Module 3 – Supporting Recovery from Trauma

Topic 1. Understanding Trauma

1. WHAT IS TRAUMA?

The term "trauma" can be used to describe "both an adverse life event" and a person's "reaction to an adverse life event" (Wigham, Hatton & Taylor, 2011). There are many definitions for the experience of trauma, but most share these common elements:

i. A person experiences an event or series of events (chronic trauma) that presents an actual or perceived threat to their life or personal safety, or to that of a family member or significant other. It is important to note that the experience of trauma centers on how the individual experiences the event. Two people may experience the same event, and one may be traumatized and not the other.

ii. The nature of the experience includes intense emotional and physical effects associated with a sense of fear, terror, and/or helplessness that overwhelm the person's internal coping resources. The experience is so distressing it fundamentally changes how the person views and makes sense of the world, including their core beliefs about themselves, other people, and the future.

iii. The effects of trauma are wide ranging and can have an ongoing influence on the person's presentation (behaviours) and perspective (thoughts and feelings).

iv. The impact of trauma can be ongoing when people do not receive support to recover (Keesler, 2014; Saakvitne, Gamble, Pearlman & Tabov Lev, 2000 cited by Crates, Spicer, Burton, & Pullen, n.d.).

It is important to note that trauma is not experienced in the same way for everyone. A person's unique perception of a traumatic event can be influenced by many factors, including age at the time of trauma, personality, coping strategies, and life skills; environmental factors such as experiences prior to traumatic events; the type and characteristics of the traumatising event; the meaning of the trauma (personal and socio cultural); and/or the availability, skills and resources of social supports during and

after the trauma (Jackson & Waters, 2015; Keesler, 2015; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014).

i. Experiences of trauma

Traumatic events can include:

- **Single episode trauma –** for example, a car accident, a natural disaster, a sexual assault, or the removal of a child from their family.
- **Chronic trauma (ongoing or repetitive exposure to traumatic events) –** for example ongoing physical, sexual and emotional abuse within a family or other daily life context (for example, residential, educational, workplace); witnessing violence between caregivers or significant others (e.g. domestic and family violence) and ongoing experiences of neglect. Developmental trauma results from early and/or ongoing trauma in childhood (Crates et al., n.d).
- **Colonization or historical trauma -** colonization is defined as "a process whereby one group of people assumes control over another group of people" (including their land, language, cultural practices and personal freedoms) (Manitoba Trauma Information and Education Centre (MTIEC), 2013a) while historical trauma is defined as "a collective complex trauma" or "psychological baggage" that "reverberates across communities but also generations…[as a consequence of] "the devastating trauma of genocide, loss of culture, and forced removal from family" (Sharing Culture, 2016). Examples of colonization and historical trauma in Australia include the forced separation of indigenous children from their families; the forced removal of indigenous people from their land; and genocide. Experiences of genocide and the Holocaust are also examples of historical trauma (Sharing Culture, 2016; MTIEC, 2013a).
- **War –** the experience of war is a traumatic event for people who are born into or live in a cultural context of war (often for many generations); people who experience the onset of war and the loss of previous security; and people who are sent to war as soldiers and military personnel (MTIEC, 2013a).

Experiences of trauma in the lives of people with intellectual disability:

People with intellectual disability can experience the same traumatic events as anyone else, including single episode, chronic, colonization/historical, and war. At the same time, research demonstrates that

people with intellectual disability (including children, young people and adults) are more likely to experience many types of trauma, including:

- Sexual abuse, physical abuse, emotional/psychological abuse, financial abuse, and neglect (either a single episode or chronic)
- Social trauma – e.g. bullying, name calling, verbal abuse, exclusion from peer and community groups (this is often chronic)
- Trauma associated with experiences of institutionalization, including removal from family, multiple care placements, loss of valued relationships with family, staff, and/or co-residents (this can be single episode or chronic)
- Trauma associated with regulation and control of personal freedom – for example, forced sterilization, and removal of children.
- Experiences of trauma may occur in family of origin, service systems, schools, workplaces, and the wider community.

Research demonstrates:

- People with intellectual disability are more likely to experience traumatic events, especially sexual and physical abuse. (Ryan, 1994; Mansell, Sobsey & Moskal, 2003).
- Children with intellectual disability report more negative life events (bereavement, life threatening illness, move of residence and injury) (Hatton & Emerson, 2004).
- People with disability are at least 3 or 4 times more likely to experience abuse than those without disability (Sobsey, 2008; Mitchell & Clegg, 2005).

ii. Effects of trauma

The Manitoba Trauma Information and Education Centre in Canada outlines seven domains in which people may experience trauma effects, including physical, emotional, behavioural, cognitive, neurobiological, relational and spiritual effects (MTIEC, 2013c). Examples of effects in these different domains are outlined below:

Physical effects include:

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)

- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted infections (STI's)
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity and
- Adolescent pregnancy

Emotional effects include:

- Depression
- Feelings of despair and hopelessness and helplessness
- Guilt
- Shame
- Self-blame
- Self-hatred
- Feeling damaged
- Feeling like a "bad" person
- Anxiety
- Extreme vulnerability
- Panic attacks
- Fearfulness
- Compulsive and obsessive behaviours
- Feeling out of control

- Irritability, anger and resentment
- Emotional numbness
- Frightening thoughts and
- Difficulties in relationships

Behavioural effects include:

- Self-harm such as cutting
- Substance abuse
- Alcohol abuse
- Gambling
- Self-destructive behaviours
- Isolation
- Choosing friends that may be unhealthy and
- Suicidal behaviour

Cognitive effects include:

- Memory lapses, especially about the trauma
- Loss of time
- Being flooded and overwhelmed with recollections of the trauma
- Difficulty making decisions
- Decreased ability to concentrate
- Feeling distracted
- Withdrawal from normal routine and
- Thoughts of suicide

Spiritual effects include:

- Feeling that life has little purpose and meaning
- Questioning the presence of a power greater than ourselves
- Questioning one's purpose
- Questioning "who am I", "where am I going", "do I really matter"
- Thoughts of being evil, especially when abuse is perpetrated by Clergy
- Feeling disconnected from the world around us and

- Feeling that as well as the individual, the whole race or culture is bad

Neurobiological effects include:

- Jittery, trembling
- Exaggerated startle response
- Alarm system in the brain remains "on"; creating difficulty in reading faces and social cues; misinterpreting other people's behaviour or events as threatening, sleep difficulty and the need to avoid situations that are perceived to be frightening
- Part of the brain systems change by becoming smaller or bigger than they are supposed to be
- Fight, flight, freeze response (which may look different from person to person) these
- Responses are involuntary

Relational effects include:

- Difficulty feeling love, and/or trust in relationships
- Decreased interest in sexual activity
- Emotional distancing from others
- Relationships may be characterized by anger and mistrust
- Being Unable to maintain relationships and
- Parenting difficulties

2. *HUMAN RESPONSES TO TRAUMA*

A trauma informed approach is important when working with people who have or may have experienced trauma, as is the case for many people with intellectual disability. A trauma informed approach requires an understanding of:

i. The Biology of Trauma (the biological changes that occur in a stress response)

ii. The Continuum of Trauma (the range of traumatic stress responses)

iii. The Trauma/Emotion/Behaviour Triad (including “Challenging Behaviours”)

iv. Trauma triggers

v. Practices for calming a trauma response

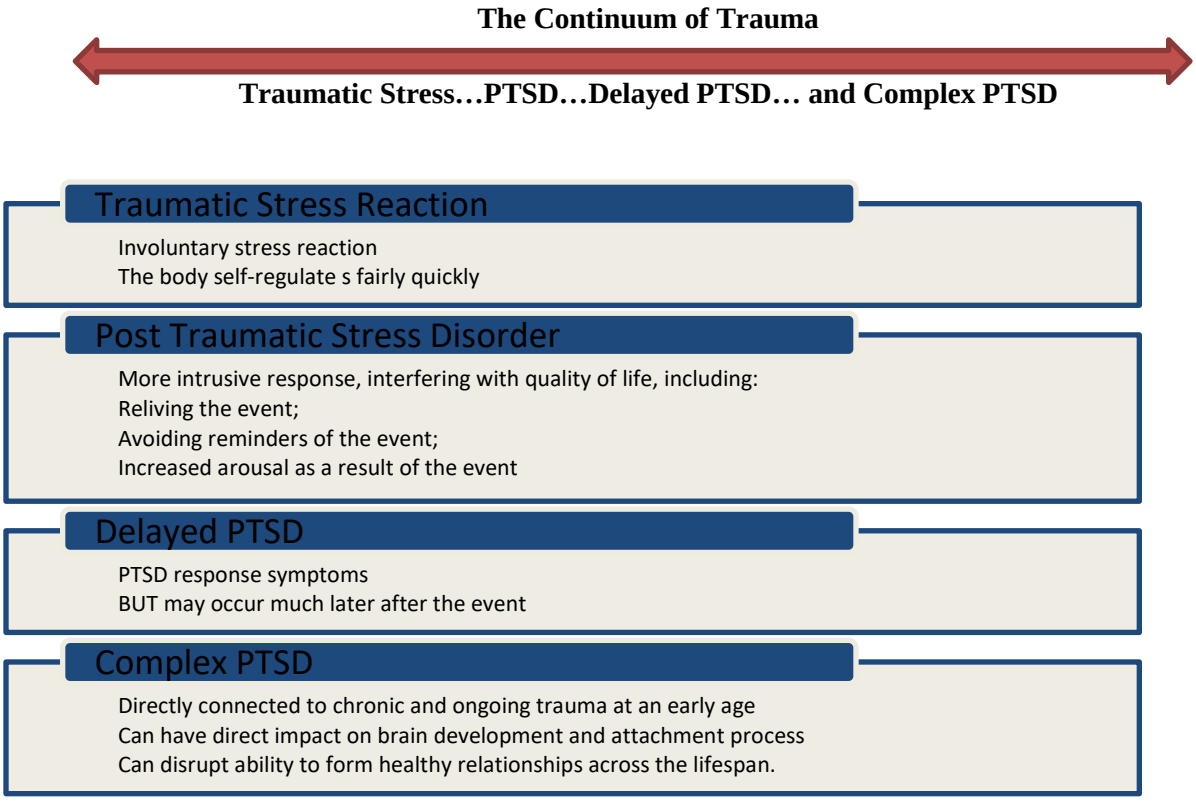
i. The Biology of Trauma

Exposure to trauma leads to "a cascade of biological changes and stress responses" (SAMHSA, 2014), including:

- **Changes in limbic system functioning** (the limbic system is a complex system of nerves and networks in the brain, involving several areas near the edge of the cortex concerned with instinct and mood. It controls the basic emotions (for example fear, pleasure, anger) and drives (hunger, sex, dominance, care of offspring).
- **Changes in cortisol levels** (cortisol is a hormone made by the adrenal glands (located on each kidney) and it is essential for life. Cortisol can: help the body to manage stress; convert protein into glucose to boost flagging blood sugar levels; work in tandem with the hormone insulin to maintain constant blood sugar levels; reduce inflammation; contribute to the maintenance of constant blood pressure; and contribute to the workings of the immune system) (https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/hormones-cortisol).
- **Changes in brain chemistry** (neurotransmitters) resulting in abnormal functioning (dysregulation) of the body's arousal and pain relieving systems.

ii. **The Continuum of Trauma**

The Continuum of Trauma provides a model for understanding the range of stress reactions a person may have in response to an experience they perceive as traumatic:



Traumatic Stress Reaction – Traumatic stress reactions can be described as "normal reactions to abnormal circumstances" (SAMHSA, 2014). A traumatic stress response may include an involuntary reaction to a situation that is experienced as highly stressful but the body is able to fairly quickly regulate itself after the stressful event. For example, having a medical procedure may trigger a significant stress response but this does not interfere significantly in the person's quality of life. A person may have a traumatic stress response to an event but not go on to develop Post Traumatic Stress Disorder (PTSD).

"Immediate reactions to trauma can vary widely and include exhaustion, confusion, sadness, anxiety, agitation, numbness, disassociation, physical arousal and blunted affect" (SAMHSA, 2014).

Post-Traumatic Stress Disorder is a more significant intrusive response to a traumatic event, and includes the ongoing experience of:

1) Reliving of the traumatic events (for example, flashbacks;
2) Avoidance of the reminders of the event; and
3) Increased arousal as a result of the event.

These three factors are considered in the formal diagnosis for PTSD. The symptoms of PTSD are ongoing; become the organizing principle of the individual's life; and interfere significantly with the person's quality of life and can be very debilitating.

"Indicators of more severe responses include continuous distress without periods of relative calm or rest, severe disassociation symptoms, and intense intrusive recollections that continue despite a return to safety" (SAMHSA, 2014).

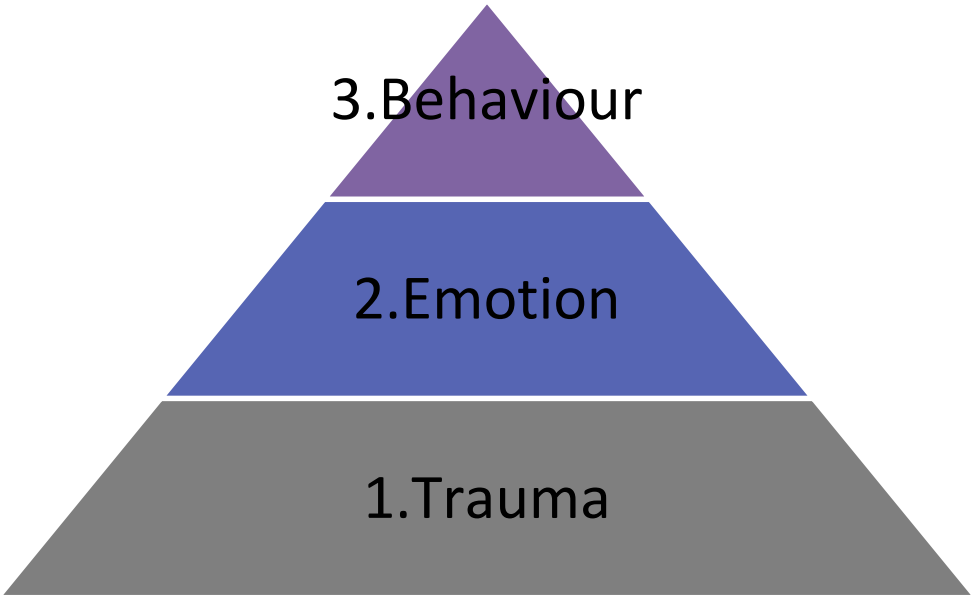
Delayed Post Traumatic Stress Disorder would include all of the symptoms and experiences listed above in the PTSD response but what is relevant to this response or impact is the symptoms may occur *much later* after the traumatic event has occurred. This can be very confusing and frightening for people who experience a traumatic event and then months or maybe even years later begin to develop symptoms of a PTSD response.

"Delayed responses to trauma can include persistent fatigue, sleep disorders, nightmares, fear of recurrence, anxiety focused on flashbacks, depression, and avoidance of emotions, sensations or activities that are associated with the trauma" (SAMHSA, 2014)".

Complex PTSD is at the far end of the continuum and is considered the most severe form of PTSD. It is characterized by a history of severe, long-term trauma at an early age in development that usually includes exposure to caregivers (parent, caregiver, or person in a position of authority) who were cruel, inconsistent, exploitive, unresponsive or violent. This type of trauma has a direct impact on brain development (and to that end can be a cause of intellectual impairment) and the attachment process (which can impact the individual's ability to form healthy relationships across the lifespan).

iii. **The Trauma/Emotion/Behaviour Triad**

The trauma/emotion/behaviour triad provides a model for understanding the relationship between traumatic events, emotional response, and behaviour.



Level 1: Trauma Event

Earlier in this presentation we looked at different types and examples of trauma events, including single episode trauma, chronic trauma, colonization or historical trauma, and war.

Levels 2 & 3: Emotional and Behavioural Responses

Emotional and behavioural responses to trauma are automatic responses triggered by the biological changes in the nervous system that we looked at earlier. These emotional and behavioural responses fall into one of three groups – fight responses, flight responses, or freeze responses. The primary (and primal) aim of these responses is **survival** of real or perceived danger (MTIEC, 2013b).

Fight responses (aimed at fighting off or frightening away the perceived danger) include:

- Crying
- Hands in fists, a desire to punch, rip
- A Flexed/tight jaw, grinding teeth, snarl
- Fight in eyes, glaring, fight in voice
- Desire to stomp, kick, smash with legs, and feet
- Feelings of anger and rage
- Homicidal or suicidal feelings
- A Knotted stomach/nausea, or burning stomach
- Metaphors like bombs, or volcanoes erupting

Flight responses (aimed at fleeing or escaping the perceived danger) include:

- Restless legs, or feet /numbness in legs
- Anxiety/shallow breathing
- Big/darting eyes
- Leg/foot movement
- Reported or observed fidgety-ness, restlessness, feeling trapped, tense
- Sense of running in life- one activity to next
- Excessive exercise

Freeze responses (aimed at hiding from the perceived danger) include:

- Feeling stuck in some part of body
- Feeling cold/frozen, numb, pale skin
- Sense of stiffness, heaviness
- Holding breath/restricted breathing
- Sense of dread, heart pounding
- Decreased heart rate (can sometimes increase)
- Orientation to threat

"Challenging Behaviours" in response to trauma:

Trauma response behaviours by people with intellectual disabilities are often labelled as "challenging behaviours". If we only consider the person's behaviour, without identifying the emotional response

underlying that behaviour, or the root cause (trauma) underneath that, our response will often be ineffective, and may cause unintended harm. Adopting a trauma-informed approach can help to to respond more effectively to people who are demonstrating behaviours that are challenging.

iv. Triggers that can activate trauma responses

A trauma response initiated by a prior event (for example, past experience of abuse, including physical, sexual, verbal abuse, neglect, abandonment) can be triggered by actions or events that occur in the present. As such, certain actions or responses by service providers, support workers and/or family members are not compatible with the needs of people who have experienced trauma because they present a risk of re-traumatising the person; escalating the “challenging behaviour” by triggering the fight/flight/freeze response; and damaging the relationship between the person and their supporter.

Actions or events commonly experienced by people with intellectual disability that could trigger a trauma response include:

- The use of restraints, restriction or aversion practices (the pairing of an unwanted behaviour with an unpleasant stimulus - for example, electric shock, or bad taste) to manage unwanted behaviours.
- Teasing, demands, parental tones, judgments, labels, or sarcasm.
- Rejection, lack of relationships, inappropriate touching.
- Lack of attention.
- Loss, death, staff turnover (Harvey, 2012).

v. Calming a trauma response

Within the human nervous system, the sympathetic nervous system (SNS) controls the body's arousal responses to perceived threat and is responsible for the "fight or flight" response; while the parasympathetic nervous system (PNS) (or “calming system”) controls homeostasis (stability) and the body at rest and is responsible for the body's "rest and digest" functions (Low, 2016). When the sympathetic nervous system is activated during a trauma response the rational mind shuts down. The sympathetic nervous system can only be calmed by the parasympathetic nervous system (not by the rational mind) and soothing calming reassurance is needed (Harvey, 2012).

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Topic 2. Supporting Recovery from Trauma: General Principles

Six foundational principles have been identified as central for supporting people with intellectual disability to recover from trauma (Jackson & Waters, 2015). These principles form a framework for providing ***trauma informed support*** to people with intellectual disability:

1. Safety
2. Relationships
3. Collaboration
4. Choices
5. Voice
6. Person-centered practice

This material is primarily drawn from the Berry Street "Taking Time" trauma informed framework for supporting people with intellectual disability (Jackson & Waters, 2015).

1. SAFETY

Safety is central to a trauma informed approach, and includes physical, psychological, social, ethical/moral and cultural safety. A trauma informed approached is committed to non-violence and addressing threats to safety:

- Threats to physical safety include exposure to physical abuse and neglect; sexual abuse, lack of safe and secure accommodation; lack of supportive relationships to turn to; unmet physical or personal care needs; and unnecessary medical procedures.
- Threats to psychological safety include emotional abuse and neglect, and rejection on the basis of disability; discrimination and bullying.
- Threats to social safety include isolation, multiple accommodation changes, multiple staffing changes; and lack of support for communication needs.
- Threats to ethical/moral safety include being forced or coerced into acting against personal beliefs and values; and lack of meaningful involvement in decisions impacting on the person.
- Threats to cultural safety include being subject to racisms or racial violence, restrictions on participating in cultural activities and communities, and restricted opportunities to develop cultural identity.

A trauma informed approach is also committed to promoting personal sense of safety by:

- Recognising personal or "subjective" sense of safety (respecting and responding to people when they identify they feel unsafe).
- Providing comfort (food, shelter, emotional support).
- Ensuring physical safety (from self and others).
- Dialogue – engaging with and supporting people to voice their safety concerns and needs.
- A safe person – supporting people to identify and/or engage with supportive relationships that they can go to for help and assistance when they feel unsafe.
- Acknowledging and/or developing personal ability to get emotional, social and physical needs met.
- Understanding and responsive staff. The AAIDD highlight the following as practices by staff who foster recovery: ***They believe in the person –*** for example, by demonstrating positive regard; building resilience; and praising character. ***They listen to the person –*** for example, by "sitting down and listening to me for 10 minutes every day"; by "letting me get it all out before you give me advice". ***They coach the person –*** for example, by using a coaching or mentoring model; by respecting individuals while fostering their skills (Karen Harvey, 2012).

2. RELATIONSHIPS

Researchers note "recovery from trauma can only occur within the context of relationships, not in isolation" (Herman, 1997 & Perry, 2005 cited in Jackson & Waters, 2015, p. 23). Overcoming experiences of trauma (which primarily occur in relationships) requires "repetitive, persistent, nurturing experiences" in relationships (Jackson & Waters, 2015, p.23). In effect, people are supported to recover from trauma by experiencing the opposite of trauma. A trauma informed approach can include helping people to develop their interpersonal skills for better relationships, and to build/strengthen relationships with supportive peers, family members and/or community members (Harvey, 2012).

3. COLLABORATION

Collaboration emphasizes the importance of partnerships with people with intellectual disability. At the heart of collaboration is the spirit of "doing with rather than for" (Jackson & Waters, 2015, p. 24). Collaborative practices include involving people with intellectual disability in planning and delivery

supports, including planning goals and setting priorities; involving people with intellectual disability in peer support and advocacy roles to share their lived experience, assist others, and contribute to social change; and respecting an individuals lived experience and the meaning they make of their own experiences.

4. CHOICES

A trauma informed approach seeks to maximise personal choice and control. Research demonstrates a person's quality of life is impacted by the degree of choice and control (or self-determination) they experience (Jackson & Waters, 2015). Research also demonstrates that people with disability rate personal choice and control as a higher priority than professionals, parents and other family members do for people with disability (Jackson & Waters, 2015).

Having choices is fundamental for personal empowerment and positive identity development. People with intellectual disability are often ignored, ridiculed, forgotten about, or left out. As a consequence of these experiences, many struggle with negative identities, for example, *not the* person who gets the job; *not the* person who gets married; *not the* person who drives; *not the* person who is popular or liked (Harvey, 2012). Having choices supports people with intellectual disability to experience personal empowerment and build a positive sense of self. Choices must:

- Be real choices, not fake ones;
- Offer real input into daily life;
- Provide experiences of being asked and being listened to, for example, '*What is bothering you?*'; '*How are you feeling?*'; '*What is going on for you?*'; '*What do you think you should do?*' (Harvey, 2012).

5. VOICE

A trauma informed approach is mindful that the experience of trauma can take away an individual's personal power, sense of personal control, and dignity. A trauma informed approach seeks to prioritise the voices of people with intellectual disability being "heard and heeded", and aims to share power in collaborative support practices.

6. PERSON-CENTERED PRACTICE

A trauma informed approach is person-centered. Person-centered practice seeks to ensure that planning, services and support are tailored to the person's needs, goals and wishes. The goal of person-centered support is to assist people with intellectual disability to gain or regain greater choice and control in their daily lives, including building strengths, skills and knowledge to support increased choice and control.

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Topic 3. Supporting Recovery from Trauma: The Role of Counselling

Topics 3, 4 & 5 are focused on counselling practice with people with intellectual disability who have experienced trauma. Counselling is a specialist response that can assist people with intellectual disability to recover from trauma and must be delivered by trained and skilled professionals. The information presented in Topics 3, 4, & 5 are designed to assist *qualified counselling practitioners* to develop their knowledge and skills when working with clients with intellectual disability. This information may also assist non-counselling service providers and support people to identify appropriate counselling opportunities for people with intellectual disability who have experienced trauma. This information does not provide foundational counselling training. Please contact an accredited provider for information on obtaining recognised counselling qualifications.

1. ASSESSING THE APPROPRIATE RESPONSE TO TRAUMA

As with any other person, people with intellectual disability who experience traumatic events do not automatically require counselling. Many people recover from trauma with the support of family, friends and their community. In some cases, a more appropriate response may be to assist family members and other support people to build their knowledge and understanding of trauma-responses; and how they can support someone to recover from trauma (this work can be done instead of or alongside individual counselling). When choosing this response, it is important that service providers develop a clear assessment of the capacity of the relationships in a person's life to support their recovery from trauma, while recognising that people with intellectual disability may have few supportive relationships; and/or may experience abuse in their personal relationships.

Counselling may be an appropriate response when people demonstrate signs of an intrusive trauma response that is interfering with their quality of life (for example, flashbacks; avoidant behaviors; and experiencing ongoing fear, anxiety and/or emotional distress). Where counselling support is indicated as an appropriate response, and is provided by a suitable qualified and skilled professional in a safe and supportive space, it can assist people with intellectual disability to:

- Process and recover from experiences of abuse;
- Build personal skills and knowledge that support increased personal safety (including developing knowledge of sex and sexuality, personal relationships, personal choice and protective behaviours);

- Promote and support improved well-being through increased self-knowledge and future goal planning, while learning and practicing new skills and strategies. For example, relationships and interpersonal communication.

2. COUNSELLING PEOPLE WITH INTELLECTUAL DISABILITY

Two to three per cent of Australians meet the criteria for a diagnosis of intellectual disability (AIHW, 2008). This increases to thirteen percent when expanded to include 'borderline' intellectual disability (IQ 70-84) (AIHW, 2008; Ferrari, 2009). As such, all counsellors have a professional responsibility to increase their competence to work with this broad group of clients, as they would any group of service users.

Why people with intellectual disability attend counselling

People with intellectual disability can attend counselling for many different reasons, just like anyone else. At the same time, we know that people with intellectual disability are more likely to experience a range of personal and social disadvantage, including associated experiences of trauma and grief and loss. It is important for counsellors to be aware of the common lived experiences of people with intellectual disability; to understand how these experiences can impact people's personal well-being and relationships; and to consider how they might present directly and indirectly in the counselling context. *See Module 1 – Introduction to Intellectual Disability for more detailed discussion of the personal and social lived experience of intellectual disability.*

At WWILD, common experiences addressed in the counselling context can include:

- Sexual violence (including recent, historical & child sexual assault)
- Domestic violence
- Post-Traumatic Stress Disorder
- Exploitation
- Grief and loss
- Ongoing vulnerability
- Social isolation
- Relationship issues
- Childhood removal – both their own and their children's
- Childhood abuse and rejection

- Behavioural issues including“at risk behaviour”
- Institutionalisation
- Housing or homelessness
- Lack of sexual awareness
- Disempowerment and low self-esteem
- Anxiety
- Offending behaviours
- Self-harm and
- Self-regulation issues

People with intellectual disability may attend counselling at generic services for these and other concerns, including eating disorders, mental health conditions, attachment issues, self-harm and suicidality, and drug and alcohol issues.

Myths and facts about counselling people with intellectual disability

People with intellectual disability are subject to many harmful myths and negative attitudes that impact on their daily lives. This can include myths about their experience of trauma and their ability to benefit from counselling support. Counsellors and therapists are not immune to these attitudes - all members of our society are exposed to negative understanding and depiction of intellectual disability.

Myth: People with intellectual disability do not experience emotions in the same way as people without intellectual disability. In other words, People with intellectual disability can’t feel.

Fact: People with intellectual disability have feelings and experience emotions in the same multiple ways as people without intellectual disability. However, they may have greater difficulty identifying their emotions and feelings and describing them verbally.

Myth: People with intellectual disability don’t suffer trauma or feel as hurt by exploitation or abuse as people without intellectual disability.

Fact: People with intellectual disability feel trauma, pain and distress from abuse as much as any other person.

Myth: People with intellectual disability lack the cognitive ability to engage meaningfully in counselling, therefor they don’t benefit from these services.

Fact: people, with or without intellectual disability, may experience difficulty with abstract thought, . People with intellectual disability can benefit from counselling, just like anyone else, if the counselling they receive is responsive to their needs. This would include support to translate abstract concepts into concrete terms.

Myth: People with intellectual disability have trouble speaking and are unable to communicate well in a counselling or therapeutic environment.

Fact: People with intellectual disability will demonstrate a wide range of verbal communication abilities. Even with limited verbal communication abilities people can communicate in many different ways if they are given the opportunity, and encouragement, to use creative means of communication.

4. THE COUNSELLING PROCESSES AND PEOPLE WITH INTELLECTUAL DISABILITY

The counselling process (or stages of counselling) used when counselling clients with intellectual disability is the same as for any client. However, it is important that counselling practitioners are aware of and responsive to the specific needs of clients with intellectual disability at different stages of the counselling process.

i. Referral

Very few counselling clients with intellectual disability will be self-referrals. Most referrals to counselling come from someone close to the client when their behaviour starts to impact on others. It is important to ensure people with intellectual disability understand why they have been referred for counselling; what counselling is and what will happen in their counselling sessions. Also what they can do if they do not want to participate in counselling (this must include supporting the person to understand any potential consequences if they choose not to attend counselling).

ii. Rapport building

'Rapport building' refers to the things we do to engage with and build a working relationship with a client or service user. Rapport building is the foundation of a trusting and meaningful relationship, and increases your chance of understanding the client's meaning of what they tell you in future counselling sessions.

The rapport building period is important for conducting an initial assessment of cognitive ability and to collaboratively establish the purpose and goals of counselling. In this period it is also important to help the client to understand the nature of the counselling relationship. This includes the role of the counsellor as a supportive, caring and friendly worker, but not as a friend. This *abstract* distinction can be difficult for some people with intellectual disability to understand. When people have few supportive or caring relationships in their lives, they can become very attached to the counselling relationship.

What helps build rapport?

- Taking time!
- Use reflective listening
- Going at the client's pace
- Showing care and respect
- Using appropriate humour – check for understanding
- Honouring the hard stuff while acknowledging resilience and
- Resisting being the expert

What is important to learn?

- The client's communication style (what will work?)
- The client's ability to think abstractly
- Their ability to recognise and articulate feelings.
- Information about their living situation
- What they like and dislike
- Who is in their life and what relationships are important to them
- A brief history
- What ability they have to tolerate discussing harder feelings, experiences and thoughts.
- Their strengths and abilities
- What they value

When will you know you are there?

- The client keeps turning up!
- When you can have a laugh
- When you can have a cry and talk about the harder stuff

- When the person can tell you that they don't understand.

iii. Confidentiality

Confidentiality can be a difficult concept for people with intellectual disability to understand. This should be explained and revisited regularly to reinforce the person's understanding, not simply discussed as a one-off at the beginning of the counselling relationship. It is helpful to introduce the word 'confidentiality' to counselling clients as it is likely that people will hear this word in other settings. Many people will be familiar with the word 'privacy', and it can be helpful to explain confidentiality in these terms. For example, counsellors could say, "I will keep what you tell me in counselling private"; or "I could get into trouble if I tell people what we talk about in counselling". It can also be helpful to talk about 'trust'. For example, counsellors at WWILD may say "What we talk about in counselling is important, and it is important that you can trust me with this information. I won't tell other people what we talk about in counselling, unless you ask me to".

It is very important to explain the limits to confidentiality and these should be revisited often. Clients with intellectual disability need to understand that they can trust their counsellor to keep their information private, but they also need to understand when the counsellor might need to talk to other people. If the counsellor has to break confidentiality and tell someone else, they should always tell the client first unless there is a risk in doing so. At WWILD, counsellors may tell their clients they will talk to other WWILD staff about their counselling work (to make sure the counsellor is doing a good job); WWILD counsellors ask their clients what it is ok or not ok for them to share with the client's support workers, caregivers, or significant others. these relationships can play an important part in supporting people with intellectual disability to practice strategies discussed in counselling, and can provide the counsellor with useful feedback on any possible changes in the client's behaviour and/or well-being. Other limits to confidentiality may include when a client threatens to self-harm or to cause harm to others.

iv. Closure

Closure needs to be discussed from the beginning of the counselling relationship so that client's don't think counselling will go on forever. Closure can be discussed as part of goal setting for counselling. For example, ask "What do you hope will be different for you when you finish counselling?"

Closure needs to be planned and worked towards. At WWILD, counsellors often move from fortnightly to monthly sessions during the closure period. It is important to be mindful of how isolated many people with intellectual disability are. Many people have few meaningful relationships in their lives, which can make the counselling relationship highly valued by the client.

Reflection and review are an important part of the closure process**.** The aim of collaborative reflection and review on closure is to highlight the shared journey undertaken while counselling. By going back to the original hopes and goals of the client, you can together look at any changes the client may now be making in their lives. Any changes in the client's choices, knowledge and behaviours over the counselling time can be discussed and celebrated. At WWILD, counsellors may ask - "What is different in your life now from when you set these goals?" Responses will probably be concrete and some are:

- *I talk to my sister now*
- *I can say no if I want to.*
- *It's ok if I don't always get things right, my Dad can help me.*
- *I'm not always going to be stuck back there, he can't hurt me now*.

Celebration is an important part of the closure process. It is important to honour the work that has been done in counselling and the changes that have been made in the client's life. At WWILD, counsellors encourage the client to say how they would like to celebrate the ending of the counselling relationship (for example, with a cake or a certificate). Some clients may want to invite significant others to the celebration. By inviting family members, support workers or significant others to the celebration the client gets to show what they have learnt with the counsellor's assistance, this may be difficult for them to articulate on their own. It also gives the people who are invited a chance to add their observations and gives them an opportunity to say how they are feeling about any changes.

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Topic 4. Supporting Recovery from Trauma: Counselling Practice

There is no "magic formula" for counselling people with intellectual disability. However, counselling practitioners will need to make certain adaptations to their counselling practice to ensure they can be responsive to the needs of people with intellectual disability, so these clients can have counselling experiences that are meaningful and helpful to them.

It is important to remember that people with intellectual disability are not a homogenous group. You will need to adapt your counselling practices to meet the needs of the individual you are working with. With that in mind, the key adaptations counsellors will need to make to their counselling practice to work effectively with people with intellectual disability are:

1. TIME

Most counselling clients with intellectual disability will take longer and will move at a slower pace than counselling clients without intellectual disability. The standard time allowed for practice – to engage, build rapport, create safety, assess and define individual and therapeutic goals – may not be sufficient for many people with intellectual disability.

People with intellectual disability may require more sessions. It may take two or three sessions to cover the same content of one session with a person without intellectual disability. Sessions may need to be shorter in length or include more breaks. People with intellectual disability may not be able to concentrate for long periods of time; or may require regular breaks to rest and refocus. Sessions may need to take place more frequently (e.g. weekly or fortnightly rather than monthly). Longer gaps between sessions may make it difficult for people to remember and build on previous sessions.

Clients may require extra time to review, evaluate, and have new ideas and concepts repeated in various forms. It is important that counsellors do not expect people with intellectual disability to develop or move forward at the same rate as clients without intellectual disability. They may need more time in counselling sessions to understand the nature of the task; to comprehend the questions being put to them; to think about the questions; to try to retrieve the relevant information from memory; and

to put the information into words. If the client is non-verbal then extra time will be needed for them to communicate what they want to say (Milne & Bull, 2006).

2. COMMUNICATION

Many people with intellectual disability will have their own communication style, and counsellors need to work out how to best communicate with each individual. Remember, *it is not the client's job to understand you; it is your job to work out how to understand them*. Supportive communication practices in the counselling context are discussed in more detail in Topic 4, however, the key points to note are:

- **Ask the person how you should best communicate with them.** If they have difficulty with verbal communication, ask the important people in their lives, for example, a family member, or a support worker. Somebody will have experience with the client and know how to best to communicate with them.
- **Use people's own language**. People with intellectual disability often speak using their own language. For example, they might use humour or a conceptual schema that are not always obvious in meaning to the counsellor. Counsellors will need to listen carefully to develop an understanding of the person's own language. Exploring the meaning of statements and keeping a 'dictionary' of phrases commonly used by the person can be a useful way of improving rapport and communication. This can also be helpful during periods of staff turnover. Listen to and use the client's wording. Some examples of people's own language used in counselling at WWILD include *"thinking backwards"* (refers to flashbacks); *"getting hitty"* (means you're not listening); *"going down, down"* (for feelings prior to self-harming); *"snaffle"* (meant 'wants to have sex with me'); and *"the crappy stuff"* (for the sexual abuse).
- **Give information in a way that is responsive to people's needs.** People with intellectual disability often experience comprehension difficulties, including difficulty understanding the many abstract concepts discussed in counselling. this includes feelings and emotions, respect, confidentiality, and being a victim or survivor); They can also have difficulty making sense of lots of information if it is presented too quickly. Abstract concepts must be translated into concrete terms. Complex information should be broken down into clear, simple and manageable chunks.
- **Build knowledge on something that is already known to the client**. For example, if they know private behaviours like dressing, showering or going to the toilet, this knowledge can be used to explain privacy in sexual behaviours and relationships.

- **Repeat information and concepts to support learning.** People with intellectual disability often have difficulty with memory. Concepts and ideas may need to be explained, discussed and revisited to support learning and retention over time.
- **Check for understanding.** Give the client permission to tell you if you have got it wrong. Don't be afraid to apologise for being confusing, and ask to start again. Assume nothing, check and recheck that you and the client have the same understanding. For example, all attempts to help a client manage severe flashbacks were failing, till the client revealed that they couldn't make them go away no matter what they did. An assumption was made, given a long history of therapy, that the client would know that flashbacks can be managed but they won't go away.

3. COMPLIANCE AND ACQUIESENCE

Counselling practitioners must remain attentive to compliance and acquiescence in communication with clients with intellectual disability. Many people with intellectual disability adopt a compliant or acquiescent communication style (for example, agreeing with others when they actually disagree, or when they do not understand what has been said). Compliance and acquiescence are learned behaviours and can be deeply ingrained. They are strategies for seeking approval from others; masking a lack of understanding; and/or protecting themselves from confusing or harmful interactions. As such, counsellors should develop their awareness of these behaviours in the counselling context and develop skills for gently checking and supporting their understanding.

Counselling professionals are in a position of power when they work with people with intellectual disability. Being aware of this power imbalance is crucial. In many cases, compliance, miscommunication and challenging behaviour may be reduced by a conscious and ongoing effort by the practitioner to decrease the power differential between themselves and their client.

Strategies that can help reduce the power imbalance in the counselling context include:

- **A welcoming and non-threatening counselling space**, that is well-equipped for flexible and creative practice. Art materials should be readily accessible to both the counsellor and the client. It is helpful to have shelves on which figurines, toys and shapes can be placed.
- **A welcoming arrangement of furniture and a choice of places to sit that are "power-neutral".** Ask the client where they would like to sit.

- **A flexible approach to counselling in different environments, where appropriate.** Some practitioners report positive gains when counselling takes place outside the clinical office environment. For example, meet in a coffee shop, go for a walk, sit in a park under the trees.
- **Avoid using jargon.** Professional language and jargon creates barriers to communication with clients with, and without, intellectual disability. Unnecessary use of professional language and jargon will only remind the client that they are unequal in the therapeutic relationship.
- **Be aware of the different labels applied to intellectual disability, and use them as little as possible.** Most people with intellectual disability do not identify with diagnostic labels or even with having a disability, due to the powerful stigmatization associated with disability. It is possible that they will have experienced disrespect in the past. It can be helpful for counsellors to ask the client what they think the counsellor might need to know about their disability. For example WWILD counsellors might ask "Is there anything like reading or writing you might need my help with so I can get this right for you?"
- **Take responsibility for communication.** Support people to feel OK to tell you if they don't understand something. Never blame a client for not understanding, it is the counsellor's responsibility to ensure the clients understanding. At WWILD counsellors might say: "Sorry, I got excited and went too fast didn't I - can we go back a bit?"
- **Non-verbility -** it is important to remember a client's inability to articulate their thoughts can be physical, emotional or cognitive.

4. SUPPORT

People with intellectual disability may require support to attend counselling. They may need help to remember and get to counselling appointments; to feel comfortable with the counsellor and the counselling process; and to help the counsellor understand the person's way of communicating.

Some clients may want to have a support person in the counselling session (at least initially). It is important people are offered the opportunity to involve a support person in counselling if that is what they want:

- Ideally, the involvement of support people will be time limited (however, this will need to be determined based on the needs and wishes of the client). For some people the need for a support person will diminish once rapport is developed and the client becomes more familiar and confident

with the counselling process; and the counsellor becomes more skilled at understanding the client's communication style. Some clients will talk more freely when they are on their own with the counsellor, but they may still require ongoing support to remember to attend their counselling and to travel to appointments.

- Support workers, family members and significant others in the client's life will have experience, knowledge and understanding of what the client already achieves in their lives.
- It is important that support people understand their role in the counselling session (this is to provide emotional support if needed, and/or to assist with communication). Support people should not talk for the client, or attempt to minimize or dismiss what the client has said (for example, when a client starts talking about feeling depressed, a support person should not interject, "but we had a nice day last week"). Counselling practitioners should be alert to support people attempting to control or constrain the focus of the counselling session or the client's freedom of expression (for example, discouraging discussion of sex or sexuality). Counsellors should also be mindful that perpetrators of abuse and neglect are often in close relationships with their victims (both with and without disability). It is imperative that perpetrators are not engaged in the counselling process as "support people" with the ulterior motive of controlling what the client tells the counsellor.

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Topic 5. Supportive Communication Practices in the Counselling Context

People with intellectual disability will have specific communication needs. In this topic we will consider common communication needs and supportive communication practices for supporting recovery from trauma in the counselling context and beyond.

1. DIFFICULTY WITH ABSTRACT THOUGHT AND COMPLEX LANGUAGE

Many people with intellectual disability have a very literal interpretation of verbal communication and can have difficulty understanding abstract concepts**.** Examples of abstract thinking that commonly cause difficulty include:

- Mathematical concepts such as time and money
- Metaphors, euphemisms and analogies
- Humour and jokes
- Emotions and feelings in themselves and in others.

Understanding emotions can be challenging for people with intellectual disability. The language used to describe emotions in abstract, yet the reality of the emotions they experience can be very concrete. People with intellectual disability often experience intense physical or behavioural responses to unexpressed emotional states. This is due to their limited means of identifying and expressing feelings. This difficulty of expression is often compounded by a high level of experienced trauma through abuse and exploitation.

Strategies:

- **Connect the abstract label of the emotion**. For example, 'when feeling sad', to the corresponding physical experience in the body, 'I cry or I'm flat'. This can help people talk about their emotional experiences, and assist them to find ways to recognise and respond to emotions. A person may not be able to talk about their 'nervousness', but can talk about 'feeling sick in the stomach'.
- **Ask questions** like "Where do you feel that?"; "Can you show me how that feels for you?"; What does your face/body do?" to help the person identify what they are feeling.
- **Approach this work with a sense of patience, commitment and curiosity**. It can take a long time to uncover the different understanding and experiences of emotions for each client.

2. MASKING AND ACQUIESCENCE

People with intellectual disability often mask their difficulty with verbal communication to avoid the stigma associated with having a disability. Masking can take the form of:

- Rote learned statements when responding to questions; when in a conversation; or to navigate everyday experiences. For example, "I don't know whether I'm Arthur or Martha".
- Learned behaviours to get care or help, to fit in, or to get someone to go away. For example, smiling inappropriately or appearing helpless.

It is very common for people with intellectual disability to take on a passive communication style, where they let the more powerful person in the conversation take the lead. In this way, acquiescence (or compliance) is a way of masking disability. Possible reasons for acquiescence include:

- The person may not understand what was said so they agree with it in an attempt to cover (or mask) their misunderstanding.
- They find it difficult to say no, particularly to someone perceived to be in authority.
- They don't want to say no or fear saying no, and agree with what is said to avoid getting into trouble.

Strategies:

- **Ask clients for advice on how best to communicate with them.** This can give counsellors valuable information while empowering the clients through communication of their needs, and is likely to reduce compliance. One of the WWILD counsellors says, "You have to make me work, because I'm the one getting paid".
- **Be alert to inconsistencies between what a client is saying and their body language.** This might indicate a real difference between what the person is saying and what they would say if they felt able or empowered to do so.
- **Work slowly and with repetition.** Check for understanding along the way to make sure the client understands the discussion and communicates their genuine wishes, opinions or decisions.
- **Do not over or underestimate what the client understands.**
- **Do not pretend to understand what the person is saying when you are not sure.**
- **Continual checking on the understanding of both the client and the counsellor is important**. It is better to gently check than to continue under false pretenses. Give the client permission to say if

they don't understand and encourage them to do so. For example, a counsellor might say "I want you to tell me if I'm not clear or I don't make sense to you, so I can do a better job".

3. ATTENTION AND MEMORY

Many people with intellectual disability experience a short attention span, have gaps in their memory, and have difficulties with memory processing. The degree to which this has an impact on communication in the counselling context depends on each individual and how well the counsellor can assess the individual's communication ability and adapt their practice accordingly.

Sometimes a client might need to talk about a particular topic or experience that initially seems unrelated to the counselling session. It is both helpful and respectful to allow the person some time to talk about their topic before focusing on the counsellor's plan for the session. Seemingly insignificant topics might turn out to be important.

Anxiety before and within the counselling session is common. Many people will understand counselling as 'talk based' and fear failing to communicate well. It is important to understand the way anxiety and stress impacts on an individual's memory, attention and concentration. Counselling may trigger a trauma response, and clients may demonstrate avoidance strategies, such as resistance.

Strategies:

- **Use more frequent, shorter sessions.** Be prepared to work slowly and with repetition.
- **Adjust the speed of your speech** to help the client comprehend and retain information.
- **Use imagery and create a visual record** of counselling sessions as a useful way of recording counselling sessions, and as a way to review, enhance memory and see change over time.
- **Normalise the use of drawing and artwork in counselling with adults**. Creating drawings to record sessions may seem child-like or embarrassing to some clients. Explore use of imagery sensitively with each client to avoid insult and or embarrassment. For example, the counsellor might say "I really like to use drawings to help me understand some things. Do you mind if we do a drawing of what we're talking about".
- **Externalising, through the use of symbols**, can be a helpful way to give a client another view of their lives. This can provide a less intrusive way to discuss alternate behaviours.

4. SEQUENCING

People with intellectual disability can have difficulties sequencing events and understanding the relationship between choices, actions and consequences**.** This can be particularly challenging when there are multiple subjects and events in the story. When people tell their story it may seem out of order or illogical, however, it is important to let the client tell their story in their own way and in their own time, in full and without interruption.

Counsellors may need to rethink their assumptions about the client's aims in telling their story. Telling a chronological, well-structured story may not be a high priority for the client. However, people will use their own language and methods of communication and this may differ greatly between individuals. For example, some people may have great difficulty telling a story in chronological order, while others may feel great discomfort when telling their story out of sequence or being interrupted.

Strategies:

- **Counsellors have a responsibility to adapt their communication** so that they can support the client to understand. Don't use jargon, and remember commonly used words like 'goals' and 'consequences' are abstract concepts that might not mean anything to clients with intellectual disability.
- Do not expect the client to conform to a standard way of storytelling
- Listen patiently as the person tells their story, sometimes this will be over a number of sessions.
- Attempt to make sense of what the client has told you as a whole. At WWILD a counsellor may draw evolving maps that include the story over time, the different relationships involved and what the client was feeling at different stages.

5. QUESTIONING

How a counsellor asks questions may lead to complexities and different outcomes when working with people with intellectual disability. The careful use of questions may ease a client's confusion and embarrassment; clarify their problems, goals and intentions; and provide them with an increased opportunity to be heard. Counselling practitioners must develop a high level of self-awareness in how they ask questions when working with client's with intellectual disability.

Strategies:

- **Use concrete questioning.** Ask Who?, Where?, When? and What? questions. Avoid Why?
- **Keep questions simple.** Pose no more than two options in one sentence when asking a person what they want. For example, "Would you like to stay home or go out tomorrow?" rather than "Would you like to stay home or go out tomorrow, or just go out for a little while?"
- **Avoid double-barreled questions.** This refers to asking two questions about different subjects in one sentence. For example, don't ask "How do you feel about going out today and going in the taxi?" Instead, ask "How do you feel about going out today?", and then ask about the taxi separately.
- **Avoid the use of negative and double-negative questions.** These can be difficult to interpret and answer because a 'yes' response to a negative question denies the proposition of the question, rather than affirming it. An example of a negative question is, "Didn't you see Mum last night?" (if the person answer's yes it means they did not see their mum). Instead, ask "Did you see your Mum last night?" An example of a double-negative question is, "Didn't your Mum tell you not to come over?" This type of question is confusing and makes it difficult for the person to know how to respond. Instead, ask "What did your Mum tell you to do?" or "What did your Mum say to you?"
- **Communicate in short sentences.** Break questions down to one main idea.
- **Use plain, simple English**
- **Signpost the conversation.** If the conversation gets confusing for you or the client, stop and say you are starting over. For example, "Can we stop talking now? I would like to check that I got what you are saying to me right".
- **Use a combination of open and closed questions.** Begin with an open question, then ask closed questions to confirm details or clarify meaning. For example, "Would you like to tell me about your family?" (open question); "And do you have an uncle?" (closed question).
- If you ask a question that is unclear or confusing, apologise and try again.

6. BEHAVIOURAL ISSUES IN COMMUNICATION

People with intellectual disability are often referred to counselling because of a behaviour change that is causing problems for themselves or others in the home, workplace, school or wider community. "Challenging behaviour" is a common term in the intellectual disability field, and is used to describe any

behaviour that negatively affects a person in their daily life, or negatively affects the people around them (Centre for Developmental Disability Health Victoria (CDDHV), 2005). The kinds of challenging behaviour that people with intellectual disability might display include:

- Aggression
- (self-harm)
- Property destruction
- defiant, hostile and non-compliant behaviour towards care givers and authorities)
- Socially inappropriate behaviour (including sexualized behaviours) and
- Withdrawal

Challenging behaviour should be viewed as a form of communication. There are many reasons why a person with intellectual disability might display challenging behaviour. These can include:

- Physical pain or discomfort that is(recognised or unrecognized)
- Medical conditions
- Medication
- Epilepsy
- Substance abuse
- Mental illness
- Trauma
- Abuse and exploitation
- Communication difficulties
- Lack of self-determination and control over life
- Social isolation
- Grief, loss and bereavement
- Life stages and transitions
- Frustration, unhappiness or fear in living and working environments

It is important that people with intellectual disability who display challenging behaviour are not labelled as “challenging” themselves. It is important not to dismiss a person’s challenging behaviour as an inevitable feature of their disability. Clients with intellectual disability who experience difficulty with their behaviour should be taken seriously and given support to explore the causes of the behaviour, and

to develop strategies to manage it. Be curious about what the behaviour means to them. Remember the problem is the problem; the person is not the problem.

Behavioural issues may also have negative impacts on the client and the counsellor within the therapeutic context. Difficult behaviour in counselling may be related to a change the client is looking for in the counsellor, or a change in any other context that is currently affecting them. It is important not to assume that because a client has arrived for their session that they want to be there or that they are ready to attend in a calm manner.

Strategies for supporting a person who is displaying challenging behaviour in counselling:

- Maintain your self-awareness and critical reflection to ensure that a client's negative reactions in counselling are not taken personally. It's probably not about you.
- Remember the client is trying to create a change and they can't see any other way to achieve this. Work hard to understand the messages behind the behaviour. Foster an environment of learning and understanding with the client, rather than punishment for what is a communication problem. At WWILD counsellors might ask "What do you want right now?"
- Create safety in the therapeutic relationship. Focus on trust and take the time needed to build genuine rapport. Demonstrate commitment to helping the client by showing that you will not judge them or refuse service due to their behaviour.
- Use symbols or artwork to help the client find other ways of expressing their needs, wants and desires.
- Try a less formal approach. Use humour. Create a new and less threatening conversation. For example, at WWILD a counsellor might ask "What would help?" One client requests playing games on an Ipad. Quiet conversation can be resumed as they play.
- Do not punish a client for their behaviour. Openly explore concepts of "other people's feelings" and "apology" through concrete examples that are meaningful for the client. For example, "How would you feel if that happened to your friend/mother (refer to someone the client respects?)"; "What would you mum/friend feel about you doing this? "(refer to a significant, non-judgmental person in the client's life).

7. CONFABULATION OR 'EXOTIC STORY TELLING'

Confabulation or 'exotic story telling' is a common technique used by people with intellectual disability to gain respect and approval from others. The stories they tell are often a reflection of the way the person wants to be seen, and are a means to try to increase other people's positive opinions of them. It is often the lack of really valuable stories that a person can tell about their lives and experiences that leads them to confabulate.

Strategies for navigating 'exotic tales' include:

- Remember that people who confabulate are not deliberately lying; they are trying to impress you.
- Don't deny, diminish or contest the client's story. There is little point in refuting what is an absolute truth for the client at that point in time.
- Don't contest the client's story. This sends the message that what the client has to say is not valued. The story may not in itself be real or valid, but the client's reason for telling it is.
- Remember that exotic stories could be true. Do not disregard anything a client says as the story will have a basis in reality..
- Practice deep listening. Try to hear the meaning behind the story the client is telling. What is the subtext? Why is the telling important right now? If it is important to get to the truth for safety reasons, find a way to ask questions that are consistent with the fantasy. This will help the client to reveal what is really happening. For example, at WWILD a client arrived excited about a new boyfriend. Past relationship show this may not be safe for the client. Enthusiasm and curiosity was shown - Great! Where did you meet? "On the train" When? Today. Do you know his name? No so how do you know he is your boyfriend? He wants me. And that re-enforces for you the need to be loved and wanted.
- Look for and value the real stories that clients can tell about themselves. Confabulation decreases when there are good, real stories to tell.

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Topic 6. Useful Counselling Approaches

In this topic we will look at how common counselling approaches and activities are used in counselling people with intellectual disability, including advice for adapting these approaches and activities to make them responsive to the needs of clients with intellectual disability.

1. A STRENGTHS-BASED APPROACH (Saleeby, 2009)

A strengths-based approach to counselling people with intellectual disability can be an appropriate and powerful way of avoiding further disempowerment of this client group. In strength-based counselling practice, clients are valued as the experts in their own lives and are supported to identify and build upon their existing skills, abilities and resources.

When using a strengths-based approach it is important that counselling practitioners do not minimise the significant impact of impairment, social disadvantage discrimination, exploitation and abuse on the lives of people with intellectual disability. A narrow focus on individual strengths and resources can mask the powerful structural forces that constrain the lives of people with intellectual disability, this can result in people feeling, or being blamed for failure to mobilise their individual strengths and resources.

2. NARRATIVE APPROACHES (White and Epston, 1990)

Narrative therapy is a client-focused, strengths-based practice that works from the fundamental position that the client is not the problem: the problem is the problem (White and Epston, 1990). Narrative therapy is based on the idea that people create a personal narrative or dominant story to give meaning to their lives and to themselves (Lambie and Milsom, 2010, p. 196). Narrative therapy engages in a process of deconstructing the person's dominant narrative to understand how that narrative influences their thoughts, feelings, behaviours and communication. It explores whether this is the story the person wants for their life (Betchley & Falconer, 2002, p. 4) and works to develop and actualize new preferred stories for their life (Matthews & Matthews, 2005).

People with intellectual disability have a great capacity to express their story. They are able to respond well to the principles and practice of narrative therapy when it is adapted to work within the parameters of their ability. Many people with intellectual disability have difficulty expressing their narratives

verbally. This can be due to: poor memory; difficulty with sequencing; difficulty understanding the causal relationship between thoughts and behaviour; and difficulty in naming their emotional and subjective states.

Clients with intellectual disability *can* express their life stories, experiences and subjective and emotional states, if they are supported to do so in a way that suits their communication abilities and style. Every person, regardless of their verbal communication ability, has a vast array of communication tools at their disposal. It is the counsellor's responsibility to find out what works for each individual. By allowing the necessary time and having a variety of communication and creative techniques available, narrative therapeutic approaches should assist the client to become the 'primary voice' in their own story – even if that story is told non-verbally and/or with the assistance of others.

2. CREATIVE APPROACHES (WWILD, 2012)

Creative approaches and the use of non-verbal or indirect communication can be helpful in overcoming the communication differences of people with intellectual disability and supporting them to tell their story. Creative techniques are useful because they are not dependent on verbal communication; they allow for indirect communication; and they can be used with imagined and/or factual narratives.

Creative techniques can include:

- *Techniques of embodied expression* **–** these involve the client using their whole body or mind to describe or show their story (examples include whole-person movement; dancing and music; acting, characterization, masks and role play; and embodied games).
- *Techniques of projected expression* **–** these involve the client using other mechanisms or objects to depict or portray their narrative (examples include drama to express the person's story through an external character; visual arts such as painting, drawing; sand tray and use of symbols; written stories and poetry).

i. Using Symbols to develop concrete understanding

Symbols can provide a useful way to help clients with intellectual disability develop a concrete understanding of the role that problems or emotions are playing in their life. Clients may need support from the counsellor to build a connection with the symbol and to link the symbol with an abstract emotion or value. It is important that counsellors allow time for clients to make their own choice about

what object they choose to represent their problem or feeling. Some people with intellectual disability may feel they should pick the item that their counsellor suggests or would choose in order to please the counsellor or be seen as capable. Counsellors need to encourage clients to take their time and choose the item that they think is right.

ii. Using creative arts to explore feelings:

Creative arts can be particularly useful when working with people with intellectual disability who have difficulty with verbal communication. The use of artwork is an effective way of concretising a person's hidden and often abstract thoughts, feelings and beliefs about themselves and their life experiences. A counsellor can use art to help a client represent how they are feeling about their present life or about an event that has happened in the past. The client's artwork is their creation, so should be theirs to keep at the end of each session. However, it is useful for the counsellor to record the drawings (either by taking a photograph or recording a written description) so the client and counsellor can reflect on the drawing at a later time.

iii. Challenges and stumbling blocks for clients with an intellectual disability:

Compliance. Clients might say yes as soon as you make a suggestion without hearing what it is you are suggesting. It is important to check if the client wants to do the activity once it is explained. The counsellor should be able to tell if the client has agreed but doesn't really want to - this is why it is important to do the activity later in counselling so the counsellor understands the client's presentation and resistance and so that the client will be more able and practiced at saying 'No" to the counsellor, knowing they have a choice.

Strategies:

- Keep reiterating the client's choices, tell them it's ok if they don't want to talk about something or do an activity.
- Give them permission to say No to you, and to others, and provide opportunities to practice this.
- Explain things fully so the client can make an informed choice.
- Watch for non-verbal cues of discomfort.

Abstraction. Many of the drawing activities used extensively with clients without an intellectual disability, don't work for clients with an intellectual disability because of the difficulty with abstraction.

For example, asking a client to draw what it's like to be them or even a feeling. Symbolism is abstract, imagining is hard and people with an intellectual disability are more likely to worry about getting it wrong through not understanding or to think that drawing especially with crayons is childish.

Strategies:

- Build concepts over time. Difficulty with abstraction doesn't mean the client won't master some ability to be more abstract.
- Reassure the client and encourage them
- Be flexible and creative. Think about what might help the individual client to communicate and progress in counselling. Use your professional assessment to know what and when an activity might be useful.
- Use cards and pictures more in the earlier sessions to encourage communication and to help ease the client. Using cards and pictures means a client can avoid what might be confronting eye contact with the counsellor.

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