ASD, Trauma, and Coordinated Care

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Abstract This chapter explores issues related to trauma in youth with Autism Spectrum Disorder (ASD) and how trauma and its sequelae can be identified and addressed through interdisciplinary coordinated care. Foundational information on trauma-informed care (TIC) and intervention strategies are provided to help guide professionals and families in better understanding common experiences of trauma in youth with ASD and effective ways to offer support and promote healing.

Understanding Trauma in Youth with ASD

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma as an event, or a series of cumulative events that are "experienced by an individual as physically or emotionally harmful" (SAMHSA, 2014, p. 7) and which subsequently impact a person's biological, psychological, social, spiritual, or emotional well-being on an ongoing basis. This definition highlights trauma as subjective, and dependent on an individual's experience with distressing events. Due to the subjective nature of trauma, it is challenging to identify what type of event or experience may be considered traumatic.

An important development in understanding the impact of trauma has been the adverse childhood experience (ACE) studies (Felitti et al., 1998). This body of research has demonstrated a strong link between traumatic experiences in childhood and negative health outcomes (Anda et al., 2006; Edwards, Holden, Anda, & Felitti, 2003). This risk is cumulative, meaning that the more ACEs a child experiences, the higher their likelihood of developing multiple physical and psychological health problems including diabetes, cardiovascular disease, depression, and suicidality (Schilling, Aseltine & Gore, 2007). Berg, Shiu, Acharya, Stolbach, and Msall (2016) conducted a study examining rates of ACEs in children with ASD. Results indicated that a diagnosis of ASD is significantly associated with a higher probability of reporting one or more ACEs. Additionally, the number of children with ASD who

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were exposed to four or more ACEs was twice as high as neurotypical peers, substantially increasing their risk for negative health outcomes. Importantly, this research focused on situational indicators of trauma such as traumatic loss, poverty, family instability (domestic violence, substance abuse), and neighborhood violence which may not fully capture the breadth of experiences common to children with ASD that may be experienced as traumatic.

Kerns et al. (2015) point out that youth with ASD:

> Encounter a number of distinct daily stressors related to their diagnosis that may have untoward effects on their emotional functioning…such as social confusion, peer rejection, prevention or punishment of preferred behaviors (e.g. restricted, repetitive interests) and sensory sensitivity to daily stimuli (e.g. lights, loud sounds) (p. 3476).

Each of these stressors when experienced cumulatively over time have the potential to be experienced as traumatic. Furthermore, characteristics of ASD such as difficulties with novel experiences, socialization, frustration tolerance, and sensory integration can result in children with ASD perceiving such sensations and experiences as more stressful and potentially traumatic than typically developing children (Kerns et al., 2015). There is also a significant body of research to suggest that trauma in the form of adverse social experiences such as peer victimization is as much as four times higher among youth with ASD than their neurotypical peers (Cappadocia, Weiss & Pepler, 2012; Hoover & Kaufman, 2018; Zeedyk, Rodriguez, Tipton, Baker, & Blacher, 2014).

Myths and Misconceptions

The study of ACEs and trauma in ASD is a relatively new field of study. As a result, treatment frameworks that exist to help children with ASD meet behavioral goals and developmental benchmarks; however trauma-focused models for intervention that focus on mental health and well-being have yet to be fully researched and developed (Fuld, 2018). There are a few key myths that have likely contributed to the delay in acknowledging trauma as an important focus for research and practice to support youth with ASD. The first is an assumption that some core features of ASD including internal focus and lack of social awareness may protect youth with ASD from the subjective experience of trauma, particularly when the traumatic event is social or relational in nature. This is a misguided assumption. Studies have found that children with ASD experience high rates of social anxiety (Bellini, 2006; Wu et al., 2015). Many children with ASD notice and are quite distressed by social exclusion and the stigma associated with ASD (Humphrey & Lewis, 2008; Locke, Ishijima, Kasari, & London, 2010; Sebastian, Blakemore & Charman, 2009). There can also be a fear among providers that inquiring about traumatic experiences will cause the child to newly recognize that a traumatic experience has occurred, or retraumatize the child. In reality, inquiring about trauma, making space to talk about it, and offering support is

critical in addressing the isolation that can be inherent in having to cope independently with the impact of trauma (The National Child Traumatic Stress Network, 2008).

Given the dearth of research in trauma-focused interventions for youth with ASD, there also may be an assumption that traditional models for youth who have experienced trauma are not effective for youth with ASD or that youth with ASD may not have the skills or capacity to participate. This is not a reason to deny youth with ASD access to trauma-informed care (TIC). In a review of diagnosis and treatment models for Post-Traumatic Stress Disorder (PTSD) in people with ASD, Rumball (2018) concluded that traditional trauma-informed treatment strategies for PTSD are applicable to people with ASD and likely to be effective. Modifications such as longer session-length and treatment time and the use of concrete language in explaining trauma and the treatment process were recommended to enhance effectiveness for people with ASD.

Challenges for Coordinated Care

There are several challenges to coordinating care as it relates to trauma in children with ASD. The first is a lack of knowledge about assessment and TIC in youth with ASD, which can make it challenging for families or care teams to find experienced providers and for providers looking to learn more about TIC to locate effective resources. As the experience of trauma is subjective, communication may also be a barrier. Some youth with ASD may not be able to effectively articulate that they have experienced trauma, even to those closest to them. Additionally, if the experience of trauma is communicated in a clinical care setting where confidentiality must be maintained, consent is required to share information about trauma with other members of a care team (school, community supports, etc.). Due to the sensitive nature of many traumatic experiences and fear of judgment or stigma, families may be hesitant to speak openly about these experiences with a broader care team.

Importantly, TIC for children requires significant family support. Depending on the type of trauma, families may be working through the challenges of the experience themselves or could be very distanced from it. Stavropoulos, Bolourian, and Blacher (2018) also point out that it can be challenging for parents to detect changes in behavior when children are young and changing regularly, and/or if the parents are coping with their own trauma. Thus, providers need to consider TIC resources to support the family in addition to the child.

Trauma-Informed Assessment

Effective assessment of individuals with ASD must include attention to stressful and traumatic life events and the impact of such experiences on a child's emotional well-being and sense of self (Berg et al., 2016). This includes not only distinct

traumatic events such as those identified in the ACE studies, but also cumulative trauma associated with an individual's social struggles, communication difficulties, and sensory sensitivities (Kerns et al., 2015). Importantly, depending on an individual with ASD's abilities related to emotional processing and expression, additional time to get to know the individual and their communication style as well as to improve identification of emotions may be required prior to effective assessment (Sivaratnam, Newman, Tonge, & Rinehart, 2015).

Presentation and Differential Diagnosis

One challenge in identifying the existence of trauma in children with ASD is that it may present differently than in neurotypical children. Children with ASD may also have difficulty communicating the subjective experience of traumatic events or the cumulation of stressors that result in a trauma reaction. Kerns et al., (2015) points out that cumulative stress or trauma may present as an exacerbation of core symptoms of ASD including self-stimulating behaviors, ritualized or stereotypic behavior, scripting, fixation on topics connected to the trauma or topics of interest that serve as a distraction from the trauma, anxiety regarding future events, social withdrawal, difficulty with social boundaries, isolation, social anxiety, or shutting down. Likewise, symptoms of PTSD and other trauma-and-stressor-related disorders include social withdrawal or avoidance, flat affect, social anxiety, sensory sensitivity, difficulty with emotional regulation, irritability, and high reactivity (American Psychiatric Association, 2013). Stavropoulos et al. (2018) highlight five domains that are especially common in both ASD and post-traumatic stress response: lack of interest in peer relationships, lack of positive emotions or difficulty communicating emotional experiences, repetition, outbursts of anxiety, irritability or aggression, and difficulty sleeping.

Many of the symptoms of a post-traumatic stress reaction mirror common symptoms of ASD and thus can remain hidden from providers who are not attuned to the potential for stress-and trauma-related symptoms in the assessment process. In addition to symptoms of stress-and-trauma-related disorders, other types of mental health struggles can be precipitated by trauma including anxiety, aggression, difficulty with attention or concentration, suicidality, and self-injury, all of which occur in higher rates among individuals with ASD than the neurotypical population (Haruvi-Lamdan, Horesh, & Golan, 2018; Mannion, Brahm, & Leader, 2014; Storch et al., 2013).

Considerations in Conducting Trauma-Informed Assessment

While none of the abovementioned symptoms in and of themselves are conclusive in identifying trauma, the appearance or worsening of any of these symptoms indicates that trauma should be considered in the assessment process. Consideration of triggers, timeline, and progression of symptoms is important; however, this can be challenging to determine in instances of cumulative stress or trauma, particularly in the cumulation of stressful social experiences. Repetition of themes connected with potential stressors or traumatic events in play, verbalizations, or general interests can also be indicative that trauma has occurred or is impacting a child's well-being. Increases in repetition or focus on specific interests unrelated to stress or trauma can also represent efforts to cope with upsetting memories or intrusive thoughts by distracting oneself from these experiences.

Due to the variability in expressive communication associated with ASD, many studies of anxiety and trauma in children with ASD rely on caregivers or other types of observer reports. This is also likely the case in clinical and other settings where assessment may occur. However, Hoover and Romero (2019) point out that this is likely to miss important components of the diagnostic picture and there is evidence to suggest that children with ASD demonstrate greater self-awareness than we may assume. Whenever possible, collateral reports of symptoms, that is reporting from caregivers, teachers, service providers, and other observers, should be combined with a child's self-reporting (in whatever way the child communicates).

Hoover and Romero (2019) developed and piloted a web-based Interactive Trauma Scale for children with ASD. This scale, while not yet extensively studied, was effective in capturing self-reported trauma symptoms among children with ASD who had a known history of trauma exposure. Other scales for measuring trauma reactions in children have been used with children with ASD including the Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS-PL) (Kaufman et al., 1997) and the Traumatic Events Screening Inventory for Children (TESI-C) (Ford et al., 2002). These assessment scales were not created to specifically capture the experience and impact of trauma in children with ASD but nonetheless may be useful.

Trauma-informed assessment should be active and ongoing when it is known that a traumatic event has occurred. However, given the prevalence of trauma in children with ASD, any professional working with children with ASD should be attuned to issues of trauma and cumulative stress as treatment implications are different if the underlying cause of a symptom is trauma. Ultimately, if it cannot be determined whether or not a child's symptoms are attributable to trauma, incorporating principles of TIC into their framework of supports and services is likely to be beneficial. These principles are helpful in creating an affirmative environment whether or not specific trauma has occurred.

Trauma-Informed Care and Intervention

Given the dearth of specific trauma-focused frameworks for youth with ASD, this section will present considerations based on the SAMHSA guidelines for trauma-informed approaches to practice and service delivery. These best-practice principles are broadly applicable across a variety of professional fields and settings. Given their applicability across different realms of care, these principles can offer guidance for a unified philosophy of care coordination across disciplines. Clinical treatment models are also discussed, recognizing that this is a developing area of research.

SAMSHA's Six Principles of a Trauma-Informed Approach

Safety. Safety when it comes to children with ASD has a dual meaning. When any person has experienced trauma, helping them regain a sense of safety and control is paramount to healing. Fostering safety often involves taking steps (1) to ensure that the event does not happen again, (2) in situations that may occur again, such as peer-victimization, ensure that the child has a concrete plan of action steps to take to exit the situation and seek help, (3) to enhance overall safety in all aspects of a child's life. The third may be especially challenging because some children with ASD may experience the world as an inherently unsafe place. It is challenging to live with ASD in a world that was not designed for neurologically diverse ways of being (Gates, 2019). In this case, enhancing safety may mean finding strategies that allow a child to function in ways that are most comfortable to them. Many behavior modification programs and expectations of school and vocational settings can be stressful. In all cases, but perhaps particularly when trauma has occurred, looking for ways to allow safety and comfort and build on strengths rather than focus on modification of maladaptive behavior may help intervene on a lack of safety of a child as a result of trauma.

Trustworthiness and Transparency. Children with ASD and their families who have experienced trauma may find it challenging to share their experience or seek help. Since trauma and its impacts are so often overlooked in youth with ASD, it is critical to spend time developing a relationship and fostering a sense of trust. Transparency is part of this process. There is often concern about what a child can understand and how much should be shared regarding the diagnosis and treatment process. A strength of people with ASD is often their transparency and it is important to echo this in a sensitive way.

Peer Support. A critical element of peer support is the opportunity to both share your story and hear the stories of others going through similar experiences who can share strategies for coping and healing. This brings about some challenges when applied to youth with ASD as for some, peer interactions can be a source of additional stress and offering support to others can also be difficult for some children with ASD. This is certainly not the case universally. Many children with ASD badly want to

engage with peers, and creating opportunities for meaningful connection around challenging experiences can be healing in multiple ways. For those who may not be ready for that type of peer connection, there is still much that can be gained from hearing stories of others, whether through books, movies, or other types of narratives. The important question is *what type of social support would help this child feel a sense of hope and belonging*? Peer support is also critically important for families of youth with ASD who have experienced trauma.

Collaboration and Mutuality. The central theme of collaboration and mutuality are of particular importance given unequal power dynamics that often exist in professional settings. SAMSHA (2014) highlights the importance of shared decision-making and relationship development, which may be especially relevant to youth with ASD who are often accustomed to being in the role of *client, patient, student, or participant.* All children in our society lack power, but perhaps more so for children with ASD who interact with so many professional settings.

Empowerment, Voice, and Choice. Connected to collaboration and shifting power dynamics are the ideas of promoting empowerment and elevating the voice of youth who have experienced trauma. Goal setting is often driven by both caregivers and professionals, and when trauma is present it is critical that the child take on as much leadership as possible. They should be fully a part of and to the extent they're able, driving decisions made about goals, treatment, needed supports and services, and daily activities. Increasing someone's sense of control and self-esteem is a critical aspect of healing from trauma. Opportunities for advocacy to prevent similar experiences of trauma for themselves and their peers can also help to increase a child's self-esteem, which is an important part of the healing process.

Cultural, Historical and Gender Issues. It is important to be attuned to the impact of multiple forms of oppression on both youth with ASD who have experienced trauma and their families. We are likely to hold implicit biases as a result of living in a society where ableism is an inherent part of our culture. Likewise, children with ASD have often grown up in a society that fails to recognize the benefits of neurodiversity. Furthermore, other aspects of a child's identity such as their race, sex, gender identity, religion, socioeconomic status, and cultural background are known to impact the quality of services they receive (Bishop-Fitzpatrick, Dababnah, Baker-Ericzén, Smith, & Magaña, 2019). Central to TIC is creating an affirmative environment that recognizes the impact of stigma and actively works to counter it, supporting a person in expressing their authentic identity. Children with ASD may feel pushed to hide the aspects of their ASD that make them unique which in and of itself can be traumatic. Utilizing a capabilities perspective (Sen, 2005) and affirming the unique aspects of their identity can help to foster resilience in overcoming and moving forward from traumatic experiences.

Clinical Treatment Models

SAMSHA's six principles offer a general trauma-informed lens through which supports and services should be delivered and this chapter has aimed to frame these general principles in terms of how professionals can apply them to understanding and approaching the experience of trauma in youth with ASD. This framework is supportive and can create a healing environment, however, it is not a therapeutic framework. While clinical treatment frameworks for addressing trauma have not been extensively researched or adapted for children with ASD, there are several that offer promising approaches and given their current evidence base in trauma-informed treatment, may be good starting points for treatment.

Cognitive Behavior Therapy (CBT). CBT is widely used with children to treat a variety of struggles related to anxiety, anger, depression, and attention and has also been applied to treating symptoms of post-traumatic stress as a result of trauma (Crawley, Podell, Beidas, Braswell, & Kendall, 2010). Core components of CBT focus on problem-solving, reframing thoughts to increase accuracy, identifying and regulating emotions, learning coping and relaxation strategies, modeling or role-playing to practice new skills, and reinforcement of healthy behaviors (Beck, 2011). CBT models focused on trauma typically incorporate additional elements of education on trauma and common reactions to trauma, processing the trauma experience, working toward a helpful way of thinking about the traumatic event(s), and addressing behavioral changes that occurred as a result of the trauma. While CBT has not been studied specifically for youth with ASD who have experienced trauma, it is the primary recommended treatment modality for the treatment of post-traumatic stress symptoms for youth in the United Kingdom (National Institute for Health and Care Excellence [NICE], 2018). While also not related to trauma, several studies have explored adaptations to CBT to enhance its effectiveness for children with ASD and it has been utilized in a variety of clinical and school settings (Rotheram-Fuller & MacMullen, 2011). Combined, this evidence suggests that CBT may be a viable approach for youth with ASD who have experienced trauma.

Trauma-Focused Cognitive Behavior Therapy (TF-CBT). TF-CBT is a trauma-focused framework building on the principles of traditional CBT and applying them specifically to trauma. This model provides therapeutic intervention simultaneously for a child who has experienced trauma and a trusted caregiver who can support the child through the healing process (Cohen, Mannarino, Kliethermes, & Murray, 2012). It incorporates the following elements, which are often noted with the acronym PPRACTICE: (1) psycho-education, (2) parenting skills [to support a child who has experienced trauma], (3) relaxation skills, (4) affective/emotional identification and coping skills, (5) cognitive coping skills, (6) telling and processing the trauma narrative, (7) in-vivo practice to work through avoidance of trauma reminders, (8) conjoint child-caregiver sessions, and (9) enhancing safety and planning for the future. TF-CBT has a strong evidence base and is widely used with children who have experienced both single-event and cumulative trauma. Holstead and Dalton (2013) conducted a study of TF-CBT for children with intellectual disabilities (ID), about a

third of whom also had ASD. That study did not find this model to be more effective than standard behavioral strategies, however, the authors did not feel evidence was strong enough to rule out TF-CBT as an effective treatment model for youth with ID and ASD. This study did not examine the effectiveness of TF-CBT in youth with ASD who did not have co-occurring ID.

Narrative and Narrative Exposure Therapies (NT and NET). Narrative therapies and a trauma-specific model called Narrative Exposure Therapy for children (KIDNET) focus on the development of a trauma narrative or a story of the traumatic event or events that have occurred. The development of the trauma narrative serves to get a child accustomed to retelling or thinking about the story so it becomes less emotionally overwhelming, help a child intellectually process and reframe the way they relate to the narrative and how it impacts their life, and if they are interested, use their story in advocacy efforts toward meaningful change. While not specifically focused on trauma, there is evidence to support narrative therapy as an effective treatment framework for children with ASD (Cashin, Browne, Bradbury, & Mulder, 2013). Importantly, when working with children, trauma narratives do not need to be a written or verbal telling of a story. Narratives can also be shared and processed through creative mechanisms such as drawing, drama, play, and music.

Creative Therapies. Several creative therapies such as animal-assisted therapeutic interventions (O'Haire, 2013), art therapies (Martin, 2009), music therapies, drama therapies, and affinity therapies (Suskind, 2016) which incorporate a person with ASD's specific interests as a central theme in the therapy process have been recommended as effective therapeutic supports for youth with ASD. The integration of creative therapies into trauma-focused interventions for children with ASD has not been researched but hold promise when considering adaptations to traditional frameworks which build on the strengths of neurodiverse features in children with ASD.

Interdisciplinary Roles in Coordinating Care

This section discusses specific roles for members of interdisciplinary care teams from a variety of settings to effectively coordinate and support youth with ASD and their families who experience trauma. Importantly, these roles often intersect, and responsibilities may not be as clearly defined as presented here. However, the discussions of each professional's role can offer good starting points for collaboration.

The Self-advocate

While the role of the young person who experienced trauma may differ somewhat based on their age, communication, and interest, their voice and choice should be the primary driver in collaboratively choosing the direction of care. It is incumbent

upon members of the care team to make space for this and ensure that the young person has the tools and supportive environment (created through the integration of SAMSHA's principles) they need to take on this role.

Case Management

Knowledge of TIC is essential for a professional (or other supportive individual) in a case management role. Case managers are critical in identifying providers with knowledge of TIC and may need to advocate for the provision and insurance coverage of trauma-informed services. As case managers may be in the role of coordinating between interdisciplinary care team members, they also play a central role in ensuring that the team provides person-centered care encompassing empowerment, voice, and choice as well as collaboration and mutuality (with both family and the young person who experienced trauma).

Education

Professionals involved in the education system play a central role in creating an affirmative and trauma-sensitive learning environment. Resources such as those provided through the Trauma and Learning Policy Initiative (Cole, Eisner, Gregory, & Ristuccia, 2013) can offer guidance to school-based professionals in fostering a trauma-sensitive climate. School-based professionals are also likely to be in a position to observe and identify symptoms and behaviors that may be indicative of a trauma response and thus may be a primary point for initial referral for trauma-informed assessment and service provision. Importantly, the school environment is uniquely positioned to offer opportunities for peer support. School professionals with knowledge of youth's background, strengths, and relationships can facilitate this connection.

Clinical Care

All clinical care professionals are likely to be involved in assessment and psychoeducation related to the impact of trauma as well as offering options for treatment and support.

Mental Health Care. Mental health care for youth with ASD who have experienced trauma should include diagnostic assessments for trauma and stressor-related disorders, consideration of ways that trauma and/or stress may exacerbate other physical or psychological symptoms, and the treatment of trauma and stress-related symptoms. Psychotherapy is a necessary service for children experiencing the sequelae

of trauma and should focus on processing the traumatic experience(s) and resulting narrative (stories) and/or cognitive schemas (ideas about safety, trust, etc.) that may have developed as a result of the trauma. Professionals providing psychotherapeutic services should work in concert with caregivers and other supportive individuals who are part of the care team to understand the child's trauma response and be able to effectively respond and offer support.

Psychiatry may also play a role in providing a trauma-informed assessment and determining differential diagnosis if it is unclear whether existing symptoms are related to trauma. Psychiatrists should work closely with clinicians providing psychotherapeutic services as these two disciplines are most effective when working in concert for assessment, differential diagnosis, and symptom relief. As clinicians providing psychotherapy often have more frequent contact with youth receiving services, they can provide valuable insight for psychiatrists making decisions as to whether medication may be an effective part of trauma-informed treatment. Importantly, psychiatrists serve a critical gate-keeping function as it relates to youth with ASD who have experienced trauma as many children are inappropriately referred for psychopharmacology when trauma is missed and symptoms are misinterpreted.

Medical Care. Medical professionals responsible for physical health and well-being also have an important role to play in trauma-informed assessment, differential diagnosis, and referral for trauma-related symptoms in youth with ASD. Primary care providers or other physicians may be the first point of contact for families when youth with ASD experience physical manifestations of trauma-related symptoms. It is imperative that healthcare professionals are attuned to the possibility of trauma contributing to physical symptomatology in order to provide appropriate referrals for mental/behavioral healthcare and other supportive services. Of course, physical symptoms should never be assumed to have a psychological basis without thorough examination and testing, however, trauma-informed assessment and services can begin concurrently with the investigation of physical symptoms. From a trauma-informed perspective, it is also critical that nurses, physicians, and any professional in the role of providing physical care fully communicate what a child should expect from examinations and when possible offer choices as to how examinations are conducted in order to offer transparency and enhance a child's sense of control.

Rehabilitation. Rehabilitative service professionals may be an important part of the care team as it relates to healing and recovery from trauma for youth with ASD. Speech-language therapy services can work to enhance communication skills and a child's ability to articulate events, thoughts, and feelings related to trauma. Increasing communication skills related to safety and asking for help can also be an important focus of speech-language therapy services. Occupational therapists also can support youth with ASD who have experienced trauma in developing skills for increasing safety. Additionally, occupational therapy can help to address sensory issues that are attributed to or exacerbated by trauma. Feelings and somatic experiences related to trauma can be an overwhelming sensory experience for anyone, particularly youth with ASD, so it is important that the sensory element of trauma is assessed and addressed. When physical therapy services are relevant, sensitivity to how trauma

may impact the experience of physical touch or physical discomfort would be important considerations on the part of the provider to ensure that the child feels in control of their body.

Community and Community-Based Services

Community-based services that enhance skills for safety are important for both prevention and recovery from trauma. Additionally, community-based service providers may offer support with some of the behavioral exposure tasks associated with therapeutic intervention for avoidance associated with trauma. The community also has the potential to provide affirmation and peer or community support.

Family

The family plays a vital role in the care team when a child with ASD (and perhaps the family themselves) have experienced trauma. The family is so often in the role of advocating for services, and their presence may provide a sense of safety for the child. Ultimately, the family's role is one of collaboration with and support for their child which can be challenging, especially if trauma symptoms have exacerbated underlying difficulties with communication and emotional regulation. The family often has to manage a dual-role on the care team of both providing support and insight and needing support. Professionals in all roles should keep this duality in mind when collaborating with families and creating care plans that may involve additional responsibilities, stressors, or demands on the part of the family.

Conclusion

This chapter has provided a general overview of the causes and presentation of trauma in youth with ASD, considerations for assessment, TIC, treatment, and the role of interdisciplinary care providers in providing comprehensive trauma-informed supports and services across settings. There is still much we need to know about this field. Ultimately, care providers being aware of the prevalence and presentation of trauma in youth with ASD and understanding their role in helping to create a sense of safety and facilitate conditions for recovery can make a significant impact in the trajectory for youth with ASD who have experienced trauma.

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