

# Persons With Developmental Disability Exposed to Interpersonal Violence and Crime: Approaches for Intervention

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**PURPOSE.** *Psychoeducational and psychotherapeutic interventions, by psychiatric advanced practice registered nurses and caregivers working with people with developmental disabilities exposed to interpersonal violence and crime, are recommended to help the individual resolve the intrapsychic trauma.*

**CONCLUSIONS.** *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.*

**PRACTICE IMPLICATIONS.** *Advanced practice registered nurses have an important role in addressing the sequelae of trauma by employing flexible, creative, and direct therapy with individuals. Additionally significant is provision of educational and supportive measures for the caregivers, who have the potential to generate an ongoing socially therapeutic environment.*

**Search terms:** *Developmental disabilities, mental health intervention, psychiatric nurses, trauma, violence*

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There are many forms of interpersonal violence encountered by persons with developmental disabilities (DD), and they have an alarmingly higher risk (estimated 4–10 times greater) of becoming a crime victim than persons without disabilities (Disabled Crime Victims Assistance, Inc., 2006). Globally, “interpersonal violence is defined to include violence between family members and intimate partners and violence between acquaintances and strangers...” (World Health Organization, 2006, p. 2). For persons with DD, specific examples include violence by housemates and/or caregivers, such as family members, residential staff, friends, 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, 2008).

Coping and adaptation are related to individual cognitive development and existing family-system stress management capacity, and they differ 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 are of importance for

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intervention. It is imperative to explore and understand levels 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 regarding 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 (Hastings).

In the chaotic aftermath of interpersonal violence, effective intervention strategies for persons with DD will revolve around enhancing their abilities to control instinctual and ingrained impulses while dealing with their home and work environments (Clements, Darvill, & Redshaw, 2006). The APRN will directly provide treatment to the individual and consultation to the team of people who directly support them, such as family, residential staff, friends, and/or teachers, who for this article will all be referred to as caregivers. Unique and innovative ways of listening to and working with these persons are required so that they can achieve their full mental health potentials by directly participating in matters that affect their lives.

The client's cooperation is imperative in ultimately developing a plan of care that will be successful (Clements et al., 2006). By adapting traditional approaches, the APRN can assist traumatized persons with DD and their caregivers to successfully navigate the impact of the event. Adaptation and creativity in shaping interventions supports the individual with DD in learning to cope and express 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) 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 that indicated Clare was manipulative, violent, sexually promiscuous, and had multiple mental health diagnoses. Records revealed several admissions to psychiatric hospitals and at least five incarcerations. Contrary to the reports, the current caregivers found Clare 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 10-year-old daughter.

The interview and review of records in 2002 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, her 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. She was often wearing dirty and threadbare clothing, and 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 behavioral 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 20s, 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 30s, 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 is a loss of a sense of safety, alterations in self-esteem, and confusion about appropriate interpersonal relationships with others and the world around her. This has been compounded by the maladaptive use of self-destructive strategies to engage with others for a limited sense of belonging.

### **The Challenges of Caregivers**

One of the primary steps to offering effective interventions for the person with DD who has been impacted by trauma is the development of the caregivers who support them every day (Barol, 2001). Very often, supporters have had little training in identifying symptoms relating to trauma or helping a person through recovery from trauma. As a result, they work with the person solely with the goal of modifying each discrete problematic or challenging behavior.

Teams struggle to support the person who may be seen as unpredictable, intermittently explosive, unable to connect, out of touch with reality, and destructive (The Team of Gregory's Journey, Inc., 2003). Without recognizing the potential cause of these behaviors, the caregivers are likely to develop their own explanations

(Barol, 2001), such as the person is spoiled, manipulative, retarded, psychotic, and criminal. In the authors' experience, the following consequences have occurred. Interventions have been crafted around an erroneous diagnosis of the problems. Medications may then be requested to sedate the individual as the quickest and most effective way of controlling negative behaviors. Caregivers have distanced themselves to fend off what they consider to be manipulation; they then withhold praise and attention and press for restriction and punishment to control the behavior of the "attention-seeking" person (Barol, 1996; McFalls, 2003).

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Caregivers with a more empathetic perspective may be considered naive and are often marginalized. The support team, composed of caregivers, 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 (Cope, Markovitz, & Phillips, 2001). Even when a diagnosis of posttraumatic stress disorder (PTSD) is determined, caregivers do not always understand intuitively the deep biopsychosocial implications (McFalls, 2003). Equally important, they frequently do not know how to help the person heal. The caregiver may believe that PTSD is another excuse professionals give to justify the need to withstand the aggressive, self-abusive, and attention-seeking behaviors, with no relief in sight.

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Primary caregivers offer a socially therapeutic environment by helping the person with DD move through life each day, understanding that daily routines are opportunities to encourage positive self-concept and teach new skills (Barol, 2001). APRNs have an important role in offering education and support to develop caregivers by helping them to understand the impact of a continuum of life circumstances, including the impact of interpersonal violence to people with DD.

### Biographical Timeline as Assessment and Intervention

The biographical timeline is both an assessment tool and a team development, education, and intervention process by which the person's caregivers, along with as many people as possible who have supported the individual over time, 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 behaviors, and interventions. Reviewing these issues developmentally, caregivers can direct their daily interventions toward filling in the developmental and experiential gaps (Barol).

Using the case of Clare, for example, the biographical timeline participants would be assisted by the 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? In Clare's case, the people who were to care for her hurt her. To whom could she turn for protection when her external resources were absent? Helping her heal would mean that the people in her daily life would have to provide an environment that could teach the basic skills of human interaction and provide safety

and consistency. The caregivers would be assisted to 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 "social" therapy, finding patience, endurance, and compassion (Barol, 1996) for the duration of reworking Clare's relationships with others as well as with herself. According to Barol (2001), the biographical timeline process opens the hearts of the caregivers. It helps them to fully step into the role of social 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 the intrapsychic trauma.

### Supportive Interventions

After completing a biographical timeline and noting significant issues related to the trauma, providing social and emotional support is of foundational importance (Barol, 2001). 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 posttrauma. Giving voice to persons with DD is a platform that permits and promotes expression, exploration, and education related to the trauma (Clements et al., 2006).

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 with DD in order to identify a trusted person, readily available (in person or by phone) 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

deescalate. This role is often transitional in nature, as it is mostly utilized during crisis situations that emerge 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, nightmares, and flashbacks and is most successfully accomplished by being proactive instead of reactive. Safety valves should be explored during nonaffectively charged time periods for the purpose of identifying self-soothing techniques that can be realistically and immediately implemented. Over time, with practice and positive feedback, the person can begin to utilize these safety-valve techniques independently. Successful use of safety valves increases a sense of mastery related to the traumatic event.

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

A socially therapeutic environment used 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 that are identified through the biographical timeline process (Barol, 2001). If any form of psychotherapy is to work, the person must be held in an environment that can sustain the person every day while he or she develops awareness of issues and changes his or her 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.

Seybert (2000), a person with a DD diagnosis, explained that frustrations build up within individuals with DD when confronted with the inability to be understood by others. These frustrations may be expressed through familiar actions—facial expression,

body language, changes in sleep and/or appetite, loss of or increased interest, cycles of mood changes, as well as aggressive and self-abusive behaviors of arousal, and behaviors of avoidance, such as withdrawal. When assessing the individual with DD, caregivers may ultimately miss symptoms of trauma responses, posttraumatic stress, and comorbid mental disorders, reporting only aggressive and self-abusive behavior.

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Additionally, people with DD struggle with the same issues of self-esteem, safety, belonging, and confidence as anyone else. People with DD are also challenged with a neurological disability that affects their abilities to process information and sometimes effectively communicate. The APRN must have flexible expectations that develop with the person from their starting point in therapy and are communicated through education to caregivers for implementation in the person's daily life. The APRN needs to acknowledge 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, Clare was reported to have aggressive behavior after experiencing bullying and teasing, which were layered upon difficulty processing information (DD) and a history of loss and trauma; these issues increased negative self-esteem and threatened her foundational sense of self, safety, belonging, and confidence. The APRN is in a position to assist the person and caregivers to develop

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self-awareness of thoughts and emotions related to the trauma, and consequential responses. Actions of aggressive and self-abusive behavior are perhaps coping mechanisms, trauma responses, and/or symptoms of PTSD.

In the home environment, persons with DD can practice expressing their emotions and actions every day. "Social" therapy is successful when a safe and responsive environment is created that improves the person's internal experience of support. Clare's positive self-concept can be redeveloped (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 become a positive reflection of personal acceptance, without accepting her unhealthy actions.

Healing occurs in the context of the relationships Clare experiences every day in her life. APRNs are in a position to provide education for Clare and her caregivers 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, communication, and how much the person is processing information like others without disabilities. Working together to create a socially therapeutic environment will give people like Clare the best possible chance for healing from trauma.

### Educational Interventions

Many individuals with DD have not had the opportunity to develop knowledge and skills to understand the impact of the trauma they have experienced or the needed coping skills and strategies to prevent future occurrences of interpersonal violence. Neither can it be assumed that caregivers possess these skills. To address

these deficits, education in groups and/or individually can be provided by APRNs. Utilizing a psychoeducational format, individuals with DD can learn new skills in a developmentally appropriate manner while in an accepting environment that recognizes and addresses the impact of individuals' emotional experiences 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 that is 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. As with all teaching, and particularly for people with DD, repeating information numerous times for it to become meaningful and memorable is necessary. Individuals should be recognized for following directions, comprehending the material, and putting the knowledge and skills into practice (Hardman et al., 2006). Resilience is the healthy by-product 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 et al., p. 10).

Caregiver education and support contribute to the well-being of individuals with DD (Cantu, 2002). Hardman and colleagues (2006) discuss relevant topics for an education group. Teaching the signs and symptoms of trauma (e.g., nightmares, flashbacks, hypervigilance, and sleep disturbance) assists the caregiver to assess for PTSD and differentiate these behaviors from everyday frustrations. Teaching basic communication skills (e.g., active listening, reflection, empathy, clarification) helps both the individual with DD and the caregiver to take time to connect and really understand what the problem is rather than just assuming the person with DD is acting out.

Preventing a crisis is possible when the caregiver knows the pattern of development of a crisis and the three basic factors that can alleviate the crisis (i.e., correct perception, institute constructive coping skills, and offer support) (Phoenix, 2007). Providing the caregivers with a current list of referrals, telephone numbers, agency's business hours, and types of services provided builds the caregiver's sense of being connected to the community and having resources in the event of a dire situation. Developing strategies for stress management can help persons with DD learn how to manage everyday frustrations and take control of their emotional lives (Hardman et al., 2006). Education is critical to assisting persons with DD and their caregivers to cope with the aftermath of interpersonal violence.

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#### **Communication as an Intervention**

Using communication techniques to work with persons with DD in therapy can help facilitate a more successful outcome for them in their homes because correct implementation of these skills ensures understanding and empathy between caregivers and persons with DD. Teaching people to label their feelings and ventilate these feelings about the trauma provides a healthy outlet for expression, thus negating the need to displace distress in hazardous ways (Echterling et al., 2005). Ivey and Ivey (2003) discussed how the basic counseling skills of reflecting feelings can be used to establish an empathetic alliance. Reflection is the skill of identifying underlying feelings that seem

present but are not articulated. The therapist makes a statement like, "I noticed that you seemed angry when talking about your mother," even though the client did not use the word anger. Reflection sends the message that the therapist is interested in the person's feelings, that emotions can be handled, and that it is important to identify feelings by name. Labeling feelings helps people to build a vocabulary that is congruent with their emotional experience. As time goes on, the individual with DD will be able to indicate that they feel anxious rather than just become agitated. Reflecting feelings also serves to unbury emotional experiences and draw attention to expressed and unexpressed affective experiences of trauma. Reflection can illuminate conflicting feelings that are best resolved by talking about the conflict (Ivey & Ivey). In addition, role modeling the technique of reflection is beneficial to the caregivers supporting people with DD, so they too can learn to elicit authentic feelings.

With consistent use of communication techniques, it becomes possible to explore the experience of victimization within a safe and trusting environment (Wheeler, 2007). Whether or not individuals with DD are able to tell their victimization stories, the APRN can respond to stated and unstated affective expressions. Some people may talk directly about their experiences of trauma and be able to articulate their feelings quite accurately. Others may be unable to express themselves due to suppressing events, denial, or due to a cognitive or physical inability to speak. Trauma victims may also be too fearful and/or ashamed to talk directly about their experiences. Often, it is necessary to normalize the feelings of shame, humiliation, fear, and anger to make it easier for the person to discuss this very personal experience of vulnerability (Phoenix, 2007).

Some people with DD who recognize that they have been hurt, do not have the language, education, or healthy experiences to understand how significantly they have been victimized, as this has been a repeated pattern in life. Often, the first step toward encouraging people to discuss their traumatic experiences is to

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develop language and understanding through education about trauma, types of interpersonal trauma, normal and expected feelings during a trauma, and expected feelings and behaviors after the trauma. This information helps people who have been traumatized to connect the dots and slowly come to a realization that they are victims of trauma and need help. Healing from trauma takes time for most individuals, with and without DD. However, the road can be tougher for the person with DD because underlying problems related to their disability are complicating factors. Furthermore, persons with DD may have experienced many traumas in their lives and have developed destructive patterns of behavior to deal with it that are not recognized as reactions to unresolved trauma.

It is imperative that caregivers and therapists remain patient and demonstrate genuine concern. Maintaining steadfastness in the repetition of linking experiences of trauma to current functioning as a means to deescalate and/or develop healthy coping strategies is a must. Identifying and responding to the underlying 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 disabilities. It is a relief to know you are not alone in feelings and behaviors. When Clare recognizes herself in others' behaviors, it then will be possible for her to correlate traumatic life experiences to her current feelings and actions. By drawing attention to the deeper feelings underlying the expressed feelings, Clare may feel understood and safe enough to begin confronting those feelings.

According to Phoenix (2007), it is only through the ventilation and deep expression of feelings that the traumatic experience can be integrated and the person is no longer subject to unconscious dissociation—a defense mechanism that kicks in automatically and unconsciously to protect the ego from too much anxiety when a person is being traumatized. It saves

the person's ego structure but can be a disturbing symptom when continued after the trauma. The purpose of trauma therapy is to help the person feel the feelings that were too overwhelming during the trauma, integrate the feelings and experience, and learn to live with the "new self" that has been traumatized but healed (Wheeler, 2007). This is a different person, and for people with DD, being different is already a sensitive issue.

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### Expanding Vocabulary

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). For those who have verbal expressive language, teaching a range of feeling words will broaden expression. By pairing a generic feeling word with a more accurate deep-feeling word, an expanded affective vocabulary may be modeled. For example, the description of a feeling previously labeled as mad might include words like resentful, annoyed, angry, and rage. To promote the expansion of a feeling vocabulary, a feeling list can be developed with individuals who are able to read or expanded to include

corresponding pictures with those who are 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 expressing themselves in an appropriate manner of their choosing (Clements, Benasutti, & Henry, 2005). Regardless of modality, APRNs should be prepared to encourage expressions of feelings, helping people to bear deeper feelings safely. Individuals may deny feelings reflected to them. Simply try a different reflection or ask for clarification by having the individuals describe their own feelings. Either way, individuals with DD are 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 it is built on a foundation of the socially therapeutic environment that is supportive, fosters communication, and offers education. APRNs help to educate persons with DD and caregivers about therapy, struggles they may experience as they process trauma internally, new coping skills, and the variety of needed supports. If Clare goes home to an environment that does not assist in her attempts to change, she will most likely give up and go back to unhealthy coping strategies. Historically, therapy for people with DD has meant behavior modification. As a result, many people with DD 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 (Clements et al., 2006). In the absence of experience or the presence of a hurtful experience, the therapist can only invite individuals to try therapy to decide for themselves if the approach and/or the therapist are right for

them (Focht-New, 2004). Trust building is key to supporting persons with DD in agreeing to any type of therapy.

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 the therapist, feelings of vulnerability, and the need for a more individualized therapeutic relationship. Group therapy is useful in creating a practice environment for role-playing and education. Groups help to normalize experiences (Yalom, 1985). 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 less verbal people to gain vicarious insight into their own experiences (Focht-New, 2004).

### Summary

People with DD experience interpersonal violence and the corresponding impact at a higher rate than people without disabilities. Coping, adaptation, and intrapsychic flexibility are a challenge to the person with DD who is experiencing trauma, their caregivers, and the APRNs who support them through psychoeducation and psychotherapeutic interventions.

For people like Clare, healing from trauma can be a long, slow process, particularly when they have had a lifetime of emotional erosion and poor nurturing in addition to experiencing major traumas. Persons with DD experience the full range of the effects of trauma that can be effectively illuminated through a biographical timeline. These human beings need time and a supportive holding environment to recondition themselves to safe and more fulfilling realities. When these needs are met and persons with DD remain symptomatic, they may benefit from traditional therapeutic approaches. What may be different are the ways supportive, communicative, psychotherapeutic, and educational interventions are adjusted for levels of communication and understanding and then implemented

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so that emotions, resultant actions, and ongoing concerns can be effectively expressed and addressed.

It is imperative that caregivers be sustained to support the person over the length of time it takes for the new and healthier experience of life to become second nature. By adapting traditional approaches, the APRN can assist traumatized persons with DD and their caregivers to successfully navigate the impact of the event. Adaptation and creativity in shaping interventions and their living environments support persons with DD in learning to cope with the impact of interpersonal violence and to express their feelings in healthy ways.

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