targeting the reintegration of traumatic memories into the individual’s biological narrative (Shapiro & Maxwell, 2002; Valiente-Gómez et al., 2017). EMDR’s eight phases consist of repetition throughout its 6-12 sessions, first focusing on the initial gathering of trauma history and strengthening of coping skills, and then followed by visualization of the traumatic memory and the reintegration process (Shapiro & Maxfield, 2002). EMDR is efficacious in the reduction of PTSD symptoms, and comparable to TF-CBT’s outcomes in addressing trauma symptoms, cross-culturally applicable and transdiagnostic, though some controversy remains over the elements of EMDR that produce these positive effects (de Jongh et al., 2019; Mevissen-Renckens, 2017; Shapiro & Maxfield, 2002; Wilson et al., 2018).

**MATCH-ADTC**

MATCH-ADTC is a modular-based therapy that can be utilized in school and clinical settings, in both group and individual sessions (Chafouleas et al., 2019). It has modular components that each focus on addressing anxiety, depression, trauma, and conduct issues in children that can be used together in sequence or individually, but MATCH-ADTC was designed for use with children with multiple areas of need to be treated within one protocol (Lucassen et al., 2015). Trauma is unlikely to occur in isolation, and the MATCH protocol offers a method of treatment that considers the
complexity of psychological issues that children and adolescents often present with, while remaining evidence-based (Hagen et al., 2019).

**TFC/TTMM**

TFC/TTMM, most commonly known as TFC, is a therapy modality based on cognitive-behavioral therapy designed for use in schools encompassing fourteen group sessions occurring over 6-8 weeks to target PTSD and symptoms resulting from single-incident trauma (NCTSN, 2012). There is no caregiver component and this model is designed specifically to be used in school settings, with each session focusing on a different skill and goal (Chafouleas et al., 2019). It can be adapted for multiple age levels and can help support a wide range of students in the aftermath of a traumatic experience (Chafouleas et al., 2019; Jaycox et al., 2008; Perfect et al., 2016).

**Trauma Focused Therapies and ID**

As individuals with ID are at a greater risk for experiencing adverse experiences in their life that lead to trauma and are at an increased likelihood of suffering from the impact of interpersonal trauma due to their cognitive limitations, leaning on systems-based interventions such as TIC offers a way to provide wide-reaching support (Keesler, 2014a; McNally et al., 2021). For children with ID who do not necessarily present trauma symptoms in the same way as neurotypical peers, to effectively utilize TIC practices at a systems-level necessitates the inclusion of ID-specific trauma symptom identification training for staff. Due to its pillars and principles, TIC provides a guiding framework for working with youth with ID, particularly in school settings, that fosters empathy, a person-first mindset, and holistic treatment (McNally et al., 2021; Talapatra et al., 2020).
It creates space for trauma trainings to incorporate knowledge of how trauma relates to ID, and how to treat youth with ID in a humane and supportive way while acknowledging their risk for trauma. Incorporating TIC into a therapy model for use with ID adds an element of prevention in the framework, and calls on systems to support the intervention and be part of the change in stopping the cycle of abuse amongst children with ID.

At the individual level, TF-CBT utilizes the CBT framework while incorporating a core trauma focus. Its model contains suggestions and adaptations for using TF-CBT with children who have developmental disabilities, and though not ID-specific, offers a useful starting place when considering ways to utilize this effective model with children with ID. For example, Cohen et al. (2017) highlight adaptations such as providing structure and routines, shortening sessions, using a slower pace, using art and visual aids, utilizing play, leaning on repetition, and incorporating individualized interests and fixations. Furthermore, they promote the notion of providing psychoeducation on trauma throughout therapy to the children and their families and incorporating families and caregivers throughout the therapeutic process to best support children with developmental disabilities given the extent to which the home environment is likely to have been disrupted by trauma (Cohen et al., 2017). All caregivers should be incorporated into the therapeutic process, as consistency is key. This may include school psychologists and other school-based mental health professionals, outside caregivers and therapists, and other guardians. Additional elements and adaptations of particular note include increased opportunities for role-playing during sessions, increased repetition of sessions, and inclusion of mindfulness and relaxation exercises, cognitive reflection exercises, and the
presence of trusted adults (Idusohan-Moizer et al., 2015; Skinner & Wrycraft, 2014; Stenfert Kroese et al., 2016). When using TF-CBT with children with ID, it is important to take into consideration the unique characteristics of the child. According to the TF-CBT tenets, it is recommended that the number of sessions devoted to each concept be determined by the time it takes for the child to exhibit a strong understanding (Thornback & Muller, 2015). For children with ID, this represents the way that TF-CBT can be flexibly applied; the number of sessions will likely be longer than the typical 8-25 sessions in baseline TF-CBT, and will likely be unique to the individual as well. TF-CBT offers an intervention that theoretically can be used with children with ID, though it requires significant adaptations. A matter complicating the process is that to be used within a school setting, further adaptations will be required, and this greatly increases the demand on school-based mental health providers if they are not able to use a readily manualized intervention to support a student with ID.

EMDR has recently begun to be investigated for its efficacy with individuals with ID (McNally et al., 2021). Though more research is needed, some preliminary findings have supported the use of EMDR for use with individuals with all levels of ID in the reprocessing of traumatic memories and the reduction of PTSD symptoms (Barrowcliff & Evans, 2015; Byrne, 2020; Mevissen-Renckens, 2017; Quevedo et al., 2021). Additional studies have found mixed results in the outcome of EMDR with individuals with ID, though many maintain a “cautious optimism” for the use of this tool with this population (Gilderthorp, 2015; Mevissen et al., 2011; Smith et al., 2021). Further, PTSD symptoms in individuals with ID were found to present typically but were instead aligned with the
developmental age of the individual and typical trauma symptom presentations. The Dutch model of EMDR incorporates instructions for this therapy model for use with age groups beginning at age one and can serve as a useful guideline for the application of EMDR with individuals with ID according to their developmental age (Mevissen-Renckens, 2017). EMDR often requires specific training on the part of the administrator, and in the absence of this training it is not an effective intervention to pull from for use with others.

MATCH-ADTC has been used in some studies with individuals with ID, and due to its modular nature offers targeted therapeutic structures for behavioral difficulties and internalizing concerns so that a child who needs a more behaviorally-based therapeutic approach can receive it (Bennett et al., 2018; Shafran et al., 2020). Modifications for use with youth with ID include focusing more attention on the core components of MATCH and extending the conceptual integration of physical and mental health throughout treatment (Shafran et al., 2020). Further research regarding the use of MATCH-ADTC with youth with ID is needed, though the flexibility of the MATCH protocol offers promise for youth with ID. TFC/TM has not been studied with the population of children with ID, though as it is a school-based intervention rooted in the framework of cognitive-behavioral therapy with a focus on trauma, this model can likely be adapted for use with children with ID as well (Idusohan-Moizer et al., 2015; Taylor et al. 2008; Unwin et al., 2015).

Overall, there are multiple trauma-focused therapies to pull from when working with a child with ID. However, all require significant adaptations to be made before use,
and none offer a readily manualized intervention at this time to be used with this population. TF-CBT and TIC offer the strongest frameworks to pull from when considering adaptations, though others such as EMDR, MATCH-ADTC, and TFC/TTMM are beginning to be researched for their effectiveness with the population of individuals with ID.

**TIC**

As a guiding framework, TIC offers a structured way to incorporate preventative and responsive trauma measures into multiple levels of intervention. It can be implemented at a systems level or an intervention level and is flexible, adaptive, and protective. TIC is a promising model to lean on when considering adapted measures to utilize with individuals with ID, as the tenets of TIC can be incorporated into existing therapeutic models and ways of engaging with the individual seeking services as well as entire school systems (Keesler et al., 2014a). Again, its general components are centered around the idea that many individuals have experienced trauma in their lives, and so any form of treatment should take that into account, even if not directly delving into the details of the trauma itself (Wilson et al., 2017). The principles of TIC include themes that span the categories of safety, cultural competence, an understanding of trauma, trustworthiness, openness, empowerment, collaboration, support, and recovery (Elliot et al., 2005; Bateman et al., 2013).

**The Four Pillars**

The TIC framework includes the four pillars of *Realize, Recognize, Respond*, and *Resist Revictimization*. These pillars provide a baseline expectation of functioning for
organizations so that to be considered a trauma-informed system in alignment with TIC, the system must be able to realize the ubiquitous nature of trauma, recognize trauma signs and symptoms, have a method in place to respond to trauma, and but further must actively help resist revictimization and prevent further trauma from occurring (Butler et al., 2011; Purkey et al., 2018; Talapatra et al., 2020). The pillars represent the four main assumptions within the TIC framework that illustrate the overarching goals of a TIC organization. The six TIC principles of (1) safety, (2) trustworthiness and transparency, (3) peer support, (4) collaboration and mutuality, (5) empowerment, voice and choice, and (6) cultural, historical, and gender issues stand in place of a specific set of procedures to preserve the flexible nature of TIC and allow it to be operationalized at multiple levels (SAMHSA, 2014). To be in accordance with TIC, all members of the organization must undergo regular trauma trainings to ensure that they are educated with up-to-date information regarding the widespread and common occurrence of trauma, be able to recognize signs of trauma in others, and then understand what steps to take to support the identified individual to try and intervene in the trauma cycle (Purkey et al., 2018; SAMHSA, 2014). With the understanding that trauma is common and has significant impacts on general functioning across all areas of someone’s life, all members within an organization must move forward knowing that these experiences are likely a factor in the behavior of others; the language that is used and the way behavior is responded to must be adjusted. In a way, a TIC framework puts all the individuals within a system on the same level – all must be developmentally educated on trauma, all must understand what
they can do to respond, and all must interact with one another with empathy and sensitivity.

The Six Principles

Along with its pillars, TIC incorporates six embedded principles throughout its model to underscore the prioritization of safety, peer support and collaboration, trustworthiness and transparency, empowerment and choice, and cultural awareness, highlighting how to reach the goals set forth by its pillars (Keesler, 2014a; Talapatra et al., 2020). The six principles of TIC provide more detailed guidance on how to ensure that TIC practices are being enacted within a system. Promoting safety is primary, as a key component of trauma’s impact is that it undermines one’s feeling of safety, both physical and psychological (SAMHSA, 2014). This would include ensuring that the physical location of the organization enacts safety measures, such as in a school ensuring that only appropriate individuals are allowed access to the building. Promoting psychological safety may indicate that the mental health and well-being of all school personnel is a high priority, and all students feel they have at least one safe person to turn to if they are in need. It represents an organizational culture that prioritizes healthy relationships and does not tolerate bullying or cruelty but creates an environment of safety for all who are part of the community.

The principle of Trustworthiness and Transparency highlights extends the principle of Safety, illustrating the importance of an organization conducting its operations with clarity and openness. Having a culture of openness promotes understanding and communication, two qualities that are important for supporting those
recovering from trauma (Purkey et al., 2018; SAMHSA, 2014). The principle of Peer Support continues to build on the previous principle, as a key component of TIC is that many people have experienced trauma, and though trauma tends to make the survivor feel isolated and cut off from their community, in reality, many others are also undergoing the process of recovery (Wilson et al., 2017). To continue to build a community of recovery and understanding, it is essential to include other important people in the survivor’s life within the recovery process. This can look like other trauma survivors or family members, or essential figures in a child’s life who are important in the process of recovery. Further, it is also important to support the development of peer relationships within the school among other students as well as interpersonal skills generally (Talapatra et al., 2020).

The principle of Collaboration and Mutuality delves into the importance of working with others when supporting trauma recovery, taking the individual’s preferences into account as well as their individual experiences. In school settings, this can look like mental health professionals consulting with the family and prioritizing the preferences of the student they are working with. This principle also stresses the importance of having all members of the organization be educated on trauma impacts, symptoms, and responses (SAMHSA, 2014). The principle of Empowerment, Voice and Choice extends these sentiments by continuing to prioritize the needs and individuality of the child. Allowing the survivor to have a say in their recovery plan and voice their concerns and preferences can help restore autonomy to an individual who has had theirs taken away through the traumatic experience. Especially for children who have
undergone trauma, carving out a space in their recovery to ensure their voice is heard is essential to their learning of coping strategies and advocacy skills that will help protect against revictimization (Talapatra et al., 2018). The final principle of Cultural, Historical, and Gender Issues highlights the understanding that each person comes from a complicated and diverse background that extends throughout generations and current society. All those involved in the TIC system must carry with them their understanding of their own biases and how to move past them to best support the others in their community. An organization that is aligned with TIC practices must enact policies and measures across the system that support cultural diversity and consider these differences at all levels, as well as how related trauma histories may be overlayed on top of the individual’s experiences (SAMHSA, 2014). See an overview of the TIC pillars and principles in Figure 1.
**TIC Pillars and Principles**

- **Safety**: prioritize both physical and psychological safety
- **Trustworthiness & transparency**: maintain clear documentation and openness in conduct
- **Peer support**: prioritize strong communities and fight individual isolation
- **Collaboration and mutuality**: work together with the child, their caregivers, and the community for best outcomes
- **Empowerment, voice & choice**: individualize treatment to the child and solicit their input
- **Cultural, historical & gender issues**: view the child in their holistic context and check your own biases

*Figure 1. TIC Pillars and Principles*

**TIC and ID**

Use of TIC with the ID population would involve ensuring adequate trauma and emotional regulation education measures for both individuals with ID and staff trainings, clear organization policies, greater choice involved in programming for individuals with ID, and focusing on creating an environment made up of people who have a sensitivity to...
trauma (Keesler et al., 2014a; McNally et al., 2021). Trauma trainings and education would include neurodiverse symptoms and common behavioral responses as well as neurotypical ones, without singling out any one member in the school or community. TIC is an especially useful framework to lean on when considering the population of children with ID, as the rates of trauma here are high, and the details of the traumatic experience do not need to be known for TIC to have a positive impact (McNally et al., 2021; SAMHSA, 2014). At its core, TIC represents the perspective of viewing all individuals through a holistic lens, understanding that it is likely that the majority of youth will experience some form of trauma during their childhood, and strives to support the wellness of individuals with that understanding in mind.

For children with ID who have experienced trauma, having access to a school that is aligned with TIC principles provides them with a greater chance of recovery, decreased likelihood of revictimization, and more of a nurturing environment in which to grow. Following the principle of Safety, all school personnel would be educated not just on trauma impacts and symptoms generally, but also on how it manifests within neurodiverse populations. If a student with ID were to engage in an atypical disruptive behavior in the classroom, there is a greater likelihood that the student would be met with increased understanding and curiosity instead of mere punishment. If the presence of trauma was uncovered, there would be supports in place to help the child, and if the behavior was not related to trauma, the environment would still be one with greater understanding and support. In accordance with Trustworthiness and Transparency, all the processes involved in supporting the child with ID would be communicated clearly to
their family and key caregivers, and with the individual to the extent possible. In accordance with the principle of Peer Support, efforts would be directed to fostering the interpersonal skills of the student with ID, including them as much as possible in the education of their peers in the least restrictive environment, and involving their family members or key caregivers in any trauma recovery or school therapy processes. In accordance with the principle of Collaboration and Mutuality, decisions for the child would be made by considering the perspectives of the key individuals involved, and the differential power dynamics at play would be recognized and neutralized. To exemplify the principle of Empowerment, Voice, and Choice, the child with ID’s perspective and preferences would be prioritized, and advocacy skills and related resiliency skills would be taught to the student. From the principle of Cultural, Historical, and Gender Issues, interventions would be designed with these factors in mind, with the individual’s unique history taken into account. See the TIC checklist guide for students with ID in Table 3 below.

**Table 3**

*TIC Guiding Checklist for Students with ID*

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<th>TIC Checklist for Students with ID</th>
<th>Realize</th>
<th>Recognize Resist</th>
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<td><strong>Safety</strong></td>
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<tr>
<td>o Prioritize advocacy, gaps in education, and rapport-building</td>
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<tr>
<td>o Highlight coping skills and prioritize resisting revictimization</td>
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<tr>
<td>o Maintain a clear and open dialogue with all parties</td>
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<tr>
<td><strong>Trustworthiness &amp; Transparency</strong></td>
<td>o Maintain documentation of planning and progress monitoring</td>
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<tr>
<td><strong>Peer Support</strong></td>
<td>o Create brave spaces for group treatment</td>
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<td></td>
<td>o Ensure that all students have access to diversity-informed education that is inclusive of ID</td>
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<tr>
<td><strong>Collaboration &amp; Mutuality</strong></td>
<td>o Include family members and other caregivers in the treatment planning and process for students with ID</td>
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<td>o Establish open communication with all involved in the plan</td>
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<tr>
<td><strong>Empowerment Voice &amp; Choice</strong></td>
<td>o Incorporate the individual’s preferences into the intervention</td>
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<td></td>
<td>o Actively involve the individual to the extent possible in the adjustment of their intervention</td>
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<tr>
<td><strong>Cultural, Historical &amp; Gender issues</strong></td>
<td>o Understand the history and current landscape of ID</td>
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<td></td>
<td>o Expand awareness of intersectional identities</td>
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**Treating Childhood Trauma in Schools**

Schools remain the place where children are most likely to have their mental health needs met (Paulus et al., 2016; Perfect & Morris; Ringeisen et al., 2003), and given that many children will be exposed to some kind of traumatic experience before they turn 18 (Overstreet & Chafouleas, 2016), schools must have structures set up to support their students on their journeys to learn best and reach their full potential. For both students with and without disabilities, untreated trauma interferes with learning, general life
functioning, cognitive processing, and forming and maintaining positive interpersonal relationships (Aas et al., 2016; Lloyd, 2020; Mulvihill, 2005). It further increases the risk of developing additional mental health disorders, substance abuse and incarceration, and continuing the cycle of generational trauma (Chafouleas et al., 2019; Dye, 2018). As schools are where children spend the majority of their time, and the broader goal of the public education system is to prepare children to be functional members of society, having ways to treat trauma in school settings today is necessary.

Currently, the types of school-based services available to children with ID include academic-based supports such as modified curricula, scaffolded instruction, smaller classroom time, and transition planning for after high school, as well as the potential for mental-health minutes to be added to their IEP if they are needed (Pezzulo, 2013). While utilizing evidence-based practices (EBPs) is the ideal way for school psychologists and mental health professionals to provide care, these EBPs of all forms often need to be adapted in some way to be used successfully with individuals with ID (Ali et al., 2013). Even though the majority of individuals with ID present with a form of mild ID (Boat & Wu, 2015), this frequent need for tool adaptation often makes the process of helping these individuals more complex (Man & Kangas, 2020). When it comes to adapting tools to best fit an individual with ID, it is necessary to understand the specific needs of that child and the current state and rigor of available research and have an awareness of tools on the horizon (Knaapen, 2013; Man & Kangas, 2020). In this case, expert opinion and professional experience are also sources of substantial support, especially when research is lacking.
Systems Level

To help address trauma at a systems level in education, one key way to enact positive change is to lean on the model of TIC (Keesler et al., 2014a). TIC offers a framework compatible with School-wide Positive Behavior Interventions and Supports (SWPBIS) to train all school staff and personnel in trauma symptom identification and response (Perfect & Morris, 2011). This way, all adults in the building are on the same page regarding how to best create trauma-sensitive environments, how to identify basic trauma symptoms in students, and to understand what next steps to take to connect the child and family with targeted resources (Maynard et al., 2019; Record-Lemon & Buchanan, 2017; Ridgard et al., 2015; Wiest-Stevenson & Lee, 2016). Trauma symptoms in children can manifest in a variety of ways that can negatively impact their academic, social, and emotional functioning both inside and outside of school (Chafouleas et al., 2019; Dye, 2018). Increasing school personnel training to include at least these basics of trauma symptom identification, and how these symptoms might appear differently for students with disabilities, is a first step in systems-level change to help stop the cycle of trauma in today’s youth. Given that children are not likely to disclose their experiences of abuse to others, especially experiences that fall in societally taboo territories such as sexual abuse, adults who work in school settings must be trained in the signs of what to look for to help care for their students (London et al., 2005).

Organizational Level

There are many different kinds of trauma that a child can experience (Chafouleas et al., 2019), and many of these traumatic experiences are outside the control of the
school community. However, schools have the power to provide education and training to help promote skills in students beyond academics to foster self-advocacy, healthy interpersonal boundaries and relationships, and teach signs of abuse and trauma to their students. Children do not learn in isolation, and to most effectively flourish in school, and later in society, schools must accept their role in educating children has permanently strayed beyond pure academics. Many schools across the US have guidelines for implementing social-emotional learning (SEL) curricula to help address some of these areas of development and there are outside organizations prepared to help schools continue these endeavors (Hoover, 2019; Rose et al., 2021; Son & Draws, 2017).

While it is important to keep in mind the many different types of adverse experiences a child can go through, one that routinely has been tied to significant negative life outcomes when untreated is sexual trauma. Sexual trauma carries with it additional layers such as the taboo of discussing this type of abuse openly, the stigma of discussing events of a sexual nature, and the confusing emotions that result from this specific kind of abuse especially when it occurs at younger ages of development. At older ages, sexual abuse can lead to additional difficult situations, such as early or atypical sexual behavior, unsafe sexual behavior, dissociation, and increased risk for mental health disorders, substance abuse struggles, difficulty with interpersonal relationships, self-harm, suicidal ideation, re-victimization, and perpetuation of generational trauma (Beitchman et al. 1991; Collin-Vézina et al., 2013; Fortin-Langelier et al., 2019). Schools can intervene in this cycle by teaching students throughout the school year skills that foster healthy interpersonal relationships and boundaries, self-advocacy skills, sexual
health education and safe practices, diversity awareness, and signs of abuse and how to respond. Having access to this information in a developmentally appropriate way with checks for deep understanding is especially important for students with ID, who are likely to receive their main sexual health information through schools (Rowe & Wright, 2017), and who are at increased risk of being taken advantage of by individuals without ID due to ID-specific vulnerabilities, and at risk of causing interpersonal harm to other individuals with ID due to lack of topical education or deep understanding of appropriate boundaries (Martinello, 2015).

A way to enhance the interpersonal skills of individuals with ID, and students generally, and halt the cycle of trauma is to embed learning opportunities into the school system throughout developmental levels. Schools have the chance to work with and support children throughout their initial periods of development and can provide supports in ways beyond pure academic education – especially in ways that support the social and emotional health and well-being of their students. Currently, all 50 states have federal funding for sexual health curricula in public education settings, however, this funding is mandated to be for abstinence-based sexual education only (Son & Draws, 2017; Treacy et al., 2017) – a practice that is not evidence-based and does not help address the sexually transmitted infection epidemic nor help combat teen pregnancy (Shapiro & Brown, 2018; Son & Draws, 2021). This is of special concern to students with disabilities, who are likely to receive their only sexuality education through school settings and are legally required by IDEA to receive evidence-based education (Individuals with Disabilities Education Act, 2004; Treacy et al., 2017). When students with ID can partake in school-
based sexual health education classes, they often struggle to fully access the information (Rowe & Wright, 2017). Outside of structured academic classes, students are typically continuing to learn from their peers and their environments, gathering knowledge through the “ignored curriculum” that students with ID often struggle to access (Gougeon, 2009; Moljord, 2018; Rowe & Wright, 2017). Combined, this indicates that sexual health education in schools is necessary, especially for students with ID, and most importantly needs to be delivered in a way that is accessible to students at varied developmental levels.

There are currently no streamlined federal guidelines for sexual health education in public schools across the United States, leaving a wide range of educational opportunities available to students learning in the public domain; only 20 U.S. states mandate that sexual health education in schools be medically and factually accurate (Shapiro & Brown, 2018; Willis et al., 2017). Students with disabilities have the same rights to have autonomy over their bodies and the rights to pursue happiness as students without disabilities (Treacy et al., 2017), especially students with ID who have historically been wrongly denied their sexual rights and forcibly sterilized (Byrne, 2018; Committee on Bioethics, 1999).

As the current landscape of sexual health education in U.S. public schools stands, students with disabilities are uniquely posed to help move education forward as they are legally mandated to receive evidence-based interventions, and much of the current sexual health education in public schools today is not. Moving away from abstinence-based sexual health education towards more evidence-based practices not only would help arm
students with disabilities with accurate information to take with them throughout their lives, but the general student body as well, and this element could serve as a crucial factor in interrupting the cycle of sexual trauma among individuals with ID. Though curricula may need to be adjusted, students with ID are in a position to gain significantly from having access to sexual health, general health, and social-emotional curricula in schools that are taught explicitly, but so is the rest of the country (Räty et al., 2016). When students with ID exit public education and graduate into the world, these individuals will then be better prepared to make safe and responsible decisions and advocate for themselves. When students in general have received evidence-based sexual health curricula throughout their school years, they are better prepared to make healthy choices for themselves and others and live more autonomous lives.

**Individual Level**

At the individual student level, often Tier 3 in public schools that utilize a multi-tiered system of supports (MTSS) framework, there is room for targeted trauma intervention. While systems-level change and school-wide preventative frameworks are ideal to have in place, it is also necessary for schools to be prepared with individualized interventions that can be implemented at the student level. Individual school-based trauma interventions are designed for short-term implementation to effectively address trauma symptoms in school settings and help support the child to be their best self. There are a variety of models that can be used in school settings to help address individual trauma symptoms, as well as interventions that have been specifically designed for use in
schools (Chafouleas et al., 2019; Distel et al., 2019; Jaycox et al., 2006; Langley et al., 2015; Hoover, 2019).

Despite the variety of trauma interventions available to the neurotypical population for use in therapeutic settings with individuals and families that touch on various types of childhood trauma, as well as the options available specifically for use in school settings, there remain limited choices for interventions to pull from when working with a student with ID. Children with a label of ID or Multiple Disabilities under an IEP in public school settings ages 3-21 account for around 8% of students receiving special education services (NCES, 2021). This means that of the 14% of overall students, or 7.3 million students, receiving special education services, around 584,000 of them are qualifying for a label of ID. Based on the statistics that children with ID are at the highest risk of children with disabilities of experiencing sexual abuse and three to six times more likely than their nondisabled peers to experience abuse (Keesler et al., 2014; Martinello, 2015; Treacy et al., 2017; Wissink et al., 2015), and despite rates of abuse statistics varying significantly due to lack of disclosure and decreased likelihood of disclosing during childhood, if around 20% of women and 10% of men from the general population report experiencing sexual abuse (Shevlin et al., 2015b), the majority of those 584,000 students are at risk. They are at risk for suffering from sexual abuse both from other individuals with ID and individuals without ID, for having their symptoms being misidentified due to lack of trauma training among school staff, lack of trainings that incorporate trauma symptoms in children with disabilities, and lack of adapted or targeted resources for when their trauma has been realized. This indicates that while students with
ID make up a small percentage of students attending school overall, they are a high-risk group in need of targeted trauma treatments for use in school settings. While the current most effective trauma therapy models were not originally designed for students with ID, there have been promising outcomes seen through models that have been adapted for children with ID in mind. These adaptations include multi-modal service delivery, higher use of manipulatives, increased caregiver involvement, repetition of concepts, concrete examples and real-life practice, checks for understanding, and the incorporation of fundamental knowledge about healthy sexual practices, safe boundaries, self-advocacy, and interpersonal relationships (Campbell & Gilmore, 2014; Keesler, 2014b; Rowe & Wright, 2017; Talapatra et al., 2020; Taylor et al., 2008; Unwin et al., 2015).

**Role of the School Psychologist**

Within the field of school psychology, providers are uniquely positioned to be able to help individual students who would otherwise be overlooked by systems that focus primarily on the majority. School psychologists are equipped with skills that enable them to navigate both school and mental health systems and work with children across the spectrum of age and ability level – some for a significant number of years in a child’s life. For these reasons, school psychologists are in a prime position to implement tools specifically for students with ID and trauma and help intervene in these adverse cycles as they begin. School psychologists are some of the people who are most likely to form relationships with a student with ID in school and some of the people who are most likely to be able to notice symptoms of trauma and abuse in a child. Even if school psychologists do not have specific experience working with a student with ID, they can
fall back on their training in mental health and education to be more ready to help children with low-frequency struggles.

In schools, school psychologists have the potential to weave adapted measures for students with ID and trauma-informed practices such as TIC into their work on multiple levels. They can be a force to promote the importance of integrating trauma-informed trainings and practices to staff and students and helping create an overall environment that is sensitive to trauma experiences even if individual experiences are not explicitly discussed. This can be a first step in the process towards better care for students who have experienced trauma in the past and can set the culture of the school to be a place that is understanding of the ubiquitous nature of trauma, and thereby be a place of trust, empowerment, and safety (Keesler et al., 2014a). Even in the face of a limited selection of specific tools to use when working with students with ID, promoting an approach such as TIC school-wide can be an important first step in the process of helping not just students with ID who may have experienced trauma, but all students and staff in the school who have had adverse experiences. Additionally, schools can work to expand trauma trainings to include signs and symptoms as they pertain to students with disabilities, and students with ID.

School psychologists have the potential to help implement a wide variety of curricula outside of pure academic supports and can be leaders in the charge to include students with ID in these learning opportunities (Perfect & Morris, 2011). Numerous curricula and guidelines are available that have the potential to assist with teaching students with ID interpersonal and adaptive skills, including PEERS for social skills.
trainings (Rose et al., 2021), the National Sexual Education Standards (NSES) for guidelines on comprehensive sexual health education (Son & Draws, 2021; Treacy et al., 2017), and the Family Life and Sexual Health Curriculum (FLASH) for a comprehensive sexual health curriculum (Son & Draws, 2021), as well as following the lead of other evidence-based practices in this area. There are numerous organizations outside of the US that have spearheaded the movement to enact developmentally appropriate healthy relationships curricula to all grade levels starting in kindergarten that encompass wide-ranging interpersonal and personal skills, evolving into sexual health education in older grade levels (Hoover, 2019; de Melker, 2015; Mevissen et al., 2018; Schutte et al., 2014; UNESCO, 2018). Further, school-based mental health professionals such as school psychologists are well-equipped to deliver individualized targeted interventions due to their in-depth and varied training, though they can also be delivered by other school-based mental health workers such as school-based therapists and social workers (Reinbergs & Fefer, 2018). By understanding the landscape of available resources and being advocates for inclusivity regarding students with disabilities, especially students with ID, school psychologists can go far in helping ensure that these students have access to and can access this important educational material that can support them throughout their lives.

**SAFEST KID: Proposed Model**

*SAFEST KID: A Sexual Assault Framework in Education to Support Trauma in Kids with Intellectual Disability* is a proposed model that aims to encapsulate the current
understanding of the intersecting landscape of school systems, mental health, ID, and sexual trauma. It pulls from multiple existing therapeutic models and programs that target various elements of this intersection and combines them to create a full-system model that is both responsive and preventative. The epidemic of rampant sexual abuse occurring within the population of individuals with ID is a symptom of a greater systemic issue (Chafouleas et al., 2019; Shapiro, 2018), and a therapeutic model that only targets a symptom will never cure the illness. For these reasons, the SAFEST KID model is designed on three levels: systems, organizational, and individual. The first two levels, systems and organizational, are included for consideration and are more conceptual in nature and will lean on the TIC Pillars. The third level, the individual level, provides the more in-depth targeted intervention component of SAFEST KID to be used in schools with students with ID and sexual trauma and exemplifies the TIC principles. SAFEST KID incorporates elements from all three of these levels to provide school psychologists, school organizations, and school districts with a map towards progressive change to help stop the cycle of sexual abuse within our society. Individuals with ID are often forgotten in today’s world, yet they have the power to be the keystone piece of this change. If resources can be designed to help teach these students important tools for fostering healthy relationships, self-advocacy, and sexual rights, then they can be translated to helping all students as well. Yet, it is not enough to stop at an individualized intervention for one student. The path that led that student with ID to experience sexual trauma needs to be interrupted at multiple places to prevent that point of trauma from being reached in the future (Chafouleas et al., 2019). The sexual taboo within the United States has gone
on for too long (Byrne, 2017; Rowe & Wright, 2017; Treacy et al., 2017), and has left an
insidious trail of destruction in its wake. An entire overhaul is needed to enact long-
lasting change. There will be barriers to the implementation of a full-system model
to address sexual trauma in today’s students with ID, however, if success is obtained for this
population, it represents a bright light and hope for all students in this country.

The SAFEST KID model is divided into three sections to represent these three
main areas of focus to enact long-lasting change. The aim is to enact them all together,
however school-based mental health practitioners, school administrators and additional
school personnel can also implement them separately. The three levels are: individual
intervention (level 3); organizational intervention (level 2); and system intervention (level
1). The organizational level and system level are included as supportive elements in the
SAFEST KID model and are aligned with the TIC pillars realize, recognize, respond, and
resist, with the understanding that a detailed examination of the individual level is first
needed to inform the later models. Beginning with the most specific and targeted level
within the microsystem can serve to inform the broader ecological levels at play, and so
level 3 will align with the TIC principles of safety, trustworthiness and transparency,
peer support, collaboration and mutuality, empowerment voice and choice, and cultural,
historical and gender issues. See the ecological perspective below in Figure 2.
Figure 2. SAFEST KID: Ecological perspective

Level 1

Level 1 is included in this model as an element of support and theoretical consideration. At the broadest level, to target the epidemic of sexual trauma in students with ID, a more expansive understanding of trauma symptoms is needed from all school personnel. Level 1 prioritizes the TIC pillars of realize, recognize and respond, by aiming to spread awareness and information about the impact and manifestation of trauma and trauma symptoms to all adults who work with children in school settings. There is a movement to turn all schools across the country into trauma-informed schools, which involves district-wide staff training in trauma symptom understanding and identification and trauma response (Maynard et al., 2019; Record-Lemon & Buchanan, 2017;
Overstreet & Chafouleas, 2016; Ridgard et al., 2015; Wiest-Stevenson & Lee, 2016). To align with the tenets of TIC, a school system must consider each of the four pillars and the six principles, striving to be a place where all personnel are educated in neuro-diverse trauma in terms of its symptoms, impact, and commonality. Further, schools must foster safe and supportive environments, strive for transparency throughout their decision-making, engage collaboratively with school personnel, students and families, seek to empower their community members and acknowledge historical factors and current biases as they relate to culture, race, gender, and neurodiversity. TIC trainings currently exist and are offered through multiple organizations that understand the preventative power that this knowledge holds. TIC must be woven into all elements of schools and based on School-Wide Positive Behavior Interventions and Supports (SWPBIS; Overstreet & Chafouleas, 2016), and this training should be available to all staff – not just special education team members and teachers. The Framework for Safe and Successful Schools outlines policy recommendations to help districts establish effective practices across the board, and The School Health Assessment and Performance Evaluation (SHAPE) provides free tools to progress monitor mental health initiatives along with trauma tracking assessments (Hoover, 2019). Further, The Treatment and Services Adaptation Center provides full trauma interventions for schools that encompass a wide variety of trauma interventions and knowledge, and additional programs and resources that can be enacted at state and district-wide levels include Futures Without Violence and ACEs Connection (Hoover, 2019). For an overview of systems-based trauma trainings, see Table 4. School psychologists can be instrumental in spearheading
these initiatives, either by leading trauma-informed trainings or by advocating for the inclusion of this professional development within their districts’ trainings.

Table 4

_District Trauma Trainings Examples & Overview_

<table>
<thead>
<tr>
<th>District-Wide Trauma Trainings</th>
<th>ID Trauma Knowledge</th>
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<tr>
<td>● ACEs Connection</td>
<td>● Trauma symptoms may present differently in children with ID</td>
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<td>● Framework for Safe and</td>
<td>● Diagnostic overshadowing can interfere with trauma identification</td>
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<tr>
<td>Successful Schools</td>
<td>● Heightened risk, fewer accessible resources, and a widespread epidemic of abuse among individuals with ID increase the need for trauma-informed schools</td>
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<tr>
<td>● Futures Without Violence</td>
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<tr>
<td>● School Health Assessment and Performance Evaluation (SHAPE)</td>
<td></td>
</tr>
<tr>
<td>● Trauma-Sensitive Schools Training Package</td>
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<tr>
<td>● Treatment and Services Adaptation Center</td>
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</table>

It is imperative that schools across the US make the transition to become trauma-informed places of learning. The rates of trauma exposure in today’s youth are too high for any school to ignore this facet of life any longer. Schools across the nation have great power and potential to intervene in the generational cycles of trauma – learning does not just involve academic instruction. Schools have evolved to be the places where children develop into functional members of society, and unfortunately, this society is not a perfect place. The majority of children will be exposed to a traumatic experience in their lifetime (Cavanaugh, 2016; Wiest-Stevenson & Lee, 2016), but experiencing trauma does
not have to mean a life sentence, impaired trajectory, or wounded potential. Schools are already the place where children with ID are most likely to receive sexuality education, and they are the place where children of all kinds are most likely to receive mental health intervention (Ringeisen et al., 2003; Rowe & Wright, 2017). If schools can make the move to becoming trauma-informed institutions, thereby ensuring that their staff know the basics of trauma symptom identification and response, it can go a long way towards helping instill positive coping mechanisms, spreading empathy, and fostering resiliency among today’s youth. There are many forms of trauma, yet they are often interrelated (Chafouleas et al., 2019). Addressing the epidemic at the systems level is imperative. For this reason, the SAFEST KID model advises that schools and districts adopt a trauma-informed lens across institutions and implement district-wide staff trainings in trauma. TIC models have been designed and implemented by individual districts as well, but SAFEST KID includes a summary of training organizations that can help accomplish this endeavor. For an overview of trauma symptoms in children, see Table 5.

Table 5

Trauma Symptoms Overview

<table>
<thead>
<tr>
<th>Common Trauma Symptoms Generally</th>
<th>Common Trauma Symptoms in ID</th>
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<tr>
<td>● Avoidance of individuals,</td>
<td>● Avoidance of individuals,</td>
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<tr>
<td>situations, or specific stimuli</td>
<td>situations, or specific stimuli</td>
</tr>
<tr>
<td>● Increase in anxiety</td>
<td>● Changes in eating habits</td>
</tr>
<tr>
<td>● Increase in depression</td>
<td>● Delayed grief</td>
</tr>
<tr>
<td>● Hypervigilance</td>
<td>● Increase in self-harming behaviors</td>
</tr>
<tr>
<td>● Changes in appetite</td>
<td>● Increase in somatic symptoms such as stomachaches</td>
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</tbody>
</table>
- Changes in sleep habits or energy levels
- Persistent fatigue
- Increase in externalizing behaviors
- Developmentally inappropriate sexual knowledge or behavior
- Nightmares
- Signs of physical injury stemming from abuse
- Increase in substance use
- Academic and professional difficulties
- Dissociation
- Feelings of guilt or shame

- Overall change in baseline functioning
- Withdrawal
- Persistent fatigue
- Increase in externalizing behaviors
- Nightmares
- Signs of physical injury stemming from abuse
- Increase in fear or anxiety

Level 2

Level 2 is included in this model as an element of support and theoretical consideration. Level 2 prioritizes the TIC pillars of recognize, respond, and resist by providing an organizational intervention to interrupt the cycle of sexual trauma amongst youth through establishing intentional, comprehensive, and developmentally appropriate healthy relationship education at all school grade levels. Moving from Level 1 to Level 2 narrows the focus on sexual trauma. Sexual trauma is uniquely devastating and brings with it a specialized taboo and stigma. For all individuals, this area is difficult to navigate. There is a puritanical shadow that has remained over the United States for centuries, and its legacy is continued in the lack of compressive sexual education.
dispersed throughout the schools in the US (Kirby, 2008; Rowe & Wright, 2017). It remains in the shunned nature of discussing the sexual rights of students with disabilities, particularly with cognitive impairments and neurodiversity, and it is apparent in society’s refusal to enact evidence-based practices of functional health education for today’s youth.

Teen pregnancy rates, STD transmission, onset of sexual activities, sexual assault and trauma are all currently problematic in US society (Santelli et al., 2018), yet the problem goes deeper than these surface issues. Not only does US society lack comprehensive sexual education in public schools across the nation, but it routinely preaches abstinence-based education despite clear evidence that this form of education is ineffective, counterproductive, and often harmful (Kirby, 2008; Lynch, 2017; Rabbitte & Enriquez, 2019; Shapiro & Brown 2018; Son & Draws, 2021). Sex education first and foremost needs to be accurate, evidence-based and effective. Beyond this, it must extend beyond mere biology and acknowledge that humans are complex creatures with a wide variety of interpersonal relationships that go far past an act of friction.

Comprehensive sex education must turn towards a developmentally appropriate healthy relationships framework interwoven in educational settings beginning in kindergarten to combat the epidemic of sexual trauma in all students, especially in students with ID. To successfully resist revictimization as it relates to sexual trauma, comprehensive and accessible sexual health and healthy relationship education is needed at all school levels. A healthy relationships curriculum encapsulates sex education in a developmentally appropriate way, yet also includes social-emotional learning objectives that target healthy boundaries, self-esteem, positive friendships, interpersonal
communication, LGBTQ+ knowledge and cultural diversity, neurodiversity, consent, self-advocacy skills, and ways to combat abuse of all kinds, as well as knowledge on sexual practices, STDs and pregnancy (UNESCO, 2018). Sexual education is a small fraction of this area, yet sexual trauma is a grave symptom that has extreme consequences in the lives of survivors and society as a whole. A comprehensive healthy relationships curriculum needs to be inclusive, not based on a heteronormative framework, and woven into the rhythm of education at its onset (Rowe & Wright, 2017; Son & Draws, 2021).

All children can benefit from being taught emotional identification, effective communication, and safe interpersonal boundary skills. Further, to ensure that this information is accessible to all students, and keeping students with ID in mind, it needs to be multi-modal, consistent, interactive and visual, and include knowledge checks as well as caregivers in the process. Ideally, information would be delivered to caregivers when it is being taught in schools to students so that caregivers can continue their education at home with tools to guide them in this complex endeavor. Current systems and organizations that are spearheading these changes include the Collaborative for Academic, Social and Emotional Learning which provides SEL resources for K-12 schools, as well as the Comprehensive Sexuality Education program from the United Nations Population Fund, and the Long Live Love curriculum out the Netherlands that provides healthy relationship curricula models for a variety of grade levels (Hoover, 2019; de Melker, 2015; Mevissen et al., 2018; Schutte et al., 2014; UNESCO, 2018).

SAFEST KID advises that schools adopt a healthy relationships SEL curriculum that is interwoven throughout grade levels to teach developmentally appropriate
interpersonal and self-regulation skills. This curriculum would eventually teach sex education at older grade levels, and be accessible to all students. In order to do this, students with ID will need scaffolded support that includes checks for understanding beyond surface-level concepts, as well as repeated instruction and multi-modal teaching. Research shows that the sexual abuse epidemic and resulting trauma in individuals with ID is perpetuated by both other individuals with ID and individuals without ID (Wissink et al., 2018), indicating that enhancing education of sexual concepts and self-advocacy skills is a key element in addressing this issue. Schools are likely to be the main place where children with ID receive sexual education (Rowe & Wright, 2017), and implementing a structure across grade levels to teach healthy relationships is a way to get important information in the minds of all students; an epidemic of this size cannot be addressed through helping one person alone, and it requires the instruction of constitutes both healthy and unhealthy relationships. For an overview of SEL and healthy relationship curricula, see Table 6. School psychologists can have a role in Level 2 by aiding in push-in educational curricula such as through some of the examples listed in Table 6, or by advocating for the overall school curricula to be expanded to include healthy relationships and have it more fully embedded throughout grade levels.

**Table 6**

*SEL and Healthy Education Curricula Overview*

<table>
<thead>
<tr>
<th>SEL &amp; Healthy Relationship Curricula</th>
<th>Key Points for Students with ID</th>
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80
- Collaborative for Academic, Social and Emotional Learning
- Comprehensive Sexuality Education
- Healthy Relationships Curriculum
- Long Live Love
- Rights, Respect, Responsibility
- Second Step
- Zones of Regulation

- Areas of importance include advocacy, emotional regulation, interpersonal boundaries and skills, social norms, personal rights, and consent
- Concrete material presented in multiple modalities and individualized is most accessible
- Explicit instruction is imperative
- Heightened risk for interpersonal abuse increases the importance of accessing this education
- Repetition and generalization are key

### Level 3

Level 1 and Level 2 of the SAFEST KID model fall under preventative measures to help stop the cycle of sexual trauma in students with ID, and provide a conceptual starting point for intervening in the epidemic of sexual abuse at their respective levels, each adhering to the TIC pillars in various ways. Level 3 aims to represent each of the four TIC pillars, as well as dive deeper into the six TIC principles. Level 3 falls under a responsive intervention when sexual trauma has been identified in a student with ID, and school-based mental health treatment is needed. Schools eliminate many of the barriers for children to access mental health treatment, and, despite important considerations such as over-worked and under-staffed school-based mental health providers, school day scheduling concerns, and unplanned school crises, there remains a golden opportunity for schools to help address sexual trauma in students with ID. Family-school partnerships will be instrumental in SAFEST KID’s implementation, as it is beneficial for the child to
have their family understand the therapy’s tenets to help them be implemented at home after school hours and allow progress to build and continue (Kerig et al., 2010). For children with ID, their trauma is not always recognized for what it actually is (Focht-New et al., 2008). Current therapeutic approaches still must be adapted creatively for children with ID, as posttraumatic stress responses in this population can vary significantly (Lanius et al., 2006).

Numerous evidence-based interventions currently exist to address trauma in schools, but two of the most effective ones are TF-CBT and CBITS. CBITS was specifically designed to be implemented in schools, and TF-CBT was originally designed to target sexual trauma and has been efficacious in children as young as kindergarten (Chafouleas et al., 2019; Cohen et al., 2017). TF-CBT offers an ideal model for addressing sexual trauma in students with ID, as it has significant room for adaptation and flexibility and leans heavily on caregiver support, which is imperative for supporting students with ID. CBITS has been modeled to work within a school setting and addresses multiple forms of trauma. These interventions have already been combined into the Bounce Back intervention for elementary school-age students, utilizing individual, group, and parent elements to help children heal from trauma (Chafouleas et al., 2019; Distel et al., 2019; Langley et al., 2015). Pulling in elements from sexual health and social-emotional learning curricula for students with ID and using Bounce Back as an initial framework offers a promising avenue of sexual trauma intervention for students with ID, especially when leaning on both TF-CBT and CBITS to expand SAFEST KID for developmental adjustments and increased focus on sexual trauma. Though designed for
elementary students, the Bounce Back framework can be adapted for higher developmental levels through the additional incorporation of TF-CBT elements, while still maintaining the school-based implementation framework. To be utilized with a student with ID, similar concepts and tools like those for effective SEL learning are needed: multi-modal instruction, visuals and role-play to make abstract concepts concrete, repetition, caregiver involvement, and frequent knowledge checks for understanding. School psychologists and other school-based mental health professionals will be imperative in the implementation of Level 3, as it requires time set aside to provide mental health minutes to students with ID who have been identified as having experienced sexual trauma. It will require weekly mental health minutes and the provider to follow the Bounce Back manualized protocol alongside the SAFEST KID Level 3 adaptations. Table 7 outlines the breakdown of components across TF-CBT, CBITS, Bounce Back, and SAFEST KID.

**Table 7**

*Components of Model Framework’s Trauma-Focused and School-Based Interventions*

<table>
<thead>
<tr>
<th>TF-CBT Core Components</th>
<th>Focus on sexual trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PRACTICE components (Psychoeducation on trauma and triggers, parenting skills, relaxation skills, affective modulation skills, trauma narrative and processing, in-vivo practice, caregiver therapeutic involvement, enhancing safety and development, traumatic grief)</td>
</tr>
<tr>
<td></td>
<td>Strong rapport between mental health provider, child, and caregiver</td>
</tr>
</tbody>
</table>
| CBITS Core Components | • Cognitive Coping  
• Gradual exposure for functional impairment  
• Problem solving/conflict resolutions  
• Psychoeducation  
• Relaxation Training  
• School-based sessions and focus on school-based effectiveness  
• Trauma narrative |
|-----------------------|---------------------------------------------------------------|
| Bounce Back Additional Components | • Feelings identification  
• Positive activities  
• Social support/connecting with others |
| SAFEST KID Additional Components | • Concrete, visual, personal, individualized elements  
• Developmentally tailored psychoeducation  
• Focus on multi-modal delivery  
• Focus on repetition and role-play practice  
• Incorporate the use of manipulatives  
• Psychoeducation additionally highlights important healthy relationships and sexual health concepts  
• Real-world examples |

The proposed intervention for SAFEST KID’s Level 3 targeted intervention is based on the Bounce Back manualized treatment and augmented with ID-specific elements and rooted back in the TIC framework. The primary goals are for it to be feasible to be used within school settings, and to find anchors within the TIC pillars and principles to most clearly address sexual trauma in students with ID. To support the principle of safety, Level 3 aims to fill in gaps in relevant education, such as regarding interpersonal skills, and also provide opportunities for the student to practice self-
advocacy as well as coping skills to decrease the chances of experiencing revictimization.

To support the principle of trustworthiness and transparency, Level 3 aims to prioritize open communication and clarity with all parties involved, and keep accurate documentation including treatment planning, progress monitoring, and treatment consent data. To support the principle of peer support, Level 3 aims to create brave and safe spaces for treatment, and support the interpersonal skills of students as well as awareness about how trauma manifests across different individuals. To support the principle of collaboration and mutuality, Level 3 aims to prioritize collaboration with family members and other pertinent caregivers in the child’s life, and maintain open communication throughout the treatment process. To support the TIC principle of empowerment voice and choice, Level 3 aims to incorporate the student’s preferences into the intervention to the extent possible, and to create space for the asking of questions and clarification regarding the process itself. To support the principle of cultural, historical and gender issues, Level 3 aims to ensure psychoeducation for the interventionist that includes awareness of the historical and current landscape of ID and how it shifts in the face of intersectional identities, and viewing the student as centered within their identities.

SAFEST KID’s theoretical components at Level 1 and Level 2 are designed to be implemented consistently throughout each school year, across districts and grade levels. They aim to be a consistent presence interwoven throughout school systems as preventative approaches to sexual abuse. But for individual school-based mental health
practitioners considering when to implement Level 3 of SAFEST KID, they should follow this decision-making tree outlined below in Figure 3:

**Figure 3. SAFEST KID: Level 3 Decision-Making Tree**

**Key Points**

Combined, SAFEST KID’s three levels aim to target school-based mental health intervention at the system, organizational, and individual levels by leaning on tiered service delivery, targeted intervention based on need, and family-school partnerships.
Each level can be implemented separately, but ideally should be implemented together to target the epidemic of sexual abuse among children with ID at all levels. Despite these children often being pushed to the margins of society, they represent the best of what our society can be. When society views these individuals as the complete, complex humans with equal rights that they are, and works to build structures and systems that enable them to live a better life, the rest of society gains as well. All individuals can benefit from strategies and interventions that work for students with ID.

When implementing this model, there are a few key components to keep at the forefront of the mind. Before working with a student with ID who has experienced sexual trauma, the mental health provider should review the available case files and have a working understanding of the child’s situation as well as their personal strengths and areas of growth in order to maximally personalize treatment and build a stronger rapport. Progress monitoring and data collection are key pieces of any effective model, and so at the start of the Level 3 intervention, an assessment or screener should be administered, such as the Child PTSD Checklist to provide an initial data point. See Table 8 for additional progress monitoring options. The same tool should be utilized at the end of the intervention to measure its impact and efficacy in addressing the symptoms of concern. Throughout all work with students with ID, it is important to prioritize interactive activities, the use of visuals and manipulatives, and to strive to incorporate personalized interests and life components of the child to the extent possible.

**Table 8**

*Progress Monitoring Tools for ID and Trauma*
<table>
<thead>
<tr>
<th>Progress Monitoring Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Bangor Life Events Scale for Intellectual Disability (BLESID)</td>
</tr>
<tr>
<td>● Impact of Events Scale-Intellectual Disability (IES-ID)</td>
</tr>
<tr>
<td>● Lancaster and Northgate Trauma Scales for Intellectual Disabilities (LANTS)</td>
</tr>
<tr>
<td>● Posttraumatic Stress Checklist (PCL-5)</td>
</tr>
<tr>
<td>● Traumatic Events Screening Inventory-Child Version (TESI) [baseline screener]</td>
</tr>
<tr>
<td>● Traumatic Events Screening Inventory-Parent Version (TESI) [baseline screener]</td>
</tr>
</tbody>
</table>

The person who delivers this part of the model to the student, preferably the school psychologist, should keep in mind the additional importance of building rapport with the student, which, for a student with ID, is often a stronger factor in the success of the intervention than with a student without ID. This part of the model is meant to be activated when it has been understood that a student with ID has experienced sexual trauma, which ties back to the importance of implementing Level 1 in schools to ensure that school staff have been educated in signs of trauma in all students as well as students with more significant disabilities (Cohen & Mannarino, 2008; Talapatra, Parris & Snider, 2020).

When considering individual adaptations for a student with ID modeled along the Bounce Back framework, these primary ones follow: the inclusion of psychoeducation as it relates specifically to qualities of ID, safety precautions pertinent to students with ID, and sexual health education that was missed previously; the inclusion of communication and advocacy practice regarding the specific needs of the student; practicing the coping
skills in multiple settings and with extra repetition, including caregivers if possible; the use of behavioral activation strategies as well as cognitive restructuring to make skills feel more concrete; the incorporation of psychoeducation on interpersonal boundaries and signs of healthy relationships; the use of multi-modal elements within the trauma narrative such as art therapy techniques or physical manipulatives to decrease the abstraction; the use of visual aids to highlight the skills taught within the intervention; the practice of identifying safe individuals within the student’s life in various areas; the practice of role-play scenarios that mimic real life interactions to help support the understanding of both healthy and unhealthy relationships, and when the student is safe or unsafe; the inclusion of knowledge checks that address trauma education, coping skills, and interpersonal skills; the inclusion of additional sessions as needed for practice and repetition. See Figure 4 for an additional description of ID adaptations to Level 3 of the SAFEST KID model, and the implementation guide for Level 3’s therapeutic intervention.

<table>
<thead>
<tr>
<th>Session Focus</th>
<th>Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapport &amp; overview: why they will be working with you &amp; what kinds of things they'll be doing</td>
<td>Visual aids</td>
</tr>
<tr>
<td></td>
<td>Activity</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2</td>
<td>Feelings identification &amp; practice, communication &amp; activities for emotions, common ID stress reactions</td>
</tr>
<tr>
<td>3</td>
<td>Bodily feelings &amp; relaxation training. Practice coping skills in multiple settings and with caregivers</td>
</tr>
<tr>
<td>4</td>
<td>Helpful thoughts, behaviors &amp; routines</td>
</tr>
<tr>
<td>5</td>
<td>Boundaries &amp; safety, touch, trust &amp; advocacy</td>
</tr>
<tr>
<td>6</td>
<td>Coping skills practice</td>
</tr>
<tr>
<td>7</td>
<td>Identification of safe individuals at school and home &amp; rationale</td>
</tr>
<tr>
<td>8</td>
<td>Trauma narrative development &amp; practice</td>
</tr>
<tr>
<td>9</td>
<td>Practice safe responses to situations and real-life interpersonal scenarios</td>
</tr>
<tr>
<td>10</td>
<td>Review development of interpersonal &amp; safety skills, trauma integration &amp; coping skills</td>
</tr>
</tbody>
</table>

**Considerations:** Repeat session content as needed based on individual progress utilizing Table 8 progress monitoring tools and observations prior to termination. Follow the SAFEST KID: Level 3 Adaptations Guidelines in Appendix A for additional guidance.

*Figure 4. SAFEST KID Adaptations to Bounce Back Foundational Framework*

**Collaboration Importance**

Integrated care across home, school, and community partnerships will be instrumental in providing the strongest approach to treatment. As this therapy will be provided in a school setting, there is potential to incorporate support from any outside therapy provider and caregivers, as well as family members who spend significant time with the individual. Due to already being in an integrated setting, the school environment will enable the child to more easily apply the skills learned in these sessions to the rest of
their day. It is important for both caregivers at home, the trusted adult at school providing care, and outside community members providing treatment to be kept up-to-date and informed of the treatment process to help support the child and their progress. For this reason, establishing a strong partnership between the home, school, and potential community will be imperative in delivering this treatment as well to the extent that it is possible.

Conclusion

With the growing support that an adapted and simplified version of CBT can positively impact those with ID despite historical biases and hesitancies (Taylor et al., 2008), and research that supports the use of TF-CBT with individuals with ID, CBITS in schools, and combined interventions such as Bounce Back (Distel et al., 2019; Jaycox et al., 2012; Langley et al., 2015; Stenfert Kroese et al., 2016), it is now necessary to develop and reflect new additions to the therapeutic toolbox that can be used in schools, where the majority of children have their mental health needs addressed, and consider how to adapt them for use with students with ID. Trauma symptoms in students with ID are likely to present differently than typical peers, with a greater increase in behavioral outbursts and somatic symptoms, indicating the need to include how trauma symptoms manifest across different types of children when implementing TIC trainings (Talapatra et al., 2020). Symptoms of trauma beg to be addressed, or they are at risk for emerging in the lives of survivors via additional adverse life experiences and choices, and additional mental health struggles. This manuscript has outlined the landscape of the need for a
targeted tool to address sexual trauma in the ID population and discussed a new theoretical model that can be used in schools, with community providers, and with families specifically for students with ID and sexual trauma in the form of SAFEST KID. Trauma is diverse, individualized, and wide-reaching, and to be effectively addressed it requires intervention and change at multiple levels within the school: systems, organizational, individual.
School psychologists have been pushed to the forefront of school-based mental health services (Rossen & Cowan, 2013), and despite their extensive and far-reaching background training, many do not feel prepared to take on this role (Walcott & Hyson, 2018). School psychologists across the country are understaffed, and many schools would need 2-3 school psychologists to meet the national best practice standards (Castillo et al., 2011; Curtis et al., 2006), which already sets the stage for an uphill battle to enact real long-lasting change. Further, many school psychologists are still primarily focused on providing assessments, and though they are aware of the growing need for more school-based mental health services, are hesitant to take on trauma-informed care (TIC) practices, and in some cases, feel undertrained to work with certain segments of students, such as students with intellectual disabilities (IDs; Walcott & Hyson, 2018; Talapatra et al., 2018).

The role of the school psychologist has evolved from its first conceptualization in the early 1900s to the current school-based role as it is now known (Fagan, 2002), and it continues to evolve to meet the changing demands of the times. School psychologists established their place in school settings by spending most of their time in special education and conducting assessments for students (Fagan, 2002). Today, school psychologists are continuing to move beyond their more established roles and becoming
key mental health interventionists and crisis responders in their schools by providing mental health service minutes, social-emotional learning, consultation, and crisis management (Rossen & Cowan, 2013). Indeed, as noted by the National Association of School Psychologists (NASP; 2021), two pillars that are heading to the forefront of school psychological work are crisis intervention and mental health and behavioral intervention.

Despite this nationwide changing focus of the role of a school psychologist, there are significant growing pains. The more recent focus of the role of school psychologists to promote TIC practices and trauma-informed approaches throughout their schools and throughout the work that they engage in with students, combined with the realization that many school psychologists do not feel ready to manage symptoms of childhood trauma, highlights a significant gap in research-to-practice and school psychology training (Rossen & Cowan, 2013; Walcott & Hyson, 2018). Given that around 1 in 2 children in the US is likely to benefit from mental health support at some point in their development, but many will not receive this care (Whitney & Peterson, 2019), increasing the accessibility of mental health supports should be a serious concern for all involved. For children with disabilities, the need for TIC is even more critical as the rates of estimated trauma among this population are higher than for those without disabilities (McNally et al., 2021). Though abuse does not automatically ignite trauma, children with ID are at a three to five times greater risk of experiencing abuse than children without disabilities (Keesler et al., 2014). Because of their extensive and broad background training (see NASP Practice Model, 2020), school psychologists are in an excellent position to help
address this trauma treatment need through the provision of mental health services in schools (Eklund et al., 2013; Paulus et al., 2016; Ringeisen et al., 2003). For example, school psychologists can help address the manifestations of trauma in students in the areas of physical functioning, self-regulation, academic pursuits, and interpersonal relationships as these are all areas that their trainings have likely touched on previously (Diamanduros et al., 2018). By leaning into the role of promoting trauma-informed practices, interventions, and systems-level change, school psychologists can embody all of the practice model domains outlined by NASP.

There is a clear need for more mental health support for children in schools, especially for students with intellectual disabilities (ID), and school psychologists, in theory, are professionals who are primed to lead this charge if they have access to the right tools and supports (e.g., trauma-based in-service trainings or trauma-focused guidelines for students). Though the effects of trauma have the power to interfere with functioning at all levels, interventions addressing trauma in youth have the power to lift up and enhance functioning across all of them as well. This manuscript will, first, highlight the disconnect between need and preparation that school psychologists endorse regarding their work with childhood trauma and students with ID, and, then, review the utility of a tool (i.e., SAFEST KID) that can help support school psychologists when working with this population through the use of a Delphi Study. Implications for future training and practice will be discussed.
Research-to-Practice Gap

Research on evidence-based practices (EBPs) has delivered an expansive array of effective interventions that are legally required to be implemented in schools, yet there remains a gap between this cultivated knowledge and its application towards practice; this phenomenon is known as the “research-to-practice gap” (Grima-Farrell et al., 2012; Sanetti & Collier-Meek, 2019). Common barriers to implementation such as low implementation literacy, or lack of understanding of how to apply research to practice, difficulty adapting EBPs to fit with individual students, and lack of implementation generally continue to persist despite the fact that school psychologists often have had training in the importance of using EBPs (Grima-Farrell et al., 2012; Sanetti & Collier-Meek, 2019). Additionally, though the multi-tiered systems of supports (MTSS) and Response to Intervention (RTI) modalities in schools have been designed to incorporate EBPs throughout the tiers of need, not all schools have implemented MTSS or RTI in the most complete or effective manner (Sanetti & Collier-Meek, 2019). Without the full and correct implementation of MTSS and RTI, disseminating new and improved EBPs to students is more challenging.

Another barrier is the shortage of school psychologists. According to NASP, the ideal ratio of students to school psychologists should be 500-700:1, yet currently, the average ratio across the country hovers closer to 1500:1, and in some districts is as high as 3000:1 (NASP, 2021). School psychologist jobs are understaffed, and rates vary significantly by state, and by areas within states (Brock, 2018). Effective EBPs can only be implemented when the research-to-practice gap is examined at the individual,
organizational, and state or national levels (Ringeisen et al., 2003). This includes taking into account contextual elements like student demographics and school sizes, teacher and staff workload, district resources, and community culture as well as the practitioner experience within schools. If school psychologists across the country are often working well beyond the scope of an ideal caseload, EBPs must pivot from individual implementation and more frequently include elements targeting the organizational, district, and state systems. The shortage of school-based mental health providers also warrants additional attention to interventions that are practical and realistic for the implementor (e.g., time-friendly, easy-to-use, clear guidelines).

**Mental Health Services in Schools**

In the field of school psychology, crisis intervention and addressing trauma are moving to the forefront of the core competencies needed for the role (NASP; 2021). This rise in importance highlights not only the needs of today’s youth and a changing society but also the need for related supports throughout the school system (Rossen & Cowan, 2013). Up to two-thirds of all school-aged children will be exposed to at least one traumatic experience before they graduate high school (Overstreet & Chafouleas, 2016), and this exposure, if unaddressed, will likely interfere with their overall functioning in school and life (Afifi et al., 2016; Child Welfare Information Gateway, 2019; Monnat & Chandler, 2015; Widom et al., 2012). Schools are acknowledging that a child overcome by trauma cannot learn best, or function to the height of their potential, in any area – they are in survival mode (Rossen & Cowan, 2013). Thus, by necessity, schools are the key place to address trauma needs in youth. School-based mental health professionals, such as
well-rounded school psychologists, are the core members to help enact trauma-focused interventions. School psychologists can lead the charge to promote awareness of trauma symptoms among children to families and other educators, be leaders in utilizing trauma-informed assessments and screeners, and implement EBPs in the form of mental health interventions and SEL curricula (Diamanduros et al., 2018).

**School-Based Trauma-informed Care for Marginalized Populations**

Trauma has the potential to upend the life of anyone. Sexual trauma, in particular, has been documented to have devastating impacts on life trajectories when left untreated (Maynard et al., 2019). Trauma reshapes the individual’s worldview and can severely impact a child’s ability to learn and thrive. The way public schools are currently woven into US society sets them up as a potential entity that can help address these experiences of trauma before the full cascade effect of their impact occurs (Aas et al., 2016; Lloyd, 2020; Mulvihill, 2005; Walkley & Cox, 2013).

Children with ID who make their way through public school settings will likely need additional school supports throughout their public education journey. All children with ID receive supports through special education (Individuals with Disabilities Education Act [IDEA], 2004), but it is imperative that schools are prepared to help support students with ID if they are suspected of having experienced trauma. While children with ID experience all forms of trauma, estimates indicate that students with ID are between 1.5 and 10 times more likely to experience sexual abuse and victimization than their typically developing peers (Brown-Lavoi et al. 2014; Stevens, 2012). They are also more likely to experience repeated abuse (Sobsey & Doe, 1991). It is estimated that
approximately 13.7 percent of students with ID have experienced some form of sexual abuse; unfortunately, these rates persevere throughout the lifespan (Jones et al., 2012). While these rates are alarming, it is possible that they are an underestimate of the true experiences of students with ID (Brown-Lavoie et al., 2014; Jones et al., 2012; Sobsey & Doe, 1991; Stevens, 2012). As discussed, sexual abuse is one of the most devastating types of abuse an individual can experience, and a child with ID is no different in this regard. Though abuse and trauma are not the same thing, experiences of abuse often lead to trauma, and this negatively impacts a host of other life elements. As bedrocks of their communities and the main social center of their children, schools are positioned to acknowledge the epidemic of sexual abuse among the population of individuals with ID and capitalize on the opportunity to address a grave need, uplifting the rest of society in the process.

With the overarching goal of helping all children reach their full potential, schools should expand their services to extend beyond academics. They must understand that they are not only a place where children come to learn, but also where they come to socialize, where some come to get their meals, where they find positive role models, and where some find refuge from adversity. At the same time, some children experience adverse experiences in school as well, such as bullying, social struggles, learning challenges, and isolation, and events such as school shootings (Katsiyannis et al., 2018; Lyon, 1996; Talmus, 2019; Wang et al., 2009). Recognizing that untreated trauma costs the nation around $124 billion per year from new childhood trauma cases with a total estimate of upwards of $500 billion in overall burden (Gilad & Gutman, 2019; Fang et
al., 2012), schools must embrace an expanded safety role in the lives of youth, and strive to help children, including those with ID, address their trauma experiences.

**Tiers for Addressing Trauma in Schools**

There are three main levels from which to view ways to address trauma experiences in schools through preventative measures and interventions: systemic, organizational, and individual. From a systemic level, moving a school or district to become trauma-informed is a potential pillar of support (Maynard et al., 2019; Record-Lemon & Buchanan, 2017; Ridgard et al., 2015; Wiest-Stevenson & Lee, 2016). To be trauma-informed requires school staff personnel, beyond just teachers, to undergo training in trauma symptom identification and education, to learn the signs of trauma, and to have a baseline understanding of how to interact with a student who seems to be exhibiting these symptoms (Phifer & Hull, 2016; Walkley & Cox, 2013). To be trauma-informed in a way that supports all students, including students with disabilities like ID, TIC trainings are needed across districts that incorporate trauma presentations as they manifest in children with a variety of disabilities, not only the neurotypical presentations, and to do so in a way that does not single out one student but seamlessly incorporates this extended knowledge into the trainings.

When looking at sexual trauma more specifically from the organizational level, one example of a measure of prevention with a strong evidence base is teaching healthy relationship curricula and developmentally appropriate sexual education curricula at all grade levels so children are learning emotional regulation, personal boundaries, consent, sexuality differences, and how to advocate for themselves throughout their school years.
The US is a heterogeneous amalgamation of many different cultures, worldviews, and values, which makes a one-size-fits-all approach more difficult than in some other countries. However, models of developmentally tailored sexual education at all grade levels have already been implemented with success and have been shown to improve positive sexual behavior, healthy relationships, and self-esteem—a feat made all the more important as children enter into puberty earlier and social media culture has rendered childhood less protected (Robinson et al., 2019; Shackleton et al., 2016; UNESCO, 2018). Increasing knowledge and advocacy skills surrounding healthy relationships of all kinds serve as a protective mechanism for students against emotional and sexual trauma (Santelli et al., 2018; Shapiro & Brown, 2018). As children with ID are most likely to receive their sexual health education from schools (Rowe & Wright, 2017), and are mandated to receive evidence-based interventions (Treacy et al., 2017), addressing this need among children with ID to interrupt the cycle of sexual abuse simultaneously uplifts the rest of students by providing integrated developmentally appropriate sexual health and healthy relationships curricula throughout the school years instead of ineffective abstinence-only education.

At an individual level, school-based interventions for trauma treatment should ideally be ready to be implemented for students of all developmental levels, not only neurotypical students. Further, even typical social-emotional or behavioral interventions can be bettered by adopting a trauma-informed lens (Pawlo et al., 2019). Given the day-to-day differences within a school week, the workload of school-based mental health
providers, and barriers to streamlined care within schools, clinical therapy models often do not translate directly into school settings. Instead, they often require adaptation or need to be designed originally with the school setting in mind. Ideally, when a student has been identified by their school as someone who would benefit from a mental health intervention, they would be able to access an evidence-based intervention consistently until the treatment plan has been completed to foster their overall well-being and support their ability to learn best. In a school setting, it is likely that there will be a need for the mental health intervention to be adapted beyond just the needs of the student to encapsulate both the details of the school setting as well as the time available within the school week to provide the mental health service.

Though the likelihood of being exposed to a traumatic event varies across the US, rates are high enough that the vast majority of interventions in a school setting stand to improve their efficacy by incorporating trauma-informed elements. When considering children with ID, the odds are unfortunately such that they will likely require a therapeutic intervention at some point during their school years to address trauma and better support their overall functioning across the facets of their life, including the educational setting. The landscape of need is clear, and it is time for targeted interventions for children with ID to follow.

**Barriers to Addressing Trauma in Schools**

There are barriers to implementing the systemic, organizational, and individual pillars of intervention. Lack of school funding, lack of human resources, parental pushback, and stigma are likely to cause challenges (National Center for Education...
Statistics [NCES], 2018). The majority of school personnel in the country do not feel equipped or trained to deal with childhood trauma (Walcott & Hyson, 2018). Establishing a healthy relationship curriculum that transitions to a sexual education curriculum throughout grade levels in particular is a challenge within the US, as all 50 states only receive federal funding for abstinence-based sexual education despite it being proven to not be an evidence-based practice that does not increase positive sexual behavior, does not lower rates of teen pregnancy, does not teach safe sexual practices, and does not delay the onset of sexual activity (Kirby, 2008; Shapiro & Brown, 2018). Only 24 states have mandates in place to teach their students about sex education at all, and only 11 states include the terms “healthy relationships,” “consent,” and “sexual assault” in their guidelines, this is despite research showing that having access to informed sexual health education in schools positively impacts the life trajectory of students in many ways (Robinson et al., 2019; Shackleton et al., 2016; Shapiro & Brown, 2018; United Nations Educational, Scientific and Cultural Organization; 2018). The reality of sexual education in schools across the US varies significantly both between states and within states, if it is taught at all.

Additional barriers to implementing strong mental health supports and interventions in schools include the research-to-practice gap. As discussed, this gap highlights the disconnect between tools being examined and vetted at a theoretical research level and then getting those tools into the hands of practitioners in the field. Not all evidence-based tools available are being applied in practice where they could be beneficial. In terms of providing evidence-based interventions to students with
disabilities as is legally mandated by IDEA (2004), the lack of evidence-based sexual health education and favor of abstinence-only education in this country is particularly disturbing. Students with ID and other students with disabilities have legal mandates on their side to access accurate information and evidence-based education, and this includes supplemental health curricula such as healthy relationships or sexual health education.

Also, ideally, one school psychologist should be serving 500-700 students, however in most states across the US, school psychologists are often stretched thin, and again, one school psychologist is likely to serve between 1,500 and 3,000 students depending on where they reside (Castillo et al., 2011; Curtis et al., 2006). Within this workload, an average of 14% of students between the ages of 3-21 receive special education services through their school, or over 7.3 million children; 6% of those students qualify for an Individualized Education Program (IEP) label of ID, and 2% of those students qualify for Multiple disabilities, which requires at least one label to be ID (NCES, 2021). What these statistics mean, given the higher rates of abuse and trauma experienced by youth with ID, is that there is a small but significant group of students who are at a high risk of needing mental health support during their school years who are less likely to receive it, and some of the professionals best equipped to provide that service are overworked and feel underprepared to take on this challenge. For this reason, supports that are established to help the individual student must take into account the systems that they will live in, and lean on them to take the burden off of just the individual to enact change.
Overall, there is still a dearth of evidence-based knowledge at the intersection of school psychology, ID, and sexual trauma. Broadly, when a child experiences an adverse life experience, there is a need to establish individualized supports to properly address this potential trauma and the related cascade effects. When an ID diagnosis is present, additional questions need to be addressed depending on the type of adverse experience that has occurred. Some of these questions include how to protect the individual rights of this person moving forward, and how specific skills and concepts can be taught to better protect this person from re-victimization. For example, in traditional trauma-informed therapy (e.g., TF-CBT), psychoeducation is often centered around the significance of the trauma and how it is woven into the survivor’s life. When considering how to apply this method of treatment to the population of ID, it is necessary to insert additional supports beyond the psychoeducation on trauma. Skills in the realms of social relationships, self-advocacy, and interpersonal boundaries may not routinely be explicitly taught to the student with ID, and these students may have been further excluded from any academic opportunities that may have touched on these skills due to their disability (Brock, 2018; Brock & Schaefer, 2015; Parris et al., 2021). To stop the cycle and perpetuation of trauma in this population, treatment modalities must take these gaps into account, and address them as they move through the treatment of trauma. A traumatic experience cannot be viewed in isolation with any child, and for a child with ID this is no different. However, even when removing the layer of sexual trauma, there exists a limited pool of targeted TIC resources for school psychology practitioners to pull from when they find themselves working with students with ID. Despite the current understanding in the field
that the population of students with ID are at high risk of experiencing various forms of trauma, with a significantly heightened risk of experiencing sexual trauma, the limited body of school-based intervention research remains. Although the need for targeted resources is clear, the research is only beginning to catch up.

As we now know, school psychologists are often stretched thin in many parts of the US (NASP, 2021; Ringeisen et al., 2003), yet they are still some of the few mental health providers who are positioned to help the population of children with ID and sexual trauma. They are exposed to a wide array of students over the years, and if trained in the identification of trauma symptoms in the ID population, are more ready to spot these signs and symptoms in their student population (Gubi et al., 2019; Eklund et al., 2018). Schools are still the place where many children receive mental health supports (Paulus et al., 2016; Ringeisen et al., 2003), and they function as a community hub that connects families, who are the experts on the child, with academic and mental health supports, the experts in the field. Schools eliminate some of the significant barriers to treatment such as cost, time, and transportation, and already have a set structure in the lives of most individuals (Reardon et al., 2017). This unique combination of factors sets up school psychologists to be some of the most aptly positioned mental health professionals to move the field forward in helping to treat students with ID and sexual trauma. School psychologists are likely to see the child in school regularly already and may have a baseline understanding of their behavior and needs. Should abuse occur in the child’s life, school psychologists may be some of the few informed individuals who can spot any changes in behavior or functioning from the child’s baseline, and be ready to take the
steps necessary to check in on the child’s well-being, and continue to provide support as long as it is needed.

Taking these factors (e.g., limited resources, limited time) into consideration, it is imperative that the field put forth a model that not only helps address sexual trauma in children with ID in school settings but also can be realistically used in practice, taking into account the demands of the school psychology workload and the day-to-day reality of educational settings. For the remainder of this manuscript, one such proposed model, the SAFEST KID (Hudson et al., in preparation), will be deeply explored, specifically the depth, breadth, and utility of the intervention. Schools have a large role to play in intervening in the epidemic of sexual trauma among individuals with ID, and a key avenue is through incorporating EBPs into supplemental health curricula as well as core academic curricula. Further, as schools are required to provide a free and appropriate education to all students, including students with disabilities, it is in their best interest to make this process easier to carry out for their students with ID who often require additional supports and interventions. However, there is limited research currently on efficacious tools specifically designed for TIC for youth with ID, and when an individual with ID presents with layered variables such as sexual trauma, the availability of targeted interventions is even more limited.

Purpose of Proposed Study

This study aims to draw a consensus about what elements work to create a viable model of targeted therapeutic intervention for students with ID and sexual trauma, using
the SAFEST KID: *A Sexual Assault Framework in Education to Support Trauma in Kids with Intellectual Disability* model. Many of the components of the SAFEST KID model are poised to benefit all students in school and in the larger society. Spreading the tenets of TIC and implementing healthy relationships curricula set up all students for success; effective interventions to address sexual trauma in students with ID are also interventions that can be extended for use with other students. There is a need for more comprehensive and targeted interventions to support students with ID and sexual trauma, and this study aims to help meet that need. By drawing on the scholarly, practitioner, lived, and community expertise surrounding ID and sexual trauma through the use of a Delphi methodology, this study aspires to create a viable SAFEST KID model. A Delphi study draws from a panel of experts to reach a consensus and is a tool used to create meaningful data in the absence of extensive existing research (Iqbal & Pipon-Young, 2009). To establish a therapeutic intervention adapted for students with ID and sexual trauma, a Delphi study offers the power of many minds and years of experience to join forces to create the best model for current practitioners working in school settings.

**Components of SAFEST KID**

School psychologists are well-trained and well-rounded school-based mental health practitioners who are often stretched thin in the services they would ideally like to provide. The SAFEST KID model aims to support this understanding through the inclusion of systems-based preventative measures to help erect pillars of support beyond the individual level. This model is a therapeutic intervention adapted for students with ID and sexual trauma that is created around the pillars and principles of TIC, which serve to
better anchor the intervention to a well-researched grounded theoretical framework (see manuscript 1). It is designed to be implemented by school psychologists, who are both specifically trained mental health providers in school settings and uniquely suited to work with students at the intersection of ID and trauma. The proposed model of SAFEST KID offers interventions at three different levels, two conceptual and one applied: systems (included for conceptual consideration), organizational (included for conceptual consideration), and individual (to be the primary focus of study).

Understanding that broader preventative measures need to be widely implemented to intervene in the cycle of sexual trauma among children with ID, Level 1 of the model offers guidelines for implementing TIC across systems that work with children, such as schools and school districts, and provides content for further research studies at a future date. This aspect introduces trauma trainings that include trauma presentations for children with disabilities and implements them across these whole systems.

Level 2 focuses on the organization, such as an individual school, and states the need for comprehensive sexual education and healthy relationships curricula at all grade levels, with content tailored to the developmental levels of children, also providing conceptual content for future research studies beyond the one this manuscript will discuss. It is important that children with disabilities like ID can access the material from these curricula in order to learn adaptive and interpersonal skills explicitly and help stop the cycle of sexual trauma through preventative education and practice.

Finally, Level 3 of the model offers guidelines for an individualized targeted therapeutic intervention for children with ID and sexual trauma that can be implemented
in a school setting. It combines the research on common and effective adaptations made for children with ID and applies them to a set of general intervention adaptation guidelines as well as to the *Bounce Back* manualized therapeutic model, which itself is based on Cognitive Behavior Intervention for Trauma in Schools (CBITS) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) components and tailored for children 5-11.

**Method**

The following section describes the method and procedure necessary to develop the foundations for a useable and effective intervention for students with ID who have experienced sexual trauma that school psychology practitioners working in school settings can use. The goal was to gather a consensus on what tools and strategies current experts in the field of school psychology who work with students with ID and trauma are using to address the mental health needs of this population, as well as how a new model can fill the gaps, and what structure would be feasible to implement in real practice. The results of this study were used to inform the development of Level 3 of the SAFEST KID model to better ensure its viability in applied practice.

**Research Questions**

The guiding question for this study is what elements, based on four areas of expertise (i.e., community, lived, practitioner, scholarly), are needed to render the SAFEST KID model practical and useful. The following research questions were posed to help guide this inquiry:
1. How can the SAFEST KID model become viable for school-based practitioners?

2. How could school-based practitioners adhere to the pillars and principles of TIC when working with children with ID and sexual trauma schools?

3. What are the barriers to school-based implementation of a therapeutic intervention for children with ID and sexual trauma?

The Delphi Method

Due to the limited body of evidence in the research regarding treatment of children with ID and sexual trauma in school settings, the Delphi method was an ideal tool for investigation (Iqbal & Pipon-Young, 2009; Keeney et al., 2001). It drew from the knowledge and experience of expert panelists in the field with the aim of reaching a consensus regarding the SAFEST KID treatment model. Within the area of research of Implementation Science, the field of study devoted to understanding how to close the research-to-practice gap, Delphi methods have been used to help understand what barriers are at play (Sanetti & Collier-Meek, 2019). At the intersection of school psychology, the implementation of mental health best practices and evidence-based practices, and treating students with ID and sexual trauma, a Delphi method of inquiry was uniquely suited to provide practical information to connect theoretical models and applied practice. At the same time, it allowed space for the development of new models tailored to lived experiences by being rooted in the theme of community-based research (Brady, 2015). In sum, the Delphi method drew from the expertise of individuals in the field – through their knowledge of research, best practices, practitioner experience, and lived experience (Hallowell & Gambatese, 2010; Iqbal & Pipon-Young, 2009). Though there may be
limited research on interventions at the intersection of ID and sexual trauma in school settings, there is still ample expertise within the field, and various types of experts have important knowledge that can be drawn upon via the Delphi method. The Delphi method typically involves a panel of experts between 15-35 in number, and three rounds of inquiry (Linstone & Turoff, 2002; Stone Fish & Busby, 2005), though 8 participants is considered the lower limit to achieve significance (Ogbeifun et al., 2016).

The primary step was to conduct an open-ended scoping session (Donohoe & Needham, 2009), which can be used as a preliminary round of data collection before the formal rounds begin to generate ideas (Iqpal & Pipon-Young, 2009). The first formal round posed questions to the panel of experts with the aim of gathering data from open-ended inquiries to cast a wider net for information gathering (Brady, 2015). The subsequent rounds built on the feedback obtained from the first round of questioning, and the focus of information-gathering narrowed in nature during each subsequent round with the aim of achieving consensus in response to the research questions (Brady, 2015; Iqpal & Pipon-Young, 2009; Turoff, 1970). Feedback from each round of questioning was provided to the panel of experts so they could correct or comment upon previous information, and participants had the opportunity to review each finished step in the process before proceeding if consensus had been achieved (Brady, 2015). After the third iterative round, it was unlikely that participants would change their responses significantly, and so it was the aim for a consensus to be reached after the completion of the third round of questioning, generally agreed to be 80% agreement or higher among participants for each item (Iqbal & Pipon-Young, 2009).
Study Design

Delphi studies generally follow the three-stage framework of preparation, convergence, and consensus (Donohoe & Needham, 2009). These stages encompass the recruitment of expert panelists, the scoping round, the multiple iterative rounds of questionnaires, analyses and feedback processes between each questionnaire, and the final member check. This study followed the structure of disseminating a preliminary scoping round of information gathering based on open-ended questions that have been piloted, followed by three rounds of questioning (Q1, Q2, Q3) that build off each other based on thematic analyses of the prior rounds (Brady, 2015; Braun & Clarke, 2006; Iqbal & Pipon-Young, 2009).

As there are specific research questions with separate categories, multiple participants, and open-ended questions, data was collected and analyzed after each round of questioning via thematic analysis and structural coding to inform the questionnaires used in each subsequent round (Creswell & Poth, 2018). Data from each questionnaire was returned to the panelists for the opportunity to comment on and review during the next survey to ensure that it accurately reflected the sentiments and thoughts of the panelists while aiming to minimize attrition and containing the information in as few surveys as possible (Brady, 2015). This data was then used to augment the SAFEST KID model to create the final products that incorporate the gathered information into the therapeutic model of intervention at Level 3 and general TIC IDST adaptation guidelines. As a point of clarification, while all the components of Levels 1, 2, and 3 of SAFEST KID were described to the study participants, Levels 1 and 2 were only described briefly.
for conceptual purposes and Level 3 was described in detail, as it was the focus of the study. This was done with the aim of soliciting feedback to enhance the framework and details of the proposed model as it applies to Level 3. All surveys were administered to participants online through Qualtrics software, which participants completed on their own time.

**Study Pilot**

The Delphi study for SAFEST KID began with a pilot study to better ensure that the structure of the questionnaire enabled the panelists to communicate their expertise accurately and effectively in a timely manner, with the focus of the pilot being to review the Scoping round questions before their dissemination (Geisen & Bergstrom, 2017). Piloting the study served to both help ensure a streamlined basis for consensus and to increase the validity of the selected questions by checking that the questions are intelligible, answerable, and accessing the desired information by an outside party (Clibbens et al., 2012). Only the Scoping round was piloted as it is the round that sets the stage for the subsequent questionnaires, and piloting every round of the study increases the chance for participant attrition, a main limitation of Delphi studies, and a total of five rounds of participation were already anticipated to be required (Clibbens et al., 2012; Donohoe & Needham, 2009).

For the pilot study, convenience sampling was used, though targeted sampling was primarily used in the parent study (Donohoe & Needham, 2009; Iqbal & Pion-Young, 2009). As the primary purpose of the pilot study was to test its validity and usability, a pilot sample size of 10% of the parent study was targeted (Connelly, 2008),
resulting in 1 person completing the pilot. The pilot was completed by a fellow school psychology doctoral graduate student not eligible for the study but familiar with ID, schools, and sexual trauma. Based on the pilot study, several changes were made to the initial questionnaire to streamline completion, including breaking apart two questions with multiple parts into several individual questions to encourage experts to comment thoughtfully on each of the parts instead of the general question.

**Preparation Stage**

The first stage of the study is the Preparation stage, which focused on the recruitment of consenting and eligible participants upon IRB approval, and continued through the Scoping round to inform Q1. The Scoping round collected information from open-ended questions regarding the nature of practices related to working with children with ID, information on types of interventions and adaptations used, additional curricula available to children with ID, and types of sexual trauma supports and interventions for children with ID. The Scoping questionnaire was administered online via Qualtrics survey software through the University of Denver, and participants were given two weeks to respond.

Due to difficulties with participant recruitment, which stretched over six months, to obtain a sufficient starting sample size, the initial start date of the survey was delayed, and the Scoping round was disseminated only after 10 participants had been recruited. Multiple rounds of recruitment were attempted over months to obtain a sufficient sample size, with the recruitment letter being redrafted and sent out, and a flyer being sent out after the two recruitment letters failed to gather sufficient participants. No key elements
of the recruitment materials were altered, but the packaging was adjusted to incentivize participants to join the study. Due to difficulties with recruitment and the process taking significantly longer than anticipated, though 17 participants were initially recruited and completed the background questionnaire, it is hypothesized that this delay contributed to the significant attrition at the start of the survey. This attrition will be discussed further in the limitations section.

**Convergence Stage**

The second stage of the study is the Convergence stage, focused on the iterative rounds of questioning of Q1, Q2, and Q3 with the aim of gathering expert data to achieve consensus in answering the posed research questions. Answers are not likely to change significantly after the third round of questioning (Iqbal & Pipon-Young, 2009), and so it was predicted that questionnaires would end after Q3. Q3 was the final survey to be completed by the participants, and Q1, Q2, and Q3 were built based on answers coded from the previous surveys. Consensus was originally set at 80% (Iqbal & Pipon-Young, 2009), but due to participant attrition, all items that did not achieve 100% consensus had opportunities in subsequent surveys for participants to share additional commentary about them. Participants were informed when items had reached consensus and were given the opportunity to comment on components at the end of each section within the surveys. Items were voted on by participants in surveys until consensus was reached. 17 experts completed the background survey, 8 completed the Scoping round and Q1, 5 completed Q2, and 4 completed Q3.

**Consensus Stage**
The final stage of the study is the Consensus stage, focused on the incorporation of all the data gathered from the panelists after the iterative rounds with consensus among participants achieved. Consensus remained set at 80% agreement from all remaining participants. Data from the study was used to answer the posed research questions and to enhance the SAFEST KID model, informing the adapted version of *Bounce Back* and the set of TIC-IDST intervention guidelines. The acronym IDST is utilized throughout the remainder of this study to represent the group of individuals with intellectual disability and sexual trauma.

**Respondents**

For this study, topical experts were initially categorized into two groups having expertise in schools and on ID, and having expertise on sexual trauma and ID, though a third group was added during the study when multiple experts qualified for expertise on ID and both sexual trauma and schools (i.e., a third “both” category). It was an inclusionary requirement of participation to have expertise in at least two out of the three categories, with one of the two categories required being expertise in ID. Experts were sought who had scholarly, practitioner, and community expertise within the three groupings. This allowed the pool of participants to be represented by individuals or families who are involved in community support or advocacy groups for ID and/or sexual trauma, practitioners who have professional experience working with individuals with ID and/or sexual trauma, and/or researchers who have studied individuals with ID and/or sexual trauma, though the majority of experts who participated in the study were mental health practitioners working in either school or clinical settings, and most commonly
were psychologists. Table 9 describes the inclusionary and exclusionary criteria for panelists.

**Table 9**

*Criteria for Expert Panelist Participation*

<table>
<thead>
<tr>
<th>Type of Expertise</th>
<th>Inclusionary Criteria</th>
<th>Exclusionary Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ID</strong></td>
<td>Has worked with 5+ individuals who have a label of ID OR has worked with an individual with ID for 1+ years</td>
<td>Has worked directly with fewer than 5+ individuals with ID AND has worked for less than 1 year with a person with ID</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Has ID themselves</td>
</tr>
<tr>
<td><strong>Schools</strong></td>
<td>Is a school psychologist or other school-based mental health practitioner AND has 3+ years of experience working in a school setting</td>
<td>Is not a school-based mental health practitioner OR has less than 3+ years of experience working in school settings</td>
</tr>
<tr>
<td><strong>Sexual Trauma</strong></td>
<td>Has worked with 5+ individuals who have sexual trauma OR has 1+ years of research experience in sexual trauma</td>
<td>Has never worked directly with an individual with sexual trauma AND has never researched sexual trauma</td>
</tr>
</tbody>
</table>

These individuals were recruited from research, community, and practitioner settings, with expertise being defined as familiarity with the ID population understanding that meaningful relationships can be formed with individuals deeply over a year, and
wanting to capture early career practitioners as well as veterans, though lowering the threshold below the recommended five years due to concerns that this niche crossover would make participant recruitment difficult (Hallowell & Gambatese, 2010). Seventeen experts were recruited at the start of the study based on the recommendation of retaining between 8-50 panelists throughout the study and due to this number taking several months to obtain, thus reaching a recruitment time limit and needing to begin the study despite lower numbers than desired (Hallowell & Gambatese, 2010; Linstone & Turoff, 2002). Attempts were made to fight attrition, including sending follow-up messages, reminding participants of the need for research in this area to support vulnerable persons, and regular check-ins with participants (Iqbal & Pipon-Young, 2009; Sumson, 1998); however, attrition was still a significant issue. Due to participant attrition, only 5 participants remained at the beginning of Q3, and only 4 completed the final survey.

**Recruitment of Participants**

Panelists were recruited through multiple means of solicitation, including emails and phone calls to research universities and listservs, national organizations, academic medical centers, school psychologist forums and social media channels, and through targeted sampling and convenience sampling of community networks (Donohoe & Needham, 2009; Iqbal & Pipon-Young, 2009). All potential panelists were emailed an overview of the study demonstrating the need for this research and how their participation will be of importance, as well as a consent form that includes the projected study timeline, study details, and general requirements. Participants who were interested were directed to an initial screener survey to collect background and demographic
information to determine eligibility and establish expertise, and to gather preliminary
information on their experience with Level 1 and Level 2 interventions related to
SAFEST KID. All communications were conducted virtually through email and online
survey software, including the subsequent rounds of scoping questionnaires, Q1, Q2, Q3,
and final feedback of the results. Participants remained anonymous to one another
throughout the course of the survey and afterwards. Follow-up messages and notes of
gratitude were sent via email as well with the aim of enhancing respondence rates and
participant satisfaction and minimizing participant attrition. Recruitment materials and all
additional survey material can be found in the Appendices.

**Sampling Methods**

The main sampling methods utilized in this study were targeted sampling and
convenience sampling. These methods were selected to ensure that the correct expertise
was drawn upon for this study, due to the specific intersection of school system, sexual
trauma, and ID expertise. This was done to access a selection of individuals from diverse
backgrounds, geographic locations, ages, and experience who are all linked through their
involvement in professional, advocacy, or topical organizations related to ID, schools,
and sexual trauma. Convenience sampling involved the recruitment of specific
individuals who meet study criteria (Stratton, 2021) and were known for their specific
expertise in either schools and ID or sexual trauma and ID; this was also utilized to
complete the pilot study.

**Recruitment of ID & School Experts**
For all sets of experts, potential panelists were recruited through The Arc and its statewide chapter services, research university listservs and academic medical centers, as well as community and national topical organizations. For example, the Arc serves as a national and local resources for individuals with ID, connecting individuals with ID, families with members with ID, advocates, and leaders in the realm of ID to one another and to targeted supports and community. The Arc contains local chapters across the United States as well as individual state chapters to streamline resources, all with contact information publicly available. Panelists were solicited through topical public forums related to school psychology as well, and through targeted and convenience sampling. An email outlining the study details, invitation for participants, and links to the consent form, eligibility/demographics Qualtrics survey and scoping questions was delivered (see Appendix B).

Recruitment of ID & Sexual Trauma Experts

Potential panelists with expertise in ID and sexual trauma were solicited through The Arc and its statewide chapters, research university listservs and academic medical centers, as well as community and national topical organizations. Panelists were solicited through targeted and convenience sampling in addition to solicitation through public forums and targeted organizations. An email outlining the study details, invitation for participants, and links to the consent form, eligibility/demographics Qualtrics survey and scoping questions was delivered with the request that it be disseminated within the organization (see Appendix B).

Diversity of Expertise
Diversity of expertise (i.e., community, lived, practitioner, and scholarly) was sought out via the multiple avenues of recruitment. By soliciting participants through national organizations, research universities, academic medical centers, and community forums, a wide range of expertise had the possibility to be represented. The participants who elected to participate in the survey largely had expertise in ID and both schools and sexual trauma (53% at the start of the study), 29% had expertise in ID and schools, and 18% had expertise in ID and sexual trauma. Of note, the requirements were not that the expert had to have expertise in individuals with ID who suffered sexual trauma, but separately had experience working with individuals with ID and with individuals who had experienced sexual trauma. Though the expert panelists ranged in their length and type of experience, they were largely White women between the ages of 35–44. This homogeneity does not reflect the diversity of the country but does mirror that of the population of school psychologists (NASP, 2021). However, the lack of gender and racial diversity in the recruited participants should be noted and kept in mind throughout the study. Further details of each round of participants will be described in later section to help inform the analyses.

Data Collection and Analysis

Participants were recruited and data was collected over multiple months following IRB approval from the University of Denver. Multiple rounds of participant recruitment were conducted, and participants were administered several surveys over the course of the study, beginning with the background and eligibility survey, followed by the Scoping Round survey, Q1, Q2, and Q3. All data collection was conducted through Qualtrics.
surveys online through the University of Denver and through email correspondence. Participants submitted their email addresses for correspondence but remained anonymous throughout the study to the other participants. Data was deidentified during analysis, and participants were identified to the researcher through their email addresses and IP addresses.

Data was coded throughout the course of the study primarily using structural coding and thematic analysis (Saldaña, 2009). Though data was primarily inductively coded, they were grouped structurally from the onset into three initial categories that were linked to the three research questions. These avenues were utilized to allow the respondents’ data to guide the conclusions, rather than assuming that they would align with the current foundation built on literature review. Structural coding was initially utilized to maintain the three general categorical groupings of “Adaptations for ID,” “TIC,” and “Barriers,” though the category labels themselves were later polished into their final forms of School-Based Implementation, Providing Trauma-Informed Care, and Barriers to Implementation. All survey responses were subjected to an initial coding pass, with information being organized into one of the three main categories that were used to streamline the list of codes. Codes were then condensed and analyzed into a smaller set of concepts that represented the descriptive statements participants had first submitted and used to create the final list. These summarizing concepts remained grouped into the initial three categories but were later further organized into subcategories as well. Finally, the polished list of categories, subcategories, and concepts was fed back to participants with opportunities to give feedback on the analysis and to state whether they agreed that the
concepts were relevant to the research questions. Examples of coding can be found in Appendix E. General themes were also drawn from the participants’ answers, which were used to inform the final products that were created, such as many participants not being explicitly familiar with the structure of TIC, but being aware of the sentiments of it, as well as many participants struggling with the lack of valid, varied, and respectful interventions for children with ID, especially nonverbal children.

**Background and Eligibility Survey**

The background and eligibility survey provided participants with the informed consent process and rationale for the study and collected demographic data that included zip code, race/ethnicity, gender, age, education level, and length of experiences in their profession, amount of experience working with children with ID and with sexual trauma, and experiences with different types of school settings, trauma programs and healthy relationship programs. It also probed for experience with MTSS and confirmed consent to move forward. These questions were asked in the background and eligibility survey to ensure that participants met the expert criteria, and to screen for familiarity with the concepts presented for theoretical consideration in SAFEST KID’s Level 1 and Level 2 regarding trauma-informed school systems and healthy relationship curricula. Seventeen respondents completed the background and eligibility survey, which can be found in full in Appendix C.

**Scoping Round**

Following the background and eligibility surveys, the Scoping round was administered which asked open-ended questions to the participants to collect information
on their familiarity with the pillars and principles of TIC, as well as what current strategies and interventions they use when working with children with ID. The Scoping round also asked about the barriers participants have encountered in working with this population, what an ideal intervention currently looked like in their minds for supporting children with ID and sexual trauma, and finally presented participants with the draft of the SAFEST KID model for initial feedback. The themes that were generated led to condensed concepts which were fed back to the participants through Q1, Q2, and Q3 to generate consensus on components to answer the three research questions of how SAFEST KID can become viable for school-based practitioners, how could school-based practitioners adhere to the pillars and principles of TIC when working with children with ID and sexual trauma, and what are the barriers to school-based implementation of a therapeutic intervention for children with ID and sexual trauma (IDST). Examples of the coding process can again be found in Appendix E. 8 participants completed the Scoping round, which can be found in full in Appendix C.

Q1

Q1 was developed based on the preliminary information that was obtained from the background and eligibility survey and the Scoping round and expanded upon the preliminary themes that were coded from those two measures. The purpose statement, consent statement, and research questions were included again at the start of Q1 to re-anchor the participants in the rationale for the study, and remind them of the voluntary consent agreement and ability to withdraw at any time. Q1 presented participants with additional open-ended questions to supplement the information from the Scoping round.
Examples of questions include, *what is the best way to identify gaps in skills when working with a child with ID or IDST?* and, *what is the best way to promote an understanding of the impact of sexual trauma on children with ID in your place of work?* Explanation of the pillars and principles of TIC was included in the SAFEST KID model that was shared with the experts initially, though the questions presumed some degree of familiarity when asked in the Scoping round and were later reframed in Q1 to elicit the desired information without participants needing to be explicitly familiar with TIC itself. Q1 asked open-ended questions that aligned with the pillars and principles of TIC but did not discuss them directly. Instead of asking how participants adhered to the principles of peer support, Q1 asked, *what is the best way to incorporate group work or peer support into your interventions with a child with ID or IDST?* Q1 was analyzed along with the background and eligibility survey and Scoping round to generate the initial set of concepts that were then fed back to the participants. Eight participants completed Q1, which can be found in full in Appendix C.

**Q2**

Q2 was presented to the participants asking them to agree or disagree with the themes that were analyzed and coded, grouped into the three main categories: School-Based Implementation, Providing Trauma-Informed Care, and Implementation Barriers. Within the category of School-Based Implementation, the subcategories of Intervention-Specific Adaptations, Planning, and Logistics were utilized for organization, and the opportunity to expand in an open-ended response box was included. Within the category of Providing Trauma-Informed Care, the subcategories of Training and Practice were
utilized for organization, and the opportunity to expand in an open-ended response box was included. Within the category of Implementation Barriers, the subcategories of Access to Resources, Skill Level, and Logistics were utilized for organization, and the opportunity to expand in an open-ended response box was included. Within each of these subcategories, participants were asked to select whether they agreed or disagreed that the concepts were important to consider for the subcategory and main category in terms of providing support to children with IDST within a trauma-informed lens. Five participants completed Q2, which can be found in full in Appendix C.

**Q3**

Q3 was presented to the remaining participants based on the analysis from Q2. Q2 generated significant consensus from the remaining participants, though only 5 participants remained who completed Q2. Participants were presented with the rates of respondent agreement for each of the concepts voted on, and asked to reconsider the concepts that did not reach consensus in the prior round. Due to low participant numbers, participants were given the opportunity to further expand on any concept that had less than 100% consensus agreement as well as the chance to write in any further comments about any of the survey components they had after completing Q3. Four participants completed Q3, which can be found in full in Appendix C. All but two concepts achieved consensus during this round and were subsequently removed from the final list. The final list of concepts that achieved consensus was summarized and delivered back to the remaining participants for a final member check, with the opportunity to endorse or comment on any changes or edits participants would make after reviewing the list.
Participant Demographics

Of the 17 participants who initially participated in the SAFEST KID study, the majority identified as White women between the ages of 35-44 residing in the Mountain West region of the United States. At the onset, one participant identified as male, one participant identified as Hispanic, and two participants identified as over the age of 65. The general lack of diversity among participants in this study is considered a limitation of the study, as though the demographics of this study align with that of the pool of licensed school psychologists in the U.S. (Goforth et al., 2020), they do not reflect that of the general U.S. population, and this is a current limitation within the general profession of school psychology.

The majority of participants in the SAFEST KID study had obtained a doctoral degree, with the second most common educational attainment level being a master’s degree. School psychologist was the most commonly reported profession, followed by clinical psychologist and educational psychologist, and the range of experience in the field ranged from 2 years to over 50 years. Among the recruited experts, experience further ranged from 0 to over 50 years working in a school, 2 to over 50 years of working with children with ID, and 0 to over 30 years of working with children who have experienced sexual trauma. Participants were grouped into three main pools in the study, including experts on ID and schools, experts on ID and sexual trauma, and experts on ID and both schools and sexual trauma. In this study, participants reported experience working with between 6-200 children with ID and 2-350 children with sexual trauma. Further, participants reported having worked in a wide variety of school settings,
including private, public and charter schools, and at all grade levels from preschool, elementary school, middle school, high school, and university to administration and advocacy as well as residential treatment centers and medical day treatment centers. A detailed breakdown of the initial study participant demographics can be found in the table below, and a review of the demographic data of participants who remained throughout each round will be presented as well.

### Table 10

**Participant Demographics**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>ID + School Experts</th>
<th>ID + Sexual Trauma Experts</th>
<th>ID + Schools and Sexual Trauma Experts</th>
<th>Total</th>
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</table>
As the aim of the qualitative Delphi study is to pull the lived experience from a panel of experts, it is important to understand the demographics of the individuals who are present throughout each round of the study. Attrition is a known and expected limitation of Delphi studies, and so if it occurs despite research attempts to minimize it, the pool of respondents must be reviewed at each step to adjust the lens through which results are being interpreted. The following table includes a review of the participant demographic information across the Scoping round, Q1, Q2, and Q3.

**Table 11**

*How Expert Groups Changed Across Rounds Due to Attrition*

<table>
<thead>
<tr>
<th></th>
<th>Initial Pool: 17 Experts</th>
<th>Scoping Pool: 8 Experts</th>
<th>Q1 Pool: 8 Experts</th>
<th>Q2 Pool: 5 Experts</th>
<th>Q3 Pool: 4 Experts</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID and School Experts</td>
<td>5/17 (29%)</td>
<td>2/8 (25%)</td>
<td>2/8 (25%)</td>
<td>1/5 (20%)</td>
<td>¼ (25%)</td>
</tr>
<tr>
<td>ID and Sexual Trauma Experts</td>
<td>3/17 (18%)</td>
<td>2/8 (25%)</td>
<td>2/8 (25%)</td>
<td>0/5 (0%)</td>
<td>0/4 (0%)</td>
</tr>
<tr>
<td>ID and both School and Sexual Trauma Experts</td>
<td>9/17 (53%)</td>
<td>4/8 (50%)</td>
<td>4/8 (50%)</td>
<td>4/5 (80%)</td>
<td>3/4 (75%)</td>
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</table>
Though attrition was significant across the rounds, the remaining participants throughout the study continued to represent expertise on both ID and sexual trauma and ID and schools. The main group that dropped off was the pool with expertise only on ID and sexual trauma, so after Q1 all experts had substantial knowledge about school systems as well as ID, and the majority of respondents in each round fell into the joint expertise category. The table below describes the remaining participants in greater detail who remained in the Scoping round, Q1, Q2, and Q3.

Table 12

**Participant Demographics Across Study Rounds**

*Key: Experts on ID and schools (S); experts on ID and sexual trauma (T); experts on ID and both schools and sexual trauma (B); Total (A)*

<table>
<thead>
<tr>
<th>Round Aspects</th>
<th>Scoping: 8 Experts (Attrition from 17)</th>
<th>Q1: 8 Experts (No Attrition)</th>
<th>Q2: 5 Experts (Attrition from 8)</th>
<th>Q3: 4 Experts (Attrition from 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>S</td>
<td>T</td>
<td>B</td>
<td>A</td>
</tr>
<tr>
<td>Total Percentage</td>
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<td>13</td>
<td>63</td>
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<td>Gender</td>
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The initial group of participants was spread across the Mountain and Pacific West, with two experts hailing from the Northeast, and ranged in age from 25-34 years old to 65+ years old, though the mode age group was 35-44 years old. The majority of participants identified as White females, with the exception of one White male, one Hispanic woman, and one woman abstaining. The majority of initial respondents held doctoral degrees and worked professionally as school psychologists. Across the whole group, there was a range of 2-50 years of experience in their profession, with a mean of 14.8 years, a range of 0-50 years working in schools with a mean of 13.5 years, a range of 2-50 years of experience working with children with ID, with a mean of 14.9 years, and a range of 0-30 years of experience working with children with sexual trauma, with a mean of 10.1 years. The group began with a range of having worked with 6-200 children with ID, with a mean of 69.5, 2-350 children with sexual trauma, with a mean of 40.5, and experience working in both private and public schools including charter schools, elementary, middle, high and K-12 schools, at the university level, in residential treatment centers, and specialized schools for children with higher needs. At the start, 29% of experts qualified under the category of ID and School experts, 18% qualified under the category of ID and Sexual Trauma experts, and 53% qualified under the category of ID and both School and Sexual Trauma experts. To qualify for the joint
category, participants had to meet minimum criteria for both the ID and School and ID and Sexual Trauma expert categories.

In the Scoping round, the expert demographics shifted somewhat as the number of panelists fell from 17-8. Representation from the Northeast was dropped, leaving only representation from the Mountain and Pacific West, and the respondents identified as White women and one Hispanic woman. Their reported ages were in the categories of 25-34, 35-44, and 65+, and representation from the 55-64 age bracket was lost. The remaining participants identified as school, clinical, and educational psychologists with master’s and doctoral degrees, and reported a range of 3-50 years in their profession, with a mean of 12 years, a range of 1-50 years of experience working in schools, with a mean of 11.6 years, a range of 2-50 years of experience working with children with ID, with a range of 11.9 years, a range of 0-25 years of experience working with individuals with sexual trauma, with a mean of 6.7 years, a range of 1-200 children with ID worked with, with a mean of 52.6 years, and a range of 0-50 children with sexual trauma worked with, with a mean of 12.75 years. The group of experts reported experience working in both private and public schools including charter schools, elementary, middle, high and K-12 schools, universities, residential treatment centers and specialized schools for students with higher needs. In the Scoping round, 25% of participants fell into the ID and School expert category, 25% fell into the ID and Sexual Trauma expert category, and 50% fell into the ID and both School and Sexual Trauma expert category. The same respondents returned to complete Q1, and so demographics did not change. It is unclear why the study experienced such a high rate of attrition between the first survey and the Scoping round,
but no attrition between the Scoping round and Q1, though one hypothesis is the length of
time it took to initiate the Scoping round after the background survey due to the ongoing
process of recruitment. As Q1 was sent out soon after the Scoping round, it is likely that
participants were still motivated to continue the study as all surveys after the Scoping
round were sent out 1-2 weeks apart.

Q2 experienced some attrition which impacted the demographics of respondents,
including the loss of representation from experts who fell into the ID and Sexual Trauma
category, though expertise on sexual trauma was still represented by the participants who
fell into the joint expertise category. Q2 maintained representation from both the
Mountain and Pacific West and maintained its representation of White women and a
Hispanic woman, but it lost its representation of participants over the age of 65 and
educational psychologists. Participants remaining were between the ages of 25-44,
reported both master’s and doctoral degrees, and worked as school and clinical
psychologists. In this round, experts reported between 3-13 years of experience in their
profession, with a mean of 7.2 years, a range of 3-17 years of experience working in
schools, with a mean of 7.6 years, a range of 2-17 years of experience working with
individuals with ID, with a mean of 7 years, a range of 0-15 years of experience working
with children with sexual trauma, with a mean of 5.4 years, a range of 1-200 children
with ID having worked with, with a mean of 54.2 children, and a range of 0-50 children
with sexual trauma having worked with, with a mean of 15.8 children. Experts endorsed
experience working in both private and public schools including charter schools,
elementary, middle, high and K-12 schools, and residential treatment centers and
specialized schools for students with higher needs. Overall, in Q2, demographics became more homogenous, and the breadth of expertise shrunk as individuals at the end of their careers dropped out of the study. Individuals remaining were primarily White women between the ages of 25-44 from the Western region of the US working as professional psychologists who have worked in schools with children with ID and children with sexual trauma between 5-10 years. The range of number of children worked with was more varied, with the greatest difference in experience being the number of children with ID worked with, with one respondent endorsing over 200 children, though others reported numbers around 10 and 50 children.

In Q3, one more participant dropped out of the study. This did not impact the demographic shift as much as the attrition leading into the Scoping round and Q2, as representation was maintained between the Mountain and Pacific West region of the US, and both White and Hispanic women with master’s and doctoral degrees working as school and clinical psychologists. The expert who dropped during this round was an early career psychologist, and though all experiences shared provided valuable information, the averages in the respondents’ years of experience increased during this round. Q3 respondents reported a range of 3-13 years of experience in their profession, with an average of 8.3 years, a range of 3-17 years working in schools with a mean of 8 years, a range of 3-17 years of experience working with children with ID, with a mean of 8.3 years, a range of 0-15 years of experience working with children with sexual trauma, with a mean of 7.3 years, a range of 1-200 children with ID worked with, with a mean of 65.3 years, and a range of 0-50 children with sexual trauma having worked with, with a range
of 15.5 years. Q3 experts endorsed experience working in both private and public schools including charter schools, elementary, middle high, and K-12 schools, and residential treatment centers.

Overall, while attrition was significant across the rounds of this study, it primarily occurred at the beginning of the study and is hypothesized to be related to the amount of time the recruitment process in its entirety took to complete. Many of the participants who dropped were individuals who were recruited at the beginning of the process, and the participants who remained throughout the entirety of the study were participants who were recruited in the middle or towards the end of the preparation segment and thus had a more streamlined experience of survey completion. What this information means, is that the bulk of the information from this study came from a group of respondents who were largely White females from the Mountain West region of the US, with master’s and doctoral degrees between the ages of 25-44, working as school psychologists, with expertise in both ID and school and ID and sexual trauma. Professional experience levels reported, and the demographics just mentioned, put the continuing group largely at the early-to-mid practitioner level, though a wide range of professional environments were reported and represented. The demographics of the group that remained perpetuate the White female perspective that currently overshadows the field of school psychology, and this caveat is important to keep in mind. Though demographic parameters were not set at the beginning of the study, it was imperative that expertise across all three categories of ID, school, and sexual trauma was represented. This most important component was maintained throughout the study despite the rates of attrition. As this element was
maintained, the information gathered from the participants can still be used to inform the
development of a model that supports children with ID and sexual trauma in schools,
though it must be cautioned that the information is coming from a group of experts that is
demographically homogenous.

Results

The results of each round of the study will be described in detail below. These
will include the themes, concepts and categories gathered and analyzed from participant
answers. Demographic changes between rounds due to attrition will also be discussed.

Scoping Round

From the Scoping round and Q1, concepts were developed that were fed back to
the participants in the subsequent survey rounds to vote on their significance. The aim of
the Scoping round was to better understand the nature of the experts’ knowledge and
generate themes through the asking of open-ended questions related to the three research
questions: How can SAFEST KID become viable for school-based practitioners?; How
could school-based practitioners adhere to the pillars and principles of TIC when
working with children with ID and sexual trauma?; What are the barriers to school-
based implementation of a therapeutic intervention for children with ID and sexual
trauma (IDST)?

To do this, the Scoping round probed experts specifically on their knowledge of
TIC as they understand them, and asked participants to describe how they currently
adhere to the pillars and principles of TIC in their work. Participants were also asked in
the Scoping round to describe what interventions, strategies, or tools they use when
working with children with ID, and what barriers they have come across in this process. At the end of the survey, participants were given a copy of the working draft of the SAFEST KID model and asked for initial feedback. The full Scoping survey can be found in Appendix C1.

**Scoping Round Themes**

In reviewing the Scoping Round data, several initial themes emerged. A main theme was that half of the respondents did not endorse familiarity with TIC in terms of the pillars and principles despite having endorsed familiarity with trauma-informed care generally. Participants consistently reported practices and concerns that aligned with the pillars and principles of TIC but did not all view them as being part of that framework. Half of the participants did endorse familiarity with the explicit structure of TIC, and their reported practices and concerns also aligned with the pillars and principles. Based on this feedback, questions related to TIC practices were asked indirectly, highlighting the sentiments from the pillars and principles instead of their formal categories in order to elicit the information desired from participants.

A second theme that emerged was not having access to evidence-based tools designed for children with ID. Experts commented that they often struggled with the lack of variety and lack of valid assessments and interventions for children with ID. In their critique of the tools available to them, experts commented that intervention language was often too verbose, or tended to use language that was over-simplified to the point of being disrespectful to the child’s age.
A related theme that emerged was how communication skill level was often a barrier to care, in particular when the child was at the nonverbal skill level. Highlighting communication challenges, one expert gave context regarding feeling unsure if the child felt safe, and worrying if they were causing inadvertent harm to a child as they were not able to verbally communicate. When asked about important elements of an intervention for this population, they commented:

*Because I/DD students often do need physical support much longer than their peers, and perhaps for their lifetimes, I think any such curriculum would need to focus on context and purpose. Young adults do not always actually consent to hygiene support (e.g., a nonverbal I/DD student who actively resists having his bottom wiped after a bowel movement), and we are not great at talking through our own behavior with them. If we forcibly touch their bottom here, how do they know it would be inappropriate in a different context? I work with our paraprofessionals on talking through 'I'm going to clean you here in the school bathroom with my gloves on because my job is to keep your body clean and healthy'. Consent gets very blurry in these situations, and a program for I/DD and sexual trauma would need to address the absolute need for some physical support for some people, even if it isn't with their consent, and how to differentiate that experience from assault when they might physically and emotionally feel very similar.*

This answer highlighted important elements of consent/assent, the difficulties of nonverbal communication levels, safe vs. unsafe touch across different contexts, hygiene,
staff training, usable and valid interventions that take these elements into account, and the
day-to-day demands of what a child’s regular supportive routines look like. In particular,
it shows some examples of difficulty that arise when a need for physical safety clashes
with psychological safety and conveys pragmatic concerns of how to balance one while
trying to heal the other.

Another prevalent theme in the Scoping round answers was that of “going to the
child,” essentially meeting the child and their family where they currently are. This came
forward in a variety of ways, such as adapting interventions to the child’s preferences and
skill levels and working to support the family by connecting them to the community or
including them in interventions. It also came forward in the descriptions of developing
rapport with the child through practices such as play therapy and music therapy, instead
of leaning on those tools as the main source of intervention. Almost all participants
highlighted the nuanced nature of developing rapport with a child with ID who may be at
a nonverbal skill level or who may use a communication device, and repeatedly
mentioned the importance of having a strong relationship with the child before moving
forward with any intervention. Experts tied rapport not only to trust and understanding
but to ensuring that assent was present and that interventions were conducted with
respect, with one participant writing that it is important not to “baby” the child because
their current skill levels may not align with what is expected of their age.

A fourth main theme repeatedly highlighted was the importance of training other
staff members and care providers in TIC and in basic behaviors of ID. Experts shared that
they often take it upon themselves to do this work, and have found this lack of knowledge
to be a barrier over their years of practice, particularly in the form of having to “mythbust” preconceived incorrect notions about children with ID. One expert shared that this role comes out for her in the form of advocacy, writing:

“I have had to strongly advocate for my students during their trauma responses because the new admin team at my school does not understand how trauma can manifest or recognize the signs of trauma.”

This answer shows how an expansion of trauma trainings to all school personnel could serve to take some of the burden off the school psychologist or primary school-based mental healthcare provider, thereby increasing the sentiment of the community approach to care. Increased education regarding trauma symptoms and basic behaviors of ID to a wider audience does not just improve the safety of the individual child and decrease the workload of the provider, but it also helps build the ethos of community and togetherness.

Scoping Round Categories and Concepts

From the Scoping round, three categories were created to begin organizing the concepts that were expanded upon in later rounds: TIC Framework, Tools for ID, and Barriers. Within TIC Framework, 23 initial concepts were identified; within Tools for ID, 26 initial concepts were identified; within Barriers, 16 initial concepts were identified. These concepts were later combined with Q1 to generate the final categories and the concept list that was presented to participants in Q2.

Scoping Round Reflections
In the Scoping round, it became clear that some participants were concerned that they were not explicitly familiar with TIC’s pillars and principles. It may have been beneficial to remind participants of the context of the study, provide a more detailed description of the specific components of TIC at the start of the Scoping round survey, to redirect participants back to the SAFEST KID model linked in the background survey, or to re-link the model in the Scoping survey. Having all of the information repeated and located in multiple places would have likely increased ease of access and decreased frustration that any participants may have experienced during the survey completions. To this end, it may have been beneficial to begin by indirectly asking how participants understood and practiced the pillars and principles of TIC. In directly asking about “TIC,” 50% of the experts in the Scoping round indicated that they did not have familiarity with TIC despite having extensive experience working with children with trauma.

Clarification also should have been made at the onset that all answers are valuable, even if a respondent does not have an answer to a question, as that information is still informative. Despite these difficulties, participants responded thoughtfully. Their answers were combined with those from Q1 to the concept list for subsequent rounds.

Q1

Q1 continued to ask open-ended questions to participants and fill in the gaps that remained during the Scoping round, clarifying elements brought up previously and expanding on participant knowledge. Results from Q1 were funneled into the three working categories of TIC Framework, Tools for ID, and Barriers. 20 initial concepts
were identified within the category of Tools for ID, 19 initial concepts were identified within TIC Framework, and 15 initial concepts were identified within Barriers.

All categories and initial concepts were combined between Q1 and the Scoping round to create the streamlined list of concepts and categories presented to the experts in Q2 in the form of three categories, eight subcategories, and 74 concepts. The first category of Tools for ID was renamed *School-Based Implementation* and contained 3 subcategories: the subcategory of *Intervention-Specific Adaptations* which contained 15 concepts; the subcategory of *Intervention Planning* which contained 7 concepts; the subcategory of *Logistics* which contained 6 concepts. The second category of TIC Framework was renamed *Providing-Trauma Informed Care* and contained 2 subcategories: the subcategory of *Training* which contained 6 concepts; and the subcategory of *Practice* which contained 22 concepts. The third category of Barriers was renamed *Implementation Barriers* and contained 3 subcategories: the subcategory of *Access to Resources* which contained 4 concepts; the subcategory of *Skill Level* which contained 6 concepts; the subcategory of *Logistics* which contained 8 concepts. The complete list of categories and concepts coded, as well as the frequency counts of the codes upon initial collection and their percent agreement in the subsequent rounds, can be found in Table 13 below.

**Table 13**

*Concept Codes and Agreement*

<table>
<thead>
<tr>
<th>Category Subcategory</th>
<th>% Mentioned in Scoping</th>
<th>% of Agreement in Q2</th>
<th>% of Agreement in Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Concept</td>
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</table>
## School-Based Implementation

### Intervention-Specific Adaptations

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1. Using visual aids</td>
<td>1. 63</td>
<td>1. 100</td>
<td>1. *</td>
</tr>
<tr>
<td>2. Using video aids</td>
<td>2. 50</td>
<td>2. 100</td>
<td>2. *</td>
</tr>
<tr>
<td>3. Modeling</td>
<td>3. 38</td>
<td>3. 100</td>
<td>3. *</td>
</tr>
<tr>
<td>4. Simplifying language</td>
<td>4. 38</td>
<td>4. 100</td>
<td>4. *</td>
</tr>
<tr>
<td>5. Using multi-modal delivery</td>
<td>5. 38</td>
<td>5. 100</td>
<td>5. *</td>
</tr>
<tr>
<td>6. Repeating concepts as needed</td>
<td>6. 38</td>
<td>6. 100</td>
<td>6. *</td>
</tr>
<tr>
<td>7. Including incentives for participation</td>
<td>7. 25</td>
<td>7. 60</td>
<td>7. 75-</td>
</tr>
<tr>
<td>8. Incorporating play therapy</td>
<td>8. 13</td>
<td>8. 80</td>
<td>8. *</td>
</tr>
<tr>
<td>10. Incorporating art therapy</td>
<td>10. 13</td>
<td>10. 100</td>
<td>10. *</td>
</tr>
<tr>
<td>11. Incorporating real-world examples</td>
<td>11. 13</td>
<td>11. 100</td>
<td>11. *</td>
</tr>
<tr>
<td>15. Having opportunities for movement</td>
<td>15. 13</td>
<td>15. 80</td>
<td>15. *</td>
</tr>
</tbody>
</table>

### Intervention Planning

<p>| | | | |</p>
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<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Building rapport</td>
<td>1. 50</td>
<td>1. 100</td>
<td>1. *</td>
</tr>
<tr>
<td>2. Individualizing based on personality</td>
<td>2. 50</td>
<td>2. 80</td>
<td>2. *</td>
</tr>
<tr>
<td>3. Incorporating structured choice</td>
<td>3. 50</td>
<td>3. 100</td>
<td>3. *</td>
</tr>
<tr>
<td>4. Having mixed skill level group work (including children with and without ID)</td>
<td>4. 38</td>
<td>4. 80</td>
<td>4. *</td>
</tr>
<tr>
<td>5. Shortening session length</td>
<td>5. 13</td>
<td>5. 100</td>
<td>5. *</td>
</tr>
<tr>
<td>7. Using task analysis to develop mastery criteria for targeted skills</td>
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</table>

### Logistics

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Interviewing the family to understand context</td>
<td>1. 63</td>
<td>1. 100</td>
<td>1. *</td>
</tr>
<tr>
<td>2. Consulting with other providers</td>
<td>2. 50</td>
<td>2. 100</td>
<td>2. *</td>
</tr>
<tr>
<td>3. Having regular check-ins with families</td>
<td>3. 38</td>
<td>3. 100</td>
<td>3. *</td>
</tr>
<tr>
<td>4. Pushing into other classes to provide services</td>
<td>4. 25</td>
<td>4. 100</td>
<td>4. *</td>
</tr>
<tr>
<td>5. Having session time regularly built</td>
<td>5. 25</td>
<td>5. 100</td>
<td>5. *</td>
</tr>
<tr>
<td>6. 13</td>
<td>6. 100</td>
<td>6. *</td>
<td></td>
</tr>
</tbody>
</table>
6. Focusing on skill mastery instead of a set number of sessions

<table>
<thead>
<tr>
<th>Providing Trauma-Informed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Training</strong></td>
</tr>
<tr>
<td>1. Learning continuously (e.g., through reading, professional development, trainings, informal conversations)</td>
</tr>
<tr>
<td>2. Providing psychoeducation to families on IDST</td>
</tr>
<tr>
<td>3. Having providers trained in de-escalation and crisis response strategies</td>
</tr>
<tr>
<td>4. Having all staff members (e.g., teachers, mental health providers, custodians, etc.) trained in basic trauma principles</td>
</tr>
<tr>
<td>5. Having all staff members (e.g., teachers, mental health providers, custodians, etc.) trained in basic behaviors of ID</td>
</tr>
<tr>
<td>6. Providing psychoeducation to students with ID on a wide range of interpersonal topics (e.g., consent, public vs. private behavior, relationships, safe vs. unsafe touch, self-advocacy)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Screening for trauma through assessments</td>
</tr>
<tr>
<td>2. Screening for trauma through behavioral observations</td>
</tr>
<tr>
<td>3. Utilizing formal assessment data (e.g., social/emotional, academic, cognitive)</td>
</tr>
<tr>
<td>4. Assessing formal skill level (e.g., social/emotional, academic, cognitive)</td>
</tr>
<tr>
<td>5. Checking for physical or legal evidence in cases of suspected or confirmed abuse</td>
</tr>
</tbody>
</table>

| | 6. 63 | 6. 100 | 6. * |
| | 7. 63 | 7. 100 | 7. * |
| | 8. 63 | 8. 100 | 8. * |
| | 9. 63 | 9. 100 | 9. * |
| | 10. 63 | 10. 100 | 10. * |
| | 11. 63 | 11. 100 | 11. * |
| | 12. 63 | 12. 100 | 12. * |
| | 13. 63 | 13. 100 | 13. * |
|   | Observing and analyzing behavior  | 14. 50 | 14. 100 | 14. * |
|   | (e.g., signs of distress/comfortability, behavior changes) | 15. 50 | 15. 100 | 15. * |
|   | 7. Screening for family needs (e.g., social determinants of health) | 16. 38 | 16. 100 | 16. * |
|   | 8. Connecting the family with community supports as needed | 17. 38 | 17. 100 | 17. * |
|   | 9. Viewing behavior in the context of the person’s history | 18. 25 | 18. 100 | 18. * |
|   | 10. Understanding the family’s generational trauma | 19. 25 | 19. 100 | 19. * |
|   | 13. Modeling consent | 22. 13 | 22. 100 | 22. * |
|   | 15. Communicating with respect | 22. 13 | 22. 100 | 22. * |
|   | 16. Advocating for the child’s needs | 23. 13 | 23. 100 | 23. * |
|   | 20. Having explicit expectations for sessions | 27. 13 | 27. 100 | 27. * |
|   | 22. Making time for your own self-care | 29. 13 | 29. 100 | 29. * |

### Implementation Barriers

**Access to Resources**

1. Level of all staff training in working with students with ID 1. 38 1. 100 1. *
2. Level of all staff training in working with students with trauma 2. 38 2. 100 2. *
3. Assumptions about ID (e.g., myth-busting) 3. 25 3. 100 3. *

**Skill Level**

1. Specific adaptations without infantilization 1. 38 1. 100 1. *
2. Communication level (e.g., nonverbal) 2. 38 2. 100 2. *
3. 3. 25 3. 100 3. *
4. 4. 25 4. 100 4. *
3. AAC Devices
4. Assessing for understanding
5. Assessing for assent/consent
6. Range of skill levels among children with ID

<table>
<thead>
<tr>
<th>Logistics</th>
<th>1. Lack of valid assessment tools for use with children with ID</th>
<th>2. Lack of variability of assessment tools for use with children with ID</th>
<th>3. Scheduling constraints (e.g., school, family, provider)</th>
<th>4. Lack of data from other staff members</th>
<th>5. Physical structure of the building (e.g., private location, distance from classrooms)</th>
<th>6. Cultural and linguistic differences</th>
<th>7. Telehealth</th>
<th>8. Lack of rapport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. 38</td>
<td>2. 38</td>
<td>3. 38</td>
<td>4. 25</td>
<td>5. 13</td>
<td>6. 13</td>
<td>7. 13</td>
<td>8. 13</td>
</tr>
<tr>
<td></td>
<td>1. 80</td>
<td>2. 80</td>
<td>3. 80</td>
<td>4. 80</td>
<td>5. 60</td>
<td>6. 100</td>
<td>7. 80</td>
<td>8. 80</td>
</tr>
</tbody>
</table>

**Q1 Themes**

During Q1, several additional themes emerged. Similar themes from the Scoping round were highlighted that included struggling with the lack of evidence-based tools for children with ID, the importance of building rapport and meeting the child and family where they currently are, and the need to educate other staff members as well as family members in the behaviors of ID and trauma, myth-busting when possible. Additionally, the theme of using data was salient in this round of responses, such as striving to use evidence-based assessments and interventions, using pre-existing data from the child’s file, and being transparent in practice in terms of progress monitoring skills and documenting work.
Regarding educating others on understanding ID and trauma, one expert described some difficulties with the demands of daily life and team-based care:

“I think the best way to continue to learn about the history of ID is true carefully placed reading, and or in-service training. It’s a tough thing to accomplish because many of the support staff are there for a job, and when they go home, that’s it. This is not to say that they are not effective when they are on the job. Not at all. It’s a reality that they have a family that they need to tend to after they leave their appointment.”

Q2

In Q2, participants were presented with the streamlined list of concepts and categories and asked to agree or disagree if the concept listed was important to the question posed (e.g., Please rate if you AGREE or DISAGREE that the following Intervention-Specific Adaptation themes are important to the implementation and adaptation of school-based interventions for students with ID or IDST). Using the cutoff of 80% agreement for a concept to have reached consensus, two concepts did not reach consensus in Q2: the concept of including incentives for participation under the category of School-Based Implementation and the concept of physical structure of the building (e.g., private location, distance from classrooms) under the category of Implementation Barriers. Participants were also given the optional opportunity to respond open-endedly to questions at the end of each category as well as at the end of the survey if they had other comments they had not been able to yet share. The majority of concepts achieved consensus in Q2.
Q3

Though the majority of the concepts reached consensus in Q2, in Q3 participants were again presented with the current level of consensus of each concept and given the opportunity to comment on any concept that had not reached 100% agreement. In this way, Q3 was used primarily to confirm the information obtained in Q2. In Q3, participants were asked to vote on the two concepts that had not achieved 80-100% agreement in previous rounds, including incentives for participation and physical structure of the building (e.g., private location, distance from classrooms). The former returned from Q3 with a 75% agreement, and the latter with a 50% agreement. Failing to meet the criterion threshold for consensus, both concepts were eliminated from the final list. The concepts remaining at the conclusion of Q3 considered to be agreed upon by this study’s participating experts can be found as follows in Table 14 below.

Table 14

Final Concepts

<table>
<thead>
<tr>
<th>Category</th>
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<tbody>
<tr>
<td>Subcategory</td>
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<tr>
<td>1. Concept</td>
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School-Based Implementation

Intervention-Specific Adaptations

1. Using visual aids
2. Using video aids
3. Modeling
4. Simplifying language
5. Using multi-modal delivery
6. Repeating concepts as needed
7. Incorporating play therapy
8. Incorporating music therapy
9. Incorporating art therapy
10. Incorporating real-world examples
11. Generalizing intentionally
12. Using manipulatives/toys
13. Incorporating mindfulness techniques
14. Having opportunities for movement

**Intervention Planning**
1. Building rapport
2. Individualizing based on personality
3. Incorporating structured choice
4. Having mixed skill level group work (including children with and without ID)
5. Shortening session length
6. Having intentional breaks during sessions
7. Using task analysis to develop mastery criteria for targeted skills

**Logistics**
1. Interviewing the family to understand context
2. Consulting with other providers
3. Having regular check-ins with families
4. Pushing into other classes to provide services
5. Having session time regularly built into the schedule
6. Focusing on skill mastery instead of a set number of sessions

**Providing Trauma-Informed Care**

**Training**
1. Learning continuously (e.g., through reading, professional development, trainings, informal conversations)
2. Providing psychoeducation to families on IDST
3. Having providers trained in de-escalation and crisis response strategies
4. Having all staff members (e.g., teachers, mental health providers, custodians, etc.) trained in basic trauma principles
5. Having all staff members (e.g., teachers, mental health providers, custodians, etc.) trained in basic behaviors of ID
6. Providing psychoeducation to students with ID on a wide range of interpersonal topics (e.g., consent, public vs. private behavior, relationships, safe vs. unsafe touch, self-advocacy)

**Practice**
1. Screening for trauma through assessments
2. Screening for trauma through behavioral observations
3. Utilizing formal assessment data (e.g., social/emotional, academic, cognitive)
4. Assessing formal skill level (e.g., social/emotional, academic, cognitive)
5. Checking for physical or legal evidence in cases of suspected or confirmed abuse
6. Observing and analyzing behavior (e.g., signs of distress/comfortability, behavior changes)
7. Screening for family needs (e.g., social determinants of health)
8. Connecting the family with community supports as needed
9. Viewing behavior in the context of the person’s history
10. Understanding the family’s generational trauma
11. Modeling boundaries
12. Modeling confidentiality
13. Modeling consent
14. Balancing physical and psychological safety
15. Communicating with respect
16. Advocating for the child’s needs
17. Using strength-based language
18. Having cultural humility
19. Having a trauma-informed classroom approach to care
20. Having explicit expectations for sessions
21. Obtaining assent
22. Making time for your own self-care

Implementation Barriers

Access to Resources
1. Level of all staff training in working with students with ID
2. Level of all staff training in working with students with trauma
3. Assumptions about ID (e.g., myth-busting)
4. Available funding

Skill Level
1. Specific adaptations without infantilization
2. Communication level (e.g., nonverbal)
3. AAC Devices
4. Assessing for understanding
5. Assessing for assent/consent
6. Range of skill levels among children with ID

Logistics
1. Lack of valid assessment tools for use with children with ID
2. Lack of variability of assessment tools for use with children with ID
3. Scheduling constraints (e.g., school, family, provider)
4. Lack of data from other staff members

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5. Cultural and linguistic differences  
6. Telehealth  
7. Lack of rapport

The remaining participants were delivered this completed list and given the opportunity to endorse or further comment on any of its components in a final member check. Participants reiterated that building rapport with the child in creative ways is imperative and highlighted the benefits of play therapy for this role. The concepts listed were then used along with the themes to inform general use guidelines and specific details of the SAFEST KID model.

**Discussion**

To have an intervention adapted for a child with ID does not just mean to have the intervention simplified into concrete language with manipulatives and visuals. On a much broader scale, it means taking into account the lived experience of a person who cannot always communicate exactly what they want or say what they mean and meeting them at the threshold of their lived experience. In the absence of a shared language, a greater understanding of their history and environment is needed, as well as education in behavior and situation. A team approach with frequent check-ins is likely warranted, and care provided must be given under the umbrella of first meeting the child where they are - “going to the child” and their family.

**Findings**

Overall, many of the initial themes identified by participants aligned across three main categories of School-Based Implementation, Providing Trauma-Informed Care, and
Implementation Barriers, and participants reached a consensus on the concepts presented to them in terms of agreeing on what elements are important to consider for interventions for children with IDST. Despite attrition throughout the study, the needed expertise was represented in each round, as participants reviewing each round had expertise in both ID and Schools and ID and Sexual Trauma. Though their answers should be viewed through the lens of demographic homogeneity, the experts’ kinds of experiences are still relevant to answering each of the research questions. The group that remained throughout the study can be considered representative of the most relevant group of participants: school psychologists with expertise in ID, schools, and sexual trauma. Each of the three research questions will be discussed separately, though there is overlap among them.

**Research Question 1**

The first research question, *How can SAFEST KID become viable for school-based practitioners?*, was answered primarily through the collection of concepts under the main category of School-Based Implementation. These elements include some well-represented in the literature, such as practicing multi-modal intervention delivery, and expecting to incorporate visual and video aids, modeling and role-play, toys and manipulatives, play, music and art therapy for both rapport-building and concept retention, and prioritizing opportunities for breaks and movement. One of the key findings from the study consisted of a fundamental shift in intervention measurement: instead of following a set number of sessions to provide the intervention, it is best to instead use mastery criteria for targeting a specific skill, and shift expectations of intervention duration based on the child’s skill level both in terms of specific session...
length as well as the entirety of the session duration. This would involve utilizing an intervention model less as a streamlined protocol and more as a module-based aid targeting specific skills for the child in question. This shift goes deeper into the framework of intervention that would benefit a child with ID and trauma, underscoring the importance of going to the child, and requiring a more nuanced understanding of where the individual is coming from in terms of their experiences, current skills, and ideal goals in addition to healing from trauma. Repetition should be done to the extent needed, with checking progress against the mastery criteria identified through task analysis, or the breaking down of learning steps into their basic components (Sidon & Franzone, 2009).

Additional key pieces that emerged from the study aligned with holistic approaches, including taking the time to better understand the child and their family through intake interviews and background information gathering. These should be considered to gain an understanding of the familial dynamics and landscape, as well as the child’s preferences and trauma history. A team approach should be prioritized, with consultation among other providers as needed as well as regular check-ins with the family regarding concept retention, general functioning, changes in situation, and how to continue the learning at home.

In terms of how to practically implement the intervention, interviews should be initiated after identification based on behavioral observation and concern or after a known incident has occurred. Intervention delivery will depend on the schedules of the provider, school, child, and family, but should aim to be regularly incorporated into the
schedule. Components can be delivered either by pushing into other classes or having regular pull-out times, whichever schedule and system works best for the individuals involved.

**Research Question 2**

The second research question, *how could school-based practitioners adhere to the pillars and principles of TIC when working with children with ID and sexual trauma?*, was answered primarily through the category of Providing Trauma-Informed Care. As a reminder, the four pillars of TIC are Realize, Recognize, Respond, and Resist Revictimization, and the six principles of TIC are Safety, Trustworthiness and Transparency, Peer Support, Collaboration and Mutuality, Empowerment Voice and Choice, and Cultural, Historical and Gender Issues. Based on expert response, there are specific ways practitioners can aim to adhere to these pillars and principles, including learning continuously through both formal and informal means, as well as communicating this knowledge through formal and informal means. Suggestions included attending professional development seminars and conferences, reading on one’s own time, and discussing information with colleagues in quotidian conversations. An important concept mentioned again was that of “myth-busting,” especially in informal conversations, and for practitioners to make an effort to correct misconceptions that they come across on a day-to-day basis that pertain to ID and IDST.

Another core theme in adhering to the components of TIC was to promote specific training of all staff members in both basic trauma principles as well as basic behaviors of ID, including teachers, mental health providers, custodians, and
administrators. In this realm, ensuring that providers are trained in de-escalation and crisis response strategies is also an important piece of this equation. These elements stretch upwards to the systems-level intervention but are important to consider when operating from a team approach. Within the targeted intervention itself, it is important both to include families in the educational process on IDST, as well as to incorporate interpersonal skill-building as needed for the child depending on their skill level. This is relevant for both the SAFEST KID model of intervention as well as the general guidelines of care.

Additional intervention components include actively screening for trauma symptoms through assessments and behavioral observations and leaning on formal assessment data available or assessing further as needed. Providers can check for publicly available information regarding legal evidence in cases of confirmed abuse or can be sure to screen for physical evidence in cases of suspected abuse. The underlying notion should be to attend to changes in a child’s behavior, and to view difficult behavior through the lens of curiosity and concern rather than punishment in striving to view the child within the context of their history and their family’s history. When interviewing the family, providers can also screen for family needs and help connect the family to community supports if it is warranted. Within the intervention, continuing to actively model boundaries, confidentiality, and consent is important, as well as maintaining an environment of respect, checking for assent, and balancing both physical and psychological safety to the extent possible. This can be done through using strength-based language, tailoring interventions to the child’s individuality, and having cultural
humility in the process. Advocating for the child may be necessary in the form of trying to connect the family with community supports or ensuring that the child receives intervention regularly during the school week.

Outside of the intervention, it was mentioned that it is imperative to ensure that providers themselves are making time for their own self-care. Working with children who have experienced any kind of trauma can be difficult in a myriad of ways, one of which being the emotional toll it can take on a provider. Though the nature of the mental health profession necessitates self-care to already be a priority, its need is worth highlighting in this specific context as well.

**Research Question 3**

The third research question, *What are the barriers to school-based implementation of a therapeutic intervention for children with ID and sexual trauma (IDST)*?, was primarily answered through the concepts gleaned from the category of *Implementation Barriers*. These barriers included some systems-level concerns regarding the level of all-staff training in both specific components of trauma as well as behaviors of ID and how this lack of information contributes to the need for day-to-day myth-busting. They also included as barriers general school funding and provider access to helpful interventions. Respondents repeatedly mentioned the lack of valid and variable assessment and intervention tools for children with ID as a barrier, as well as the communication skill level of the child. It is important to consider the degree of difference between a child who is nonverbal, operates an AAC device, or is able to be largely independent in their daily life. This spectrum necessitates a high degree of flexibility and
adaptability for an intervention for a child with IDST, dependent on their communication and skill levels, with special concern paid to children who cannot verbally communicate assent. Participants mentioned the worry that in the absence of this confirmation, they cannot always be sure that they are helping and not hurting, with one respondent giving the example of helping a child at a nonverbal communication level clean themselves up after using the bathroom and needing to balance the pieces of clean hygiene with physical and psychological safety.

Additional barriers to implementation include general scheduling constraints from providers, the school, and family members, as well as cultural and linguistic differences between provider and family, and the potential need to use Telehealth instead of being able to meet in person. Overall, barriers stretched from specific elements of communication between child and provider, to routine pragmatic constraints, and reiterated systems-level concerns. Some of these barriers are likely to require a case-by-case problem-solving approach, such as navigating scheduling constraints, but others, such as the gaps in staff training, can be prescribed training remedies.

**SAFEST KID Model**

Based on the results from the study, specific adjustments were made to the SAFEST KID model, and a set of guidelines were created that could be in theory applied to any model of intervention for use with children with ID and sexual trauma as a working start point for protocol adjustment for use with children with ID or IDST. These general guidelines will be discussed, as well as how they would overlay on the *Bounce Back* model, which is this model’s recommended protocol for use with children with
IDST. *Bounce Back* was chosen as a foundational protocol after reviewing many evidence-based models of intervention for its grounding in both school-based intervention, trauma-informed care, and elementary-school focus (see manuscript 1).

The SAFEST KID model is grounded in both trauma-informed care and ecological systems theory and incorporates these elements through its recommendations at the systems, organizational, and individual levels of intervention. Though this study primarily focused on targeting the individual level of intervention, results underscored the importance of addressing gaps in care at the other two levels as well, specifically in the form of staff training and family education as it pertains to both ID and sexual trauma, separately as their own concepts and combined as IDST.

**TIC Guidebook for IDST & SAFEST KID Enhanced Model**

The identified concepts from this study were aggregated into a general guidebook that can be used as a starting place for intervention adaptations for the population of children with IDST. The TIC Guidebook for IDST was applied to the SAFEST KID model using the *Bounce Back* protocol as the working foundational protocol, as *Bounce Back* was initially intended to be the foundational protocol for the SAFEST KID model but during the study it became clear that a flexible set of guidelines was also warranted should *Bounce Back* for any reason not be appropriate for the child. Additionally, neither experts nor researcher claim to be an expert on *Bounce Back* itself, though the literature supports its use as the foundation for this model. Both the guidebook and model can be found in full in the Appendix section under Appendix F; samples and descriptions of the guidebook and SAFEST KID model are also included below.
First described are several slides from the TIC Guidebook for IDST section, which in its entirety outline the general framework that can be leaned on when thinking through adapting other interventions for this population. Initially, the guidebook includes a review of the pillars and principles of TIC, as well as the key used throughout the slides to anchor readers to which TIC principles are reflected on that page. Included in the Appendix are other slides that review the basics of ID and signs of trauma in individuals with ID. Included below are the depictions of the full SAFEST KID model with all three levels of care, outlining the theoretical components listed in the broader two conceptual levels of TIC training and healthy relationship implementation. Additionally included in the Appendix are steps for implementing care at these two described levels. The slides included below highlight the steps for providing care at Level 3, the individual intervention level for a child. They describe the identification, task analysis, intervention adaptation, progress monitoring and family check-in process, and how the process can loop back into itself to support the child. Figure 5 includes excerpts from the TIC Guidebook for IDST.
TIC Overview: Principles

1. Safety: Preventative, recognizability, and psychological safety
2. Trustworthiness & Transparency: Maintain clear documentation and openness in practice
3. Peer Support: Empowering students and school communities through collaborative learning
4. Collaboration & Mutuality: Empowerment, voice & choice
5. Empowerment, Voice & Choice: Advocacy for the voice of the child and the needs of the community
6. Cultural, Historical, & Gender Issues: Diversity in education and research on gender, equity, and social justice

Steps for Providing Care: SAFEST KID Model

Healthy Relationships
Accurate and expansive SEL curricula taught at all grade levels (K-12) embedded throughout the year and adapted for a range of skill levels

Therapeutic Intervention
School-based therapy adapted for children at different skill levels, targeted towards children with ID and IDST

TIC Training
Diversity-informed trauma training across systems for all school personnel (e.g. administrators, mental health providers, teachers, custodians, etc.)
Steps for Providing Care: Level 3

Identification
A child with IDST has been identified, or you have noticed sufficient signs in a child that warrant support and investigation.

Step 1

Task Analysis
Skills and needs are to be formally and informally assessed, existing data utilized, families involved, and intervention frameworks selected.

Step 2

Intervention Adaptations
Mastery criteria are developed, and interventions are utilized according to which skills they addressed, ignoring recommended session length and time in favor of the child’s needs. Using a community-based approach and multi-modal delivery are imperative.

Step 3

Repeat
Providers should continue working on skill support with the child as needed, moving onto other areas after mastery of one skill has been obtained.

Step 4

Progress Monitoring & Family Check-Ins
Child progress should be measured according to the skills they are learning instead of working through set sessions of protocols, and providers should schedule regular check-ins with families and other relevant staff members.

Step 5

Step 1: Identification

Observe Changes in Behavior
Attend to behavioral changes that align with typical trauma symptoms and those that are common among children with ID, but view all changes with curiosity and concern instead of discipline or dismissal.

Begin Establishing Rapport
Begin establishing rapport with the child if rapport has not already been formed, utilizing the modalities of play, music, and art therapy as needed, or generally implementing Child Directed Play.

Report Abuse
Note physical signs of abuse as well as behavioral, reporting any and all suspected instances of child abuse to both the school and Child Protective Services as well as any other relevant authorities.

Develop Intervention Structure
Obtain consent and assent for working with the child, formulate regular schedule for the intervention, and decide on a foundational framework and necessary adaptations.

Work with the Family
After a child has been identified with IDST who needs support, reach out to the family to gather a more detailed history to the extent possible to better understand the child's life and family dynamic, and provide education to the family if it is needed and welcomed. Connect the family to community supports as needed and as is possible.
Step 2: Task Analysis

1. Skill Gap & Mastery Criteria
   - Utilize the framework of task analysis to create a list of skills to focus on, breaking each skill into smaller components until the child’s level has been reached.
   - Establish criteria that would indicate the child has mastered each skill and is ready to progress onto another. View all needs as skills to the extent possible.

2. Incorporate Existing Data
   - Utilize data that already exists in the child’s file, public records, or school system to help increase understanding of the child’s life and dynamic. Practice viewing the child within the context of their history—their lived experience, cultural landscape, and family system.

3. Assessments
   - Conduct further assessments as needed, such as baseline trauma screens to support progress monitoring and evidence-based intervention delivery. Conduct additional family interviews as needed to help support understanding.

4. Intervention Selection
   - Based on the information obtained, select full protocols or parts of interventions to implement with the child with 1:1, 1:2, focusing on skill development instead of adhering to specific protocol sessions. For a child with ID/BD, using the Bounce Back Framework is an ideal foundation.

Step 3: Intervention Adaptations

01. Turn protocol sessions and set timelines into:
   - Skill gap measurement and mastery criteria benchmarks
   - Repetitive practice of concepts during set times each week during school
   - Stretching session practice over many sessions to increase familiarity and retention and move the child’s own pace

02. Shift verb phrase or lecture-heavy intervention components into elements with:
   - Concrete language with real-world examples and role-play support
   - Manipulatives, visuals, videos, and general multi-modal delivery
   - Opportunities for movement and engagement with peers across skill levels

03. Work with families to support skill practice at home:
   - Include families from the start of the intervention
   - Share updates on skill development and education to the extent possible
   - Provide instructions for families to practice specific skills with the child at home

04. Incorporate structured choice as much as possible:
   - Involve the child in their intervention by developing a rapport, obtaining their consent, incorporating their preferences, and putting examples and role-play situations from the child’s own life

05. Intertwine trauma support with interpersonal skill development:
   - Ensure that skill gaps are being addressed by maintaining a focus on learning skills regarding interpersonal safety, self-advocacy, boundaries, and consent
   - Make space for processing trauma at the child’s level focusing on creating physical and psychological safety, and either developing a trauma narrative or protocol for what to do should a similar situation arise in the future
Figure 5. TIC Guidebook for IDST

Additionally included below in Figure 6 are excerpts of the enhanced SAFEST KID model. This model presumes that providers have access to and are utilizing the
Bounce Back protocol as their foundation, which can be accessed online for free from the Center for Safe and Resilient Schools and Workplaces website. The slides included below attempt to integrate the components of the guidebook based on the themes and concepts identified from this study, and enhance the information identified from the existing literature. Key components of this model include (1) being viewed in a module format, with providers being advised to check back in on skills and feeling free to repeat materials and “sessions” as needed and (2) moving at the child’s pace and understanding that these sessions will not likely map cleanly onto a 10-week intervention course. Further, it recommends frequent and repeated check-ins with families, and trauma progress monitoring based on the child’s communication and skill level. There is flexibility for the modules to be used individually or in group settings as needed, and suggestions for how to make the modules multi-modal, though ultimately it will depend on the child and provider. Building rapport is key and highlighted, as are skills specific to interpersonal relationships and bodily awareness. The full slides of the model are included in full in Appendix F, though samples are included here.

Overall, the model is designed to be used flexibly, with the child’s family involved, leaning on information from other care providers, and applied not on a strict timeline but instead with modules, informed by an understanding of the meaning of behaviors of a child with ID, and signs to look for that indicate sexual trauma. It is implemented with the understanding that sexual trauma can be uniquely disruptive and devastating for the child, and that special care must be taken when implementing an intervention with children with ID. Included below in Figure 6 are the first and final
slides of this part of the model, as well as the module linked to the trauma narrative portion of the intervention. Again, the model in full can be found in Appendix F.

The SAFEST KID Model: Level 3

The Sexual Assault Framework in Education to Support Trauma in Kids with Intellectual Disability:
An Adapted Individual Intervention Based on the Bounce Back Protocol

The Bounce Back protocol can be downloaded for free from the Center for Safe and Resilient Schools and Workplaces at: https://app.traumagawareschools.org/resources_public
Figure 6. SAFEST KID Enhanced Model (Level 3)

Limitations
Several limitations were present at the onset of this study and several developed over its lifetime. The limitations of attrition, diversity, bias, and validity and reliability will be discussed below. These limitations lead to caution in terms of generalizability and should give pause to readers in terms of their representativeness of overall experts in the field. However, within the data there is important information to consider in terms of answering the study’s overall research questions and at the very least the information obtained can serve as an initial launching point for future studies in this area going forward.

**Attrition**

Due to the nature of a Delphi study having multiple rounds over an extended course of time, a main concern at the start of this study was participant attrition (Donohoe & Needham, 2009), and this proved to be a significant limitation over the five total surveys that were distributed to participants. Though 17 participants initially consented to partake in the study, only 5 remained at the start of Q3. Though Delphi studies can have a wide range of number of experts serving on the panel (Iqbal & Pipon-Young, 2009), with the ideal number of experts ranging between 10 and 50 (Linstone & Turoff, 2002), a general minimum number is considered to be 8 individuals (Ogbeifun et al., 2016). One way to combat participant attrition is to ensure front-loading of the study expectations throughout the process, and another is to prepare for possible participant attrition is to seek out a greater number of panelists at the onset. This was attempted through the multiple rounds of recruitment administered over several additional months with the goal of obtaining enough participants that significance would be maintained despite attrition.
through the end of the study, however, this may have inadvertently led in part to such high rates of attrition as it caused a long delay for some of the participants between the first point of contact and the Scoping round. Despite attempts to retain participants, attrition continued across each subsequent round within this study and is considered the main limitation overall.

Despite the Delphi study lacking in the specialized complexity of other research methods (Iqbal & Pipon-Yong, 2009), it is a unique tool to gather community expertise and pool knowledge that may exist outside of the research literature. In the study, a caution to consider is the potential over-simplification of concepts that can occur throughout the rounds, either due to the time restrictions of the study, necessary length of Round questionnaires (e.g., Q1, Q2, and Q3) to keep to timelines and to caution against participant attrition, or due to artificial consensus from panelists agreeing with the group conclusions in the face of their own individual outside life demands. This limitation can also potentially be addressed by front-loading the information and panelist expectations at the onset of the study and throughout the rounds as reminders, in a similar manner to supporting participant retention. To this end, background information was included at the beginning of the Scoping round as well as in recruitment materials to inform participants briefly of the foundation of the study and to serve as an anchor before the survey.

For all limitations to this study, providing clear expectations and information at the beginning to ensure that potential panelists are fully informed of the high need for this research, the value of their knowledge, and the projected timeline and individual expectations can serve to protect against some of the limitations present within the Delphi
study structure and was attempted to be done throughout the study when communicating deadlines and landscape. However, due to the recruitment period taking significantly longer than anticipated, original timelines were not able to be adhered to. Other protections include sending individual follow-ups and reminders at the end of each round of surveys, adding a human element connection across time and distance and aiming to serve as an anchor amidst the workload of outside life. Further, participants were informed of the rationale of conducting it, information of previous results, and reminded to complete the next round of the survey after a week had passed since its start. All surveys were designed to be completed within one hour over 1-2 weeks in an attempt to prioritize both detailed information-gathering as well as minimize participant attrition, though at several points during data collection it was required to individually reach out to participants and prompt their completion. However, due to the nature of questionnaire development throughout the Delphi process and the anticipated reoccurring need to revitalize participants during subsequent survey rounds, only an estimated timeline was presented to participants at the onset of the study. It is hypothesized that the lack of detailed dates at the onset of the study outlining the specific weeks of expected involvement contributed to participant attrition over time, in addition to the delay at the start of the study. In future studies, if possible, it would likely be best to strive to outline as detailed as possible the expected deadlines for participants at the onset of the survey instead of just including the general expectations and to prepare for any possible delays that may occur during the recruitment process. Overall, the number of participants included in the study ideally is balanced by the amount of time it takes to analyze each
round of results and the length of time of the overall study and between rounds as it relates to participant attrition (Donohoe & Needham, 2009), with the goal of minimizing participant attrition as much as possible and maintaining the general demographics of the study throughout its course. A key element is to be aware of how the representation of expertise is changing throughout the rounds due to attrition, and to understand how this informs and colors the data that is being gathered from the study.

The attrition that occurred over the study, while impacting the overall study numbers, did not as significantly impact the participant demographics throughout each round. The body of expertise in terms of subject area remained roughly consistent across rounds, with at least half of the panel of experts per round having expertise in ID and both schools and sexual trauma. The two largest changes in demographics from attrition were in participant age ranges and years of expertise. Between Q1 and Q2, participants over the age of 65 were lost to attrition, and with them their 50+ years of professional experience with the populations of interest. This attrition between Q1 and Q2 led to the remaining pool of experts being a much younger pool of experts with less professional experience compared to that of the group in the previous round. It is unknown what impact this loss had on the remaining data collection, though the perspective and experience gained from lengthy careers in the psychology profession was a valuable addition to the previous rounds.

The attrition was addressed by looking more deeply into the demographic details of each round’s expert panel, striving to understand clearly who was on the other side of the surveys answering the questions. In this way, despite the attrition, meaningful
qualitative information could be gleaned from the thoughtful answers of the experts who did remain. Further, particular attention was paid to the changing balance of participant expertise. This was done to ensure that questions were still being posed to a group that had the correct subject matter expertise to answer them. If the subject matter expertise had changed substantially across rounds due to attrition, it would have had significant impacts on the resulting data and analysis.

**Validity and Reliability**

Reliability asks how likely it is that a different researcher will obtain the same results from the study the way it was conducted (consistency), and validity asks whether the study is measuring in various ways what it is claiming to study (accuracy). The reliability and validity of Delphi studies often depend on the response rates obtained in the study, the number of rounds of questionnaires, the degree of attrition, the use of member checking, and whether the researcher is entering the study with preconceived biases about the results (Hasson et al., 2000). To this end, a pilot study was utilized to enhance the validity of the study, ensuring that the preliminary questions were posed in such a way that they elicited the answers they were intended to elicit (Clibbens et al., 2012). This helped ensure that the foundation of the study is grounded in its validity. Following the prescribed structure of the Delphi study’s iterative rounds of questionnaires and providing feedback to participants was intended to enhance the validity of the study and ensure it was measuring what it was intending to measure. To enhance reliability, as the outcomes of this study are heavily based on the individual experiences and opinions of participants included in this study and the number of experts,
a second thematic coder was intended to be utilized to add support to the thematic conclusions drawn from each subsequent round. Due to time constraints, a second rater was unable to be recruited, and the lack of inter-rater reliability serves as an additional limitation to the study. This limitation in reliability leads to the subsequent limitation of bias discussed in the next section.

These limitations of validity were addressed through the use of a pilot study for the scoping round, and through the careful monitoring of changing participant expertise after attrition. In this way, attempts to check that the study was still assessing what it was intended to assess were completed. To address reliability, the researcher made routine attempts to view the results of the surveys in light of the participant demographics, as well as her background. Though the data was not coded by a second researcher, it was coded multiple times by the same researcher to ensure that her conclusions were reliable against each other.

**Bias**

Through the use of the pilot study, the study’s validity was enhanced and checked before the full study was initiated, and bias was a consideration in the background throughout the study. The lack of a second coder resulted in only one person coding the Delphi data, which introduced unchecked bias and should be considered a limitation of this study. Finally, though demographic information was collected at the onset of the study, and the study participants were not fully representative of the demographic information of this country and were more aligned with the demographics of school psychologists currently in the US (Goforth et al., 2020), this should still be considered a
large source of bias overall. To this end, it is likely that there was bias in respondent information due to the lack of representation and diversity generally, as well as in the coding of answers as only one researcher analyzed the results. With this in mind, results should be viewed with an understanding that this document and product have been filtered through the predominantly White, female, early-to-mid-career school psychologist’s lens. To address this bias, the researcher viewed the data collected against this homogenous backdrop and looked back into the research specifically for how school psychology practitioners of color engage with children with ID, though further research is needed. Ideally, the preliminary data should be taken as a foundational component of future studies that are able to be conducted with participant demographics reflective of the U.S. student population and with a greater number of experts in the pool. In these future studies, opportunities should be made to comment on previous data collected from the SAFEST KID study, as well as to confirm its findings.

**Author Positionality.** Though one may strive for objectivity, all work and thoughts are always filtered through each of our subjective lenses of how we see the world – none of us can escape this innate trait of being human, and all of us must acknowledge it. Without other researchers checking the data codes, and without other members of a research team assisting in parts of the analysis, it is such that the work in these pages is filtered through my lens and my bias as the author of these manuscripts. I would like to fully acknowledge this component and describe the weight that my own experiences may hang on this work. All results of this study, and really all words in this document, should be digested with the understanding that I am a White educated
American woman who has spent the majority of my three decades being a student and living in the Northeast, Midwest, and Mountain West regions of the US. I have had people close to me suffer from sexual trauma, have healed from sexual trauma myself, and have family members with intellectual disabilities. The pieces I write about in these pages are close to my heart and close to my soul, and I acknowledge that my personal experiences, explicit and implicit, have played a role in the shape of this study. Readers are encouraged to read the narrative of these manuscripts and view the entirety of this work against this background.

**Implications for School Psychologists**

The job of a school psychologist can sometimes feel isolating when the large swath of responsibilities for too many students rests primarily on one person’s shoulders. Many school psychologists make it a priority to implement a team-based approach in their work, though it can be challenging. A key takeaway from this study, research, and model is that it is imperative to work with others at the individual level (e.g., families of the student or other staff members), the organizational level (e.g., advocating for school-wide interventions), and the systems level (e.g., fighting to have district-wide training of all staff in basic trauma principles and behaviors of children with disabilities) for long-lasting, meaningful, sustainable change. Additionally, there are multiple action items that can be implemented by an individual at various levels. These are presented in Table 15.

**Table 15**

*Action Items*

<table>
<thead>
<tr>
<th>General Strategy</th>
<th>Specific Action</th>
</tr>
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| Advocate for trauma-informed trainings to be regularly given during the school year and required for all school staff and personnel. | Work with administration to highlight the cost-saving measures that could come from this increased education, creating committees or subcommittees in the school to pilot programs, or utilizing all-school assemblies to convey information.  

*Examples of Trainings:*  
- ACEs Connection  
- Framework for Safe and Successful Schools  
- Futures Without Violence  
- School Health Assessment and Performance Evaluation (SHAPE)  
- Trauma-Sensitive Schools Training Package  
Treatment and Services Adaptation Center |
| Advocate for the regular presence of inclusive and accessible healthy relationship curricula at all grade levels that check for student learning. | Work with administration to test run one of the curriculum below in a consenting classroom, or enlist teachers across grade levels to teach them as part of the regular coursework, progress monitoring throughout the year.  

*Examples of Curricula:*  
- Collaborative for Academic, Social and Emotional Learning  
- Comprehensive Sexuality Education  
- Healthy Relationships Curriculum  
- Long Live Love  
- Rights, Respect, Responsibility  
- Second Step  
- Zones of Regulation |
| Reframe interventions with children with ID or IDST to “go to the child” | Prioritize building rapport with the child first, such as through play, music, and art, and striving to gain a nuanced understanding of the child as an individual. For children at the non-verbal skill level, this is additionally important.  

Utilize task analysis to create skill-based intervention goals, focusing on the developed mastery criteria to progress monitor skill development instead of attempting to adhere to session timelines or guidelines. Move at the child’s pace and conceptualize skills across all domains of life. |
<p>| Reframe interventions with children with ID or IDST to routinely involve caregivers | Build rapport with the child’s family or caregivers to the extent possible and conduct background interviews prior to intervention delivery with the aim of better understanding the child’s landscape and history. |</p>
<table>
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<tr>
<th>Throughout the process so they can both understand and practice the intervention components in part at home.</th>
<th>Share education with the family or caregivers throughout the intervention process, working through their current understanding and helping them to practice parts of the intervention at home throughout the weeks as well.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice “myth-busting” formally and informally when able.</td>
<td>Formally, in presentations or trainings, make a point to address common biases or preconceived notations regarding ID or trauma, taking time to highlight the discrepancies and have audiences practice unlearning these pieces. Informally, take the time to speak up in conversations with others when a myth is mentioned or being discussed, and politely correct what was being conveyed.</td>
</tr>
</tbody>
</table>
| Continue to learn and educate oneself about components of ID and sexual trauma. | Consider looking into the following websites and resources for continuing education on ID and on sexual trauma:

- The Arc
- National Institute of Child Health and Human Development
- American Association on Intellectual and Developmental Disabilities
- The National Child Traumatic Stress Network
- Substance Abuse and Mental Health Services Administration
- Rape, Abuse & Incest National Network
- National Public Radio |

There are deeply ingrained systemic issues that will take time and effort to unravel when it comes to supporting children with ID, IDST, or sexual trauma, and the work to break the cycle cannot fall on the shoulders of only one person within a school. Cycles of abuse extend across generations, and though there are multiple points at which one can intervene, to address the epidemic of sexual abuse among the population of those with ID will take many people working at each level of intervention. At the end of it all,
helping a child with IDST requires viewing them against the backdrop of their full life, and working with the elements of that context to ensure rapport, behavioral understanding, family dynamics, and personal care when working to help them heal.

**Future Research**

Though this study aimed to make a first attempt at pulling significant levels of expertise from practitioners working with children with ID and sexual trauma, attrition during the study was a main limitation. Future studies could build on the information that was obtained, utilizing a larger sample size that is more representative of the general US population, and striving for greater levels of significance. Beyond these studies, the next studies that are needed are ones that are able to test adapted measures for use with children with ID or IDST and to begin building out the evidence-based tool kit for interventions and assessments for this population. Studies that are able to continue aggregating the lived experiences of current practitioners as well as ones that can evaluate manualized interventions are needed.

Additionally, further research regarding the impact of staff-wide trauma trainings that incorporate information about behaviors exhibited by children with disabilities on various levels would be promising, relating back to SAFEST KID’s Level 1, looking into how making this education accessible to staff and families impacts long-term functioning of children over time. Future research might also consider longitudinal studies that look at a wider array of outcomes when children are taught expansive and inclusive sexual health throughout their school-aged years, relating back to SAFEST KID’s Level 2. Measures that look at general social-emotional functioning, trauma rates, feelings of
connectedness to the community, and recovery in the face of adverse life experiences could be some that might be administered to students over the course of their school-aged years. Both of these directions, looking into the impacts of wide and inclusive TIC trainings and regular and comprehensive healthy relationship curricula on school systems and the well-being of students over time, would require significant investments on the researcher, school system, and student parts, but would go a long way to providing evidence of kinds of systemic changes that can positively influence our society as a whole.

**Conclusion**

The SAFEST KID model aims to contribute to the holistic perspective towards caring for some of society’s most vulnerable citizens, children with ID. Through literature review and expertise from practitioners in the field, this model intends to combine society’s various types of knowledge to create a map of intervention at the multiple levels needed to address and end the epidemic of sexual abuse among this population. It provides several levels for conceptual consideration and presents a working adapted model for intervention to support children with IDST for use in a school setting. This model and others designed for use with this population should be studied in practice to ensure their efficacy and helpfulness, and information should continue to be sifted from the passionate providers who are working in the field each day to support these children, but it provides a place for future research to grow and aims to shed light on the various elements that need to remain in focus if long-lasting change is to take place. Though there are many barriers, known and yet to be discovered, that line the road on this
journey at each level, there are also many people united in their care and passion working each day to make this world a lighter place for us all.
CLOSING COMMENTARY

There is a “silent epidemic” of sexual abuse perpetuating across generations among our children with ID (Shapiro, 2018), and to fully address and reverse this epidemic, society needs to take a step back and reconceptualize how it views caring for these children. Trauma itself impacts the general population at alarming rates, with up to half of children today likely to experience a traumatic event before they turn 18 (Saunders & Adams, 2014). For all children, it is likely that a significant portion who would benefit from mental health treatment will not receive it (Whitney & Peterson, 2019). Yet for children without ID, there are a variety of interventions ready to be wielded to help support them if they can access care (Chafouleas et al., 2019; Brock et al., 2016; Hanson & Wallace, 2018; Hoover, 2019; Perfect et al., 2016). In comparison, children with ID face an even greater mountain. Rates of trauma in this population, particularly sexual trauma, are vastly elevated (Eastgate et al., 2011; Frawley & Wilson, 2016; Rowe & Wright, 2017), and the likelihood of it being recognized when it occurs is lowered due to various factors such as diagnostic overshadowing, miscommunication, and under-reporting (Byrne, 2017; Keesler, 2014b). Even if it is recognized, it is difficult to access appropriate resources for care (Hanreddy & Östlundb, 2019; Rowe & Wright, 2017; Treacy et al., 2017). Though reported rates of abuse vary significantly, it is estimated that individuals with ID are up to 10 times more likely to experience sexual
abuse than individuals without disabilities (Blaustein, 2013; Chafouleas et al., 2019; Shapiro, 2018; Talapatra et al., 2020). Contributing to the difficulty, children with ID in the US face the Western taboo that frowns upon the open discussion of sexual abuse, and face communication barriers generally (Byrne, 2017; Martinello 2015; Treacy et al., 2017). They also must contend with the historical stigma that individuals with ID are not sexual beings and therefore cannot experience sexual trauma (Byrne, 2018), and the outdated belief that interventions that have been shown to help children without ID cannot be adapted for children with ID (Taylor et al., 2008). Understanding these factors, it is clear there is a need for tools to support children with ID as well as tools to quell this epidemic. One system that is uniquely positioned to aid in this battle is our school system.

The United States is made up of people of many different backgrounds, cultures, languages, and dreams, but throughout all these lives, people are all brought together within the school systems to learn throughout their childhood. Increasingly so, at their best, schools are places for children not just to learn basic academic principles but to understand how to be part of a society, how to engage interpersonally, and how to grow into confident and capable selves. Currently, schools are where children are most likely to have their mental health needs met, supported by school-based mental healthcare providers such as school psychologists (NASP, 2016). Avenues for care are continuously being carved out during the school week as schools themselves eliminate some of the traditional barriers to care such as transportation, cost, and family scheduling difficulties (Reardon et al., 2017). Though there are individual challenges within every school and
school system, as community hubs linking people from across levels of society, schools can also function as anchors for societal change. In these manuscripts, it is clear that school-based mental health professionals are trained to support children from many backgrounds and needs at the individual level, and to advocate for systems-level changes at broader levels. In US public schools, school psychologists are often stretched thin (NASP, 2021), and so any sustainable intervention that requires the support of school-based mental health professionals will also need to work to change the cause of the suffering, not just address the suffering itself.

Outside of the moral imperative, there is a financial incentive as well. It is estimated that untreated trauma in the US costs the nation billions: around $124 billion per year from new childhood trauma cases and over $500 billion in the overall burden of untreated trauma (Gilad & Gutman, 2019; Fang et al., 2012). These numbers are significant, and likely are an underrepresentation of the true cost as not all loss can be quantified – how can one put an exact number on a life cut short by the weight of untreated pain? But the numbers that have been calculated make it clear that addressing childhood trauma is imperative financially as well as morally. Supporting children with ID and sexual trauma is part of that narrative.

Manuscript One outlined the rationale for why an intervention is needed to help address the epidemic of sexual abuse among children with ID and proposed the SAFEST KID three-level model grounded in the literature of ID, sexual trauma, and school systems while being rooted in ecological systems theory and trauma-informed care. Manuscript Two consisted of a Delphi study to analyze knowledge from individuals in
the field with expertise in ID and school systems, ID and sexual trauma, or expertise in all three categories, to enhance the proposed model of SAFEST KID outlined in Manuscript One. Based on this information, and from the multi-round Delphi study’s panel of experts, the SAFEST KID: A Sexual Assault Framework in Education to Support Trauma in Kids with Intellectual Disability model was augmented and elucidated, encapsulating two theoretical levels of prevention, and one practical level of intervention.

While the study experienced significant attrition over its course, the qualitative information gathered was rich in information and was incorporated into the SAFEST KID model through the study’s generated themes and concepts. A key adjustment made to Level Three included the conceptual shift from a session-based or time-based intervention to a module-based and skill-based one, highlighting the importance of meeting the child where they currently are. Additional important adjustments included expanding the understanding of holistic treatment, incorporating the family and other team members more intentionally and as routine parts of the intervention, as well as making it a point to gain a detailed background history on the child and family to establish wider rapport, increase individual understanding, and cement the team dynamic. Many elements of the proposed model and information pulled from the literature were confirmed through the Delphi study, including the importance of using multi-modal delivery, having frequent breaks, making concepts more concrete and relevant to the child’s life, as well as having cultural humility and working with the known barriers of limited tools, funding, and time, workload stress, and the communication skill level of the child.
In Level One, SAFEST KID describes the path towards trauma-informed school systems, where all school personnel, not just mental health professionals, are trained in TIC practices that are both inclusive towards children with disabilities and part of regularly updated and diversity-informed trainings. In Level Two, SAFEST KID explains how integrating inclusive and expansive healthy relationship curricula into all grade levels throughout the year can function as a preventative measure against the epidemic of sexual abuse among children with ID and serve to improve the interpersonal relationships of all students in the process. In Level Three, the focus of the Delphi study and expert feedback, SAFEST KID describes guidelines for the adaptation of any intervention for use with a child with ID, based on their individual self, need, and skill set, and suggests the use of the Bounce Back manualized protocol as a foundation for work with children with IDST while providing suggested adapted modules.

At its core, SAFEST KID is a community-based model of care, and to be successful it requires work from individuals at all levels of our society. By putting children with ID at its center, it shows that no one in society can live in isolation, and everyone has a better chance of being their best selves when they care for those who cannot always fully care for themselves. The main message from these manuscripts is not what modality of delivery or particular manipulative is best suited for use in an intervention with a child with ID, or even just that there is an epidemic of abuse among children with ID. It is that to adequately support children with IDST, one must take a step back and reconceptualize what it means to give care. Impactful care for this population involves understanding and building a relationship with both the child and their family.
and working intentionally with other personnel in the school system as well as key figures in the child’s life. As the results from the Delphi study show, it asks for a shift in organization from time-based progress to skill-based progress, considering a wider set of skills that may have been missed at some point in the child’s trajectory, and overall to truly strive to meet the child and family where they currently are by gaining an integrated understanding of the person, the condition, and the need. Impactful care for children with ID asks for a wrap-around, holistic approach, fully integrated into their community and with a clear view of who each child is as an individual, working to educate all caregivers as well as children in the process of healing. To achieve this requires change and camaraderie at the broader levels of care described in Level One and Level Two, because enacting long-lasting, sustainable change requires the community in its entirety.

How a society cares for its most vulnerable people reflects the depths of its humanity. It is the hope that SAFEST KID illuminates a way to lift up children with ID and provides a path forward to help make schools and society safer places for all kids.

Putting children with ID first reflects the heights of what the world can be.
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APPENDIX A1: RECRUITMENT EMAIL 1

Dear ____,

My name is Ashley Hudson, and I am currently a school psychology doctoral student at the University of Denver working under my advisor, Dr. Devadrita Talapatra, PhD. I am in the process of completing my dissertation on creating an adapted therapeutic model to be used in schools with children with intellectual disability (ID) and sexual trauma, and am seeking experts in the areas of ID, schools, and sexual trauma to serve as panelists in my Delphi research study. To be eligible to participate in this study, you:

- Have 1+ years of experience working with children with ID, or have worked with at least 5 children with ID, or have a family member with ID
- Have 3+ years of experience in school settings as a mental health practitioner OR have 1+ years of experience related to sexual trauma

If these descriptions match your experience and expertise, I would greatly appreciate your participation in this study to help support children with ID and to help add targeted resources to your toolbox.

The aim of this study is to pool the collective knowledge of experts such as yourself relating to current supports and curricula available to children with ID, intervention methods available to support children with ID and sexual trauma, feelings of preparedness to work with this population, and where the need lies in developing or accessing these targeted supports. As you may know, children with ID are at a greatly higher risk for experiencing traumatic events in their life, especially in the form of sexual abuse. The rates of sexual abuse are so high among this population that it has been dubbed a “silent epidemic.”

For this study, you will be involved in completing four rounds of questionnaires over a multi-month period. The answers to these questionnaires will remain anonymous and will be aggregated together to inform the following rounds. All of your participation will be anonymous and will remain confidential. As a thank you for your participation, you will be given access to the final guidelines at the end of the study.

If you have additional questions about this study, please do not hesitate to contact me at ashley.hudson@du.edu. If you are interested in serving as an expert panelist in this study, please fill out the survey below. If you are eligible, a brief questionnaire will appear next.

https://udenver.qualtrics.com/jfe/form/SV_2lgHp6y1vOe82TY

Thank you so much for your time and consideration!

Best,

Ashley Hudson, MA
University of Denver
CALLING *ALL EXPERTS!

Hello! I am currently a school psychology doctoral candidate in the process of recruiting study participants to complete my dissertation titled SAFEST KID: A Sexual Assault Framework in Education to Support Trauma in Kids with Intellectual Disabilities.

For this Delphi study, I am seeking participants who will serve as experts on intellectual disability and school systems or on intellectual disability and sexual trauma.

*To be eligible for this study, you have:

- 1+ years of experience working with children with ID, or have worked with at least 5 children with ID

AND either have

- 3+ years of experience in school settings as a mental health practitioner OR have 1+ years of experience related to sexual trauma

If this sounds like you, please consider serving as an anonymous expert on this panel. Your expected contribution would be as follows:

- Completion of a background survey questionnaire and a Scoping Round survey, estimated to take no more than an hour.
- Completion of 3 subsequent online questionnaires over the course of 4-8 weeks depending on participant response time. Each questionnaire is expected to take no more than an hour to complete and I ask that you complete it within 1 week of it being sent out.
- Review of each set of analyzed survey results after their completion (in total 3 sets), which I will send out to ensure that the analysis reflects your responses. Each of these reviews should take no more than one hour to complete.
- In total, I am asking for 7 hours of your time over 4-8 weeks to help create tools to support students with intellectual disabilities. Your responses will be de-identified and no personal information shared.

In exchange for your time, effort and expertise, I will send you the completed dissertation model and a free resource guide on trauma-informed care. You also will be helping a historically marginalized population receive services and be contributing to the fight against the epidemic of sexual abuse amongst this population.

If you have additional questions about this study, please do not hesitate to contact me at ashley.hudson@du.edu. If you are interested in serving as an expert panelist for this
study, please fill out the attached survey. If you are eligible and consenting, a brief questionnaire will be emailed to you afterward.

Eligibility Survey:

https://udenver.qualtrics.com/jfe/form/SV_2lgHp6y1vOe82TY

Thank you sincerely for your consideration and support.

Best,

Ashley Hudson, MA
SEEKING EXPERTS ON INTELLECTUAL DISABILITY (ID)

- Do you have:
  - 1+ years of experience working with children with an ID OR have worked with 5+ children with an ID?
- If so, do you also have:
  - 3+ years of experience working as a school-based mental health practitioner OR have 1+ years of experience related to sexual trauma?

SCAN THE QR CODE TO PARTICIPATE IN A DISSERTATION RESEARCH STUDY TO

1. CONTRIBUTE TO YOUR FIELD
2. HELP A HISTORICALLY MARGINALIZED POPULATION RECEIVE SERVICES
3. GET A FREE RESOURCE GUIDE ON TRAUMA-INFORMED CARE

Contact ashley.hudson@du.edu for more details
APPENDIX B: RECRUITMENT/ELIGIBILITY QUESTIONNAIRE

SAFEST KID Dissertation Study: Consent Form & Background Questionnaire

You are invited to participate in a research study of SAFEST KID: A Sexual Assault Framework in Education to Support Trauma in Kids with Intellectual Disability. The purpose of this study is to gather data from experts surrounding their experiences working with children with intellectual disability and sexual trauma, with the aim of creating a set of guidelines to use when considering how to adapt an intervention for this population, or where to start when considering creating one. You were selected as a possible participant in this study because you are either an expert on intellectual disability and sexual trauma, or intellectual disability and schools.

If you decide to participate, please understand your participation is voluntary and you have the right to withdraw and discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled. The alternative is not to participate. If you decide to participate, please complete the following survey. Your completion of this survey indicates your consent to participate in this research study. The survey is designed to gather data on ways to support children with intellectual disability and sexual trauma. It should take no more than 1 hour to complete. You will be asked to answer questions about your experience with children with intellectual disabilities and sexual trauma, trauma-informed practices in school systems, and healthy relationship curricula practices of which you may be aware. You will also be asked demographic questions for representation purposes. No benefits accrue to you for answering the survey, but your responses will be used to expand the field of intellectual disability and sexual trauma research, and to help provide better services for children at this intersection. Any discomfort or inconvenience to you are expected to be minimal, and they are not expected to be any greater than anything you encounter in everyday life. Data will be collected using the Internet; no guarantees can be made regarding the interception of data sent via the Internet by any third party. Confidentiality will be
maintained to the degree permitted by the technology used.

We strongly advise that you do not use an employer issued device (laptop, smartphone etc.) to respond to this survey.

Your decision whether or not to participate will not affect your future relationships with the University of Denver. If you decide to participate, you are free to stop at any time; you may also skip certain questions that do not pertain to eligibility criteria for this study if you don’t want to answer them or you may choose not to return the survey.

Please feel free to ask questions regarding this study. You may contact me if you have additional questions at ashley.hudson@du.edu (Ashley Hudson), working under Devadrita Talapatra, PhD (devadrita.talapatra@du.edu).

If you are not satisfied with how this study is being conducted, or if you have any concerns, complaints, or general questions about the research or your rights as a participant, please contact the University of Denver (DU) Institutional Review Board to speak to someone independent of the research team at (303) 871-2121, or email at IRBAdmin@du.edu.

De-identified data from this study may be shared with the research community at large to advance science and health. We will remove or code any personal information that could identify you before files are shared with other researchers to ensure that, by current scientific standards and known methods, no one will be able to identify you from the information we share. Despite these measures, we cannot guarantee anonymity of your personal data.

Thank you for your time.
Sincerely,

Ashley Hudson, MA
Morgridge College of Education
University of Denver

Devadrita Talapatra, PhD
What is your email address?

What is the zip code where you primarily work?

Gender: how do you identify?
Female
Male
Non-binary
Prefer to self-identify:

What race/ethnicity best describes you?

What is your age range?
18-24
25-34
35-44
45-54
55-64
65+

What is your highest level of education obtained?
High school
Associates degree
Bachelors degree
Masters degree
Doctoral degree

What is your profession?

How many years of experience do you have working in your profession?

How many years of experience do you have working in schools?

How many years of experience do you have working with children with ID?

How many years of experience do you have working with children with sexual trauma?

How many children with ID have you worked with?

How many children with sexual trauma have you worked with?
What types of school settings have you worked in over your life?


What is your experience with any of the following trauma training programs? Are there additional ones not listed that you are familiar with that you can comment on?

a. ACEs Connection  
b. Framework for Safe and Successful Schools  
c. Futures Without Violence  
d. School Health Assessment and Performance Evaluation (SHAPE)  
e. Trauma-Sensitive Schools Training Package  
f. Treatment and Services Adaptation Center


What is your experience with any of the following healthy relationship/social-emotional learning curricula? Are there additional ones not listed that you are familiar with that you can comment on?

a. Collaborative for Academic, Social and Emotional Learning  
b. Comprehensive Sexuality Education  
c. Healthy Relationships Curriculum  
d. Long Live Love  
e. The Circles Curriculum  
f. Rights, Respect, Responsibility
g. Second Step
h. Zones of Regulation

What is your familiarity with multi-tiered systems of supports (MTSS) in schools?

Do you consent to partake in this study that is projected to occur over one month to help increase the nature of supports for children with ID?

Yes, I consent
No, I do not consent
APPENDIX C1: SCOPING SURVEY

SAFEST KID: Scoping Round Questionnaire

This part of the survey should take no more than 1 hour to answer, but feel free to write as much or as little as you'd like.

What are the principles and pillars of Trauma-Informed Care (TIC) as you understand them? Which of these do you adhere to most strongly in your work?

How do you support the TIC pillars of realize, recognize, respond, and resist in your work?

How do you adhere to the TIC principle of safety in your work? What are the skills you have that promote this principle?
How do you adhere to the TIC principle of trustworthiness and transparency in your work? What are the skills you have that promote this principle?

How do you adhere to the TIC principle of peer support in your work? What are the skills you have that promote this principle?

How do you adhere to the TIC principle of collaboration and mutuality in your work? What are the skills you have that promote this principle?

How do you adhere to the TIC principle of empowerment voice and choice in your work? What are the skills you have that promote this principle?
How do you adhere to the TIC principle of **cultural, historical, and gender issues** in your work? What are the skills you have that promote this principle?

What interventions, strategies, or tools do you use when working with children with ID?

What barriers have you come across when working with children with ID?

What is an ideal intervention you would like to have for children with ID and sexual trauma, based on your areas of expertise and experiences?
SAFEST KID Model
How is the SAFEST KID model useful for practitioners?

a. How is this model applicable to your content area?
b. What elements are needed in this model to make it viable, based on your expert opinion?
c. What else would you like to see included in this model?
SAFEST KID: Ecological perspective

TIC Training
Level 1
Diversity-informed trauma training across systems for all school personnel

Healthy Relationships
Level 2
Accurate and expansive SEL curricula taught at all grade levels (K-12)

Therapeutic intervention
Level 3
School-based therapy

Preventative
- Realize
- Recognize
- Respond

Preventative
- Recognize
- Respond
- Resist

Responsive
- Safety
- Trustworthiness & Transparency
- Peer Support
- Collaboration & Mutuality
- Empowerment Voice & Choice
- Cultural, historical & gender issues

TIC Pillars and Principles

Safety: prioritize both physical and psychological safety

Trustworthiness & transparency: maintain clear documentation and openness in conduct

Peer support: prioritize strong communities and fight individual isolation

Collaboration and mutuality: work together with the child, their caregivers, and the community for best outcomes

Empowerment, voice & choice: individualize treatment to the child and solicit their input

Cultural, historical & gender issues: view the child in their holistic context and check your own biases
## TIC Guiding Checklist for Students with ID

<table>
<thead>
<tr>
<th>TIC Checklist for Students with ID</th>
<th>Realize</th>
<th>Recognize</th>
<th>Respond</th>
<th>Resist</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safety</strong></td>
<td></td>
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<td></td>
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<tr>
<td>• Prioritize advocacy, gaps in education, and rapport building</td>
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<tr>
<td>• Highlight coping skills and prioritize resisting revictimization</td>
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<tr>
<td><strong>Trustworthiness &amp; Transparency</strong></td>
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<tr>
<td>• Maintain clear and open dialogue with all parties</td>
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<tr>
<td>• Maintain documentation of planning and progress monitoring</td>
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<tr>
<td><strong>Peer Support</strong></td>
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<tr>
<td>• Create brave spaces for group treatment</td>
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<td></td>
</tr>
<tr>
<td>• Ensure that all students have access to diversity-informed education that is inclusive of ID</td>
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<tr>
<td><strong>Collaboration &amp; Mutuality</strong></td>
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<tr>
<td>• Include family members and other caregivers in the treatment planning and process for student with ID</td>
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<tr>
<td>• Establish open communication with all involved in the plan</td>
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<tr>
<td><strong>Empowerment Voice &amp; Choice</strong></td>
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<tr>
<td>• Incorporate the individual’s preferences into the intervention</td>
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<tr>
<td>• Actively involve the individual to the extent possible in the adjustment of their intervention</td>
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</tr>
<tr>
<td><strong>Cultural, Historical &amp; Gender issues</strong></td>
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<tr>
<td>• Understand the history and current landscape of ID</td>
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<tr>
<td>• Expand awareness of intersectional identities</td>
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</tbody>
</table>
SAFEST KID: Level 3 Decision-Making Tree

- Student with ID and history of sexual abuse identified
  - Report to Child Protective Services if report not already made
    - Assess for signs and symptoms of trauma within the child using disability and diversity symptom guidelines
      - No trauma symptoms identified
        - Continue to monitor child for behavioral changes
      - Trauma symptoms identified
        - Set up meeting with child guardians to explain how treatment model can help
          - Assess child’s developmental, skill and trauma level if not known
            - Develop rapport with student and develop treatment plan with guardian input
              - Follow the SAFEST KID Level 3 therapy session model with adjustments based on developmental, skill, and trauma level as needed
**Individual Session Overview**

Follow the SAFEST KID Level 3 therapy session model with adjustments based on developmental, skill, and trauma level as needed

Utilize progress monitoring tools from SAFEST KID

<table>
<thead>
<tr>
<th>Session Focus</th>
<th>Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Rapport &amp; overview: why they will be working with you &amp; what kinds of things they'll be doing</td>
<td>Visual aids</td>
</tr>
<tr>
<td>2 Feelings identifications &amp; practice, communication &amp; activities for emotions, common ID stress reactions</td>
<td>Visual aids</td>
</tr>
<tr>
<td>3 Bodily feelings &amp; relaxation training. Practice coping skills in multiple settings and with caregivers</td>
<td>Visual aids</td>
</tr>
<tr>
<td>4 Helpful thoughts, behaviors &amp; routines</td>
<td>Social stories</td>
</tr>
<tr>
<td>5 Boundaries &amp; safety, touch, trust &amp; advocacy</td>
<td>Visual aids</td>
</tr>
<tr>
<td>6 Coping skills practice</td>
<td>Visual aids</td>
</tr>
<tr>
<td>7 Identification of safe individuals at school and home &amp; rationale</td>
<td>Visual aids</td>
</tr>
<tr>
<td>8 Trauma narrative development &amp; practice</td>
<td>Art supplies</td>
</tr>
<tr>
<td>9 Practice safe responses to situations and real-life interpersonal scenarios</td>
<td>Visual aids</td>
</tr>
<tr>
<td>10 Review development of interpersonal &amp; safety skills, trauma integration &amp; coping skills</td>
<td>Visual aids</td>
</tr>
</tbody>
</table>

**Considerations:** Repeat session content as needed based on individual progress utilizing Table 8 progress monitoring tools and observations prior to termination

Follow the SAFEST KID: Level 3 Adaptations Guidelines in Appendix A for additional guidance
# Suggested Progress Monitoring Tools for ID and Trauma

<table>
<thead>
<tr>
<th>Progress Monitoring Tools</th>
<th>Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bangor Life Events Scale for Intellectual Disability (BLESID)</td>
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<tr>
<td></td>
<td>Impact of Events Scale-Intellectual Disability (IES-ID)</td>
</tr>
<tr>
<td></td>
<td>Lancaster and Northgate Trauma Scales for Intellectual Disabilities (LANTS)</td>
</tr>
<tr>
<td></td>
<td>Posttraumatic Stress Checklist (PCL-5)</td>
</tr>
<tr>
<td></td>
<td>Traumatic Events Screening Inventory-Child Version (TESI) [baseline screener]</td>
</tr>
<tr>
<td></td>
<td>Traumatic Events Screening Inventory-Parent Version (TESI) [baseline screener]</td>
</tr>
</tbody>
</table>
APPENDIX C2: Q1

SAFEST KID: A Sexual Assault Framework in Education to Support Trauma in Kids with Intellectual Disability
Dissertation Data-Collection Round: Q1

Purpose Statement:
There is a grave need for additions to the school psychologist’s toolbox to support students with intellectual disability (ID) and sexual trauma. These children are especially vulnerable to adverse life experiences overall and are at a particularly high risk of experiencing sexual abuse and resulting trauma. Children with ID are less likely to have their trauma symptoms identified by those around them, as symptoms do not always present in the same way as their neurotypical peers, and trauma symptoms are more likely to be grouped into the rest of their disability through diagnostic overshadowing. Additionally, individuals with ID are at risk both from abuse perpetrated by individuals without ID, and from other individuals with ID as well. For the population of children with ID, schools remain the place they are most likely to have their mental health needs met, and schools are the place where they are most likely to receive any form of sexual health education. The epidemic of sexual abuse among the population of individuals with ID has recently come to light, and many of these individuals are at risk of suffering from resulting sexual trauma. This study aims to aggregate your expertise and lived experiences into the SAFEST KID Model to support children with intellectual disability and sexual trauma by developing a therapeutic framework for school-based mental health practitioners to use in school settings.

Consent Statement:
Your participation is voluntary and you have the right to withdraw and discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled. If you continue to consent to participate, please complete the following survey.

This survey is designed to gather information from your expertise as it relates to the following research questions:
1. How can the SAFEST KID model become viable for school-based practitioners?
2. How could school-based practitioners adhere to the pillars and principles of TIC when working with children with ID and sexual trauma in schools?
3. What are the barriers to school-based implementation of a therapeutic intervention for children with ID and sexual trauma?
The following questions should take no more than 1 hour to complete, though you are welcome to write as much or as little as you’d like. There are no wrong answers, rather these question are asked to tap into your expertise as it pertains to working with children with intellectual disabilities. Answers of all lengths are valuable. If you have any questions as you complete this survey, please reach out to me at ashley.hudson@du.edu

*The acronym "IDST" will be used to represent "children with intellectual disability who have experienced sexual trauma."

What is your email address?

What is the best way to identify a child with ID or IDST and their need for support?

Think back to some of the tools and interventions you have utilized when working with a child with ID or IDST - what specifically about these tools did you find helpful and sustainable to use?
What elements were missing from these tools and interventions you've used in the past?

What are some of the practical constraints you have experienced (e.g. time limits, school schedules, family schedules, workload, choice of intervention, funding, etc.) when providing interventions to a child with ID or IDST?

What is the best way to identify gaps in skills when working with a child with ID or IDST?

What is the best way to document or progress monitor your intervention sessions when working with a child with ID or IDST?
What is the best way to incorporate group work or peer support into your interventions with a child with ID or IDST?

What is the best way to incorporate the family when you are providing interventions to a child with ID or IDST?

What is the best way to incorporate the child’s preferences when providing interventions to a child with ID or IDST?

What is the best way to continue to learn about the history of ID and supports for children with ID or IDST?
What is the best way to promote an understanding of the impact of sexual trauma on children with ID in your place of work?

---

Thank you for your thoughtful responses! This is the final part of Q1. If you are satisfied with your answers, click the red arrow below to submit your responses.
APPENDIX C3: Q2

SAFEST KID Dissertation Study: Q2

What is your email address?

In this round, you will be asked to review the answers to the questions that have been asked thus far from the Scoping Round and Q1 that fell within three main categories: school-based implementation; trauma-informed care; implementation barriers. You will be asked to review the responses that were coded for each of these three main categories, and rate if you AGREE or DISAGREE with the mentioned themes being important to one of those main categories.

100% of respondents mentioned the importance of using data-based decision-making and noted the importance of using observations when supporting the child and family. Respondents also mentioned matching the progress monitoring tool to the skill in question that is being targeted instead of having a specific progress monitoring tool to use.

Regarding evidence-based assessments, please rate if you AGREE or DISAGREE that the following mentioned interventions are important to consider for skill-building when working with children with ID or IDST:

<table>
<thead>
<tr>
<th></th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>UNFAMILIAR</th>
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</thead>
<tbody>
<tr>
<td>5 is Against the Law</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Circles Curriculum</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Zones of Regulation</td>
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<tr>
<td>Second Step</td>
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<td>Unstuck</td>
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<td>WeThinkers</td>
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<tr>
<td>Superflex</td>
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</table>
Category 1: School-Based Implementation

Please rate if you AGREE or DISAGREE that the following Intervention-Specific Adaptation Themes are important to the implementation and adaptation of school-based interventions for students with ID or IDST:

<table>
<thead>
<tr>
<th>Theme</th>
<th>AGREE</th>
<th>DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using visual aids</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Using video aids</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Modeling</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Simplifying language</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Using multi-modal delivery</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Using manipulatives/toys</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Having opportunities for movement</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Incorporating play therapy</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Incorporating music therapy</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Incorporating art therapy</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Incorporating real-world examples</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Generalizing intentionally</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Repeating concepts as needed</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Incorporating mindfulness techniques</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Including incentives for participation</td>
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</tbody>
</table>
Please rate if you AGREE or DISAGREE that the following Intervention Planning Themes are important to the implementation and adaptation of school-based interventions for students with ID or IDST:

<table>
<thead>
<tr>
<th><strong>Using task analysis to develop mastery criteria for targeted skills</strong></th>
<th>AGREE</th>
<th>DISAGREE</th>
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<thead>
<tr>
<th><strong>Having mixed skill level group work (including children with and without ID)</strong></th>
<th>AGREE</th>
<th>DISAGREE</th>
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<table>
<thead>
<tr>
<th><strong>Building rapport</strong></th>
<th>AGREE</th>
<th>DISAGREE</th>
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<table>
<thead>
<tr>
<th><strong>Individualizing based on personality</strong></th>
<th>AGREE</th>
<th>DISAGREE</th>
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<table>
<thead>
<tr>
<th><strong>Incorporating structured choice</strong></th>
<th>AGREE</th>
<th>DISAGREE</th>
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<tr>
<th><strong>Shortening session length</strong></th>
<th>AGREE</th>
<th>DISAGREE</th>
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<table>
<thead>
<tr>
<th><strong>Having intentional breaks during sessions</strong></th>
<th>AGREE</th>
<th>DISAGREE</th>
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Please rate if you AGREE or DISAGREE that the following Intervention Logistics Themes are important to the implementation and adaptation of school-based interventions for students with ID or IDST:

<table>
<thead>
<tr>
<th><strong>Pushing in to other classes to provide services</strong></th>
<th>AGREE</th>
<th>DISAGREE</th>
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<table>
<thead>
<tr>
<th><strong>Having session time regularly built into the schedule</strong></th>
<th>AGREE</th>
<th>DISAGREE</th>
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</table>
Category 2: Providing Trauma-Informed Care

Please rate if you AGREE or DISAGREE that the following Training Themes are important to providing trauma-informed care to children with ID or IDST:

Having all staff members (e.g., teachers, mental health providers, custodians, etc.) trained in basic trauma principles  

<table>
<thead>
<tr>
<th>AGREE</th>
<th>DISAGREE</th>
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<td></td>
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<tr>
<td>Practice Themes</td>
<td>AGREE</td>
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<td>--------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Having all staff members (e.g., teachers, mental health providers, custodians, etc.) trained in basic behaviors of ID</td>
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<tr>
<td>Having providers trained in de-escalation and crisis response strategies</td>
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<tr>
<td>Providing psychoeducation to families on IDST</td>
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<tr>
<td>Providing psychoeducation to students with ID on a wide range of interpersonal topics (e.g. consent, public vs. private behavior, relationships, safe vs unsafe touch, self-advocacy)</td>
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<tr>
<td>Learning continuously (e.g. through reading, professional development, trainings, informal conversations)</td>
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</tbody>
</table>

Please rate if you AGREE or DISAGREE that the following Practice Themes are important to providing trauma-informed care to children with ID or IDST:

<table>
<thead>
<tr>
<th>Practice Themes</th>
<th>AGREE</th>
<th>DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening for trauma through assessments</td>
<td></td>
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<tr>
<td>Screening for trauma through behavioral observations</td>
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<td></td>
</tr>
<tr>
<td>Activity</td>
<td>Column 1</td>
<td>Column 2</td>
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<tr>
<td>-------------------------------------------------------------------------</td>
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<tr>
<td>Screening for family needs (e.g., social determinants of health)</td>
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<tr>
<td>Connecting the family with community supports as needed</td>
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<tr>
<td>Viewing behavior in the context of the person's history</td>
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<tr>
<td>Understanding the family's generational trauma</td>
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<td></td>
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<tr>
<td>Balancing physical and psychological safety</td>
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<tr>
<td>Modeling boundaries</td>
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<tr>
<td>Modeling confidentiality</td>
<td></td>
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<tr>
<td>Modeling consent</td>
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<tr>
<td>Obtaining assent</td>
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<tr>
<td>Having explicit expectations for sessions</td>
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<tr>
<td>Communicating with respect</td>
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<tr>
<td>Advocating for the child's needs</td>
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<tr>
<td>Having cultural humility</td>
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<tr>
<td>Making time for your own self-care</td>
<td></td>
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<tr>
<td>Using strength-based language</td>
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<td></td>
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<tr>
<td>Activity</td>
<td>Agree</td>
<td>Disagree</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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<tr>
<td>Observing and analyzing behavior (e.g. signs of distress/comfortability, behavior changes)</td>
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<tr>
<td>Having a trauma-informed classroom approach to care</td>
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<td></td>
</tr>
<tr>
<td>Utilizing formal assessment data (e.g. social/emotional, academic, cognitive)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessing formal skill level (e.g. social/emotional, academic, cognitive)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checking for physical or legal evidence in cases of suspected or confirmed abuse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Optional) Other comments to consider about providing trauma-informed care to children with ID or IDST?

---

Category 3: Implementation Barriers

Please rate if you AGREE or DISAGREE that the following Access to Resources Themes are important barriers to consider when striving to provide school-based interventions to children with ID or IDST:
<table>
<thead>
<tr>
<th>Available funding</th>
<th>AGREE</th>
<th>DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of all staff training in working with students with ID</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Level of all staff training in working with students with trauma</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Assumptions about ID (e.g. mythbusting)</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Please rate if you AGREE or DISAGREE that the following Skill Level Themes are important barriers to consider when striving to provide school-based interventions to children with ID or IDST:

<table>
<thead>
<tr>
<th>Communication level (e.g. nonverbal)</th>
<th>AGREE</th>
<th>DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAC Devices</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Assessing for understanding</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Assessing for assent/consent</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Specific adaptations without infantilization</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Range of skill levels among children with ID</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Please rate if you AGREE or DISAGREE that the following Logistics Themes are important barriers to consider when striving to provide school-based interventions to children with ID or IDST:

263
<table>
<thead>
<tr>
<th>Issue</th>
<th>AGREE</th>
<th>DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telehealth</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Lack of data from other staff members</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Lack of valid assessment tools for use with children with ID</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Lack of variability of assessment tools for use with children with ID</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Lack of rapport</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Scheduling constraints (e.g. school, family, provider)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Physical structure of the building (e.g. private location, distance from classrooms)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Cultural and linguistic differences</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

(Optional) Other comments to consider about barriers to providing school-based, trauma-informed interventions to children with ID or IDST?
(Optional) Anything else you would like to add that you have not yet gotten to share?

Thank you for your time and thoughtful responses in completing this survey. Please press the red arrow below and look for the confirmation page to be sure your responses have been submitted successfully.

If you have any questions with this survey, please do not hesitate to reach out to me at ashley.hudson@du.edu
APPENDIX C4: Q3

SAFEST KID Dissertation Study: Q3

What is your email address?

In this round, you will be asked to review the answers that have been generated from Q2 and reflect further on the pieces that are still disagreed upon, with the aim of generating consensus in this final survey.

There were three main categories that were asked about regarding providing services for children with ID or IDST: school-based implementation; trauma-informed care; implementation barriers. You will be presented with the themes that reached consensus in each of the categories, and if interested, will have the option of answering further questions about the concepts that did not reach consensus.

The following curricula mentioned achieved consensus that they are useful when working with students with ID or IDST, based on the respondents who were familiar with them:

- Zones of Regulation (100%)
- Circles Curriculum (100%)

The following curricula mentioned achieved less than 80% consensus. Please select whether you agree or disagree with their use for students with ID or IDST:

<table>
<thead>
<tr>
<th></th>
<th>AGREE</th>
<th>DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second Step (75%)</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Unstuck (66%)</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Superflex (75%)</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
Category 1: School-Based Implementation

80%-100% of respondents agreed that the following Intervention-Specific Adaptation Themes are important to the implementation and adaptation of school-based interventions for students with ID or IDST, and are now locked in:

- Using visual aids (100%)
- Using video aids (100%)
- Modeling (100%)
- Simplifying language (100%)
- Using multi-modal delivery (100%)
- Using manipulatives/toys (100%)
- Having opportunities for movement (100%)
- Incorporating play therapy (80%)
- Incorporating music therapy (80%)
- Incorporating art therapy (100%)
- Incorporating real-world examples (100%)
- Generalizing intentionally (100%)
- Repeating concepts as needed (100%)
- Incorporating mindfulness techniques (100%)

The following theme only achieved 60% agreement, so please select whether you agree or disagree with this theme as important to providing adapted interventions for students with ID or IDST:

<table>
<thead>
<tr>
<th></th>
<th>AGREE</th>
<th>DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Including incentives for participation</td>
<td>○</td>
<td></td>
</tr>
</tbody>
</table>

Though they are locked in, if you disagree that the following are unimportant to providing adapted interventions for students with ID or IDST, please elaborate on the following theme below:
Incorporating play therapy

Though they are locked in, if you disagree that the following are unimportant to providing adapted interventions for students with ID or IDST, please elaborate on the following theme below:

Incorporating music therapy

80%-100% of respondents agreed that the following Intervention Planning Themes are important to the implementation and adaptation of school-based interventions for students with ID or IDST, and are now locked in:

- Using task analysis to develop mastery criteria for targeted skills (80%)
- Having mixed skill level group work (including children with and without ID) (80%)
- Building rapport (100%)
- Individualizing based on personality (80%)
- Incorporating structured choice (100%)
- Shortening session length (100%)
- Having intentional breaks during sessions (100%)

Though they are locked in, if you disagree that the following are unimportant to providing adapted interventions for students with ID or IDST, please elaborate on the following theme below:
Using task analysis to develop mastery criteria for targeted skills

80-100% of respondents agreed that the following Intervention Logistics Themes are important to the implementation and adaptation of school-based interventions for students with ID or IDST, and are now locked in:

- Pushing into other classes to provide services (100%)
- Having session time regularly built into the schedule (100%)
- Focusing on skill mastery instead of a set number of sessions (100%)
- Interviewing the family to understand context (100%)
- Consulting with other providers (100%)
- Having regular check-ins with the family (100%)

(Optional): Any further comments regarding providing adapted interventions to students with ID or IDST?

Category 2: Providing Trauma-Informed Care

80-100% of respondents agreed that the following Training Themes are important to providing trauma-informed care to children with ID or IDST, and are now locked in:

- Having all staff members (e.g. teachers, mental health providers, custodians, etc.) trained in basic trauma principles (100%)
• Having all staff members (e.g. teachers, mental health providers, custodians, etc.) trained in basic behaviors of ID (100%)
• Having providers trained in de-escalation and crisis response strategies (100%)
• Providing psychoeducation to families on IDST (100%)
• Providing psychoeducation to students with ID on a wide range of interpersonal topics (e.g. consent, public vs. private behavior, relationships, safe vs. unsafe touch, self-advocacy) (100%)
• Learning continuously (e.g. through reading, professional development, trainings, informal conversations) (100%)

80-100% of respondents agreed that the following Practice Themes are important to providing trauma-informed care to children with ID or IDST, and are now locked in:

• Screening for trauma through assessments (100%)
• Screening for trauma through behavioral observations (80%)
• Screening for family needs (e.g. social determinants of health) (100%)
• Connecting the family with community supports as needed (100%)
• Viewing behavior in the context of the person’s history (100%)
• Understanding the family’s generational trauma (100%)
• Balancing physical and psychological safety (100%)
• Modeling boundaries (100%)
• Modeling confidentiality (100%)
• Modeling consent (100%)
• Obtaining assent (100%)
• Having explicit expectations for sessions (80%)
• Communicating with respect (100%)
• Advocating for the child’s needs (100%)
• Having cultural humility (100%)
• Making time for your own self-care (100%)
• Using strength-based language (100%)
• Observing and analyzing behavior (e.g. signs of distress/comfortability, behavior changes) (100%)
• Having a trauma-informed classroom approach to care (100%)
• Utilizing formal assessment data (e.g. social/emotional, academic, cognitive) (80%)
• Assessing formal skill level (e.g. social/emotional, academic, cognitive (80%)
• Checking for physical or legal evidence in cases of suspected or confirmed abuse (100%)
Though they are locked in, if you disagree that the following are unimportant to providing trauma-informed interventions for students with ID or IDST, please elaborate on the following theme below:

Screening for trauma through behavioral observations


Though they are locked in, if you disagree that the following are unimportant to providing trauma-informed interventions for students with ID or IDST, please elaborate on the following theme below:

Having explicit expectations for sessions


Though they are locked in, if you disagree that the following are unimportant to providing trauma-informed interventions for students with ID or IDST, please elaborate on the following theme below:

Utilizing formal assessment data (e.g. social/emotional, academic, cognitive)
Though they are locked in, if you disagree that the following are unimportant to providing trauma-informed interventions for students with ID or IDST, please elaborate on the following theme below:

Assessing formal skill level (e.g. social/emotional, academic, cognitive)

(Optional): Any further comments regarding providing trauma-informed care to students with ID or IDST?

Category 3: Implementation Barriers

80-100% of respondents agreed that the following Access to Resources Themes are important barriers to consider when striving to provide school-based interventions to children with ID or IDST, and are now locked in:

- Available funding (100%)
- Level of all staff training in working with students with ID (100%)
- Level of staff training in working with students with trauma (100%)
- Assumptions about ID (e.g. mythbusting) (100%)

80-100% of respondents agreed that the following Skill Level Themes are important barriers to consider when striving to provide school-based interventions to children with ID or IDST, and are now locked in:
• AAC Devices (100%)
• Assessing for understanding (100%)
• Assessing for assent/consent (100%)
• Specific adaptations without infantilization (100%)
• Range of skill levels among children with ID (100%)

80-100% of respondents agreed that the following Logistics Themes are important barriers to consider when striving to provide school-based interventions to children with ID or IDST, and are now locked in:

• Telehealth (80%)
• Lack of data from other staff (80%)
• Lack of valid assessment tools for use with children with ID (80%)
• Lack of variability of assessment tools for use with children with ID Lack of rapport (80%)
• Scheduling constraints (e.g. school, family, provider) (80%)
• Cultural and linguistic differences (100%)

The following theme only achieved 60% agreement, so please select whether you agree or disagree with this theme as a barrier to providing interventions for students with ID or IDST:

<table>
<thead>
<tr>
<th>Physical structure of the building (e.g. private location, distance from classrooms) (60%)</th>
<th>AGREE</th>
<th>DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>⬜</td>
<td>⬜</td>
</tr>
</tbody>
</table>

Though they are locked in, if you disagree that the following are unimportant barriers to providing interventions for students with ID or IDST, please elaborate on the following theme below:

Telehealth
Though they are locked in, if you disagree that the following are unimportant barriers to providing interventions for students with ID or IDST, please elaborate on the following theme below:

Lack of data from other staff

Though they are locked in, if you disagree that the following are unimportant barriers to providing interventions for students with ID or IDST, please elaborate on the following theme below:

Lack of valid assessment tools for use with children with ID

Though they are locked in, if you disagree that the following are unimportant barriers to providing interventions for students with ID or IDST, please elaborate on the following theme below:
Lack of rapport

Though they are locked in, if you disagree that the following are unimportant barriers to providing interventions for students with ID or IDST, please elaborate on the following theme below:

Scheduling constraints (e.g. school, family, provider):

(Optional): Any further comments regarding barriers to providing interventions to students with ID or IDST?

Thank you for your time and thoughtful responses in completing this survey. Please press the red arrow below and look for the confirmation page to be sure your responses have been submitted successfully.

If you have any questions with this survey, please do not hesitate to reach out to me at ashley.hudson@du.edu
APPENDIX C5: FINAL MEMBER CHECK

Dear Experts,

Thank you sincerely for your continued participation in this dissertation study. Your input has been thoughtful and invaluable, and it is important that you have a chance to review the final compilation of information gathered from it all. When they are completed, you will also receive copies of the final model and guidebook. Below you will find the list of concepts developed from your survey responses that we have deemed important to consider when working with children with IDST, and in order to develop a viable intervention model that adheres to the components of TIC and takes into account pragmatic barriers.

Your response is optional, though if you have any further comments or input to share they are welcome. Below you will have a chance to review and endorse or critique the final list developed. Thank you again sincerely for your time and effort during this process.

Best,
Ashley

Category
Subcategory

1. Concept

School-Based Implementation
Intervention-Specific Adaptations
1. Using visual aids
2. Using video aids
3. Modeling
4. Simplifying language
5. Using multi-modal delivery
6. Repeating concepts as needed
7. Incorporating play therapy
8. Incorporating music therapy
9. Incorporating art therapy
10. Incorporating real-world examples
11. Generalizing intentionally
12. Using manipulatives/toys
13. Incorporating mindfulness techniques
14. Having opportunities for movement

**Intervention Planning**

1. Building rapport
2. Individualizing based on personality
3. Incorporating structured choice
4. Having mixed skill level group work (including children with and without ID)
5. Shortening session length
6. Having intentional breaks during sessions
7. Using task analysis to develop mastery criteria for targeted skills

**Logistics**

1. Interviewing the family to understand context
2. Consulting with other providers
3. Having regular check-ins with families
4. Pushing into other classes to provide services
5. Having session time regularly built into the schedule
6. Focusing on skill mastery instead of a set number of sessions
Providing Trauma-Informed Care

Training

1. Learning continuously (e.g. through reading, professional development, trainings, informal conversations)
2. Providing psychoeducation to families on IDST
3. Having providers trained in de-escalation and crisis response strategies
4. Having all staff members (e.g. teachers, mental health providers, custodians, etc.) trained in basic trauma principles
5. Having all staff members (e.g. teachers, mental health providers, custodians, etc.) trained in basic behaviors of ID
6. Providing psychoeducation to students with ID on a wide range of interpersonal topics (e.g. consent, public vs. private behavior, relationships, safe vs. unsafe touch, self-advocacy)

Practice

1. Screening for trauma through assessments
2. Screening for trauma through behavioral observations
3. Utilizing formal assessment data (e.g. social/emotional, academic, cognitive)
4. Assessing formal skill level (e.g. social/emotional, academic, cognitive)
5. Checking for physical or legal evidence in cases of suspected or confirmed abuse
6. Observing and analyzing behavior (e.g. signs of distress/comfortability, behavior changes)
7. Screening for family needs (e.g. social determinants of health)
8. Connecting the family with community supports as needed
9. Viewing behavior in the context of the person's history
10. Understanding the family's generational trauma
11. Modeling boundaries
12. Modeling confidentiality
13. Modeling consent
14. Balancing physical and psychological safety
15. Communicating with respect
16. Advocating for the child's needs
17. Using strength-based language
18. Having cultural humility
19. Having a trauma-informed classroom approach to care
20. Having explicit expectations for sessions
21. Obtaining assent
22. Making time for your own self-care

Implementation Barriers

Access to Resources

1. Level of all staff training in working with students with ID
2. Level of all staff training in working with students with trauma
3. Assumptions about ID (e.g. mythbusting)
4. Available funding

Skill Level

1. Specific adaptations without infantilization
2. Communication level (e.g. nonverbal)
3. AAC Devices
4. Assessing for understanding
5. Assessing for assent/consent
6. Range of skill levels among children with ID
Logistics

1. Lack of valid assessment tools for use with children with ID
2. Lack of variability of assessment tools for use with children with ID
3. Scheduling constraints (e.g. school, family, provider)
4. Lack of data from other staff members
5. Cultural and linguistic differences
6. Telehealth
7. Lack of rapport

(Optional) Please describe if this list accurately depicts your submissions from this study, or feel free to write below further comments that you have.
You are invited to participate in a research study of SAFEST KID: A Sexual Assault Framework in Education to Support Trauma in Kids with Intellectual Disability. The purpose of this study is to gather data from experts surrounding their experiences working with children with intellectual disability and sexual trauma, with the aim of creating a set of guidelines to use when considering how to adapt an intervention for this population, or where to start when considering creating one. You were selected as a possible participant in this study because you are either an expert on intellectual disability and sexual trauma, or intellectual disability and schools.

If you decide to participate, please understand your participation is voluntary and you have the right to withdraw and discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled. The alternative is not to participate. If you decide to participate, complete the following survey. Your completion of this survey indicates your consent to participate in this research study. The survey is designed to gather data on ways to support children with intellectual disability and sexual trauma. It should take no more than 1 hour to complete. You will be asked to answer questions about your experience with children with intellectual disability and sexual trauma, trauma-informed practices in school systems, and healthy relationship curricula practices of which you may be aware. You will also be asked demographic questions for representation purposes. No benefits accrue to you for answering the survey, but your responses will be used to expand the field of intellectual disability and sexual trauma research, and to help provide better services for children at this intersection. Any discomfort or inconvenience to you are minimal, and they are not expected to be any greater than anything you encounter in everyday life. Data will be collected using the Internet; no guarantees can be made regarding the interception of data sent via the Internet by any third party. Confidentiality will be maintained to the degree permitted by the technology used.

We strongly advise that you do not use an employer issued device (laptop, smartphone etc.) to respond to this survey.

Your decision whether or not to participate will not affect your future relationships with the University of Denver. If you decide to participate, you are free to stop at any time; you may also skip questions if you don't want to answer them or you may choose not to return the survey.

Please feel free to ask questions regarding this study. You may contact me if you have additional questions at ashley.hudson@du.edu (Ashley Hudson), working under Devadrita Talapatra, PhD (devadrita.talapatra@du.edu).
If you are not satisfied with how this study is being conducted, or if you have any concerns, complaints, or general questions about the research or your rights as a participant, please contact the University of Denver (DU) Institutional Review Board to speak to someone independent of the research team at (303) 871-2121, or email at IRBAadmin@du.edu.

De-identified data from this study may be shared with the research community at large to advance science and health. We will remove or code any personal information that could identify you before files are shared with other researchers to ensure that, by current scientific standards and known methods, no one will be able to identify you from the information we share. Despite these measures, we cannot guarantee anonymity of your personal data.

Thank you for your time.
Sincerely,

Ashley Hudson, MA
Morgridge College of Education
University of Denver

Devadrita Talapatra, PhD
Morgridge College of Education
University of Denver

By clicking the box below, I confirm that I have read this form and decided that I will participate in the project described above. Its general purposes, the particulars of involvement, and possible risks and inconveniences have been explained to my satisfaction. I understand that I can discontinue participation at any time. My consent also indicates that I am at least 18 years of age. [Please feel free to print a copy of this consent form.]

☐ I agree to participate (link to survey)  ☐ I decline (link to close webpage)
### Structural Coding

**Scoping Round Question:** What barriers have you come across when working with children with ID?

<table>
<thead>
<tr>
<th>Sample of Responses</th>
<th>Initial Codes</th>
<th>Final Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Myths about children with ID not experiencing trauma from typical traumatic exposures. Barriers re: limited language or ability to understand abstract concepts. More difficulty utilizing telehealth for families further from clinic.”</td>
<td>Lack of understanding of ID (myth-busting)</td>
<td>Assumptions about ID (e.g., myth-busting)</td>
</tr>
<tr>
<td></td>
<td>Can’t tell level of understanding or engagement</td>
<td>Communication level (e.g., nonverbal); AAC devices; assessing for understanding</td>
</tr>
<tr>
<td></td>
<td>Telehealth</td>
<td>Telehealth</td>
</tr>
<tr>
<td>“Lack of community supports, lack of curriculum specific to this population, lack of social emotional assessment tools specific to this population. People tend to use curriculum that is meant for younger children, but I do not support that in my own practice.”</td>
<td>Lack of resources</td>
<td>Connecting family with community</td>
</tr>
<tr>
<td></td>
<td>Lack of assessment tools/curricula for ID</td>
<td>Lack of valid assessment tools for use with children with ID</td>
</tr>
<tr>
<td></td>
<td>Tools targeted to younger individuals</td>
<td></td>
</tr>
<tr>
<td>“When students are nonverbal and have not built trust with me yet, it is difficult to get them to buy into what I am asking them to do, whether that is to regulate their emotions, leave the space, or other things.”</td>
<td>Nonverbal communication level</td>
<td>Communication level (e.g., nonverbal)</td>
</tr>
<tr>
<td></td>
<td>Lack of rapport</td>
<td>Lack of rapport</td>
</tr>
</tbody>
</table>

Q1 Question: What elements were missing from these tools and interventions you’ve used in the past?
Sample of Responses | Initial Codes | Final Code
---|---|---
“More opportunities to involve movement and not just lecturing at the students.” | Kinetic learning, Multi-modal teaching | Having opportunities for movement, Using multi-modal delivery

“There are no valid cognitive assessments for individuals with ID.” | Validity of cognitive assessments for ID, Lack of tools designed for ID (need nonverbal resources) | Specific adaptations without infantilization; lack of valid assessment tools for use with children with ID; lack of variability of assessment tools for use with children with ID; communication level

“Videos are expensive to produce, so few curricula have them embedded. Most also rely too heavily on many, many words.” | Video aids, Multi-modal teaching | Using video aids; lack of funding; using multi-modal delivery

Thematic Analysis

<table>
<thead>
<tr>
<th>Initial Codes</th>
<th>Final Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repetition</td>
<td>Repeating concepts as needed</td>
</tr>
<tr>
<td>Steps broken down</td>
<td></td>
</tr>
<tr>
<td>Holistic perspective</td>
<td>Viewing behavior in the context of the person’s history</td>
</tr>
<tr>
<td>Individualization (interviews w family and child + observation)</td>
<td></td>
</tr>
<tr>
<td>Understand past development of child</td>
<td></td>
</tr>
<tr>
<td>Viewing behavior in the context of protection/survivor (e.g., with the history of the child in mind)</td>
<td></td>
</tr>
<tr>
<td>Behavior is about the initiator, not about the receiver</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Have cultural humility; ask questions instead of making assumptions</td>
<td></td>
</tr>
<tr>
<td>Individualization (interviews w family and child + observation)</td>
<td>Individualizing based on personality</td>
</tr>
<tr>
<td>Individualization (strengths, personality)</td>
<td></td>
</tr>
<tr>
<td>Student choice during intervention design</td>
<td></td>
</tr>
<tr>
<td>Looking for key words from families for signs of trouble</td>
<td></td>
</tr>
<tr>
<td>Looking or signs of distress</td>
<td></td>
</tr>
<tr>
<td>Using data and observations</td>
<td></td>
</tr>
<tr>
<td>Observing and analyzing behavior (e.g., signs of distress/comfortability, behavior changes)</td>
<td></td>
</tr>
</tbody>
</table>
IDST TIC Guidelines & The SAFEST KID Model

Trauma-Informed Care (TIC) Guidelines for Adapting Interventions to Support Children with Intellectual Disability and Sexual Trauma (IDST) & The Sexual Assault Framework in Education to Support Trauma in Kids with Intellectual Disability Model

TIC Overview: Pillars

- Realize the ubiquitous nature of trauma
- Recognize trauma signs and symptoms
- Respond to trauma via evidence-based systems
- Resist revictimization and prevent further trauma from occurring
TIC Overview: Principles

1. Safety
2. Trustworthiness & Transparency
3. Peer Support
4. Collaboration & mutuality
5. Empowerment, choice & choice
6. Cultural, historical, gender lessons

ID Overview: Basics

<table>
<thead>
<tr>
<th></th>
<th>Mild ID</th>
<th>Moderate ID</th>
<th>Severe ID</th>
<th>Profound ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion</td>
<td>85% of indiv</td>
<td>10% of indiv</td>
<td>4% of indiv</td>
<td>1% of indiv</td>
</tr>
<tr>
<td></td>
<td>with ID</td>
<td>with ID</td>
<td>with ID</td>
<td>with ID</td>
</tr>
<tr>
<td>IQ Range</td>
<td>50-70 points</td>
<td>35-50 points</td>
<td>20-35 points</td>
<td>&lt;20 points</td>
</tr>
<tr>
<td>Supports</td>
<td>Often can live independently</td>
<td>Often can live independently with supports, such as in group arrangements</td>
<td>Often need support for ADLs and often cannot live independently</td>
<td>Often require full-time care</td>
</tr>
</tbody>
</table>
When ID Meets Trauma: Signs to Look For

<table>
<thead>
<tr>
<th>Common Trauma Symptoms Generally</th>
<th>Common Trauma Symptoms in ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Avoidance of individuals, situations, or specific stimuli</td>
<td>• Avoidance of individuals, situations, or specific stimuli</td>
</tr>
<tr>
<td>• Increase in anxiety</td>
<td>• Changes in eating habits</td>
</tr>
<tr>
<td>• Increase in depression</td>
<td>• Delayed grief</td>
</tr>
<tr>
<td>• Hypervigilance</td>
<td>• Increase in self-harming behaviors</td>
</tr>
<tr>
<td>• Changes in appetite</td>
<td>• Increase in somatic symptoms such as stomachaches</td>
</tr>
<tr>
<td>• Changes in sleep habits or energy levels</td>
<td>• Overall change in baseline functioning</td>
</tr>
<tr>
<td>• Persistent fatigue</td>
<td>• Withdrawal</td>
</tr>
<tr>
<td>• Increase in externalizing behaviors</td>
<td>• Persistent fatigue</td>
</tr>
<tr>
<td>• Developmentally inappropriate sexual knowledge or behavior</td>
<td>• Increase in externalizing behaviors</td>
</tr>
<tr>
<td>• Nightmares</td>
<td>• Nightmares</td>
</tr>
<tr>
<td>• Signs of physical injury stemming from abuse</td>
<td>• Signs of physical injury stemming from abuse</td>
</tr>
<tr>
<td>• Increase in substance use</td>
<td>• Increase in fear or anxiety</td>
</tr>
<tr>
<td>• Academic and professional difficulties</td>
<td></td>
</tr>
<tr>
<td>• Dissociation</td>
<td></td>
</tr>
<tr>
<td>• Feelings of guilt or shame</td>
<td></td>
</tr>
</tbody>
</table>

Steps for Providing Care: SAFEST KID Model

Healthy Relationships

Accurate and expansive SEL curricula taught at all grade levels (K-12) embedded throughout the year and adapted for a range of skill levels.

Therapeutic Intervention

School-based therapy adapted for children at different skill levels, targeted towards children with ID and ID/ST.

TIC Training

Diversity-informed trauma training across systems for all school personnel (e.g. administrators, mental health providers, teachers, custodians, etc.)

Preventative: realize | recognize | respond
### Steps for Providing Care: Lower Levels

**Advocate for programs such as:**

<table>
<thead>
<tr>
<th>Level 1: TIC Training at All Staff Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ACEs Connection</td>
</tr>
<tr>
<td>• Framework for Safe and Successful Schools</td>
</tr>
<tr>
<td>• Futures Without Violence</td>
</tr>
<tr>
<td>• School Health Assessment and Performance Evaluation (SHAPE)</td>
</tr>
<tr>
<td>• Trauma-Sensitive Schools Training Package</td>
</tr>
<tr>
<td>• Treatment and Services Adaptation Center</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 2: Healthy Relationship Curricula at In Grades</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Collaborative for Academic, Social and Emotional Learning</td>
</tr>
<tr>
<td>• Comprehensive Sexuality Education</td>
</tr>
<tr>
<td>• Healthy Relationships Curriculum</td>
</tr>
<tr>
<td>• Long Live Love</td>
</tr>
<tr>
<td>• Rights, Respect, Responsibility</td>
</tr>
<tr>
<td>• Second Step</td>
</tr>
<tr>
<td>• Zones of Regulation</td>
</tr>
<tr>
<td>• Circles Curriculum</td>
</tr>
<tr>
<td>• Unstuck</td>
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<tr>
<td>• Superflex</td>
</tr>
</tbody>
</table>

### Steps for Providing Care: Lower Levels

**ID Specific Components & Key Points**

<table>
<thead>
<tr>
<th>Level 1: TIC Training at All Staff Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Trauma symptoms may present differently in children with ID</td>
</tr>
<tr>
<td>• Diagnostic overshadowing can interfere with trauma identification</td>
</tr>
<tr>
<td>• Heightened risk, fewer accessible resources, and a widespread epidemic of abuse among individuals with ID increase the need for trauma-informed schools</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 2: Healthy Relationship Curricula at In Grades</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Areas of importance include advocacy, emotional regulation, interpersonal boundaries and skills, social norms, personal rights, and consent</td>
</tr>
<tr>
<td>• Concrete material presented in multiple modalities and individualized is most accessible</td>
</tr>
<tr>
<td>• Explicit instruction is imperative</td>
</tr>
<tr>
<td>• Heightened risk for interpersonal abuse increases the importance of accessing this education</td>
</tr>
<tr>
<td>• Repetition and generalization are key</td>
</tr>
</tbody>
</table>
Steps for Providing Care: Level 3

**Identification**
A child with IDST has been identified, or you have noticed sufficient signs in a child that warrant support and investigation.

**Intervention Adaptations**
Mastery criteria are developed, and interventions are utilized according to which skills they addressed, ignoring recommended session length and time in favor of the child's needs. Using a community-based approach and multi-modal delivery are imperative.

**Repeat**
Providers should continue working on skill support with the child as needed, moving onto other areas after mastery of one skill has been obtained.

**Step 1: Identification**

**Observe Changes in Behavior**
Attend to behavioral changes that align with typical trauma symptoms and those that are common among children with IDST, but view all changes with curiosity and concern instead of discipline or dismiss.

**Report Abuse**
Note physical signs of abuse as well as behavioral, reporting any and all suspected instances of child abuse to both the school and Child Protective Services as well as any other relevant authorities.

**Step 2**

**Task Analysis**
Skills and needs are to be formally and informally assessed, existing data utilized, families involved, and intervention frameworks selected.

**Step 3**

**Progress Monitoring & Family Check-Ins**
Child progress should be measured according to the skills they are learning instead of working through set sessions of protocols, and providers should schedule regular check-ins with families and other relevant staff members.

**Step 4**

**Begin Establishing Rapport**
Begin establishing rapport with the child if rapport has not already been formed, utilizing the modalities of play, music, and art therapy as needed, or generally implementing Child Directed Play.

**Develop Intervention Structure**
Obtain consent and assent for working with the child, formulate regular schedule for the interventions, and decide on a foundational framework and necessary adaptations.

**Work with the Family**
After a child has been identified with IDST who needs support, reach out to the family to gather a more detailed history to the extent possible to better understand the child's life and family dynamic, and provide education to the family if it is needed and welcomed. Connect the family to community supports as needed and as is possible.
Step 2: Task Analysis

1. Skill Gap & Mastery Criteria
   - Utilize the framework of task analysis to create a list of skills to focus on, breaking each skill into smaller components until the child’s level has been reached.
   - Establish criteria that would indicate the child has mastered each skill and is ready to progress onto another. View all needs as skills to the extent possible.

2. Incorporate Existing Data
   - Utilize data that already exists in the client's file, public records, or school system to help increase understanding of the child’s life and dynamic. Practice viewing the child within the context of their history - their lived experience, cultural landscape, and family system.

3. Assessments
   - Conduct further assessments as needed, such as baseline trauma screenings to support progress monitoring and evidence-based intervention delivery. Conduct additional family interviews as needed to help support understanding.

4. Intervention Selection
   - Based on the information obtained, select full protocols or parts of interventions to implement with the child with ID/IT, focusing on skill development instead of adhering to specific protocol sessions. For a child with ID/IT, using the Bounce Back Framework is an ideal foundation.

Step 3: Intervention Adaptations

1. Turn protocol sessions and set timelines into:
   - Skill gap measurement and mastery criteria benchmarks
   - Repeated practice of concepts during set times each week during school
   - Stretching session practice over many sessions to increase familiarity and retention and move at the child’s own pace

2. Shift verbose or lecture-heavy intervention components into elements with:
   - Concrete language with real-world examples and role-play support
   - Manipulatives, visuals, videos, and general multi-modal delivery
   - Opportunities for movement and engagement with peers across skill levels

3. Work with families to support skill practice at home:
   - Include families from the start of the intervention
   - Share updates on skill development and education to the extent possible
   - Provide instructions for families to practice specific skills with the child at home

4. Incorporate structured choice as much as possible:
   - Involve the child in their intervention by developing rapport, obtaining their assent, incorporating their preferences, and having examples and role-play situations from the child’s own life

5. Intertwine trauma support with interpersonal skill development:
   - Ensure that skill gaps are being addressed by maintaining a focus on learning skills regarding interpersonal safety, self-advocacy, boundaries, and consent
   - Make space for processing trauma at the child’s level focusing on creating physical and psychological safety, and either developing a trauma narrative or protocol for what to do should a similar situation arise in the future

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Step 4: Progress Monitor & Family Check-Ins

**Trauma Monitoring**
- Bangor Life Events Scale for Intellectual Disability (BLESID)
- Impact of Events Scale - Intellectual Disability (IES-ID)
- Lancaster and Northgate Trauma Scale for Intellectual Disabilities (LANTS)
- Posttraumatic Stress Checklist (PCL-C)
- Traumatic Events Screening Inventory - Child Version (TESI)
- Traumatic Events Screening Inventory - Parent Version (TESI)

**Skill Mastery**
- Monitor progress based on skill development not on length of time protocols have been implemented
- Expect to stretch content over long-term delivery and to repeat content as needed

**Family Check-Ins**
- Regularly schedule check-ins with families to support community connections, family education and understanding, skill practice outside of school, and to maintain a team-based approach to care

Step 5: Repeat

- Intervention Begun
  Focus on specific skill progress and mastery instead of session numbers and weeks

- Continue Intervention as Needed
  Shift focus to additional skills after sufficient progress has been made

- Check In With Family
  Keep the family involved throughout the process

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The SAFEST KID Model: Level 3

The Sexual Assault Framework in Education to Support Trauma in Kids with Intellectual Disability:
An Adapted Individual Intervention Based on the Bounce Back Protocol

The Bounce Back protocol can be downloaded for free from the Center for Safe and Resilient Schools and Workplaces at: https://app.traumaawareschools.org/resources公開

SAFEST KID Model: IDST TIC Guidelines & Bounce Back Foundation

SAFEST KID: Module 1 (repeat as needed)
- May take multiple sessions
- Group or individual
- Focus on building trust, modeling confidentiality and boundaries, and establishing routine meeting times
- Conduct task analysis for skill gaps (e.g. interpersonal and social-emotional) if not already done
- Check in with caregivers weekly

Bounce Back: Session 1
*Treatment Expectations, Introductions, and Psychoeducation*

<table>
<thead>
<tr>
<th>Suggested Tools</th>
<th>Suggested Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Materials listed</td>
<td></td>
</tr>
<tr>
<td>- Child directed play in the form of games, art, music, or play therapy for rapport building</td>
<td></td>
</tr>
<tr>
<td>- Interview family for contextual history</td>
<td></td>
</tr>
<tr>
<td>- Progress monitor trauma symptoms or behaviors of concern initially and monthly</td>
<td></td>
</tr>
<tr>
<td>- Tangible items to represent feelings, thoughts, and behaviors</td>
<td></td>
</tr>
<tr>
<td>- Develop rapport with child and family</td>
<td></td>
</tr>
<tr>
<td>- Establish routine in child’s weekly schedule</td>
<td></td>
</tr>
<tr>
<td>- Have child feel comfortable meeting regularly with new provider and be able to state why they are meeting</td>
<td></td>
</tr>
</tbody>
</table>

1, 2, 3, 4, 5, 6
SAFEST KID Model: IDST TIC Guidelines & Bounce Back Foundation

SAFEST KID: Module 2 (repeat as needed)
- May take multiple sessions
- Group or Individual
- Add feelings identification practice in body
- Practice grouping examples into thoughts, feelings, and actions
- Practice role-playing how to tell someone safe when you feel bad
- Check in with caregivers weekly

Bounce Back: Session 2
“Rational, Feelings and Positive Activities, and Normalizing Common Reactions”

Suggested Tools
- Materials listed
- Body map, doll, or image of child to practice identifying good/bad feelings
- Progress monitor trauma symptoms monthly or at the end of the module

Suggested Goals
- Learn safe vs. unsafe feelings
- Learn to identify feelings and their place in the body

SAFEST KID: Module 3 (repeat as needed)
- May take multiple sessions
- Group or Individual
- Add deep breathing calm down practice at the beginning
- Check in with caregivers weekly

Bounce Back: Session 3
“Body Feelings (Physiological Arousal and Relaxation Training)”

Suggested Tools
- Materials listed
- Body map, doll, or image of child to practice identifying good/bad feelings
- Calm down object
- Progress monitor trauma symptoms monthly or at the end of the module

Suggested Goals
- Learn deep breathing
- Learn in what scenarios or in response to which bodily sensations to use deep breathing
SAFEST KID Model: IDST TIC Guidelines & Bounce Back Foundation

SAFEST KID: Module 4 (repeat as needed)
- May take multiple sessions
- Group or individual
- Check in with caregivers weekly

Bounce Back: Session 4 “Using Helpful Thoughts”

SAFEST KID: Module 5 (repeat as needed)
- May take multiple sessions
- Group or individual
- Review how to tell if a space is safe and if a person is safe
- Check in with caregivers weekly

Bounce Back: Session 5 “I Can Do It Ladder” (In vivo Exposure Hierarchy)

Suggested Tools
- Materials listed
- Thoughts and feelings identification / matching practice game with pictures or with concrete representational objects
- Social stories
- Progress monitor trauma symptoms monthly or at the end of the module

Suggested Goals
- Make safe choices reliably during role-play exercises
- Develop increased body awareness and control
SAFEST KID Model: IDST TIC Guidelines & Bounce Back Foundation

SAFEST KID: Module 6 (repeat as needed)
- May take multiple sessions
- Group
- Check in with caregivers weekly

Bounce Back: Session 6
"Reviewing Coping Skills"

<table>
<thead>
<tr>
<th>Suggested Tools</th>
<th>Suggested Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Materials listed</td>
<td></td>
</tr>
<tr>
<td>- Previous materials</td>
<td></td>
</tr>
<tr>
<td>- Progress monitor trauma symptoms monthly or at the end of the module</td>
<td></td>
</tr>
<tr>
<td>- Have child explain to another how to use coping skills or identify safe spaces and people</td>
<td></td>
</tr>
</tbody>
</table>

SAFEST KID: Module 7 (repeat as needed)
- May take multiple sessions
- Group
- Review skills learned so far and utilize progress monitoring trauma measures
- Check in with caregivers weekly

Bounce Back: Session 7
"Social Support and Problem Solving"

<table>
<thead>
<tr>
<th>Suggested Tools</th>
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</tr>
</thead>
<tbody>
<tr>
<td>- Materials listed</td>
<td></td>
</tr>
<tr>
<td>- Previous materials</td>
<td></td>
</tr>
<tr>
<td>- Progress monitor trauma symptoms monthly or at the end of the module</td>
<td></td>
</tr>
<tr>
<td>- Identify people and spaces in the child’s life that are safe and positive</td>
<td></td>
</tr>
<tr>
<td>- Reliably know what to do if around unsafe people and places</td>
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</tr>
</tbody>
</table>
### SAFEST KID Model: IDST TIC Guidelines & Bounce Back Foundation

#### SAFEST KID: Module 8 (repeat as needed)
- May take multiple sessions
- Group or individual
- Check in with caregivers weekly

**Bounce Back: Session 8**
*Practice with Problem Solving*

#### SAFEST KID: Trauma Narrative Module (repeat as needed)
- May take multiple sessions
- Individual
- Practice identifying safe people
- Practice identifying feelings in body
- Review coping skills each session at the beginning and end of trauma narrative work
- Check in with caregivers weekly

**Bounce Back: Trauma Narrative Session 1-3**
*Trauma Narrative*

<table>
<thead>
<tr>
<th>Suggested Tools</th>
<th>Suggested Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Materials listed</td>
<td>Make safe choices in multiple real-life / role-play scenarios</td>
</tr>
<tr>
<td>Previous materials</td>
<td></td>
</tr>
<tr>
<td>Progress monitor trauma symptoms monthly or at the end of the module</td>
<td></td>
</tr>
</tbody>
</table>

- **Materials listed**
- **Art materials**
- **Body map, doll, or picture of self**
- **Coping skills aids (e.g., safe object)**
- **Social stories**
- **Progress monitor trauma symptoms monthly or at the end of the module**

| Practice identifying how to feel safe |
| Show or tell what happened to them or where there is pain |
| Understand how to help self stay safe in the future |

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