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Persons with Developmental Disability Exposed to Interpersonal Violence and Crime:

Approaches for Intervention

(Part II of II)

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**Abstract**

**TOPIC:** Interpersonal violence and crime on people with developmental disabilities may result in a number of unhealthy coping strategies. When these occur they may be labeled as “challenging behavior” rather than recognized as post-trauma related symptoms. Psychiatric Advanced Practice Registered Nurses (APRNs) have an important role in addressing these sequelae of trauma by employing flexible, creative and direct therapy to individuals.

Additionally significant is provision of education and supportive measures for the caregivers, who have the potential to generate an ongoing socially therapeutic environment.

**PURPOSE:** To offer recommendations for psychoeducational and psychotherapeutic intervention by APRNs and caregivers working with people with developmental disabilities exposed to interpersonal violence and crime confronting intrapsychic trauma.

**SOURCES:** A comprehensive review and examination of the extant literature, clinical anecdotes and therapeutic experiences regarding intrapsychic trauma and related interventions within a frame of developmental disability.

**CONCLUSIONS:** In reality, persons with developmental disabilities experience the full affective range of the effects of trauma and may benefit from a variety of interventions. What may be different in comparison to other survivors are the ways psychotherapeutic and psychoeducational interventions are adapted so that emotions, resultant actions and ongoing concerns can be effectively expressed and addressed.

### **Background and Significance**

There are many forms of interpersonal violence (IPV) encountered by persons with developmental disabilities, (DD), and an alarmingly higher risk (estimated 4 to 10 times greater) of becoming a crime victim than persons without disabilities (Disabled Crime Victims Assistance, 2006). Globally, “interpersonal violence is defined to include violence between family members and intimate partners and violence between acquaintances and strangers...” (World Health Organization [WHO], 2006, ¶ 2). For persons with DD, specific examples include: violence by family members, caregivers, housemates and/or teachers; witnessing violence by those above; neglect or omission of adequate care; sexual/physical assault; neighborhood or “community” violence; suicide; homicide; and bullying (Focht-New, Clements, Barol, Service, & Faulkner, in press).

Coping and adaptation are related to individual cognitive development, existing “family” system stress management capacity, and differs with age (Hastings, 2002). Persons with DD may have a limited range of coping skills and are more vulnerable to stress related thoughts, feelings and, subsequently emotional and behavioral manifestations. Decreased intrapsychic flexibility and adaptation to traumatic events must be assessed and is of importance for intervention. It is imperative to explore and understand level of moral reasoning, interaction with the surrounding environment and related lifestyle culture. Violence can disrupt understanding of the protection of family, neighborhood, and friends, and create uncertainty of the wider world. Furthermore, for the person with DD, problem solving and interpretation of events and situations are typically assessed with significant value placed upon maintenance of a stable environment for intervention.

In the chaotic aftermath of IPV, to promote adaptive coping and mastery of the emotional

trauma, effective intervention strategies for the person with DD will revolve around their ability to control instinctual and ingrained impulses while dealing with their home and work environment. The APRN will directly provide treatment to the individual and consultation to the caregivers' team. Unique and innovative ways of listening to and working with the person is required so that they can achieve their full mental health potential by directly participating in matters that affect their lives, ultimately enhance development of care planning (Clements, Darvill & Redshaw, in press).

By adapting traditional approaches and using creativity with flexibility, the APRN can assist traumatized persons with DD and their caregivers to successfully navigate the impact of the event, and subsequently learn to cope and express their feelings in healthy ways. The following case scenario and related exploration of key strategies and treatment approaches provide guidance for intervention.

### **Case Study of Clare**

\*Clare (*pseudonym*) recently transferred from a psychiatric facility to a residential agency for people with DD following an incarceration for theft. The agency expressed a concern about written documents and subsequent verbal reports from the psychiatric hospital indicating that Clare was “manipulative, violent, sexually promiscuous,” and had multiple mental health diagnoses. Records revealed several admissions to psychiatric hospitals with at least 5 incarcerations. Contrary to the reports, the current caregivers found the woman to be friendly, helpful, caring, sociable, and motivated to work; as such, they found themselves waiting for the proverbial “other shoe to drop.” As part of the assessment of her early life, two agency caregivers made a trip to the woman’s home to interview Clare’s father, stepmother and Clare’s 10-year-old daughter.

The interview and review of records revealed the following: Clare was born in 1970. Her home, located in an economically depressed rural community, consisted of two bedrooms, a living/kitchen area, and a bathroom. Clare's family of origin included her mother, father, older brother, and two younger sisters. Clare's father, who was violent when inebriated, brother, and most likely her mother have had problems with alcohol use. Adding to this exposure to violence, it was noted that in her childhood a young man living with the family was later found murdered on their property. Furthermore, Clare's older brother was currently in a state prison for sexually assaulting a child. School records showed that Clare's physical condition was erratically unclean often wearing dirty and threadbare clothing with she had bruises for reasons she could not or did not explain. In school, being teased and bullied about her DD was a typical part of her day. Eventually she learned to fight back with her own behavior problems, continuing from elementary school through high school. It was clear from the records and interview that Clare's childhood home life was chaotic with repeated exposure to violence as both victim and witness.

During Clare's early adolescence her mother died and life changed dramatically. Family celebrations disappeared. She dropped out of school, was gang raped by a group of men in the community, and drugs and alcohol became a frequent activity. Finally Clare ran away and lived "on the street." In her late teens or early 20's, she became pregnant and gave birth to a little girl who was then cared for by her family. Clare's previous home life, violent experiences, losses and developmental disability quickly added up. She began to show many consequences of significant interpersonal trauma. By her early 30's, Clare was frequently psychiatrically hospitalized for suicidal threats and attempts, and was incarcerated for theft, disorderly conduct, drugs, and many acts of violence. Today Clare's family will have nothing to do with her. Much of her violence is directed toward them. After her latest incarceration and hospitalization, Clare

was placed with the residential agency. Upon exploration of her experiences it became apparent that somehow Clare had developed into a loving, caring, considerate woman who ultimately could not accept any love, care, or consideration in return. The impact of interpersonal trauma for Clare, as it is for so many other people, is a loss of a sense of safety, alterations in self esteem, confusion about appropriate interpersonal relationships with others and the world around her, compounded by the maladaptive use of self destructive strategies to engage with others for a limited sense of belonging.

### **Biographical Timeline as Assessment and Intervention**

One of the primary steps to offering effective interventions for the person with a DD, impacted by trauma, is the development of caregivers into effective social therapists providing direct support every day (Barol, 2001). Very often, these supporters have had little training in identifying symptoms relating to trauma, or supporting a person through recovery from trauma. As a result they deal with the person solely with the goal of modifying each discrete problematic or challenging behavior. However, it is more important to approach the person along a continuum of life circumstances. The person may be seen as unpredictable, intermittently explosive, unable to connect, out of touch with reality, destructive etc, and, without linking the potential cause of these behaviors, the caregivers come up with their own explanations such as “spoiled”, “manipulative”, “retarded”, “psychotic”, “criminal”.... Subsequently, interventions are then crafted around an erroneous “diagnosis” of the problems. Medications are then requested to sedate. Caregivers distance themselves to fend off manipulation, withhold praise and attention, and press for restriction and punishment to control the behavior of the “spoiled person.” Caregivers with a more empathetic perspective are considered naive and are often marginalized. The support team can be splintered, blaming each other, as attempts to change the

person's behavior fail, not realizing that they are actually missing the mark in terms of their assessment and treatment approaches. Even when a diagnosis of post traumatic stress disorder (PTSD) is determined, caregivers do not always understand intuitively the deep biopsychosocial implications. Equally importantly they frequently do not know how to help the person heal. PTSD becomes another excuse professionals give to justify a caregiver having to withstand the challenging behaviors, with no relief in sight.

The Biographical Timeline is both an assessment tool and a team development, education, and intervention process by which caregivers develop as social therapists with their professional colleagues (along with invited family members and community members) can carefully examine the course of an individual's life (Barol, 2001). As the life events are laid out chronologically on a timeline continuum, correlations are drawn, and respectful guesses are made between those life events, challenging behavior, and interventions. Reviewing these issues developmentally, the social therapists can direct their daily interventions towards filling in the developmental and experiential gaps.

Using the case of Clare, for example, the social therapists would be assisted by the Biographical Timeline facilitator to imagine what her early life might have been like given the circumstances described in the case study. What kind of parenting might she have had? What were her early experiences of love, trust, good touch and sensory integration? How was she able to build up the internal resilience so important for surviving trauma? What was her experience of the world? Caregivers hurt her and the people around her. To whom could she turn to for protection? Her external resources then were also poor. Helping her heal then would mean that the people in her daily life would have to provide an environment that could teach the basic skills of human interaction. The social therapists then understand that it is their role to painstakingly

model the behaviors that they want her to exhibit. They cannot take for granted that she knows the value of human interactions, or how to foster them. All of this will have to be built through the actions of the social therapy. They must find patience, endurance and compassion in order to “hang in there” (Barol, 1996) for the duration as Clare’s relationships with others as well as with herself are reworked. Typically, the biographical timeline process opens the hearts of the caregivers. It helps them to fully step into the role of social therapist and healers as they mindfully begin to use the routines of daily living to resolve issues, replace missed opportunities and help the person they are supporting to heal.

### **Supportive Interventions**

After completing a biographical timeline and noting significant issues related to the trauma, providing social and emotional support is of foundational importance. It is a primary facet of all approaches to restore a sense of safety and trust, establish and maintain healthy interpersonal relationships, and improve the ability to integrate the traumatic event and reinvest in a productive daily life. Such support can be immediately enhanced by establishing an *anchor for safety* and *safety valves* to use during periods of high affect or agitation which typically occur post-trauma. Giving voice to persons with DD is a platform that permits and promotes expression, exploration, and education related to the trauma (Clements, Darvill, & Redshall, in press). Two key strategies can be integrated into day to day living to develop adaptive coping and promote good mental health. For example, establishing an *anchor for safety*, as an initial strategy, involves a discussion with the person to identify a trusted person, readily available (in person, by phone, etc), and willing to be contacted during periods of high stress or behavioral decompensation. The role of this person is to provide a “safety net” or opportunity to “ventilate” and “de-escalate.” This role is often transitional in nature, as it is mostly utilized only during

“crisis” situations emerging in the days and weeks after the recent trauma and while *safety valves* are being explored and established. *Safety valve* is basically a metaphoric description for development of adaptive coping skills and self-soothing techniques. As with all traumatized survivors, integration of the event, as well as reinvestment into daily life, is often fraught with intrusive thoughts, environmental cuing, flashbacks, etc, and is most successfully accomplished by being proactive instead of reactive. Safety valves should be explored during non-affectively charged time periods, target self-soothing techniques, acceptable to the person, and, above all, can be realistically and immediately implemented. With repetition of use, re-evaluation of effectiveness and positive feedback for successes, the person can begin to reflexively utilize these safety valve techniques independently, which inherently increases a sense of mastery related to the traumatic event.

### **Socially Therapeutic Environment as Intervention**

Social therapy as an intervention is layered upon a solid foundation that meets emotional, physical health, relationship, communication, educational, and social needs in a person’s everyday life, identified through the biographical timeline process (Barol, 2001). If any form of psychotherapy is to work, the person must be held in a socially therapeutic environment that can sustain the person every day while they develop awareness of issues and change their coping strategies. Environmental supports are both internal (e.g. safety valves) and external (e.g. anchor for safety) to the person. Of significance is understanding that verbal expression and insight are not mutually exclusive and in fact there are highly intellectual people who do not or can not articulate their thoughts and feelings clearly. Seybert (2000) explains that frustrations build up within individuals with DD when confronted with the inability to be understood by others. In the midst of potentially resulting aggressive and self abusive (also known as challenging) behaviors

these frustrations are also expressed through familiar actions - facial expression, body language, and behavior such as withdrawal, changes in sleep and/or appetite, loss of or increased interest, and cycles of mood changes. Overwhelmed caregivers may ultimately miss these symptoms of trauma responses, posttraumatic stress, and co morbid mental disorders reporting only aggressive and self-abusive behavior.

Internally, people with DD, struggle with the same issues of self-esteem, safety, belonging, and confidence as anyone else. In addition, people with DD are challenged with a neurological disability that individually affects the ability to process information. The social therapist, as well as the APRN, must have flexible expectations that develop with the person from their starting point in therapy; specifically, acknowledging that what the person identifies to be the problem may not coincide with what the caregiver identifies as the issue (Focht-New, 2004). For example, in Clare's case, bullying and teasing is layered upon difficulty processing information and a history of loss and trauma, which increases negative self esteem, and threatens her foundational sense of self, safety, belonging and confidence. The APRN is in a position to assist the person and caregivers to develop self awareness, related emotions, and consequential actions. Consequential actions of challenging behaviors are perhaps coping mechanisms, trauma responses, and/or symptoms. In the person's home environment, they can practice expressing their emotions and actions every day. Social therapy is provided when a safe and responsive environment is created externally. Clare's positive self-concept can be re-developed (or maybe developed for the first time) through small steps of assisting her in recognizing her own capacities, strengths, internal resources, and value as a woman and as a human being.

The external biopsychosocial environment involves opportunities for meaningful work, friendships and other relationships, hobbies, a safe home to live in, spirituality, and more. In this

realm the people around Clare would, every day, become a positive reflection of personal acceptance, without accepting her unhealthy actions. Healing occurs in the context of her relationships. APRN's are in a position to provide education for developing social therapists in the home and work environment. This education begins with the biographical timeline process and eventually includes information about trauma and trauma reactions, mental disorders as applicable, neurobiological impact of DD, and how much the person is processing like others without disabilities. Working together to create a socially therapeutic environment will give people like Clare the best possible chance for healing.

### **Educational Interventions**

Many individuals with DD have not had the opportunity to develop knowledge and skills to understand the trauma, needed coping skills, and strategies to prevent future occurrences. Neither can it be assumed that family members and social therapists possess these skills. To address these deficits education in groups and/or individually can be provided by APRNs. Utilizing a psychoeducational format, individuals learn new skills in a developmentally appropriate manner while in an accepting environment that recognizes and addresses the impact of individuals' emotional experience on the process of learning (Brown, 2004). A rapport and commitment to learn must be established, and material is taught in a clear, concrete, and creative manner matched to the individual's cognitive abilities and learning style (Hardman, Drew & Egan, 2006). Modeling and role-playing, social and other desired skills are useful techniques with repeating information numerous times for it to become meaningful and memorable. Individuals are recognized for following directions, comprehending the material, and putting the knowledge and skills into practice (Hardman, Drew & Egan, 2006). Resilience is the healthy byproduct of educational initiatives aimed to increase awareness of violence dynamics, promote

healthy relationships and safe living, foster crisis management, assertiveness, anger-management and self-determination skills, and teach stress management techniques (Echterling, Presbury & McKee, 2005). For those that have experienced crisis, interventions that aim to build resilience can, “uncover strengths, identify coping abilities, and promote resolution” (Echterling, Presbury & McKee, 2005, p. 10). Family education and support contributes to the well being of individuals with DD (Cantu, 2002). Relevant topics for education include signs and symptoms of trauma, communication, support skills through reflecting feelings, crisis management skills, crisis prevention strategies, referral sources, stress management, and preparation for court proceedings (Hardman, Drew & Egan, 2006).

### **Communication as an Intervention**

Within a safe and trusting environment in which individuals, like Clare, feel supported, it becomes possible to explore the experience of victimization, teaching people to label their feelings about the trauma provides a healthy outlet for expression, thus negating the need to displace distress in hazardous ways (Echterling, Presbury & McKee, 2005). Basic counseling skills of reflecting feelings can be used to unbury emotional experiences, establish an empathetic alliance, draw attention to expressed and unexpressed affective experience of trauma, illuminate conflicting feelings, and model the use of a feeling vocabulary (Ivey & Ivey, 2003). Role modeling reflection is beneficial to people with DD and the social therapists supporting them.

Whether or not individuals with DD are able to tell their victimization stories, the APRN can respond to stated and unstated affective expression. Some people may talk directly about their experience of trauma, and reflect their feelings. Others may be unable to express themselves due to suppressing events, denial, or due to cognitive or physical inability to speak. Some people, such as Clare, do not realize that they have been victimized, as this has been a way of life. In

fact, in order to gain access to emotional experiences, individuals may need repeated reflections of feelings. Healing from trauma takes time for most individuals, with and without DD. It is imperative that all supporters remain patient, demonstrate genuine concern and maintain a steadfastness in their repetition of linking the experience of trauma to current functioning as a means to deescalate and/or develop healthy coping strategies. Responding to the actual feelings related to the trauma as opposed to the feelings that may present in conjunction with unhealthy displacement behavior is helpful. Clare may need to first observe similar emotions and actions in other people. This approach addresses sensitivity that some people develop about their differences or disability. It is a relief to know you are not alone in feelings and actions. From the observation, it is then possible to reflect on the outcomes or consequences. Reflection helps to emphasize Clare's care and love for others rather than her detachment. By drawing attention to the deeper feelings underlying the expressed feelings, Clare may feel understood and be able to access her actual affective state so that she can begin confronting those feelings.

For those that have verbal expressive language, teaching a range of feeling words will broaden expression. Often, people with DD have a narrower feeling vocabulary limited to the basics of mad, sad, glad and scared, however, to fully express the magnitude of trauma, stronger words are necessary (Ivey & Ivey, 2003). By pairing a generic feeling word with a deep feeling word, an expanded affective vocabulary may be modeled. To promote the expansion of a feeling vocabulary, a feeling list can be developed with individuals able to read or expanded to include corresponding pictures with those who do not. For those with more limited expressive language, alternative methods for feeling expression and description of trauma may be necessary (Bedard, Burke, & Ludwig, 1998). Individuals could be asked to express their feelings through drawing pictures, selecting a color that best represents their feelings, use of motion or music, utilizing

puppets or toys, or express themselves in an appropriate manner of their choosing (Clements, Benasutti & Henry, 2005). Regardless of modality, APRN's should be prepared to reflect the expressed feelings. Individuals may deny feelings reflected to them. Simply try a different reflection or ask for clarification by having the person describe his or her own feelings. Either way, the individual with DD is engaging in a process of exploring affect, thus becoming that much more in-tune with their emotional state of being as it relates to the experience of trauma.

### **Therapy intervention**

Therapy is a most effective intervention when built on a foundation of a socially therapeutic environment with supportive, communicative, and education interventions in place. APRNs help to educate the person with DD and caregivers about therapy, struggles the person may experience as they process trauma internally, and the variety of needed supports. If Clare goes home to a place that does not assist in her attempts to change, she will, as most people would, give up and go back to old coping strategies. Historically, therapy for people with DD has meant behavior modification. As a result many people are sensitive and react negatively to being "told what to do." The only way to counteract this perception is to give people a choice about therapy. In the absence of experience or the presence of a hurtful experience, the therapist can only invite the individual to try to decide for themselves if the approach and/or the therapist are right for them (Focht-New, 2004).

Choosing between individual and group therapy is an important decision to make with the person. Individual therapy for people with DD is a choice based on comfort with other people, feelings of vulnerability, and the need for a more individualized therapeutic relationship. Group therapy is useful in creating a practice environment for role-playing. Groups help to normalize experiences. It is useful to those who understand but are unable to verbalize their

understanding. Integrated groups of people with and without DD and those with and without clear verbal expression offer an opportunity for the less verbal people to gain vicarious insight into their own experiences (Focht-New, 2004).

### **Summary**

For people, like Clare, healing from trauma, particularly a life time of emotional erosion and poor nurturing in addition to major traumas, can be a long slow process. This human being needs time and a supportive holding environment to recondition him or herself to a safe and more fulfilling reality. Barol (1996) states that it is imperative that social therapists be supported to support the person over the length of time it takes for the new experience of life to become second nature. Interviewing individuals with DD who have overcome seriously challenging behaviors, a theme surfaced throughout: "What made the biggest difference was that my caregivers (acting as social therapists) hung in there with me through thick and thin for the several years it took for me to feel safe, understood, and to understand 'how to behave'." In reality, persons with DD experience the full range of the effects of trauma, which are effectively illuminated through the biographical timeline process (Barol, 2001) and they benefit from a wide variety of interventions (Focht-New, 2004). What may be different are the ways supportive, communicative, psychotherapeutic and educational interventions are implemented so that emotions, resultant actions and ongoing concerns can be effectively expressed and addressed. Psychiatric APRNs clearly have a vital role in this process.

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