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Trauma Focused Treatment in Individuals with Intellectual Disabilities:

A Group Treatment Approach

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Intellectual Disability is a condition that affects one's ability to learn and function independently. The condition is characterized by subaverage intellectual functioning and significant impairments in adaptive functioning, with onset occurring prior to age 18. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) uses the term Mental Retardations to describe these individual differences in cognitive and adaptive abilities. However, the term Mental Retardation has received significant criticism in recent years, and the term Intellectual Disability (ID) is being used with greater acceptance. In keeping with this trend, the term Intellectual Disability will be used throughout the current paper.

The prevalence of ID in the United States (U.S.) is estimated to be between 1% and 3% of the general population. Based upon these prevalence statistics, between 3 million and 9 million U.S. residents have an Intellectual Disability. Of persons diagnosed with ID, 85% have Mild ID, 10% have Moderate ID, 3-4% have Severe ID, and 1-2% have Profound ID; these levels of severity are distinguished based upon one's level of cognitive and functional impairment. With respect to causes for ID, three general categories of etiology have been identified: prenatal causes, perinatal causes, and postnatal causes. However, within each category there are a range of particular causes of ID that have been identified by researchers (Fletcher, Loschen, Stavarakaki, & First, 2007).

Fletcher et al. (2007) state that persons with ID are two to three times more likely to have comorbid psychiatric and behavioral problems as compared to the general population. More specifically, individuals with ID are likely to present with comorbid anxiety disorders, affective disorders, psychotic disorders, personality disorders, as well as a range of behavioral problems.

However, the mental health needs of persons with ID have traditionally been neglected (Hurley, Tomasulo, & Pfadt, 1998). For example, Nezu and Nezu (1994) reported the results of a survey of counseling and clinical psychology programs which found 67% of counseling and 75% of clinical psychology programs did not include issues pertaining to intellectual disability into the curriculum. Thus, it is not surprising that clinicians often feel ill-prepared to meet the unique needs of this population.

A broad array of factors has been found to contribute to the increased risk of psychiatric and behavioral disorders among individuals with ID. For example, Nezu, Nezu, & Gill-Weiss (1992) identified the following factors as contributing to increased psychiatric and behavioral disorders among this population:

- Low levels of social support
- Social skills deficits
- Learned helplessness/low self-efficacy
- Heightened maternal stress
- Low socioeconomic status
- Decreased opportunities to acquire adaptive coping strategies
- Increased familial stress
- Increased presence of physical disabilities
- Reading and language impairments
- Increased likelihood of chromosomal abnormalities, metabolic diseases, and infection
- Decreased inhibition in responding to stressful situations

In addition to the list of factors above, individuals with ID have higher rates of sexual trauma in contrast to the general population. Furthermore, these individuals are at increased risk for continued, and prolonged sexual trauma (Razza, & Tomasulo, 2005). Sexual abuse has been implicated in the development of a wide range of behavioral and psychiatric disorders. Given

this, there is a significant need for continued research and the development of interventions to address trauma-recovery among individuals with ID.

Sexual Trauma and Mental Illness

Individuals with mental health problems are much more likely to have experienced sexual abuse than those without mental health issues (van der Kolk, 1996). This has been demonstrated not only as it relates to sexual trauma, but all forms of trauma (van der Kolk, 1996; Walker, 1994). In fact, it has been consistently found that the majority of psychiatric inpatients have experienced some form of trauma, most often within their own families (van der Kolk, 1996).

A history of sexual abuse has been associated with the development of Post Traumatic Stress Disorder (PTSD), mood disorders, anxiety disorders, eating disorders, substance abuse/dependence, personality disorders, medical conditions, and conversion disorder (van der Kolk, 1996; Walker, 1994). Matich-Maroney (2003) demonstrated that adults with ID who had experienced sexual trauma, had greater rates of depression, anxiety, and sexual maladjustment (promiscuity, avoidance, preoccupied, or inappropriate), and were more likely to carry dual psychiatric diagnoses and be prescribed psychotropic medications, in comparison to a non-intellectually disabled controls. Thus, the need for effective psychotherapeutic treatments for this population cannot be stated strongly enough. Group psychotherapy, with appropriate modifications, has recently seen growing interest in research and subsequent support.

Group Therapy for Persons with Intellectual Disabilities

Most traditional forms of psychotherapy rely heavily on one's verbal and cognitive skills. A major innovation to psychotherapy was developed by Jacob Moreno, who promoted psychodrama and group therapy. Psychodrama emphasizes active involvement and movement, and focuses on social interaction. The psychodramatic approach provides opportunities for

emotions to be expressed in an active form, while also stimulating more sensory modalities than purely verbal methods. These techniques have not only proved useful in working with individuals with ID, but also persons with low educational attainment, learning disabilities, and severe mental illness (Hurley et al., 1998).

Group therapy is an extremely useful treatment modality for individuals with ID. Whereas, most traditional forms of psychotherapy rely heavily on cognitive ability, group therapy provides opportunities to adapt treatment interventions to those who have any level of ID. The past two decades has seen more attention being brought to the clinical utility of group therapy for individuals with ID. However, the focus has been primarily on social skills training groups. Although, these training-focused groups have demonstrated effectiveness, there remains a need to broaden the scope of intervention to include a more interactive and therapeutic format. The exclusive focus on the acquisition of social skills often neglects the potential to foster the therapeutic factors, which have been shown to be the most powerful factors involved in therapeutic change within a group modality. For example, the transition from social skills training to process can provide members with encouragement, a sense of belonging, hope, and other elements inherent in a positive group experience (Hurley et al., 1998).

A therapeutic factor is a component of group therapy that positively benefits a group member's condition. Thus, improvements in functioning come not from content, but from the group process. The therapeutic factors as presented by Yalom (2005) presents include the instillation of hope, universality (an understanding that one is not alone in his/her experience), imparting information, altruism, the corrective recapitulation of the primary family group, development of socializing techniques, and imitative behavior. It is believed that member improvement results from facilitator and member actions/interactions more so than any specific

content presented. The therapeutic factors are perhaps the most respected measures of the viability of a group. According to Hurley et al. (1998), the therapeutic factors identified by Yalom, have been observed in group psychotherapy among individuals with ID.

A promising approach to conducting group psychotherapy with individuals with ID has been through the Interactive-Behavioral Model (Tomasulo, 1992). This model uses well established group psychotherapy principles and has made modifications for individuals with ID and other developmental disabilities. The model pulls away from the psychoeducational model, allowing for the group process to be used as a therapeutic agent. The Interactive-Behavioral Model has been used in anger management, AIDS awareness training, relationship counseling, sexual abuse avoidance training, relationship counseling, vocational readiness, mental health counseling, behavior management, sex education, and parent-child education. Based upon this models wide range of clinical application, it appears that the four-stage process is more important to therapeutic change than the content itself (Hurley et al., 1998).

The Interactive-Behavioral (IBT) Model

The Interactive-Behavioral Therapy (IBT) model illustrates a dramatic shift away from curriculum-based social skills training groups, in which the primary teacher-to-member interactions have been regarded as the primary agent of learning. In contrast, the IBT model places primary emphasis on the member-to-member interactions, which is consistent with the theoretical foundations of most traditional group psychotherapy models. Thus, it is the group process that acts as the primary agent of change. It is believed by most group theorists that an individual's personality develops in relation to others. Similarly, it is believed that an individual's psychopathology develops through experiences in his or her social environment. Therefore, group therapy pioneers such as Irvin Yalom and Jacob Moreno, proposed that change

in personality style and psychopathology, can best be brought about in connection with others. This idea is nicely captured in the words of Cody Marsh an early group therapy pioneer, who said, “By the crowd they have been broken, by the crowd they shall be healed” (see Razza & Tomasulo, 2005, p. 43).

Moreno’s model of psychotherapy is particularly well suited for individuals with developmental disabilities, including ID. Through the use of active therapeutic interventions, one is able to engage behaviorally, emotionally, and verbally, which enhances the opportunities for individuals with ID to benefit from therapy. Thus, the IBT represents a modified version of the traditional form of psychodrama proposed by Moreno to address the unique needs of individuals with ID and other developmental disorder (Tomasulo, & Razza, 2006).

During the early stages of IBT development, researchers conducted a pilot study to assess the emergence of the therapeutic factors, which as noted above, are believed to serve as the primary agents of change. The researchers observed that all 14 of the therapeutic factors emerged and were captured on videotape; however, the manifestations of the therapeutic factors were often very concrete. The researchers also noted that the traditional psychodrama session format did not work as well for individuals with ID (Razza & Tomasulo, 2005).

Traditionally, psychodrama is composed of three stages: warm-up, enactment, and sharing. The warm up stage prepares members to participate in the enactment, which utilizes specific action techniques, such as role plays, role-reversal, and doubling. These strategies are used to increase emotional involvement among the group and its members. The sharing stage provides an opportunity to discuss the enactment stage and for each member to assimilate the information into his or her personal life. Persons with ID often have difficulty assimilating

meaning from the enactment stage and the group process into their own lives, which represents difficulty with abstract thinking (Razza & Tomasulo, 2005).

To compensate for individuals with ID, the researchers moved the enactment phase to a later stage in the process, noting that longer and more intense preparation for enactment was necessary. They labeled the preparation period, the orientation stage because this stage provided members with an opportunity to orient themselves to one another. The researchers noted that the orientation stage is especially important in breaking the tendency of individuals with ID to focus primarily on the “teachers,” as years of socialization (school and social skills training programs) often conditions them to do. Another modification was made, which replaced the sharing stage with a stage they refer to as affirmation. This modification removes the need for abstract thinking, and instead provides members with an opportunity to recognize one another for the therapeutic work they have done during the session (Razza & Tomasulo, 2005).

These modifications to the traditional psychodrama approach resulted in a four-stage group process model. The stages are orientation, warm-up and sharing, enactment, and affirmation. As stated above, the orientation stage is aimed at facilitating member-to-member interaction. Individuals with ID have learned to devalue their peers, and themselves, and frequently can be observed talking over one another. Thus, the orientation stage is designed to break that pattern. In order to facilitate this, it is suggested that group leaders interrupt when a member is speaking and ask the member to select another member to determine if that member is listening. If the listener demonstrates attentive listening through reiteration of what was being said, the facilitator should reinforce his or her listening with positive praise. If the member was not attending, another member is selected. If that member is unable to demonstrate listening as well, the member who was communicating is asked to repeat what he or she was attempting to

convey, and the process is repeated. Through this process, members are taught to communicate so that others can understand them, and to listen attentively while others are speaking (Tomasulo, & Razza, 2006).

During the warm-up and sharing stage, members engage in deeper disclosure and select a protagonist. During this stage there is a transition from horizontal disclosure to vertical disclosure. It is during this stage that each member discusses his or her personal agenda. In addition, if the model is being applied to a particular theme based curriculum, it is within this stage that the particular theme would come to light. From this point the group moves into the enactment stage, in which traditional psychodrama techniques are employed (e.g. role plays, role-reversal, and doubling) (Tomasulo, & Razza, 2006).

The final stage, affirmation, is one in which members are asked to provide positive feedback about what the protagonist did during the enactment stage. The protagonist is selected because it is in this role that the members experience the most vulnerability. It also provides an opportunity for the reinforcement of self-disclosure, self-awareness, and behavior change in trying a new role. The leaders are then to provide each member with positive reinforcement for any effort that suggests growth. This serves to facilitate positive feelings as the group comes to a close, and to promote increased self-esteem and positive self-regard. As the group progresses over time, members are also encouraged to provide affirmations to one another (Tomasulo, & Razza, 2006).

Tomasulo and Razza (2006) suggest that rather than a time-limited approach, the IBT therapy group be run on an ongoing, open basis. The authors report that once the facilitators have established prosocial group norms, it is relatively easy to incorporate new members. They also suggest that ongoing groups for individuals with ID and other developmental disabilities

allow for the advantage of providing an opportunity for members to be genuinely helpful to one another. Specifically, the heterogeneity in the level of assimilation to the therapy group and the differences in therapeutic gain will provide a rich environment to learn from one another. This also provides elder group members to gain self-efficacy through their ability to help newer members. This is a significant contrast to the overwhelming sense of incompetency that many people with ID experience (Tomasulo, & Razza, 2006).

Case Illustration: The Application of the IBT Model in a Women's Group

The following is an illustrative example using an imaginary group solely for educational purposes. The example will be presented as a proposed group. The illustrative sample group will be process-oriented and will meet on a continual, weekly-basis at a community mental health center that specializes in serving individuals with ID. Although the group is an open group, group membership will not exceed eight individuals at a given time. The weekly sessions will run for a period of an hour and a half to an hour and forty-five minutes, leaving some flexibility for unforeseen developments that arise during the group process that warrant additional time. Although, the group is marketed simply as a "Women's Group," and is open to any woman that chooses to participate (given that she does not meet the exclusion criteria), there will inevitably be a theme that emerges related to trauma, considering the high prevalence of trauma among women in general, and especially among women with ID.

Each member will participate in an hour long screening session prior to entry into the group. Ideally, the group screening process will include both facilitators in an effort to foster a working-alliance with both leaders, however; due to difficulty in coordinating schedules, it may be necessary for only one facilitator to conduct the group screening session. Based upon the

varying extent of member's cognitive deficits, it may be necessary to include a close friend, family member, or legal guardian in the group screening process.

Ideally, the group will be organized to include moderate heterogeneity with regard to intellectual functioning and ego functioning, and a high degree of heterogeneity with respect to interpersonal style. Individuals should not be excluded based upon IQ as it is not uncommon for individuals falling within the lower ranges of intellectual functioning to have achieved excellent compensatory skills. With respect to inclusion criteria, members must be female, have manifest interpersonal problems (but have a capacity for interpersonal relationships), and be motivated. Members should be excluded from group if there is an indication that she will not be able to participate in the group work. Specifically, if she is in a state of crisis, is actively psychotic, suicidal, or otherwise deviant (e.g. sociopathic, psychopathic, aggressive/assaultive, etc.), she should be referred to individual therapy and reassessed for group appropriateness at a later time.

In addition to assessing inclusion and exclusion criteria, the screening process should also serve to address any concerns members may have regarding group therapy, and to prepare them for the format and functions of group therapy. Specific attention should be given to issues related to myths about group therapy, client expectations, attendance, and confidentiality. Confidentiality is particularly important in therapy groups for survivors of interpersonal trauma. In the absence of security and safety, no therapeutic work can be done.

There are no group screening instruments that have been developed and/or normed for individuals with developmental disabilities. Therefore, modifications would need to be made to the existing group therapy screening instruments. For the purpose of this group, it is important to assess issues related to trauma, family dynamics, interpersonal difficulties, goals, motivational factors, and past therapy experiences. Thus, the Group Therapy Questionnaire (GTQ) is likely to

be useful. However, rather than using the GTQ in its current form, it would need to be adapted to a semi-structured interview format for members who have reading, comprehension, and/or motor skills deficits. Furthermore, assessment of process related issues and outcome pose unique challenges when working with individuals with ID. Rather than give an assessment such as the Working Alliance Inventory which is not indicated for work with this population, the process elements will be evaluated based upon a review of taped sessions. Specifically, multiple raters will view and assess the presence (or absence) of the therapeutic factors discussed above. With respect to outcome, upon member termination, facilitators will meet with the members for a debriefing session in which the Outcome Questionnaire (OQ) will be presented in a semi-structured interview format. In addition, members will be questioned regarding their experience in the group and ways that they will continue to challenge themselves to make positive change outside of therapy.

Group Members: The following do not represent actual people. The information is presented to provide a concrete case example.

- (1) Lola: 32-year-old, Catholic, heterosexual, Latina diagnosed with severe social anxiety and Moderate Mental Retardation. Lola is an only child, but she has numerous cousins whom she was close to growing up, and remains close with to this day. However, Lola often feels that her cousins try to “protect [her] too much.” For example, they often run her errands for her so that she can avoid anxiety provoking social situations. Lola currently lives with her parents and maternal grandmother, with whom she reports having good relationships. Lola remembers “always” feeling anxious around others which she attributes to her difficulty with expressive language. She recalls being made fun of by peers throughout her educational years. Specifically, she was often called a “retard,”

“dumb,” an “idiot,” and the like. She receives Social Security Disability Income (SSDI), but would like to find part-time employment. She feels that in order to gain employment, she needs to work on her communication skills, and learn to manage her anxiety. She is extremely timid, shy, and soft-spoken. She also has difficulty articulating herself, and often she gives up in the middle of a sentence when she is unable to readily communicate her thoughts. For example, she frequently looks at the floor and whispers, “nevermind.”

(2) “Sparkle”: 19-year-old African-American, heterosexual, Baptist female diagnosed with Bulimia Nervosa and Mild Mental Retardation. Sparkle was raised by her single mother until she was 4-years-old, at which point her mother died from a drug overdose. Since that time, she has lived in various foster homes, where she was subject to both physical and sexual abuse. Since she turned 18, she has been trying to make a life for herself. She is living independently, but receives case management services through the Department of Developmental Services. She is currently completing the 11th grade and working part-time at a local fast food chain. She began to binge and purge at the age of 15, but reports that her binge-purge episodes have progressively become more frequent. She is currently attending individual therapy to address her eating disorder and trauma in greater detail, but she was referred to the Women’s Group after demonstrating an interest in connecting with others and learning how to trust again. Sparkle presents as friendly, but emotionally reserved.

(3) Janine: 27-year-old, Caucasian, Protestant, heterosexual female diagnosed with PTSD and Mild Mental Retardation. Janine is a survivor of sexual trauma. Between age 9 and 11, she was repeatedly sexually abused by an older male cousin. Janine has dated on occasion, but finds that she experiences vivid flashbacks of the abuse, at times when she

has become sexually intimate with a partner. Although she desires to be married and to have children, Janine has stopped dating because the reexperiencing of the trauma became unbearable. Janine presents as friendly and submissive. Janine is engaged in individual therapy to address her PTSD in greater detail, but wants to participate in group therapy to meet others who may be able to relate to her struggles.

- (4) Teresa: 34-year-old, married, atheist, Caucasian mother of two, who is diagnosed with Mild Mental Retardation. Teresa was raised by both biological parents and has two siblings to whom she has never felt very connected to. She attributes the problems in her relationship with her siblings to the fact that they do not have an ID. Teresa is happily married and loves being a mom, but she is distressed because she has no close friends. She feels that she may be overly involved with her role as a mother and a wife, to the extent that she has lost herself somewhere along the way. She is joining the group to connect with other women and to become more self-aware. As a stay at home mom, she is used to handling all of the household responsibilities and fulfilling the needs of her husband and children. She presents as friendly-dominant.
- (5) Nina: 24-year-old, single, agnostic, bisexual, Caucasian who is diagnosed with Mild Mental Retardation and Depressive Disorder NOS. Nina is an only child and was raised by a single mother who is an alcoholic. Nina disclosed that she was molested by one of her mother's boyfriends when she was 10 years old. She did not tell anyone about the abuse until she was 18 years old. She is sexually promiscuous and she demonstrates good insight into the role her experience of sexual trauma may play in her promiscuity. However, she has been unable to change her behavior. She stated that engaging in sexual behavior makes her feel desirable, and close to others. However, this feeling of

connection is short-lived. She is experiencing symptoms of irritable depression, but does not meet criteria for MDD or Dysthymia. She is participating in the group to learn how to connect with people in ways that do not involve sex. She presents as hostile-dominant and displays a significant amount of anger regarding her relationship with her mother, who she blames for “how f***** up she is.”

- (6) Jesse: 32-year-old, African-American, single, heterosexual female who is diagnosed with Moderate Mental Retardation. Jesse was raised in various residential treatment facilities as a result of significant behavioral problems. She reported that her mother “couldn’t take care of [her].” Over the years she has had several experiences of being restrained and secluded in response to her behavioral outbursts. Jesse has since undergone extensive therapy to address her assaultive tendencies and she has been able to manage her behavior without incident for several years. However, she missed out on years of socialization with peers because of her behavior, and is unable to form close relationships with others. She is joining the group to learn how to make friends. Although, she has not been assaultive in years, she verbalizes her feelings of frustration, hostility, and anger readily at times when she becomes upset. She also tends to externalize responsibility. However, for the most part she presents as friendly, but assertive.

Group Leaders: The following do not represent actual people, but have been presented for illustrative purposes.

- (1) Sally: 43-year-old, African-American, Muslim mother of two. She has years of experience working with individuals with ID in a group modality. She is warm and friendly and has a tendency to take a directive approach in her work with clients.

(2) Nicole: 30-year-old, practicum trainee with a special interest in women's studies and trauma. She has facilitated a few process groups during her training, but she has no previous experience working with developmentally disabled individuals. She has however, familiarized herself with the available literature as it relates to working with this population. Nicole is friendly, and neither submissive nor dominant, but rather somewhere in between. She is eager to co-facilitate this group and to learn all she can from Sally.

With respect to facilitator dynamics it will be very important that the leaders meet to discuss potential dynamics between the two of them that may pose an issue to the group. For example, because Nicole is a student, and less dominant than Sally, she may be more likely to fade into the background during the group process and take more of an observer stance than a participatory one. In addition, Nicole may feel incompetent due to her lack of experience, and may struggle with feeling like she has little to contribute. It will be important for Sally to make space for Nicole and to make her feel that her contributions are appreciated.

Jesse and Nina may be problematic in the sense that they are both more dominant. However, the majority of member's lean on the side of friendliness, so this will likely pull more friendliness from Nina. Janine may play the role of "mother" for the other group member's, especially considering how many have attachment issues. Given, Janine's tendency to do everything for everyone, but herself, it will be important that the facilitators continue to take note of whether she is working on her own goal. Lola could easily get "lost in the shuffle" if permitted as a result of her extreme social anxiety. She may also struggle with some of the stronger, more assertive personalities in the group. She may experience the group as more hostile than it actually is because she struggles with asserting herself in any capacity. Thus, it

will be important to draw her out and to check-in with her regarding her experience. Another challenge for Lola may be through the level of activity required in the interventions themselves (psychodrama). Thus, it will be especially important for the facilitators to spend ample time discussing the nature of the therapy group during the screening process. There are also many members who identify with varying religious ideologies. Group facilitators must work to make sure that their interventions are inclusive of everyone. In addition, because there is a strong religious presence in the group, Nina may feel condemned for her sexual promiscuity. Thus, it is important for the facilitators to foster cohesion between group members early on, so that if these issues arise, they are likely to be contained. Although, there may be some conflict between members there is rich potential for a lot of important work to be done in this group. All of the members will be able to relate to having an ID and the stigma/discrimination associated with having a developmental disability. In addition, many members have attachment issues and trust issues, and they are all working toward a greater sense of connection to others. Thus, this group has great potential to serve as a catalyst to positive change.

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