A DELPHI SURVEY ON THE IMPLEMENTATION OF TRAUMA-INFORMED CARE TECHNIQUES FOR AUTISTIC CHILDREN

by:

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THESIS ABSTRACT

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Autistic youth and youth with intellectual and developmental disability (IDD) are at an increased risk of experiencing potentially traumatic events. As such, they may benefit from extra support across service providers; however, little knowledge on trauma exists among service providers that frequently work with autistic youth but do not directly address trauma-symptoms (e.g., Board Certified Behavior Analysts and speech-language pathologists). Fifteen experts from speech-language pathology, behavior analysis, and psychology participated in a two-round modified Delphi-closed study to gain consensus on trauma-informed practices that should be included in these guidelines. From these two survey rounds, consensus was gained for 93.6% of proposed items. Recommendations for future research include community-based participatory research to gain consensus on the generated guidelines from the autistic community in addition to the development of an educational curriculum for service providers on how to use the guidelines.

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Chapter 1: Introduction

Autism spectrum disorder (ASD) is a neurodevelopmental condition characterized by delays in social communication skills and restricted, repetitive behaviors and interests (American Psychiatric Association, 2013). About 1 in 44 children aged 8 years have been identified as autistic[1] in the United States and it occurs in all racial, ethnic, and socioeconomic groups (Center for Disease Control, 2021; Kenny et al., 2016 – See Footnote 1; Maenner et al., 2016).

While ASD can be the only diagnosis an individual has, it is not uncommon for autistic individuals to have co-occurring disorders such as depression, anxiety disorders, and intellectual disability (Lugo-Marin et al., 2019; Kerns et al., 2015; Maenner et al., 2016; Mannion & Leader, 2013). Studies indicate that 46.1-78.7% of autistic children and adolescents present with a co-occurring condition, with intellectual disability co-occurring with a diagnosis of autism for 25-42% of autistic youth (Maenner et al., 2020; Mannion & Leader, 2013). Other studies show that 40% of autistic adults present with two or more co-occurring psychiatric disorders (Lugo-Marin et al., 2019). Of these co-occurring issues, anxiety disorders, depressive disorders, and attention-deficit/hyperactivity disorder (ADHD) are some of the most pervasive (Gadke et al., 2016; Mannion & Leader, 2013). Anxiety disorders in particular are notably pervasive across the lifespan, with evidence suggesting anxiety emerges in toddlerhood to childhood, decreases during adolescences and young adulthood, and increases during emerging adulthood (Gadke et al., 2016).

Trauma and Adverse Childhood Experiences

Trauma or traumatic events can be defined as an event, series of events, or set of circumstances that are perceived as threatening and have immediate or lasting negative effects

[1] "Identity-first" language will be used as opposed to solely using "person-first" language in accordance with evidence that suggests that there is a preference for "identify-first" language among many autistic adults (Kenny et al., 2016).

on the individual's functioning (Gardner et al., 2019; King, 2021; Kerns et al., 2015; SAMHSA, 2014). Similar to a physical injury, trauma can be thought of as a psychological injury that can range from minor and easily surmountable to severe to the point of altering an individual's life course (Kerns et al., 2015). Trauma can be acute, occurring in a single event, or chronic, occurring over an extended period of time (Kerns et al., 2015). Of these two forms, chronic trauma has been shown to be the more severe as children who experience chronic trauma have a 33 - 75% risk of developing post-traumatic stress disorder (PTSD) of while the risk for children who experience acute trauma is 1 -20% (Kerns et al., 2015).

To define experiences as potential sources of trauma, we can look at adverse childhood experiences (ACEs). ACEs were first defined in the late 1990's as researchers from the US Center for Disease Control (CDC) attempted to draw connections between early traumatic experiences and adverse outcomes later in life (Waite & Ryan, 2019). From this research, ten categories emerged: sexual abuse, verbal/emotional abuse, physical abuse, emotional neglect, physical neglect, having a caregiver who experiences mental health challenges, having a caregiver who is a victim of domestic violence, incarceration of a family member, and loss of a parent due to divorce or abandonment (Waite & Ryan, 2019). Research has shown a strong correlation between the presence of ACEs and risky health behaviors, chronic health conditions, low life potential, and early death (Waite & Ryan, 2019).

Some research argues that while the aforementioned ACEs are important, other factors external to the family unit may contribute to traumatic events. Research indicates that community stressors, such as poverty, peer rejection, poor school performance, and community violence should be considered ACEs as there is also a strong correlation between these experiences and adverse outcomes later in life (Waite & Ryan, 2019). As such, some scholarship has reported on adverse experiences more broadly as potentially traumatic events (PTEs) (Cook et al., 2021; Kerns et al., 2019; Waite & Ryan, 2019). To be inclusive of adverse experiences outside of the traditional ten ACEs, these events will be henceforth referred to as PTEs.

Effects of PTEs and Trauma Related Symptoms

While not every person that experiences PTEs is guaranteed long lasting effects, some of these effects will be salient and chronic for others. Some of the most widely recognized effects of trauma are traumatic stress, which can be defined as a persistent disturbance of mood and behavior following a traumatic event, and PTSD, which can be defined as a specific set of trauma-related symptoms (TRS) (e.g., flashbacks, nightmares, memory lapses) that persevere for over a month after a traumatic event (Ford & Courtois, 2009; Kildahl et al., 2020; Kerns et al., 2015). Generally speaking, trauma symptoms can include impairments to psychological, social, physical, and adaptive functioning (Ford & Courtois, 2009; Kildahl et al., 2020; Kerns et al., 2015).

Outside of trauma-related disorders, experiences with PTEs also increase the risk of individuals developing other psychiatric mental health conditions (Gardner, 2019; King, 2021). A systematic review of research on the association between PTEs and mental health challenges found that all forms of childhood maltreatment have been associated with an elevated risk of developing major depression, social anxiety disorder, generalized anxiety disorder, and a range of other psychiatric conditions (Gardner, 2019; King, 2021).

Prevalence of PTEs

The prevalence of PTEs within the United States is fairly high, with 60% of youth experiencing a PTE before reaching adulthood (Copeland et al., 2007; Finkelhor et al., 2005; Kerns et al., 2015). However, this experience is not exclusive to the United States with similar findings reported in studies carried out in high-, middle-, and low-income countries (Waite & Ryan, 2019). Within the United States, some populations are at a greater risk of experiencing PTEs. Children with intellectual and developmental disability (IDD) are 1.5 to 3 times more likely to experience maltreatment than their peers as these children are likely to be more dependent on adults and may have difficulty communicating their experiences of harm to others (Kerns et al., 2015).

PTEs and Autism

The ASD prevalence in the United States combined with the prevalence of concomitant intellectual disability suggests that we can infer with some confidence that autistic children are at an increased risk of experiencing PTEs as compared to neurotypical peers. Autistic children are more likely to experience aforementioned PTEs as compared to same-age peers without ASD or IDD (Kerns et al., 2015; McDonnel et al., 2019; Reiter et al., 2007). Due to social communication challenges, such as perspective taking and requesting help, being a core trait of ASD, autistic children and adults alike may be at increased risk for victimization (Allely & Faccini, 2019; Kerns et al., 2015; McDonnel et al., 2019). Additionally, 63% of autistic children meet criteria for language disorder, which may make it more difficult for them to communicate their experiences with others (Kerns et al., 2015; Levy et al., 2010). An estimated 30% of all autistic children present with little to no spoken language by the time they reach school age, many of whom may use augmentative and alternative communication (AAC) systems such as the Picture Exchange Communication System (PECS) or speech generating devices (SGDs) (Tager-Flusberg et al., 2005; Tager-Flusberg & Kasari, 2013). These additional challenges can lead to communication breakdowns with untrained communication partners who are mandatory reporters, such as teachers and physicians. Concerns about the development of TRS in autistic children is compounded as some scholarship suggests that some stressors related to ASD, such as social confusion, peer rejection, prevention and/or punishment of preferred behaviors, and sensory sensitivities may contribute to chronic stress that leads to clinically significant anxiety (Kerns et al., 2015).

Autism specific PTEs. Autistic individuals are at an increased risk of experiencing maltreatment that aligns with experiences described within the ACEs framework. However, when we think broadly about other PTEs that may result in TRS or increase the individual's risk of psychiatric conditions, other factors unique to the autistic experience must be considered. One such factor is stigma associated with autism. A two-year study on the effects of stigma in

mental health patients indicated that stigma can represent a chronic and/or recurrent source of stress for these individuals with effects that persist over time (Wright et al., 2000). Furthermore, this stress has been found to impact feelings of self-worth that individuals assigned to themselves (Wright et al., 2000). While this study was not focused specifically on the autistic population, subsequent research has found that behaviors central to ASD are stigmatized by the neurotypical population and that the terms most frequently used by the neurotypical population to describe autism were negative (Butler & Gillis, 2011; Botha & Frost, 2020; Wood & Freeth, 2016; Wright et al., 2000). Additional scholarship suggests that stigma-related factors associated with being a neurominority, such as victimization and discrimination, expectation of rejection, outness, internalized stigma, and physical concealment or masking of autism characteristics, create an added stress burden beyond those of general life stress that affects overall health, mental health, and well-being (Botha & Frost, 2020). These findings serve to illustrate that in the absence of overt PTEs, such as those within the ACE framework, autistic individuals are still likely to experience recurrent stressors and circumstances that can be perceived as traumatic and contribute to the development of TRS.

Evidence Based Interventions Addressing Support Needs of Autistic Children

There are many options to address the teaching and support needs of autistic children especially through the utilization of interdisciplinary team approaches (Cardon, 2017; Donaldson, 2014; Koenig & Gerenser, 2006). Such a team may include medical providers such as neurodevelopmental pediatricians that may be involved in assessing and treating autistic children and clinical psychologists that may be involved with the assessment process and to support treatment of co-occurring psychiatric disorders. Additional team members may include special educators, autism specialists, Board Certified Behavior Analysts (BCBAs), and speech-language pathologists (SLPs) (Donaldson, 2014; Shepley & Grisham-Brown, 2019; Wong et al., 2015; Xu et al., 2019).

Teams of these professionals may be involved in implementing applied behavior analysis (ABA), which includes a broad range of interventions focused on understanding the ways the environment affects behavior through data analysis (Donaldson, 2014; Maul et al., 2016; Volkers, 2020). ABA interventions can vary greatly, from structured and clinician-lead to naturalistic and child-lead (Hancock & Kaiser, 2012). While ABA includes many different comprehensive and focused, individualized approaches with varying levels of evidence, there are many approaches such as, but not limited to discrete trial training (DTT), functional communication training (FCT), peer-mediated instruction and intervention (PMII), social narratives (SN), and Pivotal Response Teaching (PRT) that have sufficient established evidence bases that indicate positive outcomes (Donaldson, 2014; Hampton & Sandbank, 2022; Prelock & McCauley, 2012; Wong et al., 2015).

Involvement of SLPs

SLPs are professionals that specialize in areas of communication and swallowing across the lifespan, with communication being a broad term that encompasses speech production, fluency, language, cognition, voice, resonance, and hearing (American Speech and Hearing Association, 2016). Language specifically can include spoken, written, and alternative and augmented language across five domains: (a) phonology, the study of speech sounds, (b) morphology, the study of minimal meaningful units of language, (c) syntax, the study of how words can be combined in sentences, (d) semantics, or the meaning of words and word combinations, and (e) pragmatics or social communication, the rules of language in social situations (American Speech and Hearing Association, n.d.).

Given that challenges with social communication and pragmatic language are a core characteristic of ASD, SLPs often work with this population to support their needs in these areas along with any other co-occurring language difficulties the individual may be experiencing. This can include supporting individuals in a variety of areas, ranging from articulation to the

selection and use of AAC devices or systems. SLPs may also play a role in screening, evaluating, and diagnosing autistic individuals (Schwartz & Drager, 2008).

Although working with autistic individuals falls within the scope of practice of the SLP, knowledge of ASD is varied. A study by Schwartz and Drager (2008) found that some SLPs did not demonstrate a clear understanding of the characteristics of ASD nor the diagnostic process. Additionally, they found that while the curriculum of most graduate level preprofessional programs did address ASD, little time was spent on the topic (Schwartz & Drager, 2008). However, a study by Plumb and Plexico (2013) found that SLPs that graduated after 2006 reported a greater amount of coursework related to ASD in their graduate level preprofessional programs than SLPs who graduated prior to 2006, indicating a positive shift in curricular coverage. Additionally, more recent graduates reported having opportunities to work with autistic individuals during their graduate education (Plumb & Plexico, 2013). These studies combined demonstrate growth in the field of speech-language pathology, shifts in the clients SLPs work with, and an increase in the knowledge SLPs receive regarding this population. As such, we can assume SLPs knowledge of ASD and the role they play in supporting autistic people will continue to be of importance and continue to grow.

Involvement of BCBAs

Behavior analysts, such as BCBAs are among the leading service providers for autistic children (Hampton et al., 2020; Xu et al., 2019). BCBAs are graduate-level clinicians that have been credentialed by the Behavior Analyst Certification Board that train caregivers to implement strategies, conduct behavioral assessments, and create and implement behavioral plans (Donaldson et al., 2014; Hampton & Sandbank, 2022; Maul et al., 2016; Roane et al., 2016). They may also oversee the implementation of behavioral plans by SLPs as well as by other behavior analysts, such as board-certified assistant behavior analysts (BCaBAs) and registered behavior technicians (RBTs) (Donaldson, 2014; Hampton & Sandbank, 2022; Johnston & Shook, 2001).

The title of "behavior analyst" may indicate that BCBAs work solely in the domain of behavior, however, considering that all behavior is communication and that a behavioral perspective on language learning is inherent to ABA, communication is likely to be involved in intervention plans designed by BCBAs. Furthermore, BCBAs are experts in the area of ABA and directly tie communication to their goals (Maul et al., 2016; Johnstone & Shook, 2001; Koenig & Gerenser, 2006; Roane et al., 2016).

BCBAs can work with autistic children in a variety of settings, but early intervention (EI) and early childhood special education (ECSE) settings are among the most prominent (Shepley & Grisham-Brown, 2019). Within EI and ECSE, BCBAs provide a unique perspective in supporting children in need of more intense supports. BCBAs can provide evidence-based preference assessments to identify children's interests as well as provide insight to identify the forms and functions of communicative behavior for children at any communication level (Shepley & Grisham-Brown, 2019). This information can then inform intervention, specifically the domains to be targeted in intervention and the sequence in which they will be targeted to support the child in accessing their environment in a way that is socially valid (Shepley & Grisham-Brown, 2019).

Collaboration Between SLPs and BCBAs

Both SLPs and BCBAs are involved in treating core characteristics of ASD with both fields playing a role in addressing communication and behavior. As communication and behavior are connected, especially for autistic children, it can be important for intervention to be informed by both fields to support the needs of the individual. It is important for both SLPs and BCBAs to be aware of factors in the lives of the people they work with that may affect their behavior and communication, such as PTEs and the development of TRS.

Collaborative Use of Positive Behavior Supports. Positive behavior support (PBS) is an approach used to reduce inappropriate or challenging behavior by teaching more appropriate behaviors and providing other supports as necessary (Cho Blair et al., 2011).

Assessment and implementation of PBS has traditionally fallen in the realm of psychologists, teachers, or other professionals with a background in ABA such as BCBAs; however, SLPs can be trained to support this process and are frequently part of multidisciplinary teams that implement PBS (Bopp et al., 2004; Cho Blair et al., 2011). While SLPs may not seem like obvious professionals to be involved in the use of PBS, it is important to remember that all behavior is a form of communication. Because of this, SLPs can be important team members to suggest connections between challenging behaviors and communicative intent similar to the work of BCBAs (Bopp et al., 2004; Koenig & Gerenser, 2006). In particular, when working with children with IDD and challenging behavior, a multidisciplinary approach may be of importance to use interventions related to both communication and PBS (Bopp et al., 2004). For example, should the PBS involve teaching functional communication, both SLPs and BCBAs can implement assessments to determine the child's current communication skills and appropriate communicative messages in order to inform a behavior support plan (Bopp et al., 2004).

Controversy Around ABA and Speech-Language Therapy

Although there is a strong evidence base to support the role of BCBAs and SLPs in supporting autistic children, there is some controversy around the role these providers play in the lives of autistic individuals. A survey study done by Kupferstein (2018) attempted to find correlation between TRS and experiences with ABA in autistic individuals. Based on their findings, Kupferstein (2018) reported that individuals who had been exposed to ABA had a 46% likelihood of presenting with TRS. Importantly, survey design studies are incapable of determining whether a causal relation exists between receipt of ABA based interventions and self-reported TRS. While questions about the methodology of this study and the conclusion it draws,despite its numerous shortcomings, this study is widely cited by some within the autistic community that argue that ABA is abusive and leads to negative effects (Leaf et al., 2018; Leaf et al., 2021). It is important to recognize that these perspectives on treatment are out there, whether deserved or not, especially if our definition for trauma and PTEs is based on the

individual's perception of threat during an event, series of events, or set of circumstances (Gardner et al., 2019; King, 2021; Kerns et al., 2015; Leaf et al., 2021; SAMHSA, 2014).

Statement of Problem

Given the prevalence of PTEs for autistic children and the need for trauma-informed care, professionals that are commonly involved in service provision for educational and medical needs of ASD (e.g., social communication, adaptive behavior) but are not directly involved in addressing the effects of trauma (e.g., PTSD and other trauma-related disorders, depression, anxiety), such as SLPs and BCBAs, may benefit from guidelines on supporting autistic individuals that may present with trauma symptoms in order to provide trauma-informed practices across disciplines.

The purpose of this modified Delphi-closed study is to develop a set of evidence-based guidelines developed through expert consensus that SLPs, BCBAs, and other professionals with similar scope of practice can use for supporting individuals with ASD and their families who may have experienced trauma before or during therapy within the scope of their own practice and professional ethical guidelines. Guidelines like these can provide practicing professionals with a means of self-evaluating their own practices and that of their clinics for meeting trauma-informed care principles while adhering to research-based assessments and interventions within the provider's scope of practice.

Chapter 2: Literature Review

In order to support autistic children within the scope of SLPs and BCBAs, we must first review what resources are available for addressing the needs of this population. First, it is important to discuss the discourse surrounding identification and screening for PTEs. Trauma-informed care (TIC) is a framework that may be of benefit to SLPs and BCBAs in supporting autistic individuals who have experienced PTEs. In this section, we will define different definitions of this framework, discuss how it supports providers and systems in addressing the needs of clients while not directly treating trauma, and discuss how principles of TIC intersect with existing practices within the scope of SLPs and BCBAs. Barriers to implementation of these principles will also be reviewed.

Identification of PTEs/Trauma Screening

Screening for PTEs generally involves asking patients about their experiences with the traditional 10 ACEs (Finkelhor, 2018). When working with children or adults with limited language skills, caregivers may report presence of ACEs during the intake process. A universal screening for ACEs may only take about 10 minutes and parent reports suggest such screeners are acceptable and helpful (Watson, 2019).

Despite the availability of ACEs screeners, a universal screening may not be recommended. First, screening for ACEs may come across as intrusive and uncomfortable for clients and contribute to feelings of stigmatization, thus disrupting the development of a therapeutic alliance between the client and the service provider (Finkelhor, 2018). Additionally, there is no evidence that suggests that opening up about PTEs will be beneficial for children and may contribute to retraumatization (Finkelhor, 2018).

Furthermore, as discussed above, the presence of PTEs does not mean that trauma-related symptoms are present (Finkelhor, 2018; Kerns et al., 2015). Given these factors, a screening tool for TRS may be recommended (Allely & Faccini, 2020; Finkelhor, 2018; Kerns et al., 2015). However, there currently is not an appropriate reliable and valid tool available that

Table 1

Summary of Trauma-Informed Care Principles

SAMHSA's (2014) Key Assumptions	SAMHSA's (2014) Key Principles	Rajaraman et al., (2021)
	Safety	Ensure safety and trust
	Trustworthiness and transparency	
	Collaboration and mutuality	Promote choice and shared governance
	Empowerment, voice, and choice	
		Emphasize skill building
Realize widespread effects of trauma and paths for recovery	Cultural, historical, and gender issues	
Recognize signs and symptoms of trauma in clients, families, and staff		Acknowledge trauma and its potential impact
Respond by integrating knowledge about trauma into policies, procedures, and practices		
Actively resist re-traumatization		

clinicians can use to screen for these symptoms that has been normed on autistic individuals (Allely & Faccini, 2020; Kern et al., 2015). To date, extant research does not support the commonplace use of ACEs or PTE screeners with this population.

Principles of Trauma-Informed Care

TIC is an overarching framework intended to guide service provision at a system-wide level to guide care provided to all clients by the entire professional team (Goodman et al., 2016; Kildahl et al., 2019). It is an approach to treatment that represents trauma knowledge, recognition, response, and skills; however, TIC is not narrowly defined and can differ greatly across child-service systems depending on provider knowledge, skills, and ability to identify and treat trauma (Donisch et al., 2016; Goodman et al., 2016). It is important to note that providing TIC does not mean that the practices being implemented are treating trauma directly. As many individuals that receive treatment for behavioral health challenges such as trauma symptoms

receive other services, this framework can be applied by professionals across services to communicate about how to support service recipients and to support individuals' ability to manage PTEs and TRS (Substance Abuse and Mental Health Services Administration, 2014).

While there are many differences in how service providers view TIC, we can begin to define principles of this practice based on guidelines set out by the Substance Abuse and Mental Health Services Administration (see Table 1; SAMHSA, 2014). SAMHSA (2014) outlines four key assumptions of programs, organizations, and systems providing TIC. First, it is assumed that in a system providing TIC, all people at all levels within that system possess a basic realization and understanding of trauma and its effects on individuals, families, organizations, and communities (SAMHSA, 2014). This includes a basic knowledge of trauma, PTEs, TRS, and the role that different service provision systems play in supporting clients and families who have experienced trauma (SAMHSA, 2014). Second, it is assumed that all people within the system are able to recognize signs of trauma, whether through staff training or screening and assessment for TRS (SAMHSA, 2014). Third, it is assumed that the system is responsive in its application of TIC principles to all areas of functioning, from direct service provision to program policies (SAMHSA, 2014). Finally, it is assumed that the system will actively resist re-traumatization of clients and staff by promoting a low stress environment and avoiding practices that may trigger TRS and inhibit client recovery (SAMHSA, 2014).

Beyond these basic assumptions, SAMHSA (2014) outlines six principles of TIC: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues (see Table 1). In this framework, safety means that all parties, including clients, families, and staff feel physically and psychologically safe (SAMHSA, 2014). Trustworthiness and transparency support the establishment of rapport and strengthening of the therapeutic alliance. The principles of collaboration and mutuality as well as empowerment, voice, and choice emphasize the role that clients play as collaborators and self-advocates in the therapeutic process and encourages a

client- and family-centered treatment approach (SAMHSA, 2014). Peer support encourages supporting the development of "mutual self-help" with others who have experienced PTEs (SAMHSA, 2014, p. 11). Acknowledgement of cultural, historical, and gender issues involves understanding the historical inequalities, stereotypes, and biases some groups may have experienced especially within the system providing care and actively seeking to address those inequities (SAMHSA, 2014).

Trauma-Informed Care for Autistic Individuals and Individuals with IDD

As highlighted previously, individuals with IDD are at increased risk for exposure to PTEs creating a need for TIC for this population. However, there is a lack of research on TIC for autistic individuals and individuals with IDD, with existing literature varying in the way it uses terminology and reports on trauma depending on the discipline it is associated with (Cook et al., 2021). This has similarly led to a lack of knowledge and training for providers working with autistic individuals with IDD, which can make it difficult for this population to access services (Kildahl et al., 2019).

Identification of PTEs and TRS in this population presents with unique challenges. Reliance on client self-reports of PTEs may lead to underrepresentation of TRS as autistic individuals and/or individuals with IDD may experience difficulty disclosing this information (Kildahl et al., 2019). This could be due to multiple reasons, such as challenges with expressive language or challenges with perspective taking that impact the individual's ability to understand the importance of disclosing trauma (Kerns et al., 2015; Levy et al., 2010; Tager-Flusberg et al., 2005; Tager-Flusberg & Kasari, 2013). Additionally, as previously noted, screening for PTEs may be viewed as intrusive and uncomfortable for both clients and caregivers and disrupt the development of a positive therapeutic relationship (Finkelhor, 2018). Given this, screening for PTEs is likely to be insufficient for identifying trauma within this population.

Additionally, screening for TRS comes with its own set of challenges. Kildahl et al. (2019) reported that mental health professionals found that diagnoses of both ASD and IDD influence

expression of TRS with considerable variation across all individuals. As such, there currently is no way to define what ASD- and/or IDD-specific TRS look like. Part of the challenge in this area is related to how TRS present in this population. Some behaviors, such as increased perseveration, rigidity, and avoidance, can be indicative of either TRS or ASD, making it difficult to discern the root cause of the behavior (Allely & Faccini, 2020). Furthermore, TRS in this population may present as increased severity of ASD related characteristics, such as decrease in functional language use and increased rigidity, following a PTE (Kildahl et al., 2019). TRS may also appear more severe in this population as they may have fewer resources and coping strategies as compared to the general population (Kildahl et al., 2019). The addition of other co-occurring psychiatric conditions adds another layer of complexity as it can be even more difficult to determine what is contributing to presenting symptoms (Kildahl et al, 2019).

Given this, Kildahl et al. (2019) reported that detection of PTEs in this population requires service providers to focus specifically on it, summarized by the quote "If we do not look for it, we do not see it" (p. 1123). Identifying trauma requires multidimensional assessments, consideration of a broad range of PTEs outside of the traditional ACEs to include experiences that are specific to these populations, and increased awareness of how TRS may present (Kildahl et al., 2019).

Prior scholarship has identified a need for an observation-based assessment tool to identify TRS in autistic individuals and/or individuals with IDD (Allely & Faccini, 2020; Kildahl et al., 2019). Currently, screenings for TRS typically do not rely on formal standardized assessments, with clinicians opting for informal assessments and clinical judgement when screening (Kerns et al., 2019). Tools that have been developed so far focus on assessing changes in behavior, including changes to verbal communication, behavioral challenges, restrictive and repetitive behaviors, and adaptive skills (Fletcher et al., 2007; Mehtar & Mukaddes, 2011). The procedure recommended by the Diagnostic Manual-Intellectual Disability (DM-IDD; Fletcher et al., 2007) can be used to identify and understand trauma in males with ASD by identifying PTEs

and assessing changes in functioning after exposure to the event(s) rather than identifying the presence or absence of typical trauma-related symptoms (Allely & Faccini, 2020). While this research is limited to autistic adult males without IDD, the lack of research in this area suggests that this model is the current best practice for identifying the effects of trauma for autistic children (Allely & Faccini, 2020). However, with this lack of research, it may be more beneficial for clinicians to assume all clients require a trauma-informed approach to treatment in order to avoid retraumatization and monitor for changes in behavior that may indicate TRS, rather than using a screening tool to identify the presence of PTEs or TRS.

Professionals Involved in Trauma Treatment

Many different professionals can be involved in treating trauma directly. Most obviously, those in the mental health field such as psychotherapists, clinical psychologists, and psychiatrists are likely to play a role in treatment using treatment methods such as cognitive behavior therapy (CBT) or eye movement desensitization and reprocessing (EMDR) (Cook et al., 2021; Kildahl et al., 2019). Additionally, other medical professionals such as nursing staff and those in the justice and welfare fields may play a role in trauma treatment as well (Cook et al., 2021; Kildahl et al., 2019).

Professionals Involved in Intervention for Autistic Children and Those with IDD

Many of the aforementioned providers are likely to play a role in addressing symptoms associated with ASD and/or IDD as well. Those in the mental health and medical field, such as clinical psychologists and developmental pediatricians, may be involved in identifying and diagnosing ASD and/or IDD as well as treating co-occurring conditions. A wide range of other professionals may be involved as well, ranging from general and special education teachers, occupational therapists (OTs), physical therapists (PTs), BCBAs, and SLPs (Donaldson, 2014; Kerns et al., 2019; Wong et al., 2015; Xu et al., 2019).

Role and Knowledge of SLPs and BCBAs in Implementation of TIC

Although SLPs and BCBAs are often involved in working with populations with a high likelihood of being exposed to PTEs, there is varying knowledge among professionals in these fields about TIC. Kerns et al. (2019) conducted a survey to determine how frequently different disciplines screen and treat trauma and to determine professionals' perceptions of the need for TIC and barriers to service provision. Of the providers surveyed, about 21% were allied health professionals such as OTs, PTs, and SLPs and 16% were behavior analysts (Kerns et al., 2019). Results of this survey revealed that the majority of respondents did inquire about TRS as part of their practice and that they believe TIC is important (Kerns et al., 2019). However, most of the respondents also indicated that more education and training on this topic is necessary (Kerns et al., 2019).

More recently, acknowledgements and education in regard to TIC in the field of behavior analysis has grown. Rajaraman et al. (2021) identified barriers to implementation of TIC in ABA practices and outlined guidelines for implementation. Barriers identified in this article included primarily a lack of education and training (Rajaraman et al., 2021). More specifically, these authors indicated that there may be some confusion among behavior analysts around the conceptualization and definition of trauma and how that information can be applied to their interventions (Rajaraman et al., 2021). Challenges here can be difficult to overcome as most approaches in behavioral analysis focus on causes in a short timescale while effects of trauma can persist long after the event (Rajaraman et al., 2021). The lack of current evidence within the literature also serves as a barrier to implementation (Rajaraman et al., 2021). Although there are a number of publications that discuss trauma-informed approaches and advocate for the need and potential benefits for such approaches within systems such as school, there are currently no rigorous peer-reviewed randomized control trials or quasi-experimental studies that investigate these potential benefits in depth (Maynard et al., 2019). This lack of research is largely due to how recent the adoption of trauma-informed approaches is and other barriers to research such

as lack of funds and the inherent complexity of studying widespread effects of implementation within a system (Maynard et al., 2021). These factors combined mean that the creation of data informed practice guidelines is not currently supported (Maynard et al., 2021; Rajaraman et al., 2021).

Rajaraman et al. (2021) outlined four practice guidelines for implementing TIC within the discipline of behavior analysis: (a) acknowledge trauma and its potential impact, (b) ensure safety and trust, (c) promote choice and shared governance, and (d) emphasize skill building (see Table 1). Acknowledging trauma means to recognize that current behaviors may be ways of adapting to and coping with past traumatic experiences (Rajaraman et al., 2021). This includes acknowledging that stimuli in the current environment may share properties with those present during the initial PTE and thus may act as antecedents for behavior (Rajaraman et al., 2021). Similar to the SAMHSA (2014) guidelines, ensuring safety and trust acknowledges that both physical and emotional safety required to ensure client's needs are being met and provider's responses are respectful and consistent (Rajaramen et al., 2021). More broadly, safety may include creating an environment that signals to the client that there will be predictable periods without aversive stimulation, such as unpredictable threats and uncertainty (Rajaramen et al., 2021). Promoting choice can include providing and promoting choice in order to support clients in regaining a feeling of control over their lives (Rajaraman et al., 2021). Shared governance can be defined as creating a therapeutic environment in which all participants have a seat at the table; that is to say that clients get an equal say as collaborators in treatment, similar to SAMHSA's (2014) guideline on collaboration and mutuality (Rajaramen et al., 2021). Finally, emphasizing skill building can be thought of as the ways behavior analysts can emphasize empowerment for clients and families through acquisition of adaptive behavior and through positive relationships that support further learning and skill development (Rajaramen et al., 2021).

In practice, these guidelines should create a framework that allows clients to opt in or out of therapy or intervention, placing the responsibility on the clinician to create an environment the client feels safe and secure in (Rajaraman et al., 2021). Along this line, service providers should actively avoid integrating any features into their programming that could trigger a trauma response (e.g., reduce physical prompting for compliance, provide attention in other contexts instead of solely extinguishing attention gaining behavior) (Rajaraman et al., 2021). Emotional responses and presentation of TRS should also be monitored at different aspects of the treatment process in order to inform future programming (Rajaraman et al., 2021).

Crossover between TIC and other disciplines

There are similarities between currently existing practice guidelines for TIC, but these guidelines are also similar to intervention approaches that currently exist within the fields of speech-language pathology and behavior analysis. While a trauma-informed approach does warrant education and training throughout the system, there are currently intervention models and packages used by both SLPs and BCBAs that align with principles of TIC.

For example, one such intervention is enhanced milieu teaching (EMT). EMT is a naturalistic developmental behavioral intervention (NDBI) approach used to target social communication skills in autistic children (Ingersoll, 2010; Hancock et al., 2016). Strategies of this intervention are largely centered on following the child's lead (Hancock et al., 2016). The adult (e.g., clinician, parent, teacher, etc.) mirrors and expands on the child's productions, but also responds to their behaviors in order to promote self-regulation and create a positive learning environment that the child feels safe and ready to learn in (Hancock et al., 2016). EMT is often play-based to focus the intervention around the child's interests (Hancock et al., 2016).

EMT has shown some positive effects for children at risk for exposure to PTEs (Peterson et al., 2005). A single-case multiple baseline design study demonstrated that parents in families with multiple risk factors (e.g., low socioeconomic status, minority status, single parent, high life

stress, chronic challenges such as parental mental health challenges, etc.) were able to acquire and maintain EMT skills, resulting in positive language outcomes for children with language delays (Peterson et al., 2005). However, extra support was needed for all families that participated in this study, such as teaching parents additional strategies to support language use (Peterson et al., 2005). Additionally, extra support throughout the week was recommended by the researchers to better support the families in following through on at-home implementation while continuing to navigate external disrupting factors (Peterson et al., 2005).

Pivotal Response Treatment (PRT) is another example of an intervention that aligns with TIC. This NDBI focuses on taking advantage of pivotal areas of growth (i.e., motivation, self-initiations, responding to multiple cues, and self-management) in order to affect multiple aspects of behavior (Koegel et al., 2006; Verschuur et al., 2014). Similar to EMT, strategies such as following child lead, providing and encouraging choices, responding to all communication attempts, and providing treatment within a safe, naturalistic context (Koegel et al., 1999; Verschuur et al., 2014).

EMT, PRT, other similar NDBIs, and other child-lead interventions used by both SLPs and BCBAs inherently align with principles of TIC such as ensuring safety and trust, promoting choice, and emphasizing collaboration and skill building especially if parents are being taught to implement the intervention. While these factors contribute to creating a strong client- and family-centered treatment approach, they do not create a trauma-informed approach to intervention by themselves. Both SAMHSA (2014) and Rajaraman et al.'s (2021) guidelines for TIC require acknowledgement and understanding of trauma and its effects on the client and their family. Without this component, clinicians cannot practice TIC.

Barriers to Implementation

As highlighted by Rajaraman et al. (2021), one persistent barrier to implementation of TIC is the lack of rigorous empirical evidence to support the creation of practice guidelines. Currently, research of TIC focuses on interventions and practices for those who have

experienced a trauma response, such as a trauma-related disorder, or on examining symptoms and impacts of trauma (Cook et al., 2021). Some literature additionally incorporates domains of changing organizational policies; trauma screening, assessment, and treatment services; training and workforce development; cross sector collaboration; and engagement and involvement (Cook et al., 2021). However, a need for more research on cross-system collaboration, professional development and trainings for staff, and involvement of clients was highlighted in literature reviewed (Cook et al., 2021; Kerns et al., 2019). Overall, there is little information available for providers that work with populations at high risk of experiencing PTEs, but do not actively treat trauma (Kerns et al., 2019).

Purpose of Study

The purpose of this modified Delphi-closed study is to create evidence-based practice guidelines that can be used by SLPs and BCBAs to purposefully practice TIC, engage in self-reflection on use of TIC strategies, and advocate for systemic changes to promote TIC when working with autistic children and their families within their clinical settings given the prevalence of PTEs for this population and the frequency in which these professionals work with autistic children. These guidelines may provide practicing professionals with the means of self-evaluating their own practices and practices within their clinical settings for adherence to TIC principles within the provider's scope of practice.

Chapter 3: Methods

The Delphi Method

The Delphi method was originally developed in the 1950's by the Rand Corporation to forecast the impact of technology on warfare; however, it has since been applied to many different fields including education, health sciences, and speech-language pathology (Dalkey & Helmer, 1962; Evans et al., 2014; Izaryk & Skarakis-Doyle, 2017; Keeney et al., 2010). This method is used in survey studies in order to gain consensus among a group of experts in any given field by avoiding the shortcomings of face-to-face group deliberations (Dalkey & Helmer, 1962; Kenney et al., 2010). Consisting of a multi-stage survey, the Delphi method involves sending a series of questionnaires to participating experts with feedback being provided between rounds of surveys in order to gain consensus on an issue where there previously was none (Dalkey & Helmer, 1962; Keeney et al., 2010).

There are many different forms of the Delphi method currently in existence, such as the "modified Delphi" which combines some aspects of face-to-face group discussion with the anonymous iterative survey of the traditional Delphi method (Keeney et al., 2010; Schofield et al., 2018). Furthermore, no uniform method of the Delphi exists (Boulkedid et al., 2011; Keeney et al., 2010). There is currently no consensus of what consensus means while using the Delphi method nor are there specific guidelines on how many participants are required to create generalizable consensus (Boulkedid et al., 2011; Izaryk & Skarakis-Doyle, 2017). Guidelines for the Delphi method differ on the field of study and the research objective, with studies aiming to attain group support having several hundred participants from many different backgrounds and studies aiming to gain consensus from more homogeneous groups having only ten to twenty participants (Evans et al., 2014; Izaryk & Skarakis-Doyle, 2017). The design and procedures of the proposed study follow current best practices in education and healthcare where possible (Berglund et al., 2017; Evans et al., 2014; Izaryk & Skarakis-Doyle, 2017; Jiménez-Rodríguez et al., 2020; Stevens Smith et al., 2020).

Research Team

Members of the research team included a second-year graduate student with six years of experience working with autistic individuals and individuals with IDD through academic coursework and prior employment in addition to completing an undergraduate thesis focused on sibling-mediated intervention for children with ASD. Other members of the research team included an autistic special education doctoral student with one year of experience as a licensed special education teacher and three years of experiences as a behavior interventionist in a public school setting and a faculty member in special education who has worked with autistic youth as a BCBA for a total of 25 years of experience working with autistic youth and has published 93 peer-reviewed articles related to behavior analysis.

Participants

Delphi Panel Selection

Participants for the Delphi panel, referred henceforth as the panelists, were selected by the researcher using a non-probability sampling strategy combining convenience sampling and snowballing (Handcock & Gile, 2011). Screened panelists were invited to recommend additional panelists to the research team for consideration. Recruitment aimed to obtain five panelists holding their CCC-SLP, five panelists holding their BCBA or BCBA-D, and five panelists who were Licensed Clinical Psychologists for a total of 15 participants overall. Potential panelists were selected based on a literature review of trauma-informed care and faculty expert recommendation.

Each potential panelist was selected based on evidence of the following as documented by the professional's CV and their response to an initial demographic survey developed by the researcher: (a) active professional certification or licensure (SLP-CCC, BCBA, BCBA-D, LCP) or the equivalent if employed outside of the United States; (b) at least three years post graduate experience serving autistic children and/or youth with autism spectrum disorder diagnosis in early intervention, public or private pK - 12 school or clinical/healthcare setting; (c) non-tenure

track, research, and tenure-track faculty employed at university and research active practitioners holding the Doctorate; (d) has authored or co-authored a minimum of 12 publications on issues related to child or youth with autism or trauma-informed practices in pediatrics in peer-reviewed journals; (ec) reported at least one year experience supervising students or persons completing supervised experience requirements for professional licensure; and (f) reported fluency in reading, and writing in English. Panelists could be Ph.D. level with a current position of (a) career non-tenure track, research faculty, or tenure-track faculty employed at university and/or research active practitioners and (b) having authored or co-authored a minimum of four publications on issues related to child or youth with autism or trauma-informed practices in pediatrics in peer-reviewed journals or a Masters level professional who self-identified as autistic themselves or otherwise neurodiverse (e.g. attention deficit hyperactivity disorder; ADHD, obsessive compulsive disorder; OCD).

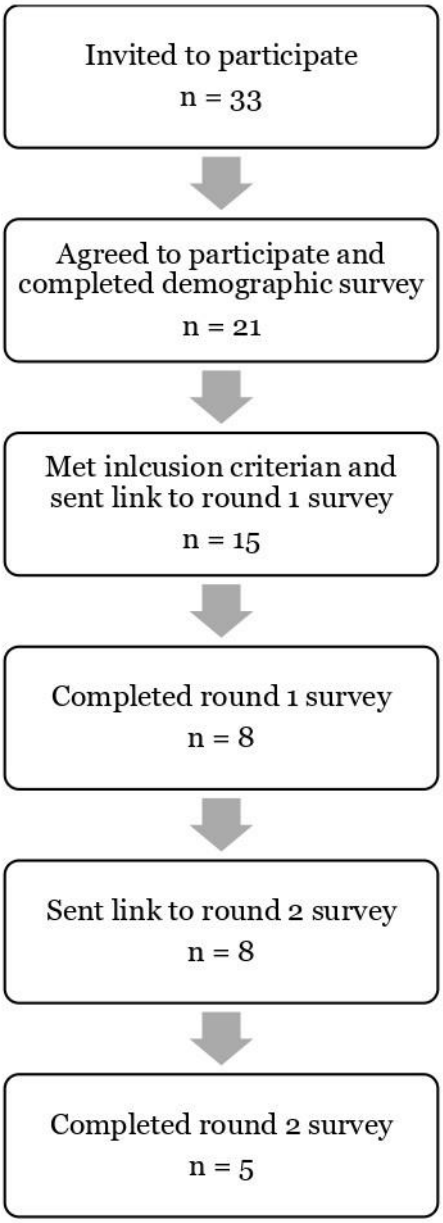
Demographic Information

Thirty-three individuals were emailed an invitation to participate with additional recruitment occurring via social media. Five (15.2%) of the invited individuals were SLPs, five (15.2%) were psychologists, 15 (45.5%) were behavior analysts, two (6.1%) were dual-certified BCBAs and Licensed Clinical Psychologists (LCPs), and five (15.2%) were dual-certified BCBAs and SLPs. Twenty-one individuals responded to the initial demographic survey which was completed between March 21, 2022 and April 6, 2022 through Qualtrics (https://www.qualtrics.com). This survey consisted of both closed and open ended questions that allowed reporting of age, gender, active professional licensure and years since first licensed, years post graduate experience serving autistic children, primary and secondary setting of their current practice/research (early intervention, public or private school or clinical/healthcare setting), current position, and number of current peer-reviewed publications related to child or youth with autism or trauma-informed practices in pediatrics in peer-reviewed journals. Participants were additionally asked to indicate if they self-identified as autistic, either with or

without an official diagnosis, in order to identify if opinions of autistic individuals were being included in survey results. The decision to include those who identify as autistic but do not have an official diagnosis was made to ensure that all who identify in some part as a member of the autistic community could have their perspective included regardless of access to a diagnosis as has been done in previous studies (Botha & Frost, 2020; Kapp et al., 2013).

Figure 1

Flowchart of Delphi Study Participants



Based on the information provided by the 22 individuals, 15 (71.4%) potential panelists met inclusion criteria and were emailed a link for the round one survey (see). Of the final panelists invited to participate, two (13.3%) were SLPs, nine (60.0%) were behavior analysts, one (6.7%) was an LCP, two (13.3%) were non-licensed psychologists holding a Ph.D., and one (6.7%) held certifications in both speech-language pathology and behavior analysis (see). Twelve (80.0%) panelists listed Ph.D. as their highest degree earned and three panelists (20.0%) listed Master's degree as their highest degree earned (see Table 2). Three (20.0%) panelists indicated that they currently work in a clinical/healthcare setting, one (6.7%) in a public or private school pre-K to 12th grade school, 10 (66.7%) in a

Table 2

Sociodemographic Characteristics of Participants

Characteristic	*n*	%
Gender		
Women	6	75.0
Genderqueer/Nonbinary	1	12.5
Prefer not to reply	1	12.5
Identify as autistic, person with autism, or neurodivergent		
Yes (diagnosed)	1	12.5
No	7	87.5
Highest degree earned		
Master's degree	1	12.5
Ph.D. or higher	7	87.5
License		
CCC-SLP	1	12.5
BCBA/BCBA-D	4	50.0
BCaBA	1	12.5
Both CCC-SLP and BCBA/BCBA-D	1	12.5
Non-practicing psychologist	1	12.5
Current setting		
Public or private PK-12 school	1	12.5
University (e.g., clinic, teaching, or research faculty)	6	75.0
Other	1	12.5

university (e.g., clinical, teaching, or research faculty), and one (6.7%) in some other setting. Four (26.7%) panelists participants indicated that they identify as autistic, a person with autism, or neurodivergent (see Table 2). The mean number of peer-reviewed publications related to autistic children authored or co-authored by participants panelists was 33.3 (SD = 41.2; see). The mean number of peer-reviewed publications related to TIC in pediatrics authored or co-authored by participants was 4.63 (SD = 10.4; see Table 3).

Procedures

Development of the Initial Survey

A two-round modified group Delphi-Closed study design (van Zolingen & Klaassen, 2003) was used to refine the trauma-informed practice guidelines drafted following a review of the literature. The thesis committee and five doctoral students with experiences and licensures relevant to the inclusion criteria for panelists (i.e. BCBAs, SLP with experience with autistic children) served as a working group to pilot the round one survey prior to its release to the

Table 3

Number of Peer Reviewed Publications Authored or Co-Authored by Participants

Topic	*M*	*SD*	Range
Autistic children	33.3	41.2	1-103
TIC in pediatrics	4.63	10.4	0

panelists in order to approximate completion time for the survey, to remove redundant survey items, and to clarify wording. Following revision of the survey, all survey rounds were distributed to panelists using Qualtrics survey software (https://www.qualtrics.com).

Round One

Following the survey pilot, a 47-item survey with 188 questions was compiled. Based on piloting, the survey was anticipated to take 50 minutes to complete during round one. Items were divided into six areas: (1) awareness of trauma and TRS, (2) acknowledge trauma and its potential impact, (3) prioritize client and therapist safety and therapist-client trust, (4) promote choice and collaboration, (5) cultivate self-determination and encourage empowerment, and (6) intervention is neurodiversity affirming (see Appendix A). Following presentation of each item on a single screen, panelists were asked whether the displayed item should be included in the final practice guidelines as is and instructed to answer with a "yes" or "no". Panelists were then asked to indicate how important they believed each item was for inclusion on a 5-point Likert scale, with a score of 1 indicating "very unimportant" and a score of 5 indicated "very important". Panelists were also asked to provide any written feedback necessary to indicate how each item should be reworded to be improved and what other considerations the panelist wished to draw attention to for further consideration.

Round Two

Following the analysis of results from the first round, 21 items were selected to remain for the second-round survey which were reworded based on qualitative feedback from the

panelists (see Appendix B). Participants were asked to answer the same questions for each item following the aforementioned wording described in the first survey round.

Compensation

For each survey round, one respondent was randomly selected to receive a $200 Visa gift card as compensation for participation.

Analysis

For each survey round, the response rate was calculated. SPSS was used to calculate measures of central tendency (i.e., mean, median, mode, and standard deviation) for each survey item on inclusion as is and perceived importance. Items with at least a 70% consensus across respondents on the question of inclusion as indicated by a dichotomous "yes" or "no" response and a mean rating of 4 or higher on the question of importance were considered to have achieved consensus for inclusion. As such, they carried over to the final guidelines and were not re-presented in round two of the survey, because these items had already achieved consensus. For the remaining items (which included those items meeting one aspect of the criteria, but not the other), the research team met as a group to review the open-ended item responses to identify potential themes and/or items to explore in the following round and discussed the resultant themes, confirming and disconfirming evidence. Across multiple survey rounds, the consistency of inter-rater agreement between panelists across survey rounds was examined and Fleiss' kappa scores were reported to provide between subject agreement scores as a measure of consistency in agreement (Fleiss, 1971; Fleiss et al., 2003).

Chapter 4: Results

The guidelines initially developed for the purpose of the Delphi study consisted of 47 items, which were divided into six areas: (1) awareness of trauma and TRS, (2) acknowledge trauma and its potential impact, (3) prioritize client and therapist safety and therapist-client trust, (4) promote choice and collaboration, (5) cultivate self-determination and encourage empowerment, and (6) intervention is neurodiversity affirming. The resultant round one survey consisted of 47 items and was anticipated to take 50 minutes to complete.

Round One

Of the 15 panelists who consented to participate and agreed to the timeline for completion, eight (53.3%) responded to the first survey round (see Figure 1). For this round, items with at least a 70% consensus across panelists on the question of inclusion as indicated by a dichotomous "yes" or "no" response and a mean rating of 4 or higher on the question of importance were considered to have achieved consensus for inclusion. Based on this criteria, 26 (55.3%) of the survey items were marked for inclusion in the final guidelines while 21 (44.7%) of the items were selected to remain in the survey for the second round (see Table 4). Furthermore, two (50.0%) items were marked for inclusion within area 1, three (50.0%) items were marked for inclusion within area 2, nine (56.3%) items were marked for inclusion within area 3, five (71.4%) items were marked for inclusion within area 4, three (75.0%) were marked for inclusion within area 5, and three (37.5%) were marked for inclusion within area 6 (see Table 5).

All eight panelists provided qualitative responses to the open-ended questions "How should the above item be reworded to be improved?" and "What other considerations should the researchers be aware of?". A review of responses to open-ended questions for the remaining twenty-one items indicated a need for clarification on the use of identity-first versus person-first language throughout the survey. Additionally, panel respondents noted a need to clarify the

Table 4

Inclusion Percentages and Central Tendency Measures on Importance of Item Inclusion for Round 1

Item Number	Include as is %	Item Importance			
		M	*SD*	Median	Mode
(1) Awareness of trauma and trauma-related symptoms					
(1a) Therapist has knowledge of the definition of adverse childhood experiences (ACEs) (i.e., sexual abuse, verbal/emotional abuse, physical abuse, emotional neglect, physical neglect, having a caregiver who experiences mental health challenges, caregiver substance abuse, having a caregiver who is a victim of domestic violence, incarceration of a family member, and loss of a caregiver due to divorce or abandonment).	77.8	4.50	.354	5.00	5.00
(1b) Therapist has knowledge of how ACEs may contribute to trauma-related symptoms.	*55.6*	*4.00*	*1.19*	*4.50*	*5.00*
(1c) Therapist acknowledges that other community stressors that are not considered under the definition of ACEs (e.g., experiences with poverty, peer rejection, poor school performance, community violence, belonging to a neurominority) can contribute to chronic stress and the development of trauma related symptoms.	87.5	4.43	.786	5.00	5.00
(1d) Therapist is aware that trauma-related symptoms in autistic children may present differently than in non-autistic children.	*87.5*	*3.75*	*.707*	*4.00*	*4.00*
(1e) Therapist is aware that trauma-related symptoms in autistic children are likely to present as changes to behavior (e.g., verbal communication, behavioral challenges, adaptive skills) and changes to autism-related symptoms (e.g., perseveration, rigidity, avoidance)	*50.0*	*3.71*	*.756*	*4.00*	*3.00*
(1f) Therapist collaborates with other members of the client's intervention team that may be involved in evaluating and/or treating trauma directly (e.g., clinical psychologists) as is appropriate.	87.5	4.25	.886	4.50	5.0

Table 4, continued

Item Number	Include as is %	Item Importance *M*	*SD*	Median	Mode
(2) Acknowledge trauma and its potential impact					
(2a) Therapist acknowledges that autistic clients may have experienced trauma even if trauma history has not been disclosed to the therapist.	*75.0*	*3.86*	*.690*	*4.00*	*4.00*
(2b) For clients who have a known trauma history, the therapist carefully considers potentially contraindicated procedures and seeks to minimize potential risks and maximize potential benefits (e.g., for clients who have experience prior food insecurity the use of edible reinforcers is potentially contraindicated).	*50.0*	*3.75*	*1.04*	*4.00*	*4.00*
(2c) During therapy sessions, therapist monitors for behavior and emotional states suggesting assent and positive engagement such as smiling, laughing, spontaneous requests, and positive message communication acts.	71.4	4.13	.991	4.50	5.00
(2d) During therapy sessions, therapist monitors for adverse reactions, such as not attending to therapy sessions, lack of engagement in therapy activities, intense emotional responding and/or avoidant or aggressive behaviors before, during, or after sessions.	71.4	4.25	1.16	5.00	5.00
(2e) If the therapist observes adverse reactions associated with stimuli in the therapeutic environment (e.g., physical prompting), the therapist engages autistic client and caregiver(s) (when relevant) in problem solving to change procedures.	*62.5*	*4.17*	*1.17*	*4.50*	*5.00*
(2f) Therapist routinely asks autistic client and caregiver(s) (when relevant) about and monitors for changes to emotional, social, physical, and adaptive functioning as these may be indicative of trauma-related symptoms or other healthcare needs.	75.0	4.43	.787	5.00	5.00
(3) Prioritize client and therapist safety and therapist-client trust					
(3a) Therapist ensures everyone (i.e., client, caregiver(s), clinicians, staff) is safe from unwanted physical touch within the clinical environment.	87.5	4.50	.756	5.00	5.00

Table 4, continued

Item Number	Include as is %	Item Importance *M*	*SD*	Median	Mode
(3b) Therapist provides choices the autistic child with choices for seating arrangements and permits flexibility.	75.0	4.13	.641	4.00	4.00
(3c) Therapist works to minimize environmental stimuli that autistic clients and their caregiver(s) have communicated as uncomfortable and/or associated with feelings of danger.	100	4.38	.744	4.50	5.00
(3d) Therapist proactively and routinely asks autistic clients and their caregiver(s) (when relevant) to let the therapist know at any time if they feel uncomfortable with the goals, procedures, or outcomes of the treatment plan.	*62.5*	*3.86*	*1.07*	*4.00*	*4.00*
(3e) To foster client feelings of safety and trust, therapist begins therapy with new clients and caregiver(s) (when relevant) with a goal of building therapeutic rapport through non-contingent reinforcement (e.g., reinforcement provided independent of client behavior), client preferred activities and materials, etc.	87.5	4.13	.835	4.00	4.00
(3f) Therapist uses skills to encourage therapeutic rapport (e.g., eye contact, muscles of facial expression, posture, affect, tone of voice, hearing the whole client, your response) such as those outlined in the E.M.P.A.T.H.Y. framework.	*50.0*	*3.60*	*1.14*	*4.00*	*4.00*
(3g) Therapist prioritizes voluntary client engagement, physical, and emotional safety.	*62.5*	*3.86*	*1.21*	*4.00*	*5.00*
(3h) Therapist regularly assesses clients for unintended harmful physical and/or social emotional effects of any intervention.	75.0	3.86	.900	4.00	3.00
(3i) Therapist regularly discloses observations (e.g., indicators of harmful physical and/or social emotional effects of intervention) to the client and caregiver(s) (when relevant) in a timely fashion so that changes can be made to intervention procedures.	87.5	3.63	.916	4.00	4.00
(3j) Therapist collaborates with client and caregiver(s) when relevant to clarify roles and expectations for all parties involved (i.e., therapists, client, caregiver(s), other members of the intervention team) throughout the treatment process.	75.0	4.29	.756	4.00	4.00

Table 4, continued

Item Number	Include as is %	Item Importance *M*	*SD*	Median	Mode
(3k) Therapist explains rationale for their intervention decisions and procedures to client and caregiver(s) (when relevant) in order to allow them to make informed decisions about therapy.	75.0	4.43	.534	4.00	4.00
(3l) Therapist provides client extra time as needed to get settled in the clinical environment (e.g., time at the beginning of the session, opportunities for exposure to treatment environment prior to beginning of therapy, etc.).	87.5	4.13	1.25	5.00	5.00
(3m) Therapist encourages curiosity, exploration, and playful, humorous interactions throughout the therapeutic relationship.	*62.5*	*3.71*	*1.11*	*4.00*	*3.00*
(3n) If crisis plans are enacted (e.g. restraint to prevent child from running out of the building into the parking lot), therapist recognizes potential harm to relationship and prioritizes repair of the relationship with the client and caregiver(s) (when relevant).	100	4.75	.707	5.00	5.00
(3o) Therapist supports their own well-being and the well-being of other staff through adequate supervision and self-care.	*75.0*	*3.75*	*.707*	*4.00*	*4.00*
(3p) Supervisors provide trauma-informed oversight to staff.	71.4	4.00	1.00	4.00	3.00
(4) Promote choice and collaboration					
(4a) Therapist provides autistic clients with regular choices between and within activities of intervention targets, activities, and materials to promote access to preferred items and interactions.	75.0	4.33	.516	4.00	4.00
(4b) If autistic client is unable to communicate preferences verbally or with an augmentative and alternative communication (AAC) system or device, therapist implements regular observational assessments (e.g. systematic preference assessment) to identify preferred items, activities, and social interactions as well as non-preferred items, activities, and social interactions.	62.5	4.67	.816	5.00	5.00

Table 4, continued

Item Number	Include as is %	Item Importance *M*	*SD*	Median	Mode
(4c) When selecting intervention goals, outcomes, and intervention procedures, therapist centers treatment planning around the client's and caregiver's experiences and listens to person's history, current context, and desired future.	*62.5*	*4.71*	*.756*	*5.00*	*5.00*
(4d) Therapist provides opportunities for autistic client and caregiver(s) (when relevant) to act as equal collaborators in selecting intervention goals and targeted outcomes whenever possible by providing information about all options for goals in a way that is accessible to the caregiver(s) (e.g., jargon-free language, primary language of client/caregiver(s), etc).	87.5	4.50	.547	4.50	4.00
(4e) Therapist provides opportunities for autistic client and caregiver(s) (when relevant) to act as equal collaborators in selecting intervention procedures whenever possible by providing information about all options for goals in a way that is accessible to the caregiver(s) (e.g., jargon-free language, primary language of caregiver, etc).	75.0	4.28	.756	4.00	4.00
(4f) Therapist implements either structured or unstructured observational assessments to identify preferences of intervention goals and outcomes for autistic clients who are unable to communicate these preferences verbally or using AAC device/system.	71.4	4.14	.900	4.00	5.00
(4g) Therapist implements either structured or unstructured observational assessments to identify preferences of intervention procedures for autistic clients who are unable to communicate these preferences verbally or using AAC device/system. (e.g., A BCBA may assess preference between two or more intervention conditions using an alternating treatment research design.).	71.4	4.50	.837	4.50	5.00
(5) Cultivate self-determination and encourage empowerment					
(5a) Therapist identifies strengths of autistic client and caregiver(s) and builds upon these to encourage the development of self-determination (i.e., client' and caregiver(s)' feelings of control over their own life, specifically as it pertains to their role in the therapeutic environment).	87.5	4.86	.378	5.00	5.00

Table 4, continued

Item Number	Include as is %	Item Importance *M*	*SD*	Median	Mode
(5b) Therapist centers therapy around client assent as determined by client's willingness to engage in therapeutic activities and observations for client's mood and behavior.	*62.5*	*4.00*	*1.15*	*4.00*	*5.00*
(5c) Therapist prioritizes protesting as a communication goal for clients who have no clear means of protesting actions, activities, materials, etc through any communication modality (e.g., verbally saying "no", indicating "no" using a speech-generating device, gesture or sign language to indicate "no", other nonverbal protest gestures and/or vocalizations, etc.).	100	4.50	.756	5.00	5.00
(5d) If client does not demonstrate assent or protests session activities, therapist will change aspects of the therapy (e.g., materials, activities, etc.) to gain client assent.	87.5	4.71	.488	5.00	5.00
(6) Intervention is neurodiversity affirming					
(6a) Therapist avoids using deficit language (e.g., "resistant", "weakness", "deprived", etc.) in all communication with autistic clients, caregiver(s), and other professionals.	*62.5*	*4.17*	*.753*	*4.00*	*4.00*
(6b) Therapist emphasizes strengths of the autistic client and use of strengths-based language (e.g., "challenges" instead of "problems" or "weakness", etc.) in all communication with autistic clients, caregiver(s), and other professionals.	87.5	4.14	.900	4.00	5.00
(6c) Therapist celebrates and reinforces the unique strengths of autistic clients by incorporating special interests, activities, and mastered skills into therapy sessions.	75.0	4.83	.408	5.00	5.00
(6d) Therapist refrains from intervention targets focused on conformity with neurotypical behavior (e.g. therapist does not prioritize eye contact, the reduction of non-harmful stereotypic behavior, etc.).	*87.5*	*3.88*	*.834*	*4.00*	*3.00*
(6e) Therapist refrains from intervention targets that prioritize complete compliance (e.g., always following adult directions) to avoid risks to physical and emotional safety.	100	4.571	.535	5.00	5.00

Table 4, continued

Item Number	Include as is %	Item Importance *M*	*SD*	Median	Mode
(6f) Therapist provides psychoeducation to caregiver(s) to provide information about neurodiversity-affirming resources and information and to empower them to make intervention decisions that align with their caregiving/parenting values, desired goals for the child, and cultural values.	62.5	4.17	.753	4.00	4.00
(6g) If caregiver(s) of autistic individuals suggest conformity or compliance goals, therapist provides skill building alternatives (e.g., engagement, neurodiversity affirming social interaction, safety goals, etc.) that are culturally sensitive.	*50.0*	*4.00*	*1.22*	*4.00*	*4.00*
(6h) Therapist addresses challenging behaviors that produce dangerous situations for the autistic client and/or others using a functional behavior assessment (FBA) approach to create a behavior support plan (BSP) that incorporates an alternative replacement behavior to obtain the same reinforcers as the challenging behavior.	*62.5*	*4.50*	*1.22*	*5.00*	*5.00*

Note. Italicized items indicate failure to meet consensus

difference between good clinical practices/standard of care and trauma-informed practices as they noted some of the items were “just good clinical practice”.

Fleiss’ kappa was calculated for quantitative measures for inclusion of survey items as is and ratings of importance of survey items. For inclusion of survey items as is, Fleiss’ kappa was -0.022 (p=0.455; see Table 6). For ratings of importance of survey items, Fleiss’ kappa was 0.012 (p=0.697; see Table 6). These indicate there is no significant inter-rater agreement. Similarly, no significant inter-rater agreement was found for individual measures (see Table 7 & Table 8). While there was similarly no significant inter-rater agreement for individual measures of importance, Fleiss’ kappa for individual measures for importance indicate that there was greater inter-rater agreement for items that were rated as important than for items rated as less important (see Table 8). Similar inter-rater agreement was found for inclusion of items as is (see Table 7).

Table 5

Consensus by Survey Area for Round 1

	Met Inclusion Criteria		Did Not Meet Inclusion Criteria	
Area	*n*	%	*n*	%
(1) Awareness of trauma and trauma-related symptoms	3	50.0	3	50.0
(2) Acknowledge trauma and its potential impact	3	50.0	3	50.0
(3) Prioritize client and therapist safety and therapist-client trust	9	56.3	7	43.8
(4) Promote choice and collaboration	5	71.4	2	28.6
(5) Cultivate self-determination and encourage empowerment	3	75.0	1	25.0
(6) Intervention is neurodiversity affirming	3	37.5	5	62.5

Table 6

Fleiss' Kappa for Round 1

Measure	*k*	*p*
Inclusion of item as is	-.022	.455
Importance of item inclusion	.012	.697

Table 7

Fleiss' Kappa for Round 1: Inclusion of Item as Is

Response	*k*	*p*
Yes	.744	.455
No	.233	.455

Table 8

Fleiss' Kappa for Round 1: Importance of Item Inclusion

Response	*k*	*p*
2	-.038	.405
3	-.080	.080
4	.029	.533
5	.071	.120

Round Two

Given the results of round one, 21 items were included in round two. Of the eight remaining participants, five (62.5%) responded to the second survey round (see Figure 1). The same criteria described above was used to identify items that met consensus for inclusion on the final guidelines. Based on these criteria, 17 (81.0%) of the survey items from this round were marked for inclusion in the final guidelines (see Table 9). Furthermore, two (66.6%) items were marked for inclusion within area 1, three (100%) items were marked for inclusion within area 2, six (85.7%) items were marked for inclusion within area 3, two (100%) items were marked for inclusion within area 4, one (100%) was marked for inclusion within area 5, and three (60.0%) were marked for inclusion within area 6 (see Table 10).

All five panelists provided qualitative responses to the open-ended questions "How should the above item be reworded to be improved?" and "What other considerations should the researchers be aware of?". A review of responses to open-ended questions for the remaining four

Table 9

Inclusion Percentages and Central Tendency Measures on Importance of Item Inclusion for Round 2

Item Number	Include as is %	Item Importance *M*	*SD*	Median	Mode
(1) Awareness of trauma and trauma-related symptoms					
(1b) Therapist has knowledge of how ACEs may contribute to trauma-related symptoms (i.e., impairments to psychological, social, physical, and adaptive functioning).	100	4.00	1.00	4.00	3.00
(1d) Therapist is aware that trauma-related symptoms in autistic children may present differently than in non-autistic children.	100	4.40	.894	5.00	5.00
(1e) Therapist is aware that trauma-related symptoms in autistic children are likely to present as abrupt changes to behavior (e.g., spoken communication, behavioral challenges, adaptive skills), including autistic traits.	*80.0*	*3.75*	*.500*	*4.00*	*4.00*
(2) Acknowledge trauma and its potential impact					
(2a) Therapist acknowledges that autistic clients may have experienced trauma even if trauma history (e.g., known presence of ACEs) has not been disclosed to the therapist.	100	4.00	.707	4.00	4.00
(2b) Therapist carefully considers potentially contraindicated procedures and seeks to minimize potential risks and maximize potential benefits, especially in consideration of known trauma history (e.g., for clients who have experience prior food insecurity the use of edible reinforcers is potentially contraindicated).	80.0	4.20	.837	4.00	4.00
(2e) If the therapist observes adverse reactions associated with stimuli in the therapeutic environment (e.g., physical prompting), the therapist engages autistic client, caregiver(s) (when relevant), and any other appropriate members of the care team in adapting the treatment goals and/or stimuli to be more supportive.	100	4.20	1.10	5.00	5.00
(3) Prioritize client and therapist safety and therapist-client trust					

Table 9

Item Number	Include as is %	Item Importance *M*	*SD*	Median	Mode
(3d) Therapist proactively and routinely reflects on autistic clients and their caregiver(s) (when relevant) to monitor assent in regard to goals, procedures, or outcomes of the treatment plan.	100	4.60	.548	5.00	5.00
(3f) Therapist uses skills to encourage positive therapeutic rapport (e.g., orientation towards client, posture, affect, tone of voice, responsivity, matching client preferences).	100	4.80	.447	5.00	5.00
(3g) Therapist prioritizes client physical and emotional safety.	100	4.80	.447	5.00	5.00
(3h) Therapist regularly assesses for unintentional harmful physical and/or social emotional effects of any assessment or intervention.	100	4.80	.447	5.00	5.00
(3i) Therapist regularly discloses observations (e.g., task avoidance, behavior escalation, any new observed behaviors) to the client and caregiver(s) (when relevant) in a timely fashion so that changes can be made to intervention procedures.	*100*	*3.80*	*.837*	*4.00*	*3.00*
(3m) Therapist encourages curiosity and exploration throughout the therapeutic relationship.	80.0	4.00	1.22	4.00	4.00
(3o) Therapist supports their own well-being and the well-being of other staff through adequate supervision and self-care (e.g., allowing time to decompress following stressful sessions, debriefing with colleagues as needed).	100	4.40	.894	5.00	5.00
(4) Promote choice and collaboration					
(4b) Therapist assesses reinforcement preferences for all clients regardless of communication style (e.g., augmentative and alternative communication/AAC systems/devices).	100	4.80	.447	5.00	5.00
(4c) When planning for intervention goals, outcomes, and intervention procedures, the therapist uses person-centered and/or family-centered planning.	100	4.80	.447	5.00	5.00
(5) Cultivate self-determination and encourage empowerment					
(5b) Therapist centers therapy around client assent as determined by observations for client's mood and behavior as well as client's willingness to engage in therapeutic activities.	100	4.80	.447	5.00	5.00

Table 9, continued

Item Number	Include as is %	Item Importance *M*	*SD*	Median	Mode
(6) Intervention is neurodiversity affirming					
(6a) Therapist avoids using deficit language (e.g., “resistant”, “weakness”, “deprived”, etc.) in favor of using strengths-based language (e.g., "opted out of", "challenge", etc.) in all communication with autistic clients, caregiver(s), and other professionals.	100	4.40	.894	5.00	5.00
(6d) Therapist refrains from intervention targets focused on conformity with neurotypical behavior (e.g. therapist does not prioritize eye contact, the reduction of non-harmful stereotypic behavior, etc.).	80.0	4.30	1.30	5.00	5.00
(6f) Therapist provides psychoeducation to caregiver(s) about neurodiversity-affirming resources and information to empower them to make intervention decisions that align with their caregiving/parenting values, desired goals for the child, and cultural values.	*100*	*3.80*	*1.30*	*4.00*	*5.00*
(6g) If caregiver(s) of autistic individuals suggest conformity or compliance goals (e.g., eye contact), therapist provides skill building alternatives that are culturally sensitive.	80.0	4.50	.577	4.50	4.00
(6h) Therapist addresses challenging behaviors that produce dangerous situations for the autistic client and/or others using a functional behavior assessment (FBA) approach to create a behavior support plan (BSP) that incorporates an alternative replacement behavior to obtain the same reinforcers as the challenging behavior.	*60.0*	*3.50*	*1.29*	*3.50*	*2.00*

Note. Italicized items indicate failure to meet consensus

Table 10

Consensus by Survey Area for Round 2

Area	Met Inclusion Criteria *n*	Met Inclusion Criteria %	Did Not Meet Inclusion Criteria *n*	Did Not Meet Inclusion Criteria %
(1) Awareness of trauma and trauma-related symptoms	2	66.6	1	33.3
(2) Acknowledge trauma and its potential impact	3	100	0	0
(3) Prioritize client and therapist safety and therapist-client trust	6	85.7	1	14.3
(4) Promote choice and collaboration	2	100	0	0
(5) Cultivate self-determination and encourage empowerment	1	100	0	0
(6) Intervention is neurodiversity affirming	3	60.0	2	40.0

items included primarily requests for rewording of items as well as a need for clarity on the expectations for providers who might use the guidelines, and a need for clarity on evidence referenced in the creation of the guidelines.

Fleiss' kappa was calculated for quantitative measures for inclusion of survey items as is and ratings of importance of survey items. For inclusion of survey items as is, Fleiss' kappa was -0.011 (p=0.837; see Table 11). For ratings of importance of survey items, Fleiss' kappa was -0.069 (p=0.189; see Table 11). These indicate there is no significant inter-rater agreement. While there was similarly no significant inter-rater agreement for individual measures of importance, Fleiss' kappa for individual measures for importance indicate that there was greater inter-rater agreement for items that were rated as important than for items rated as less important (see Table 12). Similar inter-rater agreement was found for inclusion of items as is (see Table 13).

Based on the findings of the two survey rounds, 43 of the 47 originally proposed items met criteria for consensus and were thus included in the final practice guidelines (see Appendix C).

Table 11

Fleiss' Kappa for Round 2

Measure	*k*	*p*
Inclusion of item as is	.011	.837
Importance of item inclusion	-.069	.189

Table 12

Fleiss' Kappa for Round 2: Inclusion of Item as Is

Response	*k*	*p*
Yes	.090	.190
No	.005	.941

Table 13

Fleiss' Kappa for Round 2: Importance of Item Inclusion

Response	*k*	*p*
2	-.034	.644
3	-.010	.897
4	-.139	.062
5	-.048	.532

Chapter 5: Discussion

The purpose of this Delphi study was to develop a set of evidence-based guidelines through expert consensus for SLPs, BCBAs, and other similar service providers to use for supporting autistic children and their caregiver(s) who may have experienced trauma while operating within their scope of practice. Among our panelists, responses suggest shared agreement on the importance of acknowledging trauma and its potential impact, promoting choice and collaboration, and cultivating self-determination and encouraging empowerment. However, there was less shared agreement on items regarding awareness of PTEs and TRS, how to prioritize client and therapist safety and therapist-client trust, and neurodiversity affirming practices.

Of the eight panelists who responded to the surveys, five (62.5%) were BCBAs, BCBA-Ds, or BCaBAs, one (12.5%) was a dual-certified BCBA-D and SLP, one (12.5%) was an SLP, and one (12.5%) was a non-licensed psychologists holding a Ph.D (see Table 2). The majority of articles authored or co-authored by panelists were related to autistic youth (M=33.3, SD=41.2; see Table 3) with less authored or co-authored articles that were related to TIC in pediatrics (M=4.63; SD=10.4; see Table 3). Therefore, the panel collectively shared expertise in behavior analysis and autism with less expertise in trauma and TIC in pediatrics. Additionally, only one (12.5%) of the eight respondents identified as autistic, a person with autism, or neurodivergent, indicating that most of the feedback received was from a non-autistic view of service provision (Table 2).

Quantitative Findings

Overall, 43 of the 47 originally proposed guideline items met criteria for inclusion in the final practice guidelines. Of the four that did not meet inclusion criteria, items (1e), (3i), and (6f) met criteria based on participant responses to the question of including the item as is, but not for importance of item inclusion while item (6h) did not inclusion criteria on either question (see Table 9).

While no statistically significant inter-rater agreement was found, Fleiss' kappa provided some information on how participants rated items. For both survey rounds, Fleiss' kappa indicates that there was greater inter-rater agreement to include items as is rather than to not include items (see Tables 6, 7, 8, 9, 10, & 11). As such, there was greater agreement to include items than to not include them during both survey rounds, although these findings are not statistically significant. Similarly, ratings of importance for survey round one indicates that there is greater agreement of item importance than unimportance (see Table 8). These findings are also not statistically significant; however, they do reflect findings of prior research that indicates a need for more information on trauma-informed practices for service providers working with autistic youth (Kerns et al., 2020).

Qualitative Findings

Of the 47 items included in the first survey round, four did not meet criteria for consensus by the conclusion of the second survey round. Responses to open-ended questions for items (3i), (6f), and (6h) were requests to reword the item, so it is likely that consensus would have been reached for these items if a third survey round had been conducted.

One item that did not meet inclusion criteria fell in the area of awareness of PTEs and TRS. The item reads as follows: "(1e) Therapist is aware that trauma-related symptoms in autistic children are likely to present as abrupt changes to behavior (e.g., spoken communication, behavioral challenges, adaptive skills), including autistic traits" (see Table 9). While the intent for including this item in the survey was to address the variability in how TRS may present in autistic individuals, concerns were raised by panelists about how the item may be interpreted (Allely & Faccini, 2020; Kildahl et al., 2019). Panelists' responses specifically mentioned concerns that this item may lead to over attribution of any changes in behavior to trauma. One panelist wrote, "…We would not want trauma to become some big undefinable, over-arching umbrella term because that wouldn't be addressing the actual causes…" while

another raised concerns that reading into behaviors too much could lead to falsely accusing caregivers of contributing to trauma for the individual.

This feedback indicates that it is necessary that any providers who might use these practice guidelines in the future must have awareness and education on TRS and PTEs. As discussed previously, screening for TRS in autistic individuals poses many challenges and there is currently no standardized screening tool to support service providers in doing so (Allely & Faccini, 2020; Kildahl et al., 2019). Therefore, service providers using this tool must have education and training on how to identify TRS in the individuals they work with and have knowledge on how to differentiate TRS and other causes of behavior change in order to provide TIC. Additionally, the issues raised by the panelists are important to further investigate as the co-occurrence of increased challenging behavior or other changes in behavior could be linked to innumerous child, family and other contextual variables. As such, the panelists might be rightly cautious in automatically attributing any behavioral changes to trauma.

The issues raised by the panelists highlights that the guidelines created from this Delphi study are likely to be insufficient in supporting service providers in providing TIC by itself. Moreover, other frameworks for TIC indicate that providers should have knowledge of trauma and its effects as well as knowledge on how to recognize TRS in clients (SAMHSA, 2014; Rajaraman et al., 2021). These factors indicate that education and training is necessary for service providers using the guidelines to understand what the items on the tool are addressing and why.

Limitations

The Delphi study design is not without limitations, several of which were encountered during this study.

Panel Composition

This study aimed to create trauma-informed practice guidelines that could be used by BCBAs, SLPs, and service providers with similar scopes. However, 6 (75.0%) of the participants

for this study were either BCBAs, BDBA-Ds, BCaBAs, or dual-certified SLPs and BCBAs (see Table 2). Only 1 (12.5%) panelist had expertise in psychology and one (12.5%) panelist was an SLP, not including the dual-certified participant (see Table 2). As such, the panel was primarily composed of participants with a background in behavior analysis. Due to this, there are questions about the validity of this Delphi survey's findings for fields outside of behavior analysis. Although behavior analysis and speech-language pathology have a fair amount of overlap, given the composition of this panel we cannot firmly say we have achieved consensus from fields other than behavior analysis. Additionally, only one (12.5%) panelist identified as autistic, a person with autism, or neurodivergent. As such, the consensus gained was largely from a non-autistic perspective on service provision.

Panel composition is a notable drawback of the Delphi study design. As previous research has indicated, the results of any particular Delphi survey could produce different findings with a different panel composition (Bishop et al., 2016; Izaryk & Skarakis-Doyle, 2017). As such, a panel of different individuals with similar backgrounds as the panel surveyed for this study could result in different results and should be investigated in future research.

Required Time Commitment from Participants

Another challenge inherent to the Delphi study design is the time commitment required of participants. The iterative nature of a Delphi study means participants must be willing and able to commit to participating over an extended period of time, ranging from weeks to months. As such, just as with any longitudinal study, participant attrition is an expected limitation. This study is no exception. Despite random selection of a single panelist during each round of the study to receive a $200.00 visa card over the course of this Delphi study, multiple panelists expressed that they had limited time to continue their commitment to participating in the study.

Participant Attrition

The high rate of attrition calls the validity of this study's findings into question. While attrition is an expected limitation of Delphi studies, based on past research we aimed for a

response rate of at least 70% for each survey round (Berglund et al., 2017; Izaryk & Skarakis-Doyle, 2017; Stephens Smith et al., 2020). The response rates for this study were 53.3% and 62.5% for survey rounds 1 and 2, respectively. As such, although the majority of survey items did meet criteria for consensus, we cannot say that this consensus is valid given the low number of respondents. Additional research is needed with a larger number of panelists invited to participate in an effort to obtain a 70% response rate.

It is also important to note that the research team was unable to provide more time to complete survey rounds to encourage a higher participant response rate. If participants had been allowed more time to complete survey rounds as needed, it is possible that less attrition would have been experienced.

Clinical Implications

While there are questions regarding the validity of consensus gained in this study, the guidelines created do have the potential to impact clinical practice. As previously discussed, prior scholarship has noted that many service providers such as SLPs and BCBAs would like more education and training regarding trauma and TIC (Kerns et al., 2019). The guidelines generated from this Delphi survey could serve as a starting point to support increased awareness of trauma and TIC for these providers. Additionally, providers can use the guidelines generated to self-reflect on ways in which their current practices align or misalign with the TIC principles outlined and assess ways in which they can better integrate these principles into their practice.

Suggestions for Future Research

These guidelines are merely a starting point for the work that must be done to meet the TIC support needs of the autistic children SLPs and BCBAs work with. It is important to note that these guidelines should not exist on their own. Principles of TIC previously outlined indicate that knowledge and awareness of trauma and its impact is an essential part of TIC (Rajaraman et al., 2021; SAMHSA, 2014). Likewise, this tool assumes that providers using the guidelines have prior knowledge of PTEs, ACEs, and TRS. As such, it would be beneficial for

future research to focus on examining the outcomes of training service providers to use these guidelines through education and training on the topic of PTEs, TRS, and autism. Specifically, the feasibility and acceptability of the practice guidelines for professionals, caregivers and autistic children. For those autistic children who are nonspeaking, behavioral observation measures of approach and engagement, avoidance and protest, and individualized indices of happiness will be useful in assessing the social validity of the outcomes of such practice guidelines for autistic children themselves.

Future research in this area should also include community-based participatory research (CBPR; Fletcher-Watson et al., 2019; Nicolaidis et al., 2019). There has been a push in the past decade to include autistic voices as equal partners in the research process to ensure the disability rights motto "nothing about us without us" applies to all areas that impact autistic individuals (Fletcher-Watson et al., 2019; Nicolaidis et al., 2019). While this project aimed to include voices of autistic service providers and did include an autistic research team member, and 4 panelists who identified as autistic it may be beneficial to include more autistic community partners to further support TIC guidelines in meeting the needs of this population.

Future research could also focus on applying TIC principles to other populations. While the study at hand focused on autistic youth as a neurominority, other minority groups (e.g., cultural and linguistic minorities) are likely to experience similar chronic stressors, such as victimization and discrimination (Brody et al., 2014; Marks et al., 2020; Metzger et al., 2017). Some of these minority groups are also at an increased risk for other PTEs such as experiences with poverty (Marks et al., 2020; Saegert & Evans, 2003). With this in mind, future research should aim to gain consensus on TIC practices for other minority populations that SLPs and BCBAs work with and also consensus on TIC practices for intersectional populations (e.g. BIPOC autistic children and their caregivers).

Conclusions

For autistic children receiving services from providers such as SLPs and BCBAs, a trauma-informed approach to treatment may be beneficial for supporting them in the context of intervention and preventing further harm. This study aimed to create practice guidelines for this purpose, but must also be a part of a larger conversation on the complex challenges that coincide with PTEs and TRS in this population. These guidelines have been developed through consensus by experts from behavior analysis, speech-language pathology, and psychology; however, more research needs to be completed for these guidelines to become a valid tool that can effectively support clinical practice. CBPR and the development and experimental evaluation of an educational curriculum for service providers on how to use the guidelines are recommended areas for future research.

Appendix A

Delphi Survey Round One

[[AdvancedFormat]]

[[Block:(1) Awareness of trauma and trauma-related symptoms]]

[[Question:MC:SingleAnswer:Horizontal]]
Awareness of Trauma and Trauma-Related Symptoms
(1a) Therapist has knowledge of the definition of adverse childhood experiences (ACEs) (i.e., sexual abuse, verbal/emotional abuse, physical abuse, emotional neglect, physical neglect, having a caregiver who experiences mental health challenges, caregiver substance abuse, having a caregiver who is a victim of domestic violence, incarceration of a family member, and loss of a caregiver due to divorce or abandonment).

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
[[Choices]]
1
2
3
4
5

[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(1b) Therapist has knowledge of how ACEs may contribute to trauma-related symptoms.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
[[Choices]]
1
2

3
4
5

[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(1c) Therapist acknowledges that other community stressors that are not considered under the definition of ACEs (e.g., experiences with poverty, peer rejection, poor school performance, community violence, belonging to a neurominority) can contribute to chronic stress and the development of trauma related symptoms.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
[[Choices]]
1
2
3
4
5

[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(1d) Therapist is aware that trauma-related symptoms in autistic children may present differently than in non-autistic children.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
[[Choices]]
1

2
3
4
5

[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(1e) Therapist is aware that trauma-related symptoms in autistic children are likely to present as changes to behavior (e.g., verbal communication, behavioral challenges, adaptive skills) and changes to autism-related symptoms (e.g., perseveration, rigidity, avoidance)

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
[[Choices]]
1
2
3
4
5

[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(1f) Therapist collaborates with other members of the client's intervention team that may be involved in evaluating and/or treating trauma directly (e.g., clinical psychologists) as is appropriate.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
[[Choices]]

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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[PageBreak]]

[[Block:(2) Acknowledge trauma and its potential impact]]

[[Question:MC:SingleAnswer:Horizontal]]
Acknowledge Trauma and its Potential Impact
(2a) Therapist acknowledges that autistic clients may have experienced trauma even if trauma history has not been disclosed to the therapist.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(2b) For clients who have a known trauma history, the therapist carefully considers potentially contraindicated procedures and seeks to minimize potential risks and maximize potential benefits (e.g., for clients who have experience prior food insecurity the use of edible reinforcers is potentially contraindicated)

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes

No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(2c) During therapy sessions, therapist monitors for behavior and emotional states suggesting assent and positive engagement such as smiling, laughing, spontaneous requests, and positive message communication acts.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(2d) During therapy sessions, therapist monitors for adverse reactions, such as not attending to therapy sessions, lack of engagement in therapy activities, intense emotional responding and/or avoidant or aggressive behaviors before, during, or after sessions.

Do you agree with the inclusion of this survey item as is?
[[Choices]]

Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(2e) If the therapist observes adverse reactions associated with stimuli in the therapeutic environment (e.g., physical prompting), the therapist engages autistic client and caregiver(s) (when relevant) in problem solving to change procedures.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(2f) Therapist routinely asks autistic client and caregiver(s) (when relevant) about and monitors for changes to emotional, social, physical, and adaptive functioning as these may be indicative of trauma-related symptoms or other healthcare needs.

Do you agree with the inclusion of this survey item as is?

[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?
[[PageBreak]]

[[Block:(3) Prioritize client and therapist safety and therapist-client trust]]

[[Question:MC:SingleAnswer:Horizontal]]
(3a) Therapist ensures everyone (i.e., client, caregiver(s), clinicians, staff) is safe from unwanted physical touch within the clinical environment.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(3b) Therapist provides choices the autistic child with choices for seating arrangements and permits flexibility.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(3c) Therapist works to minimize environmental stimuli that autistic clients and their caregiver(s) have communicated as uncomfortable and/or associated with feelings of danger.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(3d) Therapist proactively and routinely asks autistic clients and their caregiver(s) (when relevant) to let the therapist know at any time if they feel uncomfortable with the goals, procedures, or outcomes of the treatment plan.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(3e) To foster client feelings of safety and trust, therapist begins therapy with new clients and caregiver(s) (when relevant) with a goal of building therapeutic rapport through non-contingent reinforcement (e.g., reinforcement provided independent of client behavior), client preferred activities and materials, etc.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]

(3f) Therapist uses skills to encourage therapeutic rapport (e.g., eye contact, muscles of facial expression, posture, affect, tone of voice, hearing the whole client, your response) such as those outlined in the E.M.P.A.T.H.Y. framework.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(3g) Therapist prioritizes voluntary client engagement, physical, and emotional safety.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]

(3h) Therapist regularly assesses clients for unintended harmful physical and/or social emotional effects of any intervention.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(3i) Therapist regularly discloses observations (e.g., indicators of harmful physical and/or social emotional effects of intervention) to the client and caregiver(s) (when relevant) in a timely fashion so that changes can be made to intervention procedures.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]

(3j) Therapist collaborates with client and caregiver(s) when relevant to clarify roles and expectations for all parties involved (i.e., therapists, client, caregiver(s), other members of the intervention team) throughout the treatment process.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(3k) Therapist explains rationale for their intervention decisions and procedures to client and caregiver(s) (when relevant) in order to allow them to make informed decisions about therapy

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]

(3l) Therapist provides client extra time as needed to get settled in the clinical environment (e.g., time at the beginning of the session, opportunities for exposure to treatment environment prior to beginning of therapy, etc.).

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(3m) Therapist encourages curiosity, exploration, and playful, humorous interactions throughout the therapeutic relationship.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]

(3n) If crisis plans are enacted (e.g. restraint to prevent child from running out of the building into the parking lot), therapist recognizes potential harm to relationship and prioritizes repair of the relationship with the client and caregiver(s) (when relevant).

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(3o) Therapist supports their own well-being and the well-being of other staff through adequate supervision and self-care.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]

(3p) Supervisors provide trauma-informed oversight to staff.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[PageBreak]]

[[Block:(4) Promote choice and collaboration]]

[[Question:MC:SingleAnswer:Horizontal]]
Promote Choice and Collaboration
(4a) Therapist provides autistic clients with regular choices between and within activities of intervention targets, activities, and materials to promote access to preferred items and interactions.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(4b) If autistic client is unable to communicate preferences verbally or with an augmentative and alternative communication (AAC) system or device, therapist implements regular observational assessments (e.g. systematic preference assessment) to identify preferred items, activities, and social interactions as well as non-preferred items, activities, and social interactions.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(4c) When selecting intervention goals, outcomes, and intervention procedures, therapist centers treatment planning around the client's and caregiver's experiences and listens to person's history, current context, and desired future.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(4c) Therapist provides opportunities for autistic client and caregiver(s) (when relevant) to act as equal collaborators in selecting **intervention goals and targeted outcomes** whenever possible by providing information about all options for goals in a way that is accessible to the caregiver(s) (e.g., jargon-free language, primary language of client/caregiver(s), etc).

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(4d) Therapist provides opportunities for autistic client and caregiver(s) (when relevant) to act as equal collaborators in selecting **intervention procedures** whenever possible by providing information about all options for goals in a way that is accessible to the caregiver(s) (e.g., jargon-free language, primary language of caregiver, etc).

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(4e) Therapist implements either structured or unstructured observational assessments to identify preferences of **intervention goals and outcomes** for autistic clients who are unable to communicate these preferences verbally or using AAC device/system.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(4f) Therapist implements either structured or unstructured observational assessments to identify preferences of **intervention procedures** for autistic clients who are unable to communicate these preferences verbally or using AAC device/system. (e.g., A BCBA may assess preference between two or more intervention conditions using an alternating treatment research design.).

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

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[[Block:(5) Cultivate self-determination and encourage empowerment]]

[[Question:MC:SingleAnswer:Horizontal]]
Cultivate Self-Determination and Encourage Empowerment
(5a) Therapist identifies strengths of autistic client and caregiver(s) and builds upon these to encourage the development of self-determination (i.e., client' and caregiver(s)' feelings of control over their own life, specifically as it pertains to their role in the therapeutic environment).

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(5b) Therapist centers therapy around client assent as determined by client's willingness to engage in therapeutic activities and observations for clients mood and behavior.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes

No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(5c) Therapist prioritizes protesting as a communication goal for clients who have no clear means of protesting actions, activities, materials, etc through any communication modality (e.g., verbally saying “no”, indicating “no” using a speech-generating device, gesture or sign language to indicate “no”, other nonverbal protest gestures and/or vocalizations, etc.).

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(5d) If client does not demonstrate assent or protests session activities, therapist will change aspects of the therapy (e.g., materials, activities, etc.) to gain client assent.

Do you agree with the inclusion of this survey item as is?
[[Choices]]

Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[PageBreak]]

[[Block:(6) Intervention is neurodiversity affirming]]

[[Question:MC:SingleAnswer:Horizontal]]
Intervention is Neurodiversity Affirming
(6a) Therapist avoids using deficit language (e.g., “resistant”, “weakness”, “deprived”, etc.) in all communication with autistic clients, caregiver(s), and other professionals.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]

(6b) Therapist emphasizes strengths of the autistic client and use of strengths-based language (e.g., “challenges” instead of “problems” or “weakness”, etc.) in all communication with autistic clients, caregiver(s), and other professionals.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(6c) Therapist celebrates and reinforces the unique strengths of autistic clients by incorporating special interests, activities, and mastered skills into therapy sessions.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]

(6d) Therapist refrains from intervention targets focused on conformity with neurotypical behavior (e.g. therapist does not prioritize eye contact, the reduction of non-harmful stereotypic behavior, etc.).

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(6e) Therapist refrains from intervention targets that prioritize complete compliance (e.g., always following adult directions) to avoid risks to physical and emotional safety.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]

(6f) Therapist provides psychoeducation to caregiver(s) to provide information about neurodiversity-affirming resources and information and to empower them to make intervention decisions that align with their caregiving/parenting values, desired goals for the child, and cultural values.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(6g) If caregiver(s) of autistic individuals suggest conformity or compliance goals, therapist provides skill building alternatives (e.g., engagement, neurodiversity affirming social interaction, safety goals, etc.) that are culturally sensitive.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(6h) Therapist addresses challenging behaviors that produce dangerous situations for the autistic client and/or others using a functional behavior assessment (FBA) approach to create a behavior support plan (BSP) that incorporates an alternative replacement behavior to obtain the same reinforcers as the challenging behavior.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
[[Choices]]
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

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Appendix B

Delphi Survey Round Two

[[AdvancedFormat]]

[[Block:(1) Awareness of trauma and trauma-related symptoms]]

[[Question:MC:SingleAnswer:Horizontal]]
Awareness of Trauma and Trauma-Related Symptoms

(1b) Therapist has knowledge of how ACEs may contribute to trauma-related symptoms (i.e., impairments to psychological, social, physical, and adaptive functioning).

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
Awareness of Trauma and Trauma-Related Symptoms

(1d) Therapist is aware that trauma-related symptoms in autistic children may present differently than in non-autistic children.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(1e) Therapist is aware that trauma-related symptoms in autistic children are likely to present as abrupt changes to behavior (e.g., spoken communication, behavioral challenges, adaptive skills), including autistic traits.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[PageBreak]]

[[Block:(2) Acknowledge trauma and its potential impact]]

[[Question:MC:SingleAnswer:Horizontal]]
(2a) Therapist acknowledges that autistic clients may have experienced trauma even if trauma history (e.g., known presence of ACEs) has not been disclosed to the therapist.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]

How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
[[Choices]]
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[[Question:TE:Essay]]
How should the above item be reworded to improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(2b) Therapist carefully considers potentially contraindicated procedures and seeks to minimize potential risks and maximize potential benefits, especially in consideration of known trauma history (e.g., for clients who have experience prior food insecurity the use of edible reinforcers is potentially contraindicated).

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(2e) If the therapist observes adverse reactions associated with stimuli in the therapeutic environment (e.g., physical prompting), the therapist engages autistic client, caregiver(s) (when relevant), and any other appropriate members of the care team in adapting the treatment goals and/or stimuli to be more supportive.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes

No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

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[[Block:(3) Prioritize client and therapist safety and therapist-client trust]]

[[Question:MC:SingleAnswer:Horizontal]]
(3d) Therapist proactively and routinely reflects on autistic clients and their caregiver(s) (when relevant) to monitor assent in regard to goals, procedures, or outcomes of the treatment plan.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(3f) Therapist uses skills to encourage positive therapeutic rapport (e.g., orientation towards client, posture, affect, tone of voice, responsivity, matching client preferences).
Do you agree with the inclusion of this survey item as is?

[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(3g) Therapist prioritizes client physical and emotional safety.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(3h) Therapist regularly assesses for unintentional harmful physical and/or social emotional effects of any assessment or intervention.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes

No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(3i) Therapist regularly discloses observations (e.g., task avoidance, behavior escalation, any new observed behaviors) to the client and caregiver(s) (when relevant) in a timely fashion so that changes can be made to intervention procedures.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(3m) Therapist encourages curiosity and exploration throughout the therapeutic relationship.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(30) Therapist supports their own well-being and the well-being of other staff through adequate supervision and self-care (e.g., allowing time to decompress following stressful sessions, debriefing with colleagues as needed).

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

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[[Block:(4) Promote choice and collaboration]]

[[Question:MC:SingleAnswer:Horizontal]]
(4b) Therapist assesses reinforcement preferences for all clients regardless of communication style (e.g., augmentative and alternative communication/AAC systems/devices).

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(4c) When planning for intervention goals, outcomes, and intervention procedures, the therapist uses person-centered and/or family-centered planning.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

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[[Block:(5) Cultivate self-determination and encourage empowerment]]

[[Question:MC:SingleAnswer:Horizontal]]

(5b) Therapist centers therapy around client assent as determined by observations for client's mood and behavior as well as client's willingness to engage in therapeutic activities.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

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[[Block:(6) Intervention is neurodiversity affirming]]

[[Question:MC:SingleAnswer:Horizontal]]
Intervention is Neurodiversity Affirming

(6a) Therapist avoids using deficit language (e.g., "resistant", "weakness", "deprived", etc.) in favor of using strengths-based language (e.g., "opted out of", "challenge", etc.) in all communication with autistic clients, caregiver(s), and other professionals.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]

How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]

(6d) Therapist refrains from intervention targets focused on conformity with neurotypical behavior (e.g. therapist does not prioritize eye contact, the reduction of non-harmful stereotypic behavior, etc.).

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(6f) Therapist provides psychoeducation to caregiver(s) about neurodiversity-affirming resources and information to empower them to make intervention decisions that align with their caregiving/parenting values, desired goals for the child, and cultural values.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(6g) If caregiver(s) of autistic individuals suggest conformity or compliance goals (e.g., eye contact), therapist provides skill building alternatives that are culturally sensitive.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
[[Choices]]
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

[[Question:MC:SingleAnswer:Horizontal]]
(6h) Therapist addresses challenging behaviors that produce dangerous situations for the autistic client and/or others using a functional behavior assessment (FBA) approach to create a

behavior support plan (BSP) that incorporates an alternative replacement behavior to obtain the same reinforcers as the challenging behavior.

Do you agree with the inclusion of this survey item as is?
[[Choices]]
Yes
No

[[Question:MC:SingleAnswer:Horizontal]]
How important is the inclusion of this item? (Likert Scale: 1=Very Unimportant; 5=Very Important)
[[Choices]]
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[[Question:TE:Essay]]
How should the above item be reworded to be improved?

[[Question:TE:Essay]]
What other considerations should the researchers be aware of?

Appendix C

Trauma-Informed Practice Guidelines for BCBAs and SLPS

(1) Awareness of Trauma and Trauma-Related Symptoms

(1a) Therapist has knowledge of the definition of adverse childhood experiences (ACEs) (i.e., sexual abuse, verbal/emotional abuse, physical abuse, emotional neglect, physical neglect, having a caregiver who experiences mental health challenges, caregiver substance abuse, having a caregiver who is a victim of domestic violence, incarceration of a family member, and loss of a caregiver due to divorce or abandonment).

(1b) Therapist has knowledge of how ACEs may contribute to trauma-related symptoms (i.e., impairments to psychological, social, physical, and adaptive functioning).

(1c) Therapist acknowledges that other community stressors that are not considered under the definition of ACEs (e.g., experiences with poverty, peer rejection, poor school performance, community violence, belonging to a neurominority) can contribute to chronic stress and the development of trauma related symptoms.

(1d) Therapist is aware that trauma-related symptoms in autistic children may present differently than in non-autistic children.

(1e) Therapist collaborates with other members of the client's intervention team that may be involved in evaluating and/or treating trauma directly (e.g., clinical psychologists) as is appropriate.

(2) Acknowledge Trauma and its Potential Impact

(2a) Therapist acknowledges that autistic clients may have experienced trauma even if trauma history (e.g., known presence of ACEs) has not been disclosed to the therapist.

(2b) Therapist carefully considers potentially contraindicated procedures and seeks to minimize potential risks and maximize potential benefits, especially in consideration of known trauma history (e.g., for clients who have experience prior food insecurity the use of edible reinforcers is potentially contraindicated).

(2c) During therapy sessions, therapist monitors for behavior and emotional states suggesting assent and positive engagement such as smiling, laughing, spontaneous requests, and positive message communication acts.

(2d) During therapy sessions, therapist monitors for adverse reactions, such as not attending to therapy sessions, lack of engagement in therapy activities, intense emotional responding and/or avoidant or aggressive behaviors before, during, or after sessions.

(2e) If the therapist observes adverse reactions associated with stimuli in the therapeutic environment (e.g., physical prompting), the therapist engages autistic client, caregiver(s) (when relevant), and any other appropriate members of the care team in adapting the treatment goals and/or stimuli to be more supportive.

(2f) Therapist routinely asks autistic client and caregiver(s) (when relevant) about and monitors for changes to emotional, social, physical, and adaptive functioning as these may be indicative of trauma-related symptoms or other healthcare needs.

(3) Prioritize Client and Therapist Safety and Therapist-Client Trust

(3a) Therapist ensures everyone (i.e., client, caregiver(s), clinicians, staff) is safe from unwanted physical touch within the clinical environment.

(3b) Therapist provides choices the autistic child with choices for seating arrangements and permits flexibility.

(3c) Therapist works to minimize environmental stimuli that autistic clients and their caregiver(s) have communicated as uncomfortable and/or associated with feelings of danger.

(3d) Therapist proactively and routinely reflects on autistic clients and their caregiver(s) (when relevant) to monitor assent in regard to goals, procedures, or outcomes of the treatment plan.

(3e) To foster client feelings of safety and trust, therapist begins therapy with new clients and caregiver(s) (when relevant) with a goal of building therapeutic rapport through non-contingent reinforcement (e.g., reinforcement provided independent of client behavior), client preferred activities and materials, etc.).

(3f) Therapist uses skills to encourage positive therapeutic rapport (e.g., orientation towards client, posture, affect, tone of voice, responsivity, matching client preferences).

(3g) Therapist prioritizes client physical and emotional safety.

(3h) Therapist regularly assesses for unintentional harmful physical and/or social emotional effects of any assessment or intervention.

(3i) Therapist collaborates with client and caregiver(s) when relevant to clarify roles and expectations for all parties involved (i.e., therapists, client, caregiver(s), other members of the intervention team) throughout the treatment process.

(3j) Therapist explains rationale for their intervention decisions and procedures to client and caregiver(s) (when relevant) in order to allow them to make informed decisions about therapy

(3k) Therapist provides client extra time as needed to get settled in the clinical environment (e.g., time at the beginning of the session, opportunities for exposure to treatment environment prior to beginning of therapy, etc.).

(3l) Therapist encourages curiosity and exploration throughout the therapeutic relationship.

(3m) If crisis plans are enacted (e.g. restraint to prevent child from running out of the building into the parking lot), therapist recognizes potential harm to relationship and prioritizes repair of the relationship with the client and caregiver(s) (when relevant).

(3n) Therapist supports their own well-being and the well-being of other staff through adequate supervision and self-care (e.g., allowing time to decompress following stressful sessions, debriefing with colleagues as needed).

(3o) Supervisors provide trauma-informed oversight to staff.

(4) Promote Choice and Collaboration

(4a) Therapist provides autistic clients with regular choices between and within activities of intervention targets, activities, and materials to promote access to preferred items and interactions.

(4b) Therapist assesses reinforcement preferences for all clients regardless of communication style (e.g., augmentative and alternative communication/AAC systems/devices).

(4c) When planning for intervention goals, outcomes, and intervention procedures, the therapist uses person-centered and/or family-centered planning.

(4d) Therapist provides opportunities for autistic client and caregiver(s) (when relevant) to act as equal collaborators in selecting intervention goals and targeted outcomes whenever possible by providing information about all options for goals in a way that is accessible to the caregiver(s) (e.g., jargon-free language, primary language of client/caregiver(s), etc).

(4e) Therapist provides opportunities for autistic client and caregiver(s) (when relevant) to act as equal collaborators in selecting intervention procedures whenever possible by providing information about all options for goals in a way that is accessible to the caregiver(s) (e.g., jargon-free language, primary language of caregiver, etc).

(4f) Therapist implements either structured or unstructured observational assessments to identify preferences of intervention goals and outcomes for autistic clients who are unable to communicate these preferences verbally or using AAC device/system.

(4g) Therapist implements either structured or unstructured observational assessments to identify preferences of intervention procedures for autistic clients who are unable to communicate these preferences verbally or using AAC device/system. (e.g., A BCBA may assess preference between two or more intervention conditions using an alternating treatment research design).

(5) Cultivate Self-Determination and Encourage Empowerment

(5a) Therapist identifies strengths of autistic client and caregiver(s) and builds upon these to encourage the development of self-determination (i.e., client' and caregiver(s)' feelings of control over their own life, specifically as it pertains to their role in the therapeutic environment).

(5b) Therapist centers therapy around client assent as determined by observations for client's mood and behavior as well as client's willingness to engage in therapeutic activities.

(5c) Therapist prioritizes protesting as a communication goal for clients who have no clear means of protesting actions, activities, materials, etc through any communication modality (e.g., verbally saying "no", indicating "no" using a speech-generating device, gesture or sign language to indicate "no", other nonverbal protest gestures and/or vocalizations, etc.).

(5d) If client does not demonstrate assent or protests session activities, therapist will change aspects of the therapy (e.g., materials, activities, etc.) to gain client assent.

(6) Intervention is Neurodiversity Affirming

(6a) Therapist avoids using deficit language (e.g., “resistant”, “weakness”, “deprived”, etc.) in favor of using strengths-based language (e.g., "opted out of", "challenge", etc.) in all communication with autistic clients, caregiver(s), and other professionals.

(6b) Therapist emphasizes strengths of the autistic client and use of strengths-based language (e.g., “challenges” instead of “problems” or “weakness”, etc.) in all communication with autistic clients, caregiver(s), and other professionals.

(6c) Therapist celebrates and reinforces the unique strengths of autistic clients by incorporating special interests, activities, and mastered skills into therapy sessions.

(6d) Therapist refrains from intervention targets focused on conformity with neurotypical behavior (e.g. therapist does not prioritize eye contact, the reduction of non-harmful stereotypic behavior, etc.).

(6e) Therapist refrains from intervention targets that prioritize complete compliance (e.g., always following adult directions) to avoid risks to physical and emotional safety.

(6f) If caregiver(s) of autistic individuals suggest conformity or compliance goals (e.g., eye contact), therapist provides skill building alternatives that are culturally sensitive.

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