



# How to Hear Me

A Resource kit for Counsellors and Other Professionals  
working with people with Intellectual Disabilities



A project by WWILD Sexual Violence Prevention Association Inc.  
Disability Training Program - Victims of Crime



# How to Hear Me:

A Resource kit for Counsellors and Other Professionals working with people with  
Intellectual Disability

## RESOURCE BOOK

WWILD Sexual Violence Prevention Association Inc.  
Disability Training Program – Victims of Crime

Funded by the Department of Justice and Attorney General  
Building Capacity for Victims of Crime Services Funding Program

---

# Acknowledgements

WWILD SVP Assn Inc. would like to thank the following individuals, groups and agencies for their valued contribution in developing this resource.

To the women and men of WWILD whose lived experience informs this book. You humble us daily with your continuous demonstration of resilience and optimism. Thank you for allowing us to share your journey.

The Queensland Department of Justice and Attorney General, Victims Assist Queensland

Queensland Department of Communities, Disability and Community Care Services

Queensland Centre for Intellectual and Developmental Disability (QCIDD), The University of Queensland

Legal Aid Queensland

Sandra Seymour – Queensland Parents for People with a Disability (QPPD)

PACT – Protect All Children Today Inc

Tanja Stojadinovic – WWILD

Jill Olver – WWILD

Elly Emmet – WWILD

Community Living Association

Sarah MacDonald

Dr Gary Foster – Living Well, Spiritus

Christine Douglas

Leona Berrie

Megan Salisbury

Dr Kathy Ellem

Dr Niki Edwards

Dr Marie Knox

Michelle Moss

Dr Judy Gregory – Information Design Centre

Arden Ingari – EastWeb Web and Graphic Design



## Table of Contents

<b>Foreword .....</b>	<b>01</b>
<b>Introduction .....</b>	<b>02</b>
<b>1. Definitions of intellectual disability .....</b>	<b>04</b>
<b>2. The socio-historical context of ‘intellectual disability’ .....</b>	<b>08</b>
<b>3. Common ‘lived experience’ of people with an intellectual disability .....</b>	<b>09</b>
Living situations .....	09
Family and relationships .....	10
Education .....	11
Poverty .....	12
Social isolation and exclusion .....	13
Vulnerability to criminal victimisation .....	14
Sexual assault and exploitation .....	15
Criminal justice system over-representation .....	17
Physical health .....	17
Mental health .....	18
Self harm .....	19
Alcohol and substance misuse .....	21
Child protection system involvement and over-representation .....	22
Involvement with multiple service systems .....	24
Rights and self-determination .....	25
<b>4. Gender and intellectual disability .....</b>	<b>27</b>
<b>5. Aboriginal and Torres Strait Islander People and intellectual disability .....</b>	<b>29</b>
<b>6. Intellectual disability and people from culturally and linguistically diverse backgrounds .....</b>	<b>31</b>
<b>7. Barriers to communication for people with intellectual disability in the counselling context .....</b>	<b>34</b>
Introduction .....	34
Recognising intellectual disability .....	35
Acquiescence and masking .....	36
Attention and memory .....	37
Sequencing .....	38
Questioning .....	39
Concrete and abstract thinking .....	40
Behavioural issues in communication .....	41
Confabulation or ‘exotic story telling’ .....	43
Speaking and verbal issues .....	44
Confidentiality .....	45

<b>8. Important considerations for counselling practitioners .....</b>	<b>47</b>
Counsellors' values and attitudes .....	47
Positions of power in the counselling context .....	49
Time .....	50
Trauma .....	50
Grief, loss and bereavement .....	52
Narrative based-self-reporting and creative expression .....	53
Working well with family, paid workers and other significant support people .....	55
Duty of care and safety .....	58
<b>9. Four therapeutic approaches .....</b>	<b>60</b>
Creative approaches to practice .....	60
Narrative Therapy .....	60
Cognitive Behavioural Therapy (CBT) .....	64
Sand Tray Therapy .....	66
Art Work Therapy .....	68
<b>10. Exercises .....</b>	<b>70</b>
Using symbols .....	70
Exploring feelings through art .....	72
Flowers and rocks .....	74
The football field activity: Trauma vs hope .....	75
Crossing the river .....	77
Tree of life .....	78
The relationship ladder .....	81
Building a team .....	82
The 10 questions technique .....	83
<b>11. Tips for legal professionals .....</b>	<b>85</b>
Systemic issues .....	85
Identifying intellectual disability .....	85
Support people .....	87
Communication .....	88
Time and rapport .....	88
Memory and recall difficulties .....	88
Poor literacy skills .....	89
Acquiescence and suggestibility .....	89
Questioning styles .....	90
Narrative interviewing techniques .....	92
Advice that can be given to the judge .....	93
Capacity to give instruction .....	94
<b>12. References .....</b>	<b>96</b>
<b>Index .....</b>	<b>102</b>



## Foreword

The WWILD Sexual Violence Prevention (SVP) Association Inc is pleased to present *How to Hear Me*: a resource book and accompanying DVD that together form an important tool for building the capacity of victim support agencies, counsellors and therapists to work effectively with people with an intellectual disability who have become victims of crime.

WWILD SVP Association Inc is a not-for-profit organisation based in Brisbane, Queensland, that works with people with intellectual disability who have experienced or are at risk of experiencing sexual violence or have been criminally victimised. Through its two program areas, the Sexual Violence Prevention Program and the Disability Training Program – Victims of Crime, WWILD provides support for people with intellectual disability who are victims of crime, and to the professionals, carers and family members who support them. WWILD's work includes counselling and therapeutic groups; community education; court and legal support; research, resource development and advocacy; and information, advice, resources and referrals.

---

## Introduction

This book and accompanying DVD are designed to help build the capacity of mainstream counselling professionals to work with people with intellectual disability in their day-to-day practice. This resource is not intended to instruct professionals in the work they are already trained for, but rather to augment their existing expertise and allow them to adapt their current practice to meet the needs of a wider and more diverse client base.

Around 3 percent of people living in Australia experience intellectual disability. All counsellors have a professional responsibility to increase their competence in working with this broad group of clients, as they would with any other group of service users. In the past, people with intellectual disability have been portrayed as lacking the cognitive ability and insight to engage meaningfully in counselling. This, along with the lack of confidence that counsellors often express about working with this client group, has often led to people with intellectual disability being excluded from mainstream or generalist counselling services.

Counselling services that cater to the specific needs of people with an intellectual disability are rare. Thankfully, we are becoming more aware of people's emotional and psychological needs and there are an ever increasing number of mainstream counsellors seeking to work with this client group. This resource aims to build the capacity of mainstream services to provide quality support and therapeutic interventions for this group whose needs are still largely misunderstood and under-recognised.

Fundamental to the purpose of this resource is the knowledge that people with intellectual disability in Australia are over-represented in nearly every area of disadvantage, for a wide range of complex individual, social and systemic reasons. For the same complex reasons, people with intellectual disability are significantly more vulnerable to becoming victims of crime than other members of the population and therefore more likely to experience trauma and require therapeutic counselling and support. We have given considerable space to discussing the 'lived experience' of this disadvantage in the first half of the book to support professionals to better understand this complexity.

It is important to keep in mind as you read this book that a lot of the research referenced doesn't make a distinction between different levels of impairment (i.e. people with 'milder' forms of impairment as compared to people with more 'severe' levels of impairment). This is another reason why this book should be viewed only as a guide. Getting to know the people you are working with as unique individuals is what is most important.

This book is written from WWILD's perspective and experience of working with people with intellectual disability. It provides information to enhance understanding and practice skills in the counselling context when working with people with intellectual disability, including barriers to communication, useful therapeutic approaches, important considerations for practice and tips for legal professionals. The accompanying DVD provides a short explanation and demonstration of four individual counselling techniques that might be usefully applied in counselling practice with people who experience



intellectual disability. It aims to contribute to the conversation about how this group can be better served and supported within our community, particularly within the mainstream counselling setting. We acknowledge that it does not contain a full account of the diverse range of critiques available by which to understand the experience of people with an intellectual disability.

We hope you find this resource useful.

*Between the micro level of low self-esteem and the macro level of social disadvantage, there is also the mezzanine level of negotiating the everyday. People with a learning difficulty struggle everyday to understand what people are saying, to make themselves understood and, above all, to not appear different. However, people can and do triumph over their difficulties, even if only partially. (O'Connor & Fowkes, 2000)*



# 1. Definitions of intellectual disability<sup>1</sup>

Throughout this book, we use the term ‘intellectual disability’, but it is important to understand that it is a term that is used to convey various meanings in various settings and is often used interchangeably with ‘learning disabilities’, ‘cognitive difficulties’ and ‘learning difficulties’. Each of these terms has a slightly different definition depending on the context.

The term ‘intellectual disability’ usually describes some degree of impairment of intellectual functioning, with the degree of disability ranging from borderline to profound intellectual impairment. An individual may have an intellectual disability alone, or may also have other disabilities, including a physical disability. An individual may or may not have a distinguishing physical appearance (NSWLRC, 1996).

‘Learning difficulties’ is a generic term that refers to people who exhibit problems in developmental and academic skills. These difficulties are considered to result from one or more of the following factors: intellectual disability, physical and sensory defects, emotional difficulties, inadequate environmental experiences, or lack of appropriate educational opportunities (NHMRC, 1990, p. 2).

## Medical definitions

The American Association on Intellectual and Developmental Disabilities (formerly American Association on Mental Retardation) defines intellectual disability as:

Significantly sub-average intellectual functioning (that is, reasoning, memory, and other cognitive skills), existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety,

<sup>1</sup>This section draws heavily on MacDonald (2008, pp 10-12). Used with permission.



functional academics (basic literacy and numeracy), leisure and work. The condition arises prior to the age of 18.

The World Health Organisation, in the International Classification of Diseases and Related Health Problems (WHO, 2007), defines intellectual disability (referred to as mental retardation) as:

A condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, i.e. cognitive, language, motor, and social abilities.

The American Psychiatric Association, in the Diagnostic and Statistical Manual of Mental Disorders (4th Edn) (APA, 2000), defines intellectual disability (referred to as mental retardation) as follows:

- significantly sub-average intellectual functioning – an intelligence quotient (IQ) of approximately 70 or below;
- concurrent deficits or impairments in adaptive functioning in at least 2 of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety;
- onset before age 18 years.

## Legal definitions

The Queensland Criminal Law Code 1899 (December 2011) uses the term ‘person with an impairment of the mind’. Specifically, the interpretation on page 40 states:

A person is an ‘intellectually impaired person’ if the person has a disability –

- (a) that is attributable to an intellectual, psychiatric, cognitive or neurological impairment or a combination of these; and
- (b) that results in –
  - (i) a substantial reduction of the person’s capacity for communication, social interaction and learning; and
  - (ii) the person needing support.

## Self-definitions

Self-definitions are valuable because they give us insights into the impact of intellectual disability on individuals. Such perspectives enable people without an intellectual disability to gain an appreciation of the experience of living with an intellectual disability.

The following self-definitions are from constituents of Community Living Program (1994) and past group members of the WWILD SVP (Spork, 1994, pp. 11-14):

*(I'm) someone who takes a while to learn things.*

*I think it's being slow, and they think very simple.*

*I've got a disability and it takes me longer to work things out. But just because it takes me longer doesn't mean that I can't do it!*

*I have a learning disability which means I have had to have a lot of strength to get by day by day.*

*I have a learning difficulty and am no different from you. I can be hurt and I can be happy.*

*Sometimes you can't even see the disability inside you. You can't tell.*

*The public don't understand. Some people with intellectual disability, it could be the way they look or they might have some sort of behaviour problem and the public just make fun of it.*

*I feel mind disabilities are worse than physical disabilities. You can't touch the mind. When you see a disabled person, you can see a person when they're physically disabled, and you ask questions like 'Why is she walking like that?' You can see with your eyes what's wrong with the person but in your mind you cannot see a person with a mind disability.*

*I feel that I have a slowness in my mind but I think my mind thinks for itself. It does everything that other people do but I do not have a job because the doctors told me that stress would trigger off something in my brain and that's too high of a risk for me to take.*



*Well as far as I understand about intellectual disability, it means you might be 28 years old, you might only have the brain of a 20 year old or something. And sometimes I don't always act my age and might do abnormal things. With my learning disability and that. And so it's, yeh y'know, it's not always easy to cope with.*

Somewhere between 80 and 90 percent of people with an intellectual disability are in the 55-70 IQ range, otherwise known as the 'mild' intellectual disability group. 'Mild', however, is an unfortunate term that minimises the seriousness and challenges of living with intellectual disability (M. O'Connor, personal communication, 28 April 2011).

## 2. The socio-historical context of intellectual disability

Throughout history, people with intellectual disability have been treated in degrading, paternalistic, hostile, disrespectful and sometimes cruel ways. They have been institutionalised, marginalised and systematically pathologised. Societal views about this group have historically included a broad spectrum of beliefs ranging from the Eugenics Movement of the early 20th century, which supported the sterilisation and euthanasia of people with intellectual disability (Goggin & Newell, 2005), to current times where the rights of people who have a disability to live good lives as valued members of their community are recognised (if not fully realised) through national legislation (such as the Commonwealth Disability Discrimination Act 1992) and the UN Convention (UN, 2006).

While there have been significant shifts towards a higher level of acceptance and understanding of people who experience intellectual disability, in reality we still see a wide variety of societal, community and individual views that represent various points across the entire spectrum. For example, people who do not experience intellectual disability are sometimes afraid of interacting with people with an intellectual disability, due to their own inexperience, lack of understanding and pervading negative social views about intellectual disability. This experience of unfamiliarity and lack of involvement with people who have an intellectual disability is a direct result of the historical context where institutionalisation, segregation and various other forms of social exclusion of people with disabilities were common.

It is not surprising then, that people with intellectual disability are often excluded from the types of counselling and personal supports available to other members of the community, and that professionals working in these roles are subject to the same misunderstandings and inexperience with this group as the wider population.

### 3. Common 'lived experience' of people with an intellectual disability

Although this book discusses many of the shared experiences of people with an intellectual disability, it is important to state that, like all of us, every person comes with their own set of life experiences, skills, abilities and gifts. Although many people experience any number of the issues outlined below, the way they have experienced them will be unique. It is important to get to know the people you are working with as individuals whilst considering the wider context of people's experience.

#### Living situations

*I hated it (the hostel). The toilets and showers are no good. It gets all blocked up. The house isn't straight. The stumps are loose and they got disturbed in the big rain. The hostel was no good. He (the manager) would tell me to do things. I was washing up and cleaning. He wanted me to run his computer.... He said I couldn't stay if I didn't. So I made trouble for him. (O'Connor & Fowkes, 2000)*

The impact of a person's living situation on their overall well-being is as significant for people who have an intellectual disability as it is for any other member of the community. In fact, the security and appropriateness of a person's accommodation can impact more significantly on a person who has an intellectual disability, who may find it harder to negotiate housing challenges (such as difficult neighbours or inaccessibility to transport). Issues related to housing may be due to challenges that are related specifically to the person's disability, or to multiple social disadvantages that people with intellectual disability often experience, such as poverty, discrimination and social isolation.

People who have an intellectual disability might live independently in the community (alone or in shared housing), in a 'group home' or supported accommodation, or with friends or family members. It is interesting to note that only about 15 percent of people with moderate to high-level intellectual disability receive services in Queensland (Irons, 2011), which suggests that the vast majority of people with intellectual disability live independently in the community without the support of service agencies – either alone or with family or friends.

The complexity of a person's vulnerability is often closely related to their housing situation and level of independence in daily living. For example, people living in group home situations may have less choice and independence, and therefore may be vulnerable to abuse, neglect or exploitation by staff or other decision makers. However, people with 'mild' levels of disability who live independently and without agency support may have more choice and independence in day-to-day living, but may have limited capacity to make good choices to keep themselves safe and protected from exploitation or abuse by others (K. Ellem, personal communication, 28 April 2011).

Homelessness is a significant but under-recognised risk factor for people with intellectual disability. One recent study in the United Kingdom found that homeless people are significantly more likely to have an intellectual disability than the general population (Oakes & Davies, 2008). This is presumably due to the other inter-related risk factors that are common for this group, such as:

- Over representation in the criminal justice system
- High rates of alcohol and other drug use
- Poverty
- Poor physical and mental health
- Difficulty managing verbal communication
- Lack of appropriate education and employment opportunities
- Vulnerability to financial exploitation
- Social isolation.

It is extremely important to be aware of the client's living situation when working with clients with intellectual disability.

## Family and relationships

A client's relationships are likely to have an enormous influence on their lives. Along with their access to appropriate and secure housing, relationships are amongst the most important issues to be aware of in working with a person who has an intellectual disability. It is important for counsellors to work with an understanding of the people in a client's life, realising that relationships have the potential to protect and support as well as to harm and place a client at risk. Some helpful questions to ask might include:

- Who is in the client's life?



- What potential does the client have to develop supportive relationships?
- What about family of origin? (the family of origin is a source of support for some people, but not for others)
- Are the relationships the client has safe ones? What opportunities and/or risks do they present?

Most people have one significant adult person in their life, and it is important to gain an understanding of these relationships where possible – to identify the potential for support as well as for harm. It is also important to identify exploitative relationships, which might exist under the guise of seemingly ‘normal’ friendships or family relationships which take place out of public view and feature a style of coercion and control that takes advantage of a person’s desire for friendship and togetherness.

For some people with intellectual disability, difficulties with understanding the complicated and abstract nature of intimacy and relationships can contribute to difficulty in day-to-day life and cause vulnerability to exploitation. In addition, the sexuality of people with intellectual disability tends to be both marginalised and regulated. This has both historical and contemporary causes, which are closely related to the eugenics arguments that were prevalent early this century, to the fears associated with the increased rights of people with intellectual disability and to prevailing attitudes towards people with intellectual disability (Johnson et al., 2001, p. 21). The prevailing views about people with disabilities having sexual relationships can force people to conduct their sexual lives in secret, increasing their risk of abuse and exploitation (Johnson et al., 2001).

The experience at WWILD suggests that people with intellectual disability require in-depth engagement and education about the more abstract concepts of relationships and intimacy. For example, support workers may need to explore:

- What are public and private spaces?
- What is the difference between friends and romantic relationships?
- What makes a family?
- How do you know what you are feeling?
- How do you know what others are feeling?

## Education

School is often a challenging time for young people with intellectual disability, and many do not get the basic education they need to prepare them for adult life in the community. Approximately 60 percent of people with intellectual disability have severe communication limitations, and it is common for young people to leave school without basic levels of literacy and numeracy (AIHW, 2008).

Compared with students with physical disabilities, students with intellectual disability often require more help to learn and participate socially in the school environment. Many children who start school in ordinary classes are placed in special education classes by their



fifth year at school. Those who do not transition to special classes usually receive little extra support with their schooling (AIHW, 2008).

Issues of school culture and environment can have a big impact on a young person's ability to get the most out of their education opportunities. Common issues like bullying, segregation/congregation, stigmatisation and discrimination contribute to poorer educational outcomes for young people with intellectual disability. Issues of class and socio-economic status are also important: young people with intellectual disability who have supportive, well-resourced families and good social networks are likely to cope better with the challenges they face throughout their school years.

The transition from school into employment and adult roles is a challenging period. Many young people with intellectual disability struggle to find valued roles in their community after leaving school. The roles that people do find often have little more purpose than filling in time. Many employers struggle to understand how people with intellectual disability can be useful or effective in the workplace, or how to adapt their workplace processes to accommodate an employee with intellectual disability. As a result, many people with intellectual disability are at significant risk of unemployment or under-employment, social isolation, poverty and criminal justice system involvement (as victims or offenders or both).

*I knew there was something wrong with me. There were certain things I couldn't do in my head. Lots of students just thought I didn't want to go to school. They said things about me behind my back, things that really hurt then. They said I had brain damage.*

*Would have hated to be at Special School because people would tease you, treat you like a fool. Sometimes I would be chased and bullied by two guys, verbally abused. I used to hide. (O'Connor & Fowkes, 2000)*

## Poverty

People with intellectual disability are at much greater risk of experiencing poverty than other members of the population, due to lower levels of skill development and general capacity. This reduced capacity impacts on a person's ability to participate in employment and social opportunities that could contribute to financial security.

In comparison to their peers without a disability, people with intellectual disability are much less likely to undertake tertiary education, and have significantly lower rates of workforce participation (AIHW, 2008). People with intellectual disability are also more likely to withdraw from employment earlier in life (in their 30s), which suggests significant difficulties in maintaining employment (AIHW, 2008) and reduced employment opportunities (O'Connor & Fowkes, 2000).



Alongside employment issues, the following factors are common contributors to poverty for many people with intellectual disability:

- Poor or inappropriate education
- Physical and mental health issues, which limit employment opportunities and drain individual and family resources
- Vulnerability to financial control or exploitation
- Difficulties with managing money and financial responsibilities
- Social isolation, which reduces opportunities for support in dealing with finances
- Risk of becoming involved in the criminal justice system, either as victims of crime or offenders
- Growing up in inappropriate or unsafe accommodation.

Many of these factors alone are sufficient to place a person at risk of experiencing poverty. However, for many people with intellectual disability, a complex combination of factors are at play, and these can significantly increase vulnerability. Many of these contributors to poverty are also the consequences of poverty – and this can make poverty a cycle that is difficult to break. It is important for practitioners to be aware of the complex challenges that might be affecting their client. Day-to-day concerns about money, and the practical and emotional insecurities that this can generate, can impact significantly on a person's ability to participate in counselling on any given day.

## Social isolation and exclusion

*I'd like to have friends. It's really hard. I've tried lots of groups but none have worked out. I get really worried about if anyone is going to like me and if anyone is going to have things in common with me and it goes around in my mind and it's hard to decide to go, so a lot of times I don't. (O'Connor & Fowkes, 2000)*

Despite common perceptions that people with intellectual disability have a lot of family assistance, or that they have support from service providers or other community organisations, many people with intellectual disability experience extreme levels of social isolation. Like poverty, social isolation is both a cause and a consequence of a range of difficult life situations that many people with intellectual disability commonly experience.

Many people with intellectual disability grow up with limited family support, or within the out-of-home-care system. They may have limited capacity and resources to self-advocate and develop supportive connections with others in their local community, and are often socially restricted to organisationally-based social activities with other people with intellectual disability. This often results in a reliance on support systems and a narrow range of opportunities for developing meaningful relationships outside of those systems. Social exclusion is an important factor in explaining the social isolation of individuals. While many people with intellectual disability might be highly visible in the community, and be seen to access services and community resources, opportunities for meaningful

engagement and the full range of human relationships with others outside of the 'disability service system' are limited (Craig & Bigby, 2010).

Prejudice against people with intellectual disability is common, and there are often major challenges to the inclusion of people with intellectual disability in the social networks of people without intellectual disability. The first experiences that people without disability have of people with intellectual disability are crucial in setting their personal attitudes towards disability, and these experiences will encourage them to either exclude or include people in their social networks (Craig & Bigby, 2010).

People with intellectual disability themselves identify numerous personal and social barriers to community inclusion, such as:

- Being ignored and not accepted by others (people not talking to them)
- Having limited community facilities and opportunities for social exchange
- Transport and financial issues that decrease their access to social venues and events
- Being held back by service staff who prioritise other activities over meaningful community membership (Abbott & McConkey, 2006).

## Vulnerability to criminal victimisation

People with intellectual disability are more vulnerable to becoming victims of crime than people without a disability. MacDonald (2008) cites research into the criminal victimisation of people with intellectual disability which shows that:

- People with intellectual disability are more likely than their non-disabled counterparts to have been victims of multiple instances of domestic violence or sexual abuse and, in both disabled and non-disabled groups, women are more likely than men to have been the victims of violence
- Compared with the general population, people with intellectual disability are:
  - 2.9 times more likely to be assaulted
  - 10.7 times more likely to be sexually assaulted
  - 12.7 times more likely to be victims of robbery
- The majority of women with intellectual disability are sexually exploited by the time they reach adulthood
- Children with any type of disability are 3.4 times more likely to be abused compared to children without disabilities
- People with intellectual disability are 1.5 times more likely to become victims of crime than people without disabilities.

There is a strong perception in the community that people with disability are generally 'protected' from becoming victims of crime. However, due to the nature of intellectual disability and the life circumstances that people experience, many people are, in fact, extremely vulnerable.



## Sexual assault and exploitation

Numerous Australian and international studies report consistently high rates of sexual assault against people with intellectual disability (many studies are cited in French, 2007). French (2007) suggests that between 50 and 99 percent of people with intellectual and psychosocial impairments are subject to sexual assault at some point in their lifetimes. It is important to recognise that there is a particular absence of data on the abuse of people who are non-verbal, and this contributes to the difficulty of knowing the true rates of sexual assault.

Sexual violence is gendered, with women remaining the overwhelming victims of sexual assault (Murray & Powell, 2008). However, while much of the research focuses on women with intellectual and psychological disabilities, it is important to recognise that men and boys with intellectual disability are also highly vulnerable to experiencing sexual assault. Men with intellectual disability experience a greater risk of victimisation than men in the general population (Murray & Powell, 2008).

Murray and Powell (2008) suggest that, in addition to gender, the increased risk of sexual victimisation in people with intellectual disability may also be closely linked with vulnerability. Understanding vulnerability for people with intellectual disability is important, because it helps to illustrate where risks lie and how they can be reduced (for example, through teaching 'protective behaviour'). However, a singular emphasis on vulnerability places the responsibility for stopping sexual assault in the hands of the individual themselves, and neglects the wider society's social responsibility to value the lives and experiences of people with intellectual disability and to 'detoxify' environments that make people with disability vulnerable to sexual assault (French, 2007). For example, when a person is sexually assaulted at their home, by another resident who also has an intellectual disability, blame for the assault is most likely to be attributed to the inappropriate sexualised behaviours of the residents, rather than the inappropriate co-tenancy of particular individuals (which they, themselves, have no power to change). The co-tenancy is the result of a lack of a societal recognition that people with disabilities have a right to choose whom they live with, and not be forced into unsuitable co-tenancy arrangements due to poor policy and poor resourcing.

As French (2007) notes, when compared with the general population, sexual assault against people with intellectual disability is more likely to be repeated or continuing, and is more likely to be severe or violent. In addition, people with intellectual disability are less likely to be believed if they attempt to report that an assault occurred against them.

Sexual assault is very likely to be perpetrated by a known person, in a known and familiar location such as home or the workplace (as is the case for the general population). Common perpetrators include another person with intellectual disability who shares the same living/working/social environments, direct service providers (such as support staff, therapists and teachers), and sex offenders who seek work in residential care services because they provide increased opportunities for sexual predation (French, 2007). Sobsey (1994) argues that

people's vulnerability is further increased because our society teaches a person with disabilities to be compliant and accept anything that is done to them, without complaint, particularly from authority figures.

Due to a lack of meaningful and supportive relationships, it is not uncommon for people with intellectual disability to experience sexual assault through engaging in risky sexual behaviour in response to their strong need for companionship and relationship with others. For example, a person may accept that, in order to have their neighbour spend time with them, they need to consent to any sexual advance the neighbour makes. This may be the only way (or may be perceived by the person to be the only way) to allow them to keep the relationship with the neighbour. As is true for the general population, some people with intellectual disability who are socially isolated and in financial distress may use sex as a means to meet their everyday needs (for example, to get cigarettes, food or transport). This can place them at a much higher risk of continued sexual exploitation or sexually violent assault.

The legal complexities surrounding various responses to sexual assault can make it difficult for victims of crime who have intellectual disability to achieve justice. When both the perpetrator and the victim of a sexual assault have an intellectual disability, there can be confusion between the need to divert the offender from the criminal justice system and the need to achieve justice for the victim (French, 2007). In Queensland, the criminal code (Queensland Criminal Code Act 1899, as in force 1 July 2011, S 216) that is designed to prevent the sexual exploitation of people with intellectual disability in effect makes unlawful any sexual activity carried out with a person with intellectual disability. Within a structured service environment (such as supported accommodation), this often reduces or completely denies an individual's right to experience and express their sexuality, due to staff fears of being a party to illegal acts. In response to this untenable situation, individual service users might seek sexual expression in unsafe environments (increasing their vulnerability to sexual assault or exploitation) or perpetrate sexual assault themselves against another person within their living environment.

Caregivers and service providers, including counselling professionals, have a responsibility to provide a multi-dimensional response to sexual assault and exploitation. It is important to respond to the individual's trauma and provide strategies to decrease that person's vulnerability in the future (by questioning their living arrangements, work environments and relationships). It is also important to look beyond an individual's vulnerability to examine how our society contributes to perpetuating and intensifying people's vulnerability. Critical reflection by service providers and caregivers, about their own beliefs about the needs, rights and capacities of people with intellectual disability, should be central to this process.



## Criminal justice system over-representation

People with intellectual disability are not only over-represented as victims of crime, they are also over-represented as suspects or alleged offenders within the criminal justice system (French, 2007; Hayes, 2000, in Ellem & Wilson, 2010). Some commentators have suggested that as many as 35 percent of the young people in juvenile justice detention in Australia fall into the mild to moderate range of intellectual disability (West, 2011).

Research demonstrates that people with intellectual disability are most likely to commit offences involving impulsive or unpremeditated behaviour, rather than crimes involving planning and foresight. Offenders with intellectual disability also more likely to commit relatively minor offences, but to commit these offences repeatedly. They are also more likely to be charged with public order offences (French, 2007).

Many people with intellectual disability experience wide-ranging psychological and socio-economic disadvantages, which can predispose them to being charged with public order offences. MacDonald (2008) discusses several examples of the relationship between disadvantage and crime:

- Poor ability to manage daily life activities, such as budgeting for food and maintaining accommodation, which leads to 'survival crimes'
- Poor organisational skills and memory, which leads to a failure to meet minor legal obligations
- Lack of education and knowledge about socially-acceptable behaviours and behaviours that constitute a crime
- Limited sex education and poor ability to discriminate between 'public' and 'private' behaviours
- Visibility in public spaces, as a result of poverty, homelessness and lack of daily occupation, which attracts high levels of surveillance
- Congregation amongst high-need populations and 'survival cultures' where conflict, abuse and exploitation are common
- Learned behaviours resulting from life experiences that include lack of dignity, privacy and respect afforded to their person and property, and victimisation.

## Physical health

People with intellectual disability in Australia usually have higher levels of health-care need than the general population. However, they often have reduced or impeded access to health-care services (Lennox & Edwards, 2001) and experience significantly worse health outcomes and lower life expectancies as a result (Lennox & Simpson, 2011).

Communication problems are central to the differences in health status for people with an intellectual disability, and many mainstream health-care providers are limited in their capacity to support the complex health-care needs of this group. This may be due to the



past institutionalisation of many people with intellectual disability, where institution-based care was the norm and mainstream services were not expected to develop their capacity to provide health care for people with intellectual disability (Lennox & Edwards, 2001).

Lennox and Edwards (2001) cite some of the common health problems that Australians with intellectual disability experience at greater rates than the rest of the population:

- Visual impairment and eye problems
- Hearing and communication disorders
- Cardiovascular disease
- Spinal abnormalities
- Skin conditions
- Obesity and under-nutrition
- Nutrition and digestive disorders
- Hypertension
- Epilepsy
- Dental problems due to poor nutrition and oral hygiene
- Mental illness.

Both individual factors (such as communication barriers) and systemic factors (such as the under-developed capacity of mainstream medical services) play a big role in determining the physical health and well-being of people with disabilities. But a complex array of social factors also contribute to their health-care disadvantage – including poverty, social isolation, homelessness, domestic and family violence, criminal victimisation and criminal justice system involvement.

## Mental health

*I feel lonely a lot. I've got lots of things going on in my head all the time. I feel bad a lot of the time. I'm trying really hard at the moment to work it out. I don't know if I'll ever work it out - do you? I don't think anything is getting better. (O'Connor & Fowkes, 2000)*

People with intellectual disability are much more likely than other members of the population to experience depression, anxiety and other mental illness (Hayes, 2007). In Australia, the Australian Institute of Health and Welfare (AIHW, 2008) estimates that, in 2003, 57 percent of people with intellectual disability who were under 65 also experienced some form of psychiatric disability. Despite widespread knowledge of the prevalence of mental illness amongst people with intellectual disability, signs of mental illness, such as depression and anxiety, are often missed (UIDH, 2011).

People with intellectual disability may experience a reduced capacity to participate in standard clinical assessment processes, which can make diagnosis very difficult and result in limited access to appropriate mental health care (White et al., 2005). In the past, some



practitioners considered that people with intellectual disability were not able to develop mental illness, due to their cognitive limitations; any unusual behaviour was considered a feature of their disability. Today, unusual behaviour for a particular person is considered a good indicator that they may be experiencing psychological distress (Hughes, 2009). If a person is displaying unusual behaviour that is causing them distress, it is important to have them assessed by relevant mental health professionals. Encouraging the person to speak to their GP may be an important first step.

Once a mental illness is recognised, clinicians may face challenges in determining the most appropriate treatment and carrying out the treatment. People with intellectual disability often require intensive support from psychiatrists, psychologists, family, friends and/or support staff. For example, the process of determining the most appropriate medication can be extraordinarily stressful for the individual and their family members, as it may lead to even more difficult behaviours and situations at home. Family or support workers may decide that this is too harmful for the person (or themselves) and not complete the process before the best medication has been identified. As part of the treatment process, clinicians may neglect to consider whether different treatment approaches may be appropriate for individuals with intellectual disability – including considering the broader issues that may be contributing to the situation, or questioning whether a holistic response to the wider issues in the person's life could be beneficial (such as appropriate counselling or other non-pharmacological responses).

Hospitalisation for mental illness can be a traumatising experience for people with intellectual disability. The environment of hospital mental health units is frightening for anyone, and is particularly so for a person with intellectual disability. It may be difficult for doctors to identify what behaviours are normal for the person (and part of their disability) and what behaviours are due to a mental illness. It is essential that support workers and counsellors who know the person well advocate on their behalf to the clinicians who carry out the assessments and treatments. This will enable clinicians to get a clearer picture of what is and is not normal behaviour for this person.

## Self harm

Self harm or self-injurious behaviour (SIB) is any behaviour initiated by an individual that results in physical harm to themselves (Murray, 2003). People are particularly at risk of developing self-harm behaviours if they have limited verbal communication ability, have vision or hearing impairments, experience social disadvantage, or have a dual diagnosis of mental illness and intellectual disability. People with intellectual disability who misuse alcohol or other drugs are at greater risk of self harm and suicide than others (Murray, 2003).

The research reports widely varying prevalence rates of self-harming behaviour among adult populations with intellectual disability – ranging between 1.7 percent and 41 percent (Cooper et al., 2009). Paley (2008) reports that, amongst community-based populations,



17.4 percent of adults with intellectual disability engage in self-harming practices and, in 1.7 percent of this group, the behaviour is both frequent and severe.

Self-harming behaviour can be a particularly difficult issue for caregivers and professionals to deal with in supporting people with intellectual disability. Vicarious traumatising of caregivers is a serious issue. Paley (2008) outlines some of the common self-harm behaviours exhibited by people with intellectual disability:

- Face slapping or striking face and chest with knees
- Head slapping, rubbing or banging against surfaces
- Trichillotomania (pulling out your own hair)
- Self-induced vomiting or vomiting and re-ingesting
- Hand biting
- Eating inedible substances (pica), eating faeces (corprophagia)
- Skin-picking/picking at wounds
- Gouging of ears, mouth, nose, eyes, rectum and sexual organs
- Kicking or hitting body parts against hard surfaces.

Self harm is a serious issue for many people with intellectual disability and their caregivers. Although it is a difficult and complex condition to understand, self harm is often considered to be a way for people to cope with or express difficult emotions, when alternative means of communication are limited (DADHC, 2009).

Some reasons why people self harm include to:

- Communicate needs and wants
- Communicate that something is wrong
- Release emotions and feelings
- Produce feelings that sooth anxiety and tension (repetitive movement)
- Produce feelings of euphoria
- Punish self (relieve feelings of self-loathing or shame), or punish others
- Produce physical pain as a substitute for psychological pain, and feel the effects of opiate release in response to physical pain
- Self stimulate, or as a response to over-stimulation
- Generate a myriad of particularly-desired social or sensory responses.

Sometimes people with intellectual disability who develop early repetitive behaviours (such as rocking), which are initially beneficial for development (such as improving motor function), can later develop these behaviours to serve different purposes (such as to communicate the desire for assistance to walk). In some instances, these repetitive behaviours change over time from appropriate communication behaviours to inappropriate and self-injurious behaviour (for example, from rocking to banging head).

Understanding the reasons why a person self harms is important in any practice context, and comprehensive exploration of the issues and a commitment to helping the person communicate their needs is crucial to preventing an escalation of the behaviour. An



increase in intensity and frequency of self harm is often a sign that the person is not being heard or understood. It is important to not minimise or ignore a person's self-harm behaviour.

## Alcohol and substance misuse

Researchers argue that, although people with intellectual disability are less likely to use substances than the general population, people with intellectual disability who do use substances are more likely to abuse substances (Didden, Embregts, van der Toorn & Laarhoven, 2009). Alcohol and cannabis are the most commonly misused drugs by people with intellectual disability, and are most common among people who live independently and have less involvement with family members and/or support services (NSWCID, 2009).

Many people use alcohol and other drugs to deal with the emotional effects of traumatic experiences, to alleviate loneliness or inhibition, or to deal with physical pain. This is as true for people with intellectual disability as it is for the general population. While drug and alcohol abuse entails serious health risks for any person, it can be more difficult for a person with intellectual disability to see their problem and get appropriate help when they seek it (NSWCID, 2009).

Aside from the physical and mental health risks, people who misuse alcohol and other drugs are also further at risk of exploitation, criminal victimisation and engaging in offending behaviour (NSWCID, 2009). Community Living Association (2009) cites research which suggests that some other factors contributing to the relationship between people with an intellectual disability and substance abuse include:

- The lack of support that individuals with intellectual disability are likely to receive both from disability and mainstream services
- Use of substances to relieve anxiety, stress, other mental health issues and for self-medication
- Use of substances as a response to isolation, loneliness, boredom, stigma and exploitation
- Peer pressure and the influence of others.

One issue of major concern is that there is a lack of service response for people with intellectual disability who experience substance abuse. Mainstream addiction services may actually exclude this group due to their lack of training with people with intellectual disability (who fall into the 'too hard basket'). In addition, their usual models and responses may be ineffective (Community Living Association, 2009).

*'It gets rid of the pain, it blocks things in my head.'*

*'It just works – everything improves, my spelling, reading, maths, all the bad thoughts I have everyday disappeared.'*

*'Living in the first flat was hardest, lonely, bored. It partly started with boredom.'*

*'I wanted to blend in with all the people, cos when I was at school I used to get teased a lot. I was always the person who got left out. I just wanted to blend in, people were doing drugs so I would. I wanted to have friends and stuff.'*

(Community Living Association, 2009)

## Child protection system involvement and over-representation

People with intellectual disability are over-represented in child protection systems, both as parents and as children or young people being placed in out-of-home care (Jackson, O'Connor & Chenoweth, 2006; Lamont & Bromfield, 2010).

### Parents with intellectual disability

Parental intellectual disability is a statistically-demonstrated risk factor for child protection system involvement. However, the presence of risk does not mean that parents will abuse or neglect their children, or that parental intellectual disability necessarily means reduced parenting capacity (Lamont & Bromfield, 2010).

There are strong negative connotations associated with using the word 'risk' to identify areas where parents with intellectual disability might need extra support. Discrimination against parents with intellectual disability and the lack of support they receive to reduce the risk of harm to their children contribute significantly to the over-representation of parents with intellectual disability in the child protection system (Lamont & Bromfield, 2010). This situation is further complicated by the lack of clear definitions of 'good parenting' (or the impossibility of defining this) and the difficulties in assessing parenting capacity of people with intellectual disability. Difficulty in assessing parenting capacity is due to communication barriers, lack of training and awareness of assessors, the dominance of negative value judgements about the ability of people with intellectual disability to be good parents, or the belief that a person's disability is the singular cause of parenting difficulties. Some parents with intellectual disability do abuse their children, but there is no conclusive research to suggest that this risk is higher than in other parent groups (Healthy Start, 2011; Lamont & Bromfield, 2010).

Lamont and Bromfield (2010) report that some of the difficulties experienced by parents with intellectual disability include:

- Difficulty with problem solving
- Difficulty understanding human relationships
- Difficulty engaging positively with children



- Multigenerational involvement with child protection systems (their parents' involvement as well as their own)
- Lack of knowledge about health care and safety
- Vulnerability to other perpetrators abusing them or their children (commonly committed by the parent's partner)
- Social isolation and lack of support to parent well
- Difficulty in developing support networks
- Financial stress
- Stigmatisation and history of failure
- High levels of maternal stress which impact on bonding and attachment and contribute to more hostile parenting
- Past histories of abuse (a UK study cited by Lamont and Bromfield found that 79.6 percent of parents with intellectual disability were abused or neglected as children)
- Lack of ongoing support after the child has been removed.

While the presenting challenges for parents with intellectual disability are considerable, assessment of individual parenting ability needs to be done on a case-by-case basis, and in a way that accounts for the protective factors and strengths the parent brings, as well as the risks.

Professionals assessing parenting ability of people with intellectual disability need to engage in a high level of critical reflection about their own values and beliefs, to ensure that their assumptions about the competency of parents with intellectual disability do not cloud an accurate assessment of individual parenting. It is worth noting that, in the available research, parents with intellectual disability do not experience high rates of substance use and domestic violence, which are the two most common risk factors for child abuse and neglect (Lamont & Bromfield, 2010).

Further reading about this topic and resources for parents and practitioners are available from Healthy Start (<http://www.healthystart.net.au/>).

### **Young people with intellectual disability in (and transitioning out of) care**

All young people exiting the state care system are at significant risk of experiencing a range of difficult challenges – some that are usual for their stage of life, some that are related to their experiences in care, and some that are due to a highly-accelerated transition into adult independence from their 18th birthday (Cashmore & Paxman, 2006). Young people with intellectual disability face even greater risks, due to the lack of recognition of their needs and the lack of specialist support at this crucial time (Jackson, O'Connor & Chenoweth, 2006).

A 2006 study by Jackson, O'Connor and Chenoweth (2006) into the experiences of young people with intellectual disability who had exited out-of-home care at 18 reported that:

- Almost half of the interviewed were female and parenting a child (the average age of mothers was 20.8)

- There was a 96 percent child protection intervention rate among the parenting group; only one of the families had no form of protective intervention
- While in care, 26 percent of participants had experienced more than five placements, with some participants reporting 22, over 40 or over 50 placements
- Only one participant was in the same accommodation 2.5 years after exiting care; all other participants had experienced several types of accommodation including boarding houses, homeless shelters, public housing, private rental and foster carers
- Over half of the participants had experienced homelessness
- 17 percent of participants had been charged with a criminal offence, and 10 percent with more than one offence
- 71 percent of participants reported being victims of crime, and 67 percent of these crimes were sexual assault or rape
- 60 percent of participants had accessed mental health services, and 44 percent reported substance abuse issues.

*I was homeless for a while [after leaving foster care]. I was with this guy Sam. And then I split away from him, stayed in some flats at Kallangur, then somehow Sam and I found each other [again]. He moved into one of the flats. Then we were on the streets for 3 months, getting chased by the police, seeing the Salvos, trying to find a comfy place to stay ... I got sick. (Jackson, O'Connor & Chenoweth, 2006)*

## Involvement with multiple service systems

Due to the complexity and multiplicity of 'challenges' that people with intellectual disability can experience in their everyday lives, it is not uncommon for them to be involved with multiple service systems (either voluntarily or involuntarily). This can present a specific set of challenges, particularly relating to:

- Understanding support services and systems
- Understanding the relationships between systems
- Finding appropriate support and meaningful connection outside of service systems (where system involvement dominates)
- Living with the consequences of poor communication between involved services – 'falling through the gaps'
- Living with reduced self-determination due to heavy involvement of services (particularly if best practice around supporting decision making and sharing information between services fails to be strictly observed)
- Navigating services and systems that are 'siloed' into categories of support, rather than having opportunities to receive holistic support from fewer agencies or from the wider community (which would decrease life complexity and enhance social inclusion)
- Living with the consequences of injustices due to incompatibility between systems (for example, child protection law does not include the need to uphold the human



rights of people with a disability, and the legal system cannot provide the flexible approaches available through community-based disability services).

## Rights and self-determination

Despite the existence of the United Nations Convention on the Rights of Persons with Disabilities (UN, 2006), which has been signed and ratified by the Australian Government, major challenges remain for people with intellectual disability in realising some of their most fundamental human rights. The rights to self-determine a wide range of life choices (including place of residence, choice of co-residency, choice to access the legal justice system, choice in service providers and many fundamental day-to-day life choices) are enormously restricted for many people with intellectual disability.

From the theoretical perspective of the 'social model' of disability, it is society's response to disability that denies the human rights and self-determination of people with intellectual disability. In other words, it is not the person's disability that causes their exclusion and its associated injustices, but rather the way that a society or community responds to people with intellectual disability (and the extent to which this response values their rights and needs as community members). The lens of this ideology encourages questioning about the fundamental changes that need to be made in the practice of individuals, and on a societal scale.

The former Australian Federal Human Rights Commissioner and Disability Discrimination Commissioner Dr Sev Ozdowski OAM (2002) explains:

This social dimension of rights is particularly clear for rights for people with disabilities. A person with an intellectual disability may have more difficulty understanding information. But whether they can succeed in understanding may depend on the social context – how information is provided and what assistance is available – rather than being a purely personal issue of level of impairment. Why should we accept that this is just another instance of 'unmet needs' instead of naming it for what it is – a lack of sufficient action to ensure the human rights which as a nation we claim to be committed to. Of course there are limits to government resources. And calls for expansion of the welfare state are very much out of fashion. But we are not really talking about welfare here. We are not only talking about 'unmet needs'. We are talking about resources to enable people to enjoy free and equal citizenship. To participate in society. In fact, in many cases we are talking about resources to enable people to contribute and be productive, rather than being dependent on more passive forms of welfare assistance.

In reality, many of the challenges that are apparent in the 'lived experience' of people with intellectual disability are the result of a lack of recognition and commitment to upholding the human rights of people with a disability. For example, Article 13 of the United Nations Convention on the Rights of Persons with Disabilities (UN, 2006) states that:

Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others ... in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.

The over-representation of people with intellectual disability as victims of crime and as suspects, defendants and offenders within the criminal justice system is testament to the inaccessibility of justice for people with intellectual disability in Australia (French, 2007). People with intellectual disability are often limited in their capacity to benefit from the instruments of law and the protections that it provides due to the fundamental structures of the legal system which (inadvertently or otherwise) fail to understand and accommodate the needs of people with intellectual disability as citizens.



## 4. Gender and intellectual disability

It is important to recognise that gender and disability operate as structures of oppression for both disabled men and disabled women and that this happens in different ways, primarily because of the way in which dependence and independence are key parts of the social meanings of what it is to be a woman or a man (Morris, 1993).

Gendered analysis within the intellectual disability research literature has typically focused on issues faced by women and girls with intellectual disability (Wilson et al., 2010). This gendered analysis has usually drawn from a range of perspectives within the paradigm of feminist theory (Wilson et al., 2010). It argues that women with intellectual disability face both gender-related and disability-related discrimination, often referred to as a 'double disadvantage' (Collins & Valentine, 2003).

This body of research tells us that:

- Women with intellectual disability are more likely to experience economic disadvantage and poverty compared to men with disabilities and the general population (Mitchell, 2011)
- Women with intellectual disability are disproportionately vulnerable to victimisation, abuse, exploitation and harm. Statistics suggest that the majority of women with intellectual disability will experience sexual assault and exploitation by age 18 (MacDonald, 2008)
- Women with intellectual disability are particularly vulnerable to multiple forms of violence, abuse and exploitation in the home, community, institutions and workplaces (Frohman, 2010)
- Women with intellectual disability are routinely denied choice and autonomy over decisions regarding sexuality and fertility, and are not provided with accessible information to make informed choices (McCarthy, 2011). Women with intellectual



disability are often constructed as asexual or promiscuous and these negative stereotypes reinforce discrimination and oppression (Chenoweth, 1996)

- Women with intellectual disability who choose to become parents face attitudinal barriers such as stigma and discrimination and do not share the same rights to fulfil gendered identities. This further marginalises and devalues women with intellectual disability, in terms of their contribution to a gendered society (Collins & Valentine, 2003, p. 36).

Gendered issues are not exclusive to women and girls, yet a similar body of work looking at the male experience of intellectual disability and how it may differ to that of women is largely absent (Wilson et al., 2010). It is important to recognise that men with intellectual disability can and do experience social constructions of masculinity as oppressive. In today's cultural context, to be a disabled man is to fail to measure up to the general culture's definition of masculinity of strength, physical ability, status, authority and autonomy (Morris, 1993).

Wilson et al. (2010) argue that the themes emerging from research with males and females with intellectual disability suggest that gendered stereotypes are reinforced, particularly for males. They note that the research and literature focusing on the male experience appears to be viewed on a 'behavioural risk hierarchy' (i.e. strong research focus on behaviour management, particularly on treatment for problematised sexual behaviour), and that less research attention is given to male health (when compared with female health).

In the counselling context, it is important to recognise that gender and disability can operate as structures of oppression for both men and women with intellectual disability. Both men and women with disabilities will experience a conflict between their constructed identities as masculine/feminine and their constructed identities as disabled. They may have their masculinity and femininity (and sexuality) completely denied. Exploring society's construction of gender may help you to develop a more complex understanding of your client's experiences.

## 5. **Aboriginal and Torres Strait Islander people and intellectual disability**

According to the Australian Bureau of Statistics (ABS, 2010), in 2008 50 percent of Aboriginal and Torres Strait Islander people aged over 15 had a disability or long-term health condition. Aboriginal and Torres Strait Islander adults were 1.5 times more likely than non-Indigenous Australian adults to have a disability or long-term health condition, and were more than 3 times more likely to have an intellectual disability. In 2008, 7.7 percent of Aboriginal and Torres Strait Islander people in Australia (more than 25,000) had an intellectual disability. A similar number had a psychological disability.

Aboriginal and Torres Strait Islander people with disabilities often have unique needs, yet they continue to be 'at the periphery of all aspects of the disability sector' (Griffis, 2010). The lack of culturally-appropriate disability services and the different understandings of the concept of 'disability' in many Aboriginal and Torres Strait Islander communities make acknowledgement of the rights and needs of people with disabilities difficult to achieve. Griffis (2010) identifies these other considerations:

- Identifying as a person with a disability (that is, as a person who will receive disability support or services) is seen to add to the already significant experiences of discrimination that arise from having the label of 'Aboriginal person'. There is understandable reluctance to take on additional negative labels
- There are often no comparable words for 'disability' in traditional languages, which suggests that the experience of 'disability' may have been accepted as part of the normal range of human experience
- Aboriginal people and their families can sometimes experience significant stigma due to a cultural belief that disability is the result of 'married wrong way' or other wrong doings on behalf of the family or parents. This is more likely in communities where a more traditional lifestyle is practised
- The predominant medical model of disability (and the Australian Government's Close the Gap initiative) has focussed heavily on primary health interventions – in

contrast to the social model of disability, which acknowledges and attempts to deal with the social construction of disability and the injustices that contribute heavily to people's negative lived experience of disability

- Most Aboriginal and Torres Strait Islander people prefer to seek assistance from Indigenous organisations; few of these provide disability-specific services.

Cultural awareness is an extremely important aspect of counselling practice with Aboriginal and Torres Strait Islander people, and the differences in cultural and life experiences between Aboriginal and Torres Strait Islander people and non-Indigenous Australians can be a big deterrent for Indigenous Australians in seeking assistance from mainstream service providers (Fan, 2007).

The history of mistrust of white Australians since colonisation has a significant impact on Indigenous people's ability to trust non-Indigenous counsellors in a clinical setting. Where possible, it is important to engage with Indigenous services, community members or family members who can support an individual's engagement with a counsellor.

Relationships and kinship ties are central to the social and cultural values of many Aboriginal and Torres Strait Islander people, and it is imperative to make connections with and show respect for the family members and wider community that the person belongs to. Developing good networks within the community and with Indigenous service providers will both increase practitioners' cultural understanding as well as their clients' levels of trust in individual practitioners as people who care about their lives and want to understand their needs and lived experiences.

Counsellors need to be mindful that not all kinship ties will be helpful or supportive to their clients, and that a lot of people may be unwilling to discuss potentially 'shameful' personal issues with a worker if they think that family members will find out. These issues need to be explored and assurances need to be made to the client that family and community are welcome to be involved as much or as little as the client chooses. It might be helpful to ask a trusted person in the client's life to support them in the initial stages of counselling – to define the meaning of confidentiality for that particular person, whom they want involved, whom they do not want involved, and teasing out the issues of confidentiality and duty of care.

'Talk-based' therapies can be difficult for some Aboriginal and Torres Strait Islander people, often because practical issues relating to daily living and resources take precedence over more personal, psychological issues (Fan, 2007). The disadvantaged socio-economic and physical living conditions that many Aboriginal and Torres Strait Islander people live with are likely to be intensified for people with intellectual disability.

## **6. Intellectual disability and people from culturally and linguistically diverse backgrounds**

People with an intellectual disability who are from culturally and linguistically diverse (CALD) backgrounds will be highly likely to experience multiple forms of discrimination throughout their lives. They are likely to experience discrimination from the wider community due to their ethnicity and discrimination from both within their cultural group and the wider community due to their disability (NEDA, 2001).

In common with people with an intellectual disability, people from a CALD background will often (NEDA, 2001):

- Have language and communication difficulties that present significant obstacles in gaining access to services
- Miss out on generic and psychiatric support services
- Be unaware of the range of services and supports available and lack the knowledge necessary to access appropriate services
- Experience extreme isolation
- Experience financial vulnerability and fewer opportunities
- Experience reduced capacity to participate in social, economic, political and cultural life.

In addition, people from a CALD background may misunderstand how services operate and be misunderstood by health and welfare professionals (MMHA, 2004).

According to the National Ethnic Disability Alliance (NEDA, 2001), three-quarters of people from a non-English speaking background who have a disability miss out on accessing disability services and supports. NEDA suggests that many services seem unable to accommodate linguistic and cultural diversity because:

- Ethnic communities tend to be overlooked when considering the ‘target group’ of people with intellectual disability

- The disability service system has not adopted basic mechanisms for people from CALD backgrounds, such as interpreters or the publication of materials in languages other than English
- There are insufficient strategies and practices to ensure that people with a disability who are from CALD backgrounds, and their families and carers, participate in decision making
- The myth of extended family support is still subscribed to by both service providers and funding bodies.

Counsellors working with people with intellectual disability from CALD backgrounds need to consider their 'cultural competence' (Gow, 1999). Globalisation and migration continues to increase movement and contact across geo-political borders and continues to increase the complexity in communication between two or more cultures.

Culture is something that is learned and encompasses the beliefs, values, norms, symbols, behaviours, perceptions and customs of a people (Francisco & Carlson, 2002). Cultural practices and traditions can define roles within society, give meaning to life events, provide recognition of milestones and important transitions, and give a sense of belonging. The experiences of ethnicity and disability are interdependent and one cannot be valued over the other (NEDA, 2001).

People with intellectual disability from CALD backgrounds may not be given the opportunity to participate fully in the cultural life of their own ethnic group or that of the dominant culture. There may be multiple reasons for this: a person with intellectual disability may experience discrimination or shame within their cultural group because of their disability; a person may experience separation from their family of origin due to institutionalisation or removal from their families due to abuse or neglect; or a person with intellectual disability may receive support from a service or organisation, and that service may not provide the support required for the person to participate fully in their culture and its traditions.

Strategies that may aid cultural understanding include:

- Use an interpreter, if needed
- Develop an understanding of the client's perception of disability – how does this client (or family or culture) perceive the disability? Is this similar or different to the dominant culture?
- Develop an understanding of the roles that religion and faith play in their life and in people's well-being
- Develop an understanding of the role of cultural traditions in the client's life
- Ask whether the client has had an opportunity to fully participate in their culture's practices and traditions
- Consider why the client came to find themselves in a different culture and what impact this might have; the history of the family's migration may be significant



- Resist making generalisations about cultural groups and applying them indiscriminately in specific situations; there will be different views about disability within cultures and within family groups as well as between cultures
- Consider the impact of historic discrimination
- Develop an ability to recognise when you have been culturally insensitive or unaware (it's bound to happen) and develop strategies to recover from these mistakes.

## 7. **Barriers to communication for people with intellectual disability in the counselling context**

### **Introduction**

Challenges with communication are common for many people with intellectual disability and, while counselling practitioners need a solid theoretical basis to their work, they also need to ensure that their practice is flexible enough to respond effectively to the needs of this broad client group (O'Driscoll, 2009).

The communication styles of people with intellectual disability vary, as they do with all people. Some may be very articulate, some very talkative, and others may have very limited or no verbal communication (Gallagher, 2002). Depending on the individual client's communication style, needs and limitations, counsellors may need to talk more or talk less, make more statements than usual, give more suggestions, prompt more, rephrase the other person's words and ideas, or 'loan them the words' more than usual (Booth & Booth, in Gallagher, 2002).

IQ is not a useful indicator of a person's communication capacity. Two people with the same measured IQ can be very different in their practical abilities as well as their verbal fluency. Nor is a person's vocabulary a good indicator of their level of comprehension or communication ability (Booth & Booth, in Gallagher, 2002). In the same way, a person's chronological age may not be an adequate measure of their maturity (Dossetor et al., 2005).

Poor communication ability can have a wide impact on a person's ability to negotiate the systems necessary to live well – for example to access banks, Centrelink, the Public Trustee, medical services and so on. It is important for counselling practitioners to take these challenges into account, to enable clients to take full advantage of the support services available to them, and to assist them in communicating their experiences and needs to others.



In the literature about counselling people with intellectual disability, there is often no distinction between people with 'milder' forms of impairment and more 'severe' forms of impairment. In addition, people with more 'severe' communication difficulties are often deliberately excluded from the research. There is a real absence in the literature about how to offer counselling, treatment and support to people with intellectual disability who have very limited verbal ability or who have more 'severe' forms of impairment. More work needs to be done to better understand and respond to the needs of this group.

## Recognising intellectual disability

The term 'intellectual disability' does not describe any particular disability. Instead, it describes a collection of different types of cognitive impairment and syndromes, brought about by numerous possible causal factors.

Aside from IQ testing, which is not a reliable indicator of a person's overall capacity, there are a number of non-clinical indicators that help to identify whether a person has an intellectual disability. Some common areas of daily functioning that people with intellectual disability experience difficulty with include:

- Reading and writing
- Identifying money values or calculating change
- Finding their own phone number in the telephone directory
- Giving directions to a place they would be expected to know (they may be able to take someone there, but not give directions).

Intellectual disability might also be indicated by a range of difficulties in a person's communication, such as:

- Having a restricted vocabulary
- Having a short attention span
- Being easily distracted
- Experiencing difficulty in understanding questions
- Responding to questions either inappropriately or with inconsistent answers
- Experiencing memory difficulties
- Showing difficulty with abstract thinking and reasoning.

An individual's behaviour can be a useful indicator of intellectual disability – including being over-friendly, being eager to please, or acting in a way that is appropriate for a much younger person.

Social information about the person and their life experiences may indicate intellectual disability. For example, many people with intellectual disability receive the disability pension, or attended a special school or a special class at school. A number of people with intellectual disability find employment in sheltered workshops or attend work training programs.



If there is doubt about whether a client has an intellectual disability, counsellors can ask questions about the person's current life circumstances and past life experiences – particularly during the initial engagement and assessment process. Relevant questions may include:

- Where did you go to school?
- Did you get any extra help at school?
- How are you with reading and writing?
- What do you do during the day? Do you go to work?
- What types of things do you do for fun? To relax?
- Where do you live? Do you live with other people?
- Do you get a pension from Centrelink?

The overall picture painted by the responses to these questions should help practitioners to assess reasonably well whether or not a client has an intellectual disability. It is obviously easier to recognise more severe intellectual disability than 'mild' or 'borderline' levels. Yet it is crucial that people with less severe 'categories' of intellectual disability are recognised and provided with appropriate support, particularly as they are likely to hide their individual needs to avoid stigmatisation. People with 'mild' or 'borderline' intellectual disability are likely to be just as vulnerable as people with more severe intellectual disability, but in different ways. (For more information, see the section: 'Definitions of intellectual disability'.)

### Acquiescence and masking

People with intellectual disability often mask their difficulty with verbal communication to avoid the stigmatisation associated with having a disability. It is very common for people to take on a passive communication style, where they let the more powerful person in the conversation take the lead. In this way, acquiescence (or compliance) is itself a method of masking disability.

There are many possible reasons why acquiescence takes place, including:

- The person might not understand what is said, so they agree with it in an attempt to cover their misunderstanding (masking)
- They find it difficult to say no, particularly to someone perceived to be in authority
- They don't want to say no, or are afraid to say no, and agree with what is said to avoid getting into trouble
- They find it difficult to understand abstract information (we assume that a lot of our communication each day is straightforward when, in fact, it involves the use of a lot of abstract knowledge).



Masking can also take the form of:

- Rote learning of statements to use when responding to questions or as part of a conversation
- Learned behaviours to get care or help, to fit in, or to get someone to go away
- Rote learning of statements that simply help the person to get by and deal with their everyday experiences, for example: 'I don't know whether I'm Arthur or Martha'.

Counselling practitioners need to be alert to inconsistencies between people's stories and their body language, which might indicate a real difference between what the person is saying and what they would say if they were able or empowered to do so in that moment. Asking clients for advice on how best to communicate with them might give counsellors valuable information and empower clients to communicate their needs. This is likely to reduce compliance.

Working slowly and with repetition, and checking for understanding along the way, are useful techniques to make sure that the client understands the discussion and communicates their genuine wishes, opinions or decisions in return. It is important that counsellors do not over or underestimate what the client understands (or what the counsellor think they understand), or pretend to understand what the person is saying when they aren't quite sure. Continual checking on the understanding of both parties is important. It is better to gently check than to continue under false pretences.

## Attention and memory

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

For example, sometimes a client might need to talk about a particular topic or an experience they have had, that initially seems unrelated to the counselling session. In this case it is both helpful and respectful to allow the person some time to talk about their topic before focussing on the counsellor's plan for the session. Seemingly insignificant topics might turn out to be important, and counsellors need to assess whose needs they are meeting if they feel tempted to dismiss apparently irrelevant topics brought up by their client.

Anxiety before and within the counselling session is common. This can be caused by the understanding of many people that counselling is 'talk-based', coupled with their fear of failing in communication (Dagnan & Jahoda, 2006). Learning to understand the way that anxiety impacts on an individual's memory, attention and concentration is extremely important.

More frequent, shorter sessions can be helpful, as well as being prepared to work slowly and with repetition. Adjusting the frequency of your speech might also be necessary, to assist the person's level of comprehension and retention of what you say and the questions you ask.

The use of imagery and creating a visual record of counselling sessions is a useful technique for recording and remembering counselling sessions, and as a way to review and see development over time. However, some imagery may not work with some clients, and this needs to be explored sensitively with each client to avoid insult and/or embarrassment. For example, creating drawings to record the session might seem child-like or embarrassing to many adults with intellectual disability. Normalising the use of drawing and artwork in counselling with adults can help to break this association. For example, the counsellor might say, 'I really like to use drawings to help me understand some things, do you mind if we do a drawing of what we're talking about?' (For further discussion about using artwork and creative techniques in therapy, see the sections: 'Exploring feelings through art', 'Sand tray therapy' and 'Art work therapy'.)

### Sequencing

Similar to the common difficulties experienced with attention and memory, many people with intellectual disability have considerable difficulties in sequencing events and understanding the relationship between particular actions and their consequences. This can be particularly challenging when there are multiple subjects and events in the story.

When people with intellectual disability tell their story, it can often seem out of order or illogical. However, it is important to let the client tell their story in their own way, in their own time, in full, and without interruption. This may require counsellors to rethink their assumptions about their client's aims in telling their story. Telling a chronological, well-structured story may not be a high priority, and it is not necessary that the story is told in this way. People with intellectual disability often use their own language structures and their own methods of communicating events or experiences, and this may differ greatly between people. For example, some people have great difficulty staying in chronological sequence when they tell their story, while others may feel great discomfort in jumping out of sequence or being interrupted.

Counsellors have a responsibility to adapt their communication and thinking about the client's story to the individual client, and not expect the client to conform to a standard mode of storytelling. Counsellors working with people with intellectual disability need to listen patiently as the person tells their story, sometimes over a number of sessions, and then take what they have heard and attempt to make sense of it as a whole. Patience and time to allow the person to be heard completely are crucial.



## Questioning

Counsellors should be aware that the questioning methods they use may lead to complexities and different outcomes when working with people with intellectual disability. Unnecessarily complex questions can create confusion and embarrassment for clients. It is possible that these same clients may have the ability to answer questions well, if the questions are carefully worded.

Developing a high level of self awareness in questioning is a key strategy in this counselling context. Careful use of questioning can ease confusion and embarrassment; clarify problems, goals and intentions; and provide clients with increased opportunity to be heard as participants in meaningful conversations.

These points may be helpful when thinking about questioning in counselling with people with intellectual disability:

- Keep questions of choice simple. If you are asking a person about their preference, an outcome, or an action, pose no more than two options in one sentence. For example, say 'Would you like to stay home or go out tomorrow?' rather than 'Would you like to stay home or go out tomorrow, or just go out for a little while?'
- Avoid double-barrelled questions (asking two questions about different subjects in one sentence). For example, don't say 'How do you feel about going out today and going in the taxi?'. Instead, ask 'How do you feel about going out today?', and then ask about the taxi separately
- Avoid the use of negative and double-negative questions. These can be difficult for people to interpret and respond to, because a 'yes' response to a negative question denies the proposition of the question rather than affirming it
  - Example of a negative question: 'Didn't you see your mum last night?' (If the response is yes, it means the person did not see their mum). Instead, ask: 'Did you see your mum last night?'
  - Example of a double-negative question: 'Didn't you not hear what the train guard said?' (this type of question can make it difficult for the person to know how to respond – is their answer going to negate or affirm the proposition?). Instead, ask: 'Did you hear what the train guard said?' or 'What did the train guard say?' or 'Did you hear the train guard say anything?'
- Communicate in short sentences, not paragraphs, and break questions down to manageable sizes with one main idea
- Use plain, simple English
- If you falter in forming a clear question, apologise and try again. Say: 'Sorry, that was confusing, let me start again'. Or, reset the question: 'Can we go back to the part where you talked about ...'
- Signpost the conversation: If the conversation gets confused or confusing for either participant and you want to start over, make this explicit. Say that you are starting over

- Use a combination of open and closed questions. Begin with an open question, then ask closed questions to confirm details or clarify meaning. Example of an open question: 'Would you like to tell me about your family?'; example of a closed question: 'And do you have an uncle?'.

### Concrete and abstract thinking

Many people with intellectual disability are highly concrete thinkers. This can result in misunderstandings due to their literal interpretation of verbal communication and general difficulty understanding abstract concepts. The following examples of abstract thinking commonly cause difficulty:

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

It is useful for practitioners to increase their awareness of what is abstract, and the unconscious ways they employ abstract concepts and language in their communication with clients. Critical reflection 'in action' and after sessions is an important strategy to increase this awareness.

People with intellectual disability often speak using their 'own language' and might use humour and conceptual schemas that are not always obvious in meaning to the counsellor. Exploring the meaning of statements and keeping a record or 'dictionary' of phrases commonly used by the person can be a useful way of improving rapport and communication. This is also highly beneficial for both the counsellor and client during periods of staff turnover.

Using drawing and artwork in counselling is an important tool in helping clients with intellectual disability to gain concrete understanding of abstract concepts. For example, 'relationship' can be explored through drawings of people and visual representations of how they relate to each other. Drawing and artwork can also assist counsellors to understand what a client means when they use of particular sayings or phrases. (For more information, see the sections: 'Exploring feelings through art', 'Sand tray therapy' and 'Art work therapy'.)

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



Understanding ‘emotions’ by connecting the abstract label of the emotion to the corresponding physical experience in the body can help people to talk about their emotional experiences and find ways to recognise and respond when emotions are disturbing. For example, a person may not be able to talk about their ‘nervousness’, but can talk about ‘feeling sick’. It is helpful for counsellors to ask questions like ‘Where do you feel that?’ or ‘How do you feel that in your body?’ to help the person identify what they are feeling and when. Counsellors need to approach this work with a sense of patience, commitment and curiosity – it can take a long time to uncover the understanding and experiences of emotions of each client.

Many difference factors influence the ways that people create meaning, use the English language and respond to abstract language. It is vital to take cultural background and experience into account as well as the presence of intellectual disability. Comprehension and understanding need to be assessed for each individual, and practitioners need to ensure that their stereotypes of people with intellectual disability do not impose limited expectations on the person’s ability to communicate.

## Behavioural issues in communication

‘Challenging behaviour’ is a common term in the field of intellectual disability, and is used to describe any behaviour that negatively affects a person in their daily life, or negatively affects the people around them (CDDHV, 2005). People with intellectual disability are often referred to counselling because of a behaviour change that is causing problems for themselves or others in the home, workplace, school or wider community. Behavioural issues may also have negative impacts on the client and counsellor within the therapeutic context.

The kinds of challenging behaviour that people with intellectual disability might display include (CDDHV, 2005):

- Aggression
- Self-injurious behaviour (self harm)
- Property destruction
- Oppositional behaviour
- Socially inappropriate behaviour (including sexualised behaviour)
- Withdrawal.

It is extremely important that people with intellectual disability who display challenging behaviour are not labelled as ‘challenging’ themselves. It is the behaviour that is challenging. Challenging behaviour should be viewed as a form of communication. People supporting or counselling a person who exhibits challenging behaviour need to work hard, often over long periods of time, to understand the messages behind the behaviour.

It is important that a person’s challenging behaviour is not simply dismissed as an inevitable feature of their disability. A person’s disability can influence their behaviour, but is not necessarily the cause of the behaviour. This is particularly important given the



over-representation of people with intellectual disability in the criminal justice system. Clients with intellectual disability who experience difficulty with their behaviour should be taken seriously and given support to explore the causes of the behaviour, as well as strategies to deal with it.

There are numerous medical, psychiatric, social and environmental reasons why a person with intellectual disability might display challenging behaviour in their life and/or in the counselling context. CDDHV (2005) suggests that these can include:

- Physical pain or discomfort (recognised or unrecognised)
- Background medical conditions
- Medication
- Epilepsy
- Substance abuse
- Syndrome-specific conditions
- Mental illness
- Trauma
- Abuse and exploitation
- Communication difficulties
- Lack of self-determination and control over life
- Social isolation
- Grief, loss and bereavement
- Life stages and transitions
- Living and working environments.

People with intellectual disability sometimes change their behaviour as a way of creating change when their needs and desires are otherwise difficult to communicate and meet. Any change in a person's usual behaviour could, therefore, indicate that they are seeking to change some part of their internal or external environment, including within the counselling session.

Difficult behaviour in counselling may be related to a change the person is seeking in the counsellor, in themselves, or in any other context that is affecting them at the time. It is important not to assume that, just because a client has arrived for their session, they want to be there or are ready to be there in a calm and collected manner.

Useful strategies for supporting a person who is displaying challenging behaviour in counselling include:

- Maintain self-awareness and critical reflection to ensure that a client's negative reactions are not taken personally (for example, a client's anger may be directed at you as the counsellor, but you shouldn't take it personally and may need to seek supervision)
- Remember that the client is trying to create a change and they can't see another way of achieving it





- Foster an environment of learning and understanding about the client rather than punishment for what is essentially a problem of communication
- Change the counselling environment – consider home visits, going outside the office, sitting on the grass, going to a park, or meeting at a coffee shop
- Create safety in the therapeutic relationship – focus on trust and take the time needed to build genuine rapport. Demonstrate commitment to helping the client by showing that you will not judge them or refuse service due to their behaviour (show this by not taking their behaviour personally)
- Use symbols or artwork – these may help the client to find other ways of expressing their needs, wants and desires
- Try a less formal approach if the client withdraws – use humour, play cards, go for a walk or a drive, wash up, or create a new and less threatening conversation. Talk through doing.

Many people with intellectual disability experience difficulty empathising with others, which can lead to very difficult situations when negative behaviour is directed towards or harmful to others. This is particularly difficult for many workers to accept, particularly if they are the target of the behaviour.

It is important not to punish a client for their behaviour, but to openly explore the concepts of ‘others’ feelings’ and ‘apology’ through concrete examples that are meaningful for the client. For example, ask questions like:

- ‘How would you feel if that happened to your mother/friend?’ (refer to someone specific whom the client respects)
- ‘What would your mum/friend think about you doing this?’ (refer to a key, non-judgemental person in the client’s life).

## Confabulation or ‘exotic story telling’

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

Remember that people who confabulate are not deliberately lying, but are trying to impress. Some suggestions for navigating ‘exotic tales’ include:

- Don’t deny, diminish or contest the client’s story – there is little point in refuting what is an absolute truth for the client at that point in time
- Don’t contest the client’s story: this sends the message that what the client has to say is not valued. The story may not in itself be real or valid, but the client’s reason for telling it is
- Remember that exotic stories could be true – do not disregard anything a client says

- Practise deep listening – try to hear the meaning behind the story the client is telling. What is the subtext? Are there any inconsistencies? What is the behaviour?
- If it is important to get to the truth for safety reasons, find a way to ask questions that are consistent with the fantasy; this will help the client to reveal what is really happening
- Confabulation decreases when there are good, real stories to tell – look for and value the real stories that the client can tell about themselves.

### Speaking and verbal issues

Difficulties with speech and communication are common for many people with intellectual disability. Some people might experience difficulties with speech itself, have problems with language (including how to use and understand spoken language), or both.

There are many reasons why a person with intellectual disability might experience speech difficulties, and these reasons may or may not be related to their disability. Some of the factors that can contribute to difficulties with speech include (CYWHS, 2011):

- Physical factors and physical disability – such as low muscle tone; structural problems in the mouth, nose and throat; and conditions that affect nerve and muscle control (it is important that physical difficulty with speech does not lead to assumptions about a person's level of comprehension or language ability)
- Ear infections that can cause hearing difficulties and hearing impairment
- Intellectual disability, which slows the development of speech and language
- Acquired brain injury, which may temporarily or permanently damage the parts of the brain that deal with speech and communication
- Lack of stimulation or experience in communicating verbally
- Traumatic experiences, which can change the chemical structure in the brain and affect the ability to recognise, accurately describe or sequence even concrete concepts (discussed in Shauer, Neuner & Elbert, 2005).

Some of the particular difficulties that people can experience with speech include (CYWHS, 2011):

- Difficulty with making sounds – including saying words clearly or correctly
- Speaking fluently – without hesitating too much or stuttering
- Using words and grammar – knowing and applying the rules of word order and word use
- Choosing the right words and putting them in the right order to convey the intended meaning.

It is vitally important not to make assumptions about why a person experiences difficulties with speech. For example, people who have verbal communication difficulties due to their physical disability are often assumed to have an intellectual disability, due to the



association between intellectual disability and problems with communication. This may not be the case.

People with intellectual disability might present as having much higher levels of communication ability than they actually do. Many people with intellectual disability have numerous strategies for masking their disability, and can appear to understand and participate in conversation when their genuine level of comprehension is limited. Mimicking and copying others' language use is common, and can be convincing.

These strategies can be useful for supporting counselling practice with people who experience speech difficulties:

- Build rapport and safety in the counselling relationship. This is vital in developing the client's trust in you as someone who will help them to express themselves and their story, regardless of their speech or language problems
- Show the person that what they have to say is valued, and that there is time to be with them and hear their story
- Never pretend to understand a person's speech. Simply say 'I'm sorry, could you please say that again?'. You may need to explicitly state that you really want to understand the client, and will get better at understanding them as you get to know each other better
- If the client has little or no verbal speech, find other languages. Talk to caregivers and others who know the client about how they communicate. Do they use particular signs? Symbols? Facial gestures? Body movements or signals? Music? Dancing? Drawing? Photographs and/or other picture languages? Perhaps caregivers or family could support you to learn the best approaches
- Take time to work slowly and with respect – show interest in getting to know the client and their story, and find ways to communicate this
- Regularly check for meaning. Do not make assumptions about what the client is saying or meaning. Use examples and comparisons with other words or scenarios to check meaning.

## Confidentiality

Issues around confidentiality for people with intellectual disability can be complex in counselling practice. It is important to work with your client to find an appropriate balance between the client's right to privacy of their personal information, and the need to share information with others to promote understanding and safety, or to work together to achieve the client's goals (including family members, carers or other service providers).

Due to general difficulties in verbal communication and specific issues such as confabulation (exotic story telling), it can be difficult for counsellors to assess the need to disclose client information to third parties. Each situation needs to be assessed on a case-by-case basis, taking time to explore matters without assumption about the level of seriousness.

Compliance is a common issue in navigating confidentiality with clients who have an intellectual disability. For example, sometimes clients agree to the sharing of their personal information with third party people or organisations that they would prefer to keep the information from, but they comply with requests due to fear of the third party or fear of getting into trouble. This is most prominent in instances of ‘powerful carers’, who have a high level of influence over the person with disability (Upton, 2009).

It is useful to approach confidentiality issues as areas for negotiation. This means discussing confidentiality on a regular basis, talking about and exploring what it means, and discussing what kinds of circumstances would break it. This also means being aware of the people and relationships in the client’s life, both professional and personal – this awareness may help with the negotiation process and ethical decision making. Discussing confidentiality directly with family members, carers and supporters will help to develop a shared understanding of confidentiality, reiterate the client’s right to confidentiality, and reduce the level of acquiescence on the part of the client.

Asking a client to read a confidentiality policy or giving them a flyer about confidentiality is not sufficient. Confidentiality needs attention on a regular basis, and should not be a static agreement with the client but a moving agreement depending on the issues that come to light.

## 8. Important considerations for counselling practitioners

### Counsellors' values and attitudes

Counsellors' own views, values and attitudes influence their practice with people with intellectual disability. Individual professionals and agencies have a responsibility to rigorously examine their personal and collective beliefs about intellectual disability, and consider barriers to the inclusion of people with intellectual disability as service users and as members of the wider community. The quote below is an honest example of the challenges that many practitioners experience when first engaging with people with intellectual disability.

*Looking back on fifteen years of community work I realised that I had come in contact with a number of people with an intellectual disability. I wasn't conscious at the time that they had an intellectual disability. I thought of them as a bit slow, a bit different. I realise now that as soon as I thought of them as being different I started to detach emotionally, energy wise. They became less human, less real, less visible to me. I didn't really listen to what they were saying, I didn't really work to assist their understanding, my communication became a sort of pretend communication. Now it seems to me that this detachment is a common response of people in the community, professionals etc. to people with an intellectual disability. (Community Living Program, 1995, in O'Connor & Fowkes, 2000, p. 14)*

When human service professionals are not conscious of the personal values and attitudes they bring to their practice, they risk operating within stereotypes that disempower and disrespect people with an intellectual disability. This can influence the capacity of clients to

receive and benefit from support they might require as a person who has been exploited, abused or criminally victimised.

Counsellors and therapists are not immune to these attitudes; we have all been exposed to negative understanding and depictions of intellectual disability. Therapists are also influenced by the organisations in which they work, which often focus on treating the client's 'impairment' so the person can be as 'normal' as possible (Parkinson, 2006).

The following 'myths and realities' are good examples of ways that practitioners can positively challenge incorrect assumptions about intellectual disability.

**MYTH:** People with intellectual disability do not experience emotions in the same way as people without intellectual disability. People with intellectual disability can't feel.

**REALITY:** People with intellectual disability have feelings and experience emotions in the same various ways as people without intellectual disability.

**MYTH:** People with intellectual disability have problems with the way their brain functions and, therefore, they are unable to think.

**REALITY:** No two people think in the same way. Some people, with or without an intellectual disability, may experience difficulty with abstract thought, while others may not.

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

**REALITY:** People with limited verbal communication abilities can communicate in many different ways if they are given the opportunity and encouragement to use creative means of communication.

**MYTH:** People with intellectual disability do not feel as hurt by exploitation or abuse as people without an intellectual disability.

**REALITY:** People with intellectual disability feel trauma, pain and distress from abuse as acutely as any other person.

**MYTH:** People with intellectual disability who display 'challenging' behaviours do so because of their disability.

**REALITY:** Many people have unique behaviours as a result of them having an intellectual disability; however, 'challenging behaviour' is often a signal that the person is experiencing frustration and anger as a result of recent trauma or abuse, and needs help to deal with it. (For more information, see the sections: 'Behavioural issues in communication' and 'Self harm'.)



## Positions of power in the counselling context

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

Practical, simple and concrete strategies that can help to reduce power imbalance include:

- **The counselling space:** The counselling space itself needs to be welcoming, non-threatening and well equipped for flexible and creative practice. For example, it is helpful to have shelves on which figurines, toys, shapes and so on can be placed. Art materials should also be readily accessible to both the counsellor and the client
- **Seating:** Ask the client where they would like to sit. Arrange the environment so that it is welcoming and offers a range of places to sit that are 'power-neutral'
- **Environment:** If appropriate, move the practice into different environments. For example, it may be possible to meet in a coffee shop, go for a walk, or sit in the park amongst the trees. Practitioners with experience in this field commonly report the positive gains made when counselling takes place outside of the clinical office environment
- **Language:** Avoid using jargon – unnecessary use of professional jargon will only remind the client that they are unequal in the therapeutic relationship
- **Language:** Be aware of the different labels of intellectual disability, and use them as little as possible. Most people with intellectual disability do not identify with diagnostic labels or even with having a disability, due to the powerful stigmatisation associated with disability. Often, we use labels for different 'client groups' to meet organisational needs, with little consideration of their effects on the individuals concerned. Keep these labels for discussions with colleagues and staff, rather than for discussions with clients
- **Communication:** Take responsibility for communication and make sure that clients know that it is OK to tell you if they don't know or understand something
- **Blame:** Never blame a client for not understanding you. It is the counsellor's responsibility to ensure understanding, and a reflection of their skill as a therapist.

A 'strengths-based' approach to counselling practice with people with intellectual disability is highly appropriate and powerful in avoiding further disempowerment of this client group (Saleebey, 2009). In strengths-based counselling practice, clients are valued as the experts in their own lives, and are supported to identify and build upon their existing skills, abilities and resources.



### Time

Time is a key factor in effective counselling practice with people with intellectual disability. The standard time allowed for practice – to engage, build rapport, create safety, assess and define individual and therapeutic goals – may not be sufficient for many people with intellectual disability. Many agencies struggle to deal with high demands for service and limited staff capacity, however, flexibility in service delivery is highly beneficial (if not essential) for this client group (Brown & Hooper, 2009).

Longer sessions are not necessarily required or advised for clients with intellectual disability, because prolonged concentration can be tiring for many clients. Instead, shorter sessions on a more frequent basis might be helpful.

It is important that counsellors do not expect clients with intellectual disability to develop or move forward at the same rate as other clients. Many people with intellectual disability need more time in counselling sessions to:

- Understand the nature of the task
- Comprehend the questions being put to them
- Think about the questions
- Try to retrieve the relevant information from memory
- Put the information into words
- Say the words (or communicate in a way that suits them if they cannot speak) (Milne & Bull, 2006).

Good practice suggests that counsellors should allow double the time they normally would for the duration of therapy (Brown & Hooper, 2009). In other words, if a counsellor would typically plan to see a person for 6 sessions, they should allow 12 sessions if the client has an intellectual disability. In addition, while adjusting and tailoring materials and activities to suit the client is always part of good clinical practice, it may be more important for clients with intellectual disability.

### Trauma

An understanding of trauma and its effects is highly relevant for counselling practitioners working with people with intellectual disability (Newman, Christopher & Berry, 2000). People with intellectual disability often develop emotional problems as a result of psychological and emotional abuse, or develop a secondary mobility disability as a result of physical abuse (Horner-Johnson & Drum, 2006).

These indicators may be helpful in identifying whether a person is experiencing depression or other mental health issues (Hollins, 2006):

- Showing less interest in activities that are usually enjoyed
- Losing or gaining weight



- Difficulty getting to sleep or waking early
- Lethargy and increased time sleeping
- Avoiding other people
- Restlessness and irritability
- Feeling bad, guilty or worthless
- Loss of confidence.

While trauma can trigger depression and anxiety, other signs and symptoms are also recognised as particular responses to traumatic events. Many of the physical and cognitive responses to trauma listed below are also common experiences for people living with intellectual disability. Additional trauma may compound these beliefs and behaviours (J. Olver, personal communication, 29 August, 2011).

Signs that a person has experienced recent or historic trauma include:

- Re-living the experience (that is, being held in the past)
- Flashbacks
- Nightmares
- Blaming someone (showing lack of control)
- Hyper-vigilance
- Poor problem-solving ability
- Loss of orientation
- Problems with memory, concentration and attention
- Intrusive thoughts or images
- Poor decision making
- Dissociation
- Blaming themselves
- Sudden or gradual changes in usual behaviour
- Seeking reassurance
- Loss of skills
- Loss of bowel or bladder control
- Loss of ability to communicate
- Outbursts of anger, destructiveness or self harm
- Physical illness
- Complaining about aches and pains
- Wandering or searching.

Normalising these responses is a crucial step in supporting any person who has experienced trauma in their life. The key message is that the person is not coping because they have experienced a traumatic event, not because they cannot cope. People need reassurance that it is normal to experience these kinds of responses to trauma.

## Grief, loss and bereavement

It could be argued that grief and loss are amongst the most significant yet under-acknowledged issues for people with intellectual disability in the counselling context. All people experience grief and loss in their lives, yet people with intellectual disability often experience many losses in many areas of life over long periods of time, and these often go unrecognised (Riches, 2008). This is compounded by a common assumption of intellectual disability: that people with intellectual disability are not capable of experiencing grief. In situations of death and bereavement, many are shielded from fully experiencing the grieving process (Riches, 2008).

People with intellectual disability can experience a great sense of loss and grief simply by being aware that they are 'different' to others and feeling inadequate because they are not able to do things or communicate the same way as other people. In addition, continual negative evaluations of self, from both internal and external sources, make positive self-esteem difficult to maintain (MacHale, McEvoy & Tierney, 2009; Riches, 2008). The social construction of disability as 'other', 'different' or 'limited in capacity' can be a significant contributing factor to the sense of loss that people experience. When support for individuals is limited to meeting basic physical needs, rather than working towards achieving the same life goals as other members of the population, the presence of grief and prolonged grief reactions are not surprising.

Anger, anxiety and depression are all common grief responses for people with intellectual disability. Unfortunately, these responses are often dismissed or misinterpreted as intrinsic to the person because of their disability (MacHale, McEvoy & Tierney, 2009; Riches, 2008). Neglecting the emotional life of a person with intellectual disability can lead to complex behaviour with significant negative outcomes for the individual and those around them (Blackman, 2008). For example, a prolonged grief response of anger is likely to be misinterpreted as 'challenging behaviour', and the underlying cause of the behaviour may be missed or dismissed.

Bereavement following the death of a family member or other significant person is another important consideration. When a significant loss in a person's life is not recognised, people with intellectual disability can experience sudden emotional and behavioural difficulties, which might be exacerbated by other psychosocial factors such as social isolation, poor physical and mental health, limited support networks and limited opportunities for the expression of emotion in appropriate and helpful ways.

Understanding the concept of 'death' can be difficult for people with intellectual disability. This can be exacerbated if they are shielded from seeing their loved one after they have passed away, or discouraged from attending funerals and other important ceremonies (which provide the concrete understanding of death that people often need). Having a reality-based understanding of what it means to die is crucial in helping a person to come to terms with their loss and cope during the grieving process. Grasping the full concept of death requires an understanding of the finality of death (that death is final), the non-



functionality of death (that bodily functions cease at death), and the universality of death (that all living things die) (MacHale, McEvoy & Tierney, 2009).

In situations where counsellors are working with a client with intellectual disability who is grieving the loss of a loved one, it is helpful to assess the client's understanding of the concept of death and find concrete ways of explaining the concepts to aid in their grieving process.

Families and support staff are both important sources of support following bereavement for many people with intellectual disability. However, it is common for support people to attribute anxiety, depression or challenging behaviour to the person's disability rather than seeing it as a legitimate response to grief. Studies have also shown that support staff and carers are likely to overestimate an individual's understanding of the concept of death; this can limit the identification of grieving and attribute changes in behaviour to other causes (MacHale, McEvoy & Tierney, 2009).

These guidelines can be helpful when supporting people with intellectual disability through the grieving process (CPA, 2010):

- Ensure that support workers, carers or any other agency staff who work with the client are aware of the client's loss
- Support the client to access warm, caring and trusting relationships during their time of bereavement – key supportive relationships provide a safe basis from which to heal
- Assist the client to participate in viewing their loved one's body if they wish, and facilitate and support their attendance at memorial or funeral services or other important rituals of grief
- Repeatedly explain and communicate about the death using methods of communication that are appropriate for the client
- Support the client to keep photographs and other memorial items associated with their deceased loved one
- Help the client to memorialise their loved one's life through activities such as tree planting, artwork, memory boxes, and so on, which help the client to cope with their loss and provide a positive connection to their memory.

## **Narrative-based self-reporting and creative expression**

It is often thought that people with intellectual disability cannot participate fully in (and therefore gain full benefit from) counselling and psychotherapy, due to difficulties with verbal expression and communication. Success in therapy is typically seen to rely on the client's ability to verbally express and reflect on their story or their life narrative. The self-reporting of a person's narrative in counselling is also expected to be directly presented and grounded in fact (that is, actually reflecting their direct experience) (Upton, 2009).

Many people with intellectual disability have difficulty expressing their narratives verbally – due to poor memory, difficulty with sequencing and understanding the causal relationship between thoughts and behaviour, and difficulty in naming their emotional and subjective states. Direct communication of highly traumatic experiences is also extremely challenging (if not impossible) for many individuals (Upton, 2009).

Despite these difficulties, people with intellectual disability have great capacity to express their story. The real issue is not that individuals cannot express their narrative, but that therapists' rigid expectations of the way this is done make it seem difficult or even impossible. Clients with intellectual disability can express their life stories, experiences, and subjective and emotional states, if supported to do so in a way that suits their communication ability and style.

Every person, regardless of their verbal communication ability, has a vast array of communication tools at their disposal. It is the counsellor's responsibility to find what works for each individual. The analogy of working with a person from another cultural background can be useful: when a counsellor begins to work with a person from a different language and cultural background, they assess the person's communication ability and any other factors that influence the telling of their narrative, and then adapt the counselling practice accordingly. The same principle should be applied when working with clients with intellectual disability. If counsellors have a responsibility to work appropriately and sensitively with their client's cultural background, they have the same responsibility to adapt their practice to accommodate the communication needs of clients with a disability. As Upton (2006) notes:

*Psychotherapists need to be open and sensitive to the vast array of expressive means that these clients already have at their disposal, and be willing to enter into an encounter where that expression can be nurtured and heard as meaningful articulations of their lived experience. (Upton, 2006, pp. 32)*

Creative techniques and the use of non-verbal or indirect communication can be crucial in overcoming the communication problems of people with intellectual disability and achieving positive outcomes in therapy (Upton, 2009).

There are two broad categories of creative expression that can be used to help clients with intellectual disability to tell their story (Upton, 2009): Embodied expression and Projected expression.

**Embodied expression** includes:

- Whole-person movement
- Dancing and music
- Acting, characterisation, masks and role play
- Embodied games.



**Projected expression** includes:

- Drama to express the person's story through an external character
- Art, such as painting and drawing
- Sand tray with symbols
- Written stories and poetry.

In using these creative expression techniques, it is important to define where the creative narrative will take place – either involving the whole person (where the client uses their whole body or mind to describe or show their story), or projected onto something other (where the client uses other mechanisms such as symbols or toys to act out the narrative) (Upton, 2009). These techniques of embodied and projected expression can be of great benefit for clients with intellectual disability because the techniques:

- Are not dependent on verbal communication
- Allow for indirect communication
- Work with imagined and/or factual narratives.

The embodied and projected expression techniques allow for a self expression that matches the client's ability emotionally and cognitively, while still enabling the client to express their lived experience (for further detail see Upton, 2009). (For more information about using creative practices in therapy, see the sections 'Exploring feelings through art', 'Narrative therapy', 'Sand tray therapy', and 'Art work therapy'.)

## **Working well with family, paid workers and other significant support people**

People with intellectual disability are likely to have support from family members, paid workers or other significant people in their lives. Family members and other support people often know the person very well and are best placed to observe changes in their behaviour and well-being. Their opinions and observations should be taken seriously.

Family members and other support people can often offer useful information and clarification in situations where the client has difficulty providing detailed information. There is evidence to suggest that clients with intellectual disability will best respond to therapy when they have the support of family or paid staff to apply what they have learned with the therapist in real-life settings (Hayes, 2007). This requires the therapist to collaborate with the client's support people. It may involve allowing support people to accompany the client to sessions, supporting carers to develop the skills and understanding required to create and support change for the client, and helping carers and paid workers to develop helpful attitudes that will allow change to occur (Hayes, 2007).

Carers and supporters can help the therapeutic process by:

- Helping the client to practise the skills learned in sessions and apply the lessons from sessions to the 'real world'



- Observing what has and hasn't worked well for the client in the 'real world'
- Creating opportunities for success for the client
- Helping the client to recognise and celebrate positive change
- Learning new ways of understanding and interacting with the client to support positive relationships
- Teaching others (e.g. teachers, friends, workmates) ways they can support the client to maintain positive change.

### **Privacy and consent**

Involving family members, paid workers or other significant support people in the client's therapy will require careful consideration about issues of privacy and consent. It is important to find an appropriate balance between the client's right to privacy of their personal information, and the need to share information with others (including family members, support people or other service providers). The benefits of sharing information can include promoting understanding, increasing safety and working together to achieve the client's goals.

It is useful to approach confidentiality issues as areas for negotiation (O'Driscoll, 2009). This means discussing confidentiality on a regular basis, exploring what it means, and discussing what kinds of circumstances would break it. It also means having an awareness of the people and relationships in the client's life, both professional and personal, that can help the negotiation process and ethical decision making. Discussing confidentiality directly with family and supporters can help to reach a shared understanding. (For more information, see the section: 'Confidentiality'.)

### **Keeping the focus on the client**

When the counsellor and the client invite others to be part of a team to support change, it is important for everyone to understand that the client is the focus of the counselling sessions. When powerful family members and significant others are invited to be part of the process, it can be difficult to maintain this focus – particularly when others have their own experiences of the problem. If dominant voices share the experience of the problem, take time to explore whether the problems experienced by the support people are, in fact, experienced by the client.

### **Building the capacity of the support team**

The capacity of families and carers to support therapy and create and support change may vary. It is important to consider the context of the client's support. Who are the significant support people in the client's life? What skills and experiences do they bring to the situation? Do they need help to develop any additional skills or understanding to be able to support the client in therapy?

Be realistic about what can be achieved and refrain from putting any unnecessary pressure on anyone involved. If the counselling involves working with a parent – who is currently





caring for their child, running a household, working and dealing with other issues in their life – that parent's capacity to offer support in counselling may be significantly diminished. Asking them to take on further responsibility may be unrealistic and only set them up for failure.

The capacity of paid support workers can also vary significantly, depending on their level of training, type of supervision, the way they see their role, and the way their role is defined by the organisation they work for. It is important to be aware that paid support work can be a high-stress profession, particularly in organisations that may not have adequate training and supervision of staff (Hatton et al., 1999, in Willner, 2006).

It can be useful to distinguish between the support people who have a lasting commitment to the client and who are there 'for the long haul', and those who may be in other roles (such as paid staff) where their support is likely to be restricted and less enduring. This distinction can help counsellors to understand the capacity and limitations of various support people.

To develop an understanding of the client's support context, counsellors may need to spend time with the significant support people in client's lives (with the client's permission), to develop an understanding of how the support people see the problem and to understand their capacity to offer support around the therapeutic process.

### **Understanding the impact of carer and supporter attitudes**

The attitudes of 'significant others' in the client's life can have a significant impact on their carer's propensity to actively support positive change. When counsellors enlist the support of family members, paid staff and significant others in supporting therapy and positive change, they need to explore the attitudes that support people have towards the problem, the client and the therapy. While some carers and family members are optimistic about the client's ability to change, some may doubt this or reflect pessimism about the ability of people with intellectual disability to benefit from psychotherapy (Willner, 2006).

Whether or not a carer is motivated to help the client can depend upon their perception of the client's problem. For example, if a support person or carer believes that the client is in control of their negative behaviour, or if they feel that the difficulty being experienced by the client is something that has always been a problem in their lives, they may feel less sympathetic towards the client's experience of the problem and pessimistic about the usefulness of therapy. In contrast, if the support person feels that the client lacks control over their negative behaviours and the problem is something that is either recent or occasional, they are more likely to feel sympathetic towards the client's experience of the problem and more optimistic about the possibility for change (Willner, 2006).

In some circumstances, it may be important to consider the possibility that support people may subvert the client's therapy (either consciously or unconsciously) due to the threat the change may bring to their own role (Willner, 2006). Even if a support person is negatively

affected by the client's problem, their fear of the unknown or fear of change may influence their support or capacity to support change.

If support people have problems that influence their ability to support the client, it may be advisable to explore what options are available for them to receive support or supervision outside of the counselling sessions with the client. They may need assistance to deal with the impact in their life of changes in the client's life.

### **Duty of care and safety**

There are some extra considerations around duty of care to take into account when working with someone with intellectual disability. If the client discloses something that raises a counsellor's concern, the counsellor needs to consider a range of safety, security and ethical issues (MacDonald, 2008; J. Olver, personal communication, 9 November 2011).

Safety and security issues to explore and consider include:

- Encourage the client to consider their safety and security. Are they at risk of further victimisation? Do they need a different physical location?
- Discuss relationships regularly. Vulnerability and a lack of understanding about relationships can lead to people putting themselves at risk. Help the client to understand concepts about relationships in concrete terms
- Check back with the client over time to monitor the situation. Don't presume the client can make judgements about safety. Talk through the situation to explore their understanding of their own risk. Talk about consequences or likely outcomes of different decisions.

Ethical issues to explore and consider include:

- Inform the client of any obligations that counsellors have to report the information the client has disclosed (taking care not to compromise the safety of yourself or others). Where your obligations are not clear, seek guidance through reflecting with colleagues on the circumstances of the matter and your professional and ethical obligations
- Name any confidentiality issues
- If the matter is of a legal nature (for example, the client has disclosed that they have perpetrated or been the victim of a crime), explain that you, as their counsellor, may be called as a witness if the matter proceeds to court
- If the client has reported that they committed an offence or they are alleged to have committed an offence, reflect on any personal and/or professional values that may limit your capacity to provide effective support. If you are unable to provide support, you need to arrange alternative support options
- Support the client to clearly describe what occurred. Ask open questions (for more information, see the section: 'Narrative interviewing techniques'). Diarise the exact words that the client uses to describe the incident, preferably at the one sitting.



Diarise details such as the time between the event's occurrence and the time when the client first disclosed the event. Your task here is not to interview the client or interpret their information, but to clearly document the client's account of events at the time of first disclosure (it is possible that the client's capacity to retain or recall this information may reduce as time passes)

- Take extra care about the language used in case notes. While it is always important to take care in case notes, it can be particularly important for clients with intellectual disability, as this client group is more likely to have court procedures or need reports for government agencies. Listing the person's difficulties in case notes can work against them
- Discuss and clarify the options of reporting or not reporting the incident to the police and the likely course of events associated with each option
- Support the client to consult a lawyer or specialist agency
- Support the client to make a complaint to the police if they wish. If the client is not ready to go to the police, remember that, in time, they may change their mind.

## 9. Four therapeutic approaches

### Creative approaches to practice

The literature reviewed to develop this resource makes repeated reference to creative ways of working with people with intellectual disability. Creative approaches such as drawing, drama, psychodrama, music, puppetry, sand and storytelling, among other activities, may serve as ways for trauma victims to communicate their feelings (Carey 2006, p. 18).

WWILD practitioners have successfully used creative models of practice when working with women with intellectual disability. This area is under-researched and the information in this resource should be taken as a guide only. We would encourage counsellors to further investigate each of the four models discussed in this section through professional training.

### Narrative therapy

Narrative therapy is a client-focused, strengths-based practice that works from the fundamental position that the client is not the problem: 'the problem is the problem' (White & Epston, 1990, in Hoole & Morgan, 2008, p. 105). It is an approach commonly used at WWILD in working with people with intellectual disability.

Narrative therapy is based on the idea that people create a personal narrative or dominant story to understand and give meaning to their lives and to themselves (Lambie & Milsom, 2010, p. 196). These stories are often negative or 'problem saturated' (Matthews & Matthews, 2005). Narrative therapy engages in a process of deconstructing the person's dominant narrative to understand how that narrative influences their thoughts, feelings, behaviours and communication. It then explores whether this narrative is the story the



person wants for their life (Betchley & Falconer, 2002, p. 4), and works to develop and actualise new, preferred stories for their life (Matthews & Matthews, 2005).

## **Intellectual disability and narrative therapy**

Communication challenges are common for many people with intellectual disability and, while counselling practitioners need a solid theoretical basis to their work, they also need to ensure their practice is flexible enough to respond effectively to the needs of this broad client group. Although narrative therapy is traditionally a linguistic approach, it can be successful with people who have communication difficulties. By allowing the necessary time and having a variety of communication and creative techniques available, narrative therapeutic approaches should assist the client to become the 'primary voice' in their own story – even if that story is told non-verbally, and/or with the assistance of others (Betchley & Falconer, 2002). (For more information, see the section: 'Barriers to communication for people with intellectual disability in the counselling context'.)

It is important to carefully consider the involvement of families and other support people in the narrative therapeutic process. Because people with intellectual disability often rely on the support of other people to communicate, these other people play a significant role in developing and maintaining a certain narrative in the person's life. This may mean that therapy requires collaborating with significant people in clients' lives, in addition to collaborating with clients themselves. (For more information, see the section: 'Working well with carers and supporters'.)

## **Techniques of narrative therapy**

### **Deconstructing the dominant narrative**

An important element of using narrative therapy is ensuring that the client has an opportunity to tell their story, in their own words. Part of the practitioner's role is to listen out for the meaning behind the words and discern how these messages and stories fit into the wider context of the client's life. Genuine inquiry and understanding allows accurate identification of 'the problem' and its causes.

Deconstructing the dominant narrative involves working to understand how the dominant narrative came to be. Questions that can help in this process include:

- Who constructed the dominant narrative?
- Does the dominant narrative support or put limits on the way the client sees themselves?
- How does the dominant narrative support or put limits on how the client behaves?
- How does the dominant narrative serve the client?
- How has the dominant narrative helped or hindered the client? Or helped or hindered those around them? (Matthews & Matthews, 2005).

People with intellectual disability, particularly those who exhibit challenging behaviours, often have negative labels assigned to them – by themselves, by significant others and by

society at large. These negative, ‘problem saturated’ narratives are often supported, told and retold by the significant others in the client’s life. Both clients and the support people in their lives may need help to engage in new forms of communication with each other that develop and maintain new narratives (Betchley & Falconer, 2002).

### Externalising

One of the main tasks involved in deconstructing the narrative is identifying and naming the problem. Externalising is a common technique for achieving this. It is a process of naming the problem in a way that helps clients to separate themselves from the problem and the problematic narratives dominating their lives.

As part of externalising, the problem is given a name and the client and supporters work together to ‘defeat’ it (Hoole & Morgan, 2008, p. 109). By naming The Problem, clients can take ownership of it and their relationship with it. The therapist’s role is to listen to what the client is saying and use the client’s words where possible. Whatever label is applied to The Problem, the label must either come from the client or be readily adopted by them once it has been suggested (Matthews & Matthews, 2005).

Externalising starts with language – that is, referring to The Problem with its own identity. Some examples of naming The Problem include:

- ‘The Trouble’ to describe anti-social behaviour
- ‘The Anger’ to describe violent outbursts
- ‘The Beast’ to describe problematic gambling
- ‘The Sadness’ to describe depression and/or anxiety
- ‘The Grog’ to describe problematic drinking.

This process is seen as critical in narrative therapy. Naming the problem is a shift in language that gives the problem its own identity. Ideally, it involves the name being used by the therapist and the client, and also by significant others in the client’s life (Matthews & Matthews, 2005). This allows the practitioner, the client, their family and significant others to be critical of The Problem, without being critical of the person (Matthews & Matthews, 2005).

Examples of externalising dialogue:

#### Instead of...

I heard you became angry today  
How does your partner feel about  
your gambling?

#### Externalising

**How did The Anger trick you today?**  
**How does your partner feel about The**  
**Beast?**

The process of externalising can be taken a step further by building a more concrete identity for The Problem. This is particularly important for clients with intellectual disability. Building concrete, visual representations of The Problem, using symbols or illustrations that give it a physical form, helps to transform The Problem into something



that everyone can see and relate too. This process of making abstract concepts 'concrete' is especially important in work with people with intellectual disability.

### **'Unique exceptions' to the dominant narrative**

Finding 'unique exceptions' to the dominant narrative involves supporting the client and significant others to think about times when things have been different – times when they weren't experiencing the problem or were able to control the problem. This is an important part of supporting the client to create a new narrative for their life.

To support the client in identifying unique exceptions, the therapist asks the client to think about what life is like when the problem is not around, and listens out for things in the client's story that contradict the dominant themes in their narrative (Betchley & Falconer, 2002, p. 9). Even in the most problem-saturated stories, there will be a moment when the problem is not as strong as it usually is. These moments are the 'unique exceptions' (Betchley & Falconer, 2002, p. 9) or 'sparkling moments' (Matthews & Matthews, 2005).

Significant others in the client's life can support this process by observing and taking notice when the client behaves in a way that is unique or doesn't fit in with the dominant story. People with intellectual disability may particularly require the support of others to identify instances in their life that challenge the dominant narrative. Family members and support workers can play a big part in helping with this process outside of counselling sessions. Some examples of unique exceptions include:

- A young man who often experiences violent outbursts when teased by his peers at school manages to walk away
- A woman who experiences addiction to poker machines and feels that 'once she starts she can't stop' leaves the premises after half an hour
- A young person who self harms every day never self harms in public.

### **Re-storying**

In narrative therapy, the therapist's role is to support the client and significant others to create the new or 'preferred' story (Betchley & Falconer, 2008, p. 4). This involves a process of supporting the client to imagine a new story for their life, and how they want their life to be different.

The client has an intimate knowledge and lived experience of the problem that needs to be understood by the therapist and then used to help to address the problem. A vital part of this process is discovering and enhancing the existing skills and knowledge the client already has in dealing with the problem. These existing skills are often overlooked in a problem-saturated narrative. In addition, existing skills, gifts and abilities are often overlooked in the lives of people with intellectual disability.

Clients with an intellectual disability may require help from significant others who have been involved in helping to create the new narrative to help in telling and retelling the new story to others. This can be a difficult process, particularly as the client encounters voices that tend to reinforce the old, unhelpful narrative (Betchley & Falconer, 2002, p. 7).



Significant others may play a vital role – by creating opportunities for the new narrative to play out, supporting opportunities for success, and learning new ways to understand and interact with the client to promote the new narrative.

### **Cognitive behavioural therapy (CBT)**

Cognitive behavioural therapy (CBT) is a treatment approach that is based on the concept that the way we think affects the way we respond (O’Sullivan, Ryan & MacDonald, 2003). CBT aims to change unhelpful thoughts or cognitive processes to more helpful thought processes, allowing the client to create positive change emotionally, physiologically and behaviourally.

CBT theory holds that negative thoughts and beliefs can play a role in developing or exacerbating depression, anxiety, anger, low self-esteem, self-defeating behaviours and difficulty with coping. Therefore, CBT works to identify negative beliefs and challenge them, ultimately replacing them with more helpful, realistic beliefs that enhance the client’s ability to cope in everyday life situations (O’Sullivan, Ryan & MacDonald, 2003).

Historically, people with intellectual disability have been thought to lack the ‘cognitive abilities to understand or benefit from CBT’ (Taylor, Lindsay & Willner, 2008). However, using CBT approaches with this group is becoming more widely accepted and recent studies show its effectiveness in treating people with intellectual disability in areas such as anger management, depression, sex offending, victims of crime, and anxiety among others (Hayes, 2007 discusses several relevant studies). Despite promising results from a number of studies, the area is still relatively under-researched and rigorous studies with control groups are few.

### **Complementary skills and strategies**

The CBT treatments that are most supported in the literature incorporate non-cognitive strategies (McClure, Halpern, Wolper & Donahue, 2009). Research suggests that CBT can be most effective when used in conjunction with other skills and strategies, including:

- Mindfulness techniques (Singh, Whaler, Adkins & Myers, 2003)
- Relaxation techniques including massage (Sau-Lai & Hing-Min, 2011)
- Imagery rehearsal therapy (Stenfert Kroese & Thomas, 2006)
- Problem solving and assertiveness training (Anderson & Kazantzis, 2008; Nezu, Nezu & Arean, 1991).

### **Intellectual disability and CBT**

Research suggests that clients with intellectual disability need the following attributes, at least to some degree, for CBT to be an appropriate method of therapy (Haddock & Jones, 2006; Willner et al., in Hayes, 2007):

- Verbal IQ and verbal ability in general



- Capacity to recognise and label emotions
- Ability to differentiate between thoughts, feelings and behaviours
- Ability to link emotions and events
- Ability to express emotions
- Motivation to engage.

The client does not need to possess all of these attributes before commencing CBT. Part of the therapeutic process is to assist the client to recognise and label emotions, express emotions and differentiate between thoughts, feelings and behaviours.

Recognising emotional states is an important part of learning coping skills. It is important to remember that, even though individuals with intellectual disability may have trouble accurately labelling emotional states, they discriminate between pleasant and unpleasant emotions in exactly the same way as people without cognitive impairment (McClure, Halpern, Solper & Donahue, 2009). In general, people with mild or moderate intellectual disability can also recognise and accurately label facial expressions in others and will improve this skill with training.

### **Lived experience and CBT**

The client's lived experience and context needs to be carefully considered when engaging in any kind of CBT with a client with intellectual disability. People with intellectual disability often experience powerlessness and can experience hostile environments in their day-to-day lives. Given this reality, it can be unrealistic to expect change by concentrating solely on individual coping strategies. This is particularly the case when the client's environments are causing or significantly contributing to their emotional states and behaviour (Mirow, 2008).

### **Adapting CBT for people with intellectual disability**

It may be relevant to adapt CBT in some of the following ways to suit the communication needs of clients with intellectual disability (Haddock & Jones, 2006; Mirow, 2008; Willner & Goodey, 2006):

- Assess the client's suitability for CBT by assessing their abilities and needs in the therapeutic context (expressive/receptive communication skills)
- Concretise abstract and conceptual tasks – provide a grounding and linking of conceptual thought in a way that is meaningful for the client (perhaps by using real-life situations). Clients may find it difficult to imagine hypothetical situations
- Incorporate 'teaching' elements, such as how to identify an emotion, how the body responds to emotion, and so on
- Use visual aids
- Adapt tools and techniques so that minimal or no literacy is required
- Simplify tasks – for example, reduce the complexity of a technique, break the intervention into smaller chunks and adjust sessions to be shorter or longer

- Simplify language – for example, reduce the complexity of vocabulary and sentence structure, reduce the length of thoughts and explanations, and use short sentences and simple words
- Use concrete activities – such as drawings, games or activities to practise at home (these can create a more comprehensive learning experience)
- Use flexibility and persistence – accept that progress may be slow and that some things will take longer than you expect. If something isn't working, be prepared to try a new approach. Be creative
- Repeat concepts and check understanding – be prepared to go over the same material and check the client's understanding many times within sessions and over the course of the therapy
- Include support people – more support is likely to be needed initially, especially with homework tasks, repeating information, and reinforcing learning between sessions
- Be aware of possible client acquiescence and problems with questioning styles (for example, open versus closed questions), due to CBT's reliance on verbal IQ and verbal ability (for more information, see the section 'Questioning')
- Think about how the client may respond to the term 'homework' – many people with intellectual disability have had difficult educational backgrounds.

There is evidence in the research to support the value of involving carers and other support people to help clients to transfer the skills learnt in therapy into real life (Willner, Brace & Phillips, 2005). (For more information, see the section 'Working well with carers and supporters'.)

### Sand tray therapy

Sand tray therapy was developed by Dora Kalff in Switzerland in the 1950s, and is based on the psychological principles of Carl Jung and the work of Margaret Lowenfeld (Pearson & Wilson, 2001). Sand tray therapy is a fundamentally creative process, which involves the client creating scenes in a tray of sand, using symbols and realistic miniature figurines from the therapist's collection.

Using sand and miniatures gives clients a symbolic way of expressing their feelings and their view of the world, and thus can be used with a wide range of people with varying verbal and cognitive abilities. The sand tray provides a non-threatening approach to exploring the unconscious, and a safe space in which to explore feelings and life situations that may feel overwhelming.

Pearson and Wilson (2001, p. 2) note:

Sand play is a hands-on, expressive counselling and psychotherapy modality that has been in use for well over fifty years. It has been used with children, adolescents and adults in schools, hospitals, welfare agencies and private counselling practices. It forms a bridge between verbal therapy and the expressive therapies, combining elements of both. Sandplay allows the deeper aspects of the psyche to be worked



with naturally and in safety, and is highly effective in reducing the emotional causes of difficult behaviours.... Sandplay and symbol work help create congruence between our inner world and outer worlds. Strengthening this connection is therapeutic.

### **Before you start**

It is very important to explain, explore and discuss the process of sand tray therapy with the client before starting with the sand tray itself. Not all people will want to use the sand tray, so it is important to make sure that the client is comfortable with the idea of working with the sand and is not just agreeing with your suggestion to avoid having to say 'no'.

### **Getting started: Introducing the sand tray**

Begin the process by asking the client to sit beside the sand tray and feel the sand. This 'centres' the client in the sand tray space. The client then begins doing the basic landscaping of the sand, to set the scene for their story. The basic landscape might include mountains, valleys, rivers or plateaus, all created in the sand.

### **Choosing symbols**

Ask the client to choose symbols for the sand tray session – taking as much time as they need. Symbols are the objects that they will put in the sand, which represent the 'who' and 'what' of their story. It is often best to begin by choosing symbols to represent the client themselves and their immediate family members and/or any other significant people in their lives. Others can be added later if necessary.

People with intellectual disability do not usually have difficulty in choosing a symbol or figurine to represent themselves in sand tray work. Many people can easily identify themselves with symbolic figures, such as a prince/princess, fairy, favourite animal, or a figure of a person who looks like them. Difficulty can arise, however, when the client attempts to choose figures or symbols to represent family members or significant others. Because of their tendency to think in concrete terms, clients with intellectual disability will often look for a concrete or literal representation of their family member. The client may need assistance to associate the person with more abstract qualities, which will help them to (a) choose a fitting object or symbol for the person, and (b) think of the person's qualities and character in addition to the concrete facts (such as the way the person looks).

For example, a client might say: 'There's nothing/no one here that looks like my niece. I don't know what to pick.' The counsellor could respond with: 'You have told me a lot about your niece, and how she makes you feel happy and gives you lovely warm cuddles. What can you see here that might give nice warm happy cuddles like your niece?' The client might then (for example) choose a teddy bear or a cuddly animal to represent her niece.

Through asking questions, the counsellor does not choose the object or ascribe their own associations to what they know of the family member. Instead, they support the client to

understand the person and their relationship with the person, in more abstract, qualitative terms. Pearson and Wilson (2001, p. 1) note: 'When the sandplay figurines become symbols they begin to express the language of our unconscious. Connection to what is unconscious in us supports emotional healing and personal development.'

### **Creating the sand tray**

It is helpful for counsellors to offer a starting subject for the sand story. For example, most clients will start by using the sand tray to build the stories they have begun to tell in previous counselling conversations. With some clients, it can be helpful to start by putting family members in the sand. Then, in following sessions, add friends and other significant people. As the process becomes familiar, clients can create their own stories without input or suggestion. At the beginning, though, the technique may develop slowly, with added steps involving discussion with the counsellor.

Once the client has chosen their symbols or miniatures and has begun to feel comfortable in creating their sand tray, the session can continue without discussion. The counsellor's role is to sit at the side and observe the client making their scene. It is helpful to have a note pad handy to draw sketches of the story as it changes, and to take notes about how the story develops and the client's approach to creating it.

The experience of sand tray work can generate a great sense of achievement for the client. In many cases, feelings and thoughts that they struggle to express can be depicted symbolically in the sand.

### **Recording the work**

Recording the client's sand tray sessions photographically is a useful way of preserving the sequence of the developing narrative. Be sure to date or number each photograph. Using the photographs, counsellors and clients can collaboratively review the story over time. It is also useful to record any spoken commentary alongside the sketches.

## **Artwork therapy**

Art therapy is the therapeutic use of art making, within a professional relationship, by people who experience illness, trauma, or challenges in living. Through creating art and reflecting on the art products and processes, people can increase their awareness of self and others; cope with symptoms, stress and traumatic experiences; enhance their cognitive abilities; and enjoy the life-affirming pleasures of making art (IATO, 2011).

The art materials and artwork can be used to communicate thoughts, events, and feelings, and may provide a way of symbolising and communicating experiences. At times, images provide a more powerful communication than words, helping the client to express something that has been difficult or impossible to speak about (White, Bull & Beavis, 2008).



Artwork therapy can be a very effective way of making concrete a client's thoughts and beliefs about different areas of themselves and their life experiences. It can involve asking the person to reflect on the art they have created as something outside of themselves – thereby putting a distance between themselves and often painful experiences and emotions, and making it easier to talk about and reflect on the situation. (For more information, see the section: 'Exploring feelings through art'.)

### **Intellectual disability and art therapy**

Art therapy for people with learning disability has evolved gradually over several decades. Initially, art therapy was primarily focused on the direct therapeutic value of art making. It is now used as an active therapy to understand emotions, relationships and the client's own understanding and interpretation of their experiences (White, Bull & Beavis, 2008).

Art therapy is a useful approach in helping clients with an intellectual disability. It can assist in their understanding of abstract concepts by making concepts concrete through the use of pictures. It can be useful for people who have poor verbal ability or difficulty verbalising thoughts and feelings. Art therapy can be less threatening than other forms of therapy because it allows the therapist and the client to externalise the problem, feelings and emotions. This can allow the therapist to get a thorough understanding of the client's interpretation and insights into their experience.

## 10. Exercises

One of the biggest challenges in counselling people with intellectual disability is how to make abstract concepts (like relationships and emotions) concrete. The exercises in this section can be used to build a concrete understanding with your client. Each exercise may involve many sessions of working together with the client.

### Using symbols

Symbols can be a useful way to help clients develop a concrete understanding of the role that problems or emotions are playing in their life.

Clients may need support from the counsellor to build a connection with the symbol and to link the symbol with an abstract emotion or value.

It is important that counsellors allow time for clients to make their own choice about what object they choose to represent their problem. Some people with intellectual disability may feel they need to pick the item that their counsellor thinks they should pick, in order to please the counsellor or be seen as able. Counsellors need to encourage clients to take their time and choose the item that they think is right.

Giving the symbol a name can help to personalise the ‘problem’. The problem then becomes something the client knows and has a relationship with. This can help them to gain a sense of control over the problem – it is external to them, something that they can now see, and perhaps find ways to overcome.

After choosing the symbol, the counsellor can encourage the client to talk about when the problem is strong and what happens, or to talk about when the problem is not around and what is different.





Symbols can give clients a safe place to stand away from and talk about the problem. If they are the problem themselves, it is very difficult to imagine or create change. But, by externalising the problem with a symbol, the counsellor, client (and perhaps their carers) can work together to overcome it. (For more information, see the section: 'Externalising' in the discussion about narrative therapy.)

For example, a client may be experiencing a lot of anger, which leads them into arguments with people in their lives. This client may choose a symbol for themselves, for a person they are arguing with, and for the anger itself.



A tiger (strong and scary) may be a symbol for representing their angry feelings. Through the symbols, the counsellor and the client can explore what happens when the anger appears in a situation and gets between the client and another person.



In sandtray example above, the client chose to represent themselves as a lion hiding on the rock. The client was scared of all the bad things trying to get at her. The client chose to represent her Mum and her sister as lions who were trying to help keep the bad things away. Each symbol (character) has their own story that can be verbalised as they are placed (or not, if telling the story is too hard). A series of sandtrays over a number of sessions will show a progression of the story.

## Exploring feelings through art

As discussed in the section 'Artwork therapy', the therapeutic use of art can be particularly useful when working with people with intellectual disability who have difficulty with verbal communication. It is a very effective way of concretising a person's hidden and often abstract thoughts and beliefs about themselves and their life experiences.

If a client identifies that they are feeling sad and upset today, a counsellor could use art to help the client represent how they are feeling. For example: ask the client to select a colour that represents how they feel. Ask the client to draw a picture of a sad person, or what being sad looks like. Then choose another colour and draw some of the things that have made the client unhappy. Ask the client to choose colours to represent positive and protective feelings, such as feelings of safety. Ask them to draw some safety around the initial drawing of being unhappy.



These questions may help to promote discussion about the artwork:

- What has made this person unhappy?
- When you look at this unhappy person, what word would you use to describe them? (Encourage the client to add words to the page.)
- Can you talk about what you have drawn? (Ask specific questions if necessary.)
- What does safety look like?
- What does this person need? What would you like to give them to help them? (Encourage the client to draw those things in.)
- How do you think this person might be feeling now?

The client's artwork is their own creation, so it should be theirs to keep at the end of each session. However, it is useful for the counsellor to record the drawings in some way – either by taking a photograph or recording a written description – so the client and counsellor can reflect on drawing at a later time.

In the example below, a group was asked to make dream-catchers. The group discussed how dream catchers can stop bad dreams. But they can also catch good dreams. One of the women in the group decided hers would be a 'wish-catcher'. The woman put the word 'family' suspended in her dream catcher as a way to represent her wish for her family to be together. This exercise sparked off further conversations about what her vision for a happy family would be.



## Flowers and rocks

(Adapted by Jill Olver from Schauer, Neuner & Elbert, 2005.)

This exercise can be used to help clients to conceptualise and concretely understand concepts of trauma and hope, and the roles they play in our lives.

This exercise involves building a timeline of the client's life. Rocks are used to represent times when things have been painful, and flowers are used to represent times when things have been happy or when good things have happened. Developing a timeline helps to demonstrate to clients that in their lives they have experienced both pain and happiness.

This is particularly useful following experiences of trauma. Trauma has a way of making people feel that this is how their life has always been and that nothing will change. It holds people strongly in the past, making it difficult to change the present or even imagine a positive future.

- In a large space, stretch out a string across 2 or 3 metres.
- Introduce the concept that flowers are happiness and rocks are hard times. Have a wide variety of rocks and flowers to choose from and explain that some things might be little rocks and some things might be great big piles of rocks (give examples, like not getting a bicycle for Christmas may be one or two rocks but a parent dying may be a mountain). Give a similar description of the flowers. Don't lead the client too much with examples, as the client needs to make their own judgment about the degree of good or bad experiences.
- Ask the age of the client and how they are feeling today. Would they choose rocks or flowers today? Place their choice about 40cm from the right hand end.
- Ask about when the client were born and if they know whether their birth was a celebration for their family? Would their birth be rocks or flowers? Place the client's choice at the left end of the string.
- Ask about how the client was feeling about half way through their life so far (so if they're 42, ask about when they were 21). Place their choice of rocks or flowers about half way along the string.
- Add another occasion that you're aware of – going to school, getting married, and so on. Don't lead the client, other than to suggest the occasion and position. Depending on the client, you may need to repeat this step until they are confident with the process.
- Ask the client to continue to add to the line, putting in memories and times that are important for them. The counsellor's role here is to just observe. The far right hand space is for possibilities for the future ... how does the client imagine their lives will be in a month or a year?
- The client will stop either because they have finished or because they have dealt with more than enough emotion for one day. Express interest in the mix of flowers and rocks – there will often be a pile of rocks topped by a flower.
- Ask to photograph the line and leave it in place until after the client leaves.





In this exercise, there is no need for the client to discuss their stories. The exercise is about making visual the experiences and emotions throughout their lifetime and showing that there is an alternate story line (some flowers, despite a life of trauma and hardship).

In future sessions, you can draw the line from the photos so the client can add to or change their line as the memories increase.

## The football field activity: Trauma vs hope

(Developed by Jill Olver.)

This activity was originally devised as a group process, but it can be adapted for individuals. It is designed to show clients that, although trauma plays a large part in their lives, it is not the whole of their lives. This activity can work towards building possibilities for hope and a better future, which can be difficult to see from the depths of trauma. It is not about negating the very real effects of trauma, but opening a space for the possibility of change.

- Spend time with the client creating picture cards for words that represent concrete aspects of the person's trauma (e.g. drinking, nightmares, not eating, avoiding friends). Discuss how these are all normal responses to trauma (the client may feel

that they are the only one who does these things and is unable to cope). Extend the picture cards into feelings (anger, hopelessness, sadness, fear).

- Discuss words that might be the opposite to the trauma and feelings already identified, and create picture cards to represent happiness and hope. If the client struggles with this, encourage them to make an 'I like' collage (cutting out pictures from magazines of things they like the look of, e.g. shoes, cars, babies, dogs).
- Discuss their choices and their feelings about the objects they have chosen (e.g. happiness, love, friends, family etc). Are these things they have in their life? Are they hopes for the future? Hopes will be difficult, as the client may say they have none.
- Use 'I can' cards (cards that show pictures and phrases like 'I can sing' or 'I can be helpful'). In a group setting, ask the client to choose for someone else present in the group – what do you see another person in the group as capable of doing? Ask them to present the card and say why they chose the card. Ask others to choose for them.
- Make copies of the card so that group members can take them home as reminders of how others see them as capable.
- In the next session, ask how it felt to get a card and know that someone thinks you are helpful.
- Ask if there is a card that the client could choose for themselves.
- How does the card fit with the words and cards they made for trauma?
- At this stage, you will have two sets of cards – one set of pictures and words that represent trauma, and one set that represent happiness and hope.
- Draw a big football field. Identify Trauma and Hope as captains of opposing teams and place them at each end of the field (the group may pick an overall image to put at each end to represent each 'captain' or they may choose to write the words).
- The group can then place all of the words on the field – wherever they fit for the clients. Words that go with trauma go at one end and words that go with hope go at the other end. Sometimes clients will place the words at both ends, depending on their own experiences.

Discuss the way that a ball will bounce back and forth all over the field. Relate this to the client: despite what happens to us we can try to move to the other end of the field. Talk about what it looks like to be there. Talk about what holds them down Trauma's end of the football field and what it takes for them to be up Hope's end of the football field. This activity covers many concepts in a visual form and may take many weeks to carefully build with the client.



In this example, a group of young women chose an evil goblin to represent Trauma and chose a goddess to represent Hope. The women in this group felt that things like Anger, Sadness, Fear, Isolation, Alcohol and Drugs went with Trauma and that Choices, Appreciation, Change, Laughter, Respect and Friends went with Hope. You can see in this example that Wishes, Answers, Relationships and Dreams fit with both Trauma and Hope.

## Crossing the river

This exercise is useful for people who have experienced trauma in their past and need help to build hope for the future.

- Draw a river across a page. The upper side of the bank represents the past, the river is the present, and the bottom side of the bank represents the future.
- Use the client's words to describe their past (both good and bad things) and write them on the side of the river that represents the past. Or get them to draw or use symbols of the memorable things in their past.
- Talk about one problem (usually a behaviour, such as hitting people when you feel angry, or drinking when you feel hurt) and where this behaviour sits. Is it in the past? Is it in the present? Does the client want it in the future? What would it take to leave it in the past? Who might be able to help?
- What does the client want for their future? Some clients may find this difficult to imagine. Keep it concrete (such as no violence).



- What do they want to bring across the river from the past into the future? What do they want to leave behind?
- The future bank represents the new story the client wants for their lives.



In this example, the client has looked at what was in the past and what they want for their future. On the bank of the river that represents the past, the client has drawn their family home. They have drawn it as a place that is on fire, a place that frightens them. They have also drawn rain clouds to represent their feelings of sadness and depression. On the future bank they have a happy house where their family is together and getting along well. A happy future has been depicted with flowers and apple trees.

## Tree of life

(Adapted by Jill Olver from Ncube-Mlilo, 2006.)

This exercise helps clients to cope with tragedy and move on with their life. Its aim is to highlight for clients their existing strengths, encourage an alternative storyline to a 'problem saturated' narrative and increase a sense of connectedness with family and community. This exercise can be particularly useful when exploring issues of culture and diversity.



The exercise involves encouraging the client to build a picture of their life through the representation of a tree. Encourage the client to build their tree from the ground up, talking along the way about each of the elements that make up their tree. You can use what you know about the client to help them (e.g. you may know that the client's grandmother was a very important person who taught the client how to stick up for themselves).

#### The Ground

- The present – Where are the important places in your life now? Who are the important people in your life now? What are the important things happening now?

#### The Roots

- The past – Where do you come from? Who do you come from? What are the important things in your history (whether they are good bad or other)? Who are the people, places, animals and things throughout your life that have had a significant impact on you? (e.g. historical events, family members, significant teachers or those of influence, friends, care givers, pets, books, toys, music, toys etc.)

#### The Trunk

- You – your skills and knowledge, the things you can do, the qualities you possess, what makes you the person you are (e.g. serious, tolerant, kind, silly, practical joker etc.). What roles do you play in your life (e.g. sibling, son/daughter, partner, parent, artist, environmentalist). What are the acts of kindness you show others? Where did you learn these things? What was important to you about this?

#### The Branches

- The future – your hopes, dreams and wishes for yourself (e.g. to have a safe and happy family, to travel, to feel calm, to not have to worry about money, to become a vet, to have new friends etc.)

#### The Leaves

- The important, valued people in your life – from the past and present (e.g. family, friends, carers, teachers, other people of significant influence.)

#### The Fruit

- Gifts you have received from the important, valued people in your life (e.g. safety, love, support, kindness, education, income, laughter). Why were you given these gifts? What is it about you that meant people gave you these gifts? What fruits have you given to others?

#### Reflection

- By highlighting all the elements that make up the person (not just the problematic elements) you can encourage the client to share stories and support them to see

alternate stories. Allow plenty of time for re-telling of the person's story that includes the hopes, skills, and the things that are important to the person (these get lost with the trauma).

- If using this exercise with a group, you can create a 'forest of life' where you display all of the trees together. You can encourage group members to offer words of encouragement and support for others.

### The Storms of Life

- There are always storms in everyone's life. Externalise the problems in the client's life by referring to problems as 'storms' or 'bad weather'.
- You can talk about: Whose fault is the storm? What effects do the storms have? How do we respond to storms? What can you do during a storm? This kind of externalising of the problem can help create a shift from victimisation to bringing out skills and knowledge the person has to 'weather the storm'. Being able to do something when the storm hits can reduce the power of the storm.
- You can also point out that it doesn't storm all of the time. What are the times when there are no storms? What is happening then?



In this example, the client has been helped to articulate the things they wanted to put on the tree - especially in the trunk of the tree where the client was asked to articulate the



qualities they possessed. They found their own qualities difficult to name, so they were encouraged to consider what other people would say about them. This exercise was done in a group setting and other members of the group were called upon to name the qualities the person possesses.

## The relationship ladder

Draw (or ask the client to draw) the steps of a ladder. Under the ladder, name the different types of relationships the client has in their life.

Together, build a staircase:

- The first flight of stairs is who – e.g. your friend, the guy at the newsagent
- The second flight of stairs is behaviours – what do you do with this person – e.g. I hug my friend, I don't hug the guy at the post office. I kiss my partner on the lips, I kiss my friend on the cheek
- The third flight of stairs is feelings – how do the behaviours make you feel physically? e.g. When my brother hits me I feel pain in my arms and legs. When I hug my friend, I feel warm in my body. When my neighbour kisses me, I feel butterflies in my tummy
- The fourth flight of stairs is emotions – how do these different types of relationships make you feel emotionally? My partner makes me feel happy and sad. My friends sometimes make me feel afraid.

By building each step of the ladder, you are building concrete understandings of different types of relationships and how this person sees different relationships. You can even add another step to the ladder about public and private spaces – in what kind of places do certain behaviours occur? (e.g. I kiss my boyfriend in public (at the train station, at the shops), but my boyfriend and I touch each other's bodies in private (at home, in our bedroom when other people are in the house)).

An example of a relationship ladder for someone in an intimate sexual relationship might look like the one on the following page.

Peter – Boyfriend/Intimate Partner

Hug  
Kiss  
Have sex  
Go on dates  
Hang out together  
Have fights

Use my tongue to kiss  
Use my whole body including my private parts to have sex  
I feel yucky in my tummy when I don't want to have sex and my boyfriend does

Hugs kisses and sex make me feel loved  
Sometimes I'm sad when I don't want to have sex but my boyfriend has sex with me anyway  
I'm angry when he doesn't want to hang out with me  
I feel happy when we do fun things together

We hug in public  
We go on dates in public  
We kiss in public and in private  
We have sex in private

## Building a team

This exercise is designed to help the client to identify people who can assist them when they are experiencing problems in their life. It is the kind of exercise that may need to be returned to over time as the person develops new supportive relationships.

- Ask the client to draw an outline of their hand.
- Ask the client to name 5 people who are good to them in their life. Label the hand with the names of these people. Even when people have very few relationships in their lives, they can usually pull out the names of people whom they feel have a positive influence. It may be that when you first meet a client, the only people they can name are in paid relationships. This is OK. But it may highlight the need for the person to be supported to develop new relationships.
- Ask the client: What are the good things that these people bring to you? Even relationships that are problematic will have positive aspects to them that keep the client in the relationship.
- Ask the client: How does that person help you when the problem is present? What do they do that makes you feel better? Do they know that they do this for you? Would it help if they knew how they helped with the problem?





In this picture, the client has only felt able to nominate three helpful relationships in their life: their mum, their mum's partner Phil and their pet dog Archy. Archy was helpful to the client as a calming, non-judgemental influence. This exercise highlighted that the client needed support to identify other helpful people they could turn to.

## The 10 questions technique

The '10 Questions' technique can be useful when your questions are answered with 'I don't know' or simple yes/no answers (J. Olver, personal communication, April 2011). 'Yes', 'no', or 'I don't know' answers probably indicate that the person does not understand the question, does not want to answer the question, or is giving you the answer they think you want to hear.

The simple idea behind asking '10 questions' to find one answer is that the counsellor begins with concrete questions and then moves to abstract (more difficult) questions as understanding is built. Sometimes counsellors may need to move back and forward between concrete and abstract questions, but it always makes sense to start with the concrete.

For example, if the overall question you want to ask is 'How do you feel about your brother moving in with you?', and the person answers briefly with 'good', 'OK' or 'I don't know',

you will need to ask more questions. The following dialogue is a good example of the developing answer that begins with concrete questions and moves to the more abstract questions:

- Q. Where does your brother live now?  
 A. In Adelaide. I haven't seen him for a long time.  
 Q. Have you talked to your brother much lately?  
 A. He rings me every Tuesday night.  
 Q. When you were kids growing up, did you spend much time together?  
 A. He looked after me and taught me to ride my bike – he taught me lots of things.  
 Q. What do you do together when you see him? What would you like to do if he was here?  
 A. He could show me how to use a computer. He could help me read better.  
 Q. At the moment you live by yourself. What would be different if he was here?  
 A. I wouldn't be scared at night. He knows I'm scared.  
 Q. And in the day time I know you manage well looking after the house and keeping it tidy?  
 A. Yes he taught me to do that and I can still do that. Sometimes he can clean and wash too but he could mow the lawn.  
 Q. He sounds like a good brother, can you tell me something else you remember about him?  
 A. When Dad was yelling we would go to the park and he'd push me on the swing. That was fun.  
 Q. Sometimes big brothers can be bossy. Do you think he would do this?  
 A. He says I'm grown up too now and he can't boss me.  
 Q. Do you think your days will be different when he is here?  
 A. He will go to work so I can still go to the community centre and have time with my carer.  
 Q. Is there anything else that might be change if he was here?  
 A. I wouldn't be lonely.

This use of open questions to elicit responses about the concrete experiences of the client and her relationship with her brother helps the counsellor to get a more detailed understanding of their relationship. This forms an important part of the counsellor's psychosocial assessment of the client and the safety of her new potential living situation.



# 11. Tips for legal professionals

## Systemic issues

To best serve a client with intellectual disability, legal professionals need to understand some of the systemic issues that people with intellectual disability face when they engage with the justice system. These systemic issues include (French, 2007, p. 76):

- Access and affordability
- Stigma that results in direct and indirect discrimination (for example, police and legal representatives assume that people with intellectual disability do not make good witnesses)
- Time constraints faced by professionals working in the justice system
- Complicated and adversarial legal processes
- A lack of support systems and skills necessary to identify and work effectively with this client group
- Vulnerability to crime and over-representation in the criminal justice system (for more information, see the section: ‘Criminal justice system over-representation’).

## Identifying intellectual disability

There is currently no systematic identification of people with intellectual disability in the justice system at any of the usual entry points (such as Legal Aid, Corrective Services, police, courts or other agencies). As a result, many people with intellectual disability are not recognised as having a disability and miss out on relevant protections of the law, diversions from the criminal justice system and other appropriate assistance.

To ensure that people with intellectual disability receive appropriate support and have access to justice (either as a victim or an offender), it is critical that their intellectual

disability be identified as early as possible. When lawyers and other legal professionals are skilled in identifying intellectual disability, they can positively influence the outcomes and experiences of people with intellectual disability in the criminal justice system.

Hayes and Bleakley (discussed in MacDonald, 2008) argue that, when a person's intellectual disability is not identified, the consequences are likely to include:

- Police interviewing the person with intellectual disability without an independent third person present, as required by the Queensland Police Powers and Responsibilities Act (2000)
- Lawyers not using available defences or diversions that would be of great assistance to the person with intellectual disability
- Corrective and community services not assisting the person with intellectual disability to access tailored programs designed to assist in rehabilitation.

Several factors can impede the timely identification of the person's intellectual disability:

- The intellectual disability is often not obvious from the person's appearance, nor from brief contact with them
- The person may be adept at hiding their disability and/or deny having one when explicitly asked (out of shame, embarrassment or past negative experiences)
- The person may not identify personally as having an intellectual disability
- The person may have strong verbal skills and 'present well'
- The person may not have a formal diagnosis
- Behaviours that may indicate intellectual disability can be misinterpreted by others – for example, the behaviours can be seen as a bad attitude, as story-telling, or as indicators of guilt. Example behaviours might include aggression, joking, inappropriate behaviour, evasive or inconsistent answers, confabulation, difficulties with time and difficulties sequencing events
- The limited ability amongst most members of the community to recognise when a person has an intellectual disability.

Intellectual disability might be indicated by a range of difficulties in a person's communication, such as:

- Having a restricted vocabulary
- Being easily distracted
- Experiencing difficulty in understanding questions
- Responding to questions either inappropriately or with inconsistent answers
- Experiencing memory difficulties
- Showing difficulty with abstract thinking and reasoning.

If legal professionals suspect that their client has an intellectual disability, it is best to ask the client directly. If the client does not know or they do not wish to identify with this label, the following questions may assist to develop an understanding:

- Where did you go to school?
- Did you get any extra help at school?



- How are you with reading and writing?
- What do you do during the day? Do you go to work?
- What types of things do you do for fun? To relax?
- Where do you live? Do you live with other people?
- Do you get a pension from Centrelink?

Another indicator that a client may have an intellectual disability is the presence of a support person. This person may not readily identify themselves as the client's support person or support worker out of respect for the client who may have asked them not to do so. However, it can be helpful to ask the client about the person who is with them and what role that person plays (or how that person helps them). (For more information, see the sections: 'Definitions of intellectual disability' and 'Recognising intellectual disability').

## Support people

A client with intellectual disability will most likely require support to experience just and fair outcomes in the criminal justice system and to reduce their chances of ongoing involvement in the system. A support person may be a friend, family member, paid worker or volunteer. Legal professionals may need to clarify the role of the support person, ensure their role is appropriate, and ensure that there is no conflict of interest (LSNSW, n.d.).

A support person can assist the person with intellectual disability in the following ways:

- Support to obtain legal advice
- Support to understand information and make decisions
- Support to participate in any process affecting them
- Support to attend appointments
- Assistance to communicate with police, legal representatives and court officials
- Assistance for the police, legal representatives and court officials, to help them understand the needs of the person, their disability, their history and their lifestyle.

The support person may also work to address social issues contributing to the person's involvement in the criminal justice system including:

- Homelessness
- Poor physical and mental health
- Limited meaningful use of time
- Insufficient material and financial resources
- Abusive and exploitative relationships
- Lack of meaningful social roles
- Drug and alcohol issues
- Parenting issues.

(For more information, see the section: 'Working well with carers and supporters').

## Communication

Communication difficulties are perhaps the most significant issue faced by people with intellectual disability when they navigate the justice system. This difficulty is a result of both the communication and comprehension skills of the person with intellectual disability, and the communication skills and styles of non-disabled people within the criminal justice system in their interactions with people with intellectual disability. (For more information, see the section 'Barriers to communication for people with intellectual disability in the counselling context'.)

People with intellectual disability are a diverse group with diverse communication needs. The ability of an individual to be a witness in court should be assessed for each situation, based on the specific requirements of the task and what accommodations can be made. Despite general cognitive difficulties with memory, there is evidence that people with intellectual disability can give accurate testimony when appropriate considerations around interviewing conditions and questioning styles are made (Kebbell, Hatton, Johnson & O'Kelly, 2001).

## Time and rapport

Research indicates that, when an interviewee feels at ease in an interview setting, they are more likely to give more information, regardless of cognitive ability. Because people with intellectual disability are likely to suffer from social anxiety, low self-esteem and a lack of assertiveness, it is particularly important to spend time putting the interviewee at ease and building rapport (Milne & Bull, 2001).

Allowing time to build rapport may help the interviewer to identify 'language idiosyncrasies' used by the client. This will allow the interviewer to understand and use the terminology that is most familiar to the client, as well as provide the time required to assess the client's communication ability and needs (Milne & Bull, 2001).

It can be helpful to consider ways that will allow the client to exert some control in the interview, in order to decrease the power differential (for example, by allowing the client to determine the timing of breaks) (Milne & Bull, 2001). By taking steps to address power differentials, interviewers may decrease acquiescence, especially if the client feels able to contradict the interviewer or answer honestly when they do not know how to respond to a question.

## Memory and recall difficulties

People with intellectual disability can experience difficulty recalling dates, times and sequences of events. In legal and court proceedings, it is important that officers take care to ensure that information is not considered inadmissible solely because a person's statement



or report contains apparent inconsistencies around time, dates and sequence of events. These inconsistencies may need to be considered in terms of the person's intellectual disability, rather than in terms of vague, evasive or misleading evidence.

To check the client's understanding, ask them to repeat the information back to you in their own words. Where possible, involve the client's support networks (parent, support worker or significant other) in supporting you to give the client a consistent message and reinforce important information.

People with an intellectual disability may have difficulties concentrating for an extended period of time, and may need regular breaks when engaging in any form of cognitive activity (such as giving statements or evidence, or being cross-examined).

Dates and times of appointments or hearings may also be a problem for clients with intellectual disability. The client may need assistance to write dates and times in their diary and/or may need reminders close to appointments to remind them to come.

## Poor literacy skills

Most people with intellectual disability have poor literacy skills. Written materials are likely to confuse them unless attempts are made to accommodate their literacy level. Some people may attempt to hide their lack of understanding of written material. For example, they might say that they have read and understood a statement and sign it as a true and accurate record of a conversation when they do not have the literacy level required to read the statement. If it is necessary to use written correspondence with the client, adopt plain and simple English. Where possible, have someone go through any written material with the client at their pace, so that any misunderstanding can be clarified. Then, check the client's understanding by asking them to explain their understanding of the material. (For more information, see the section: 'Attention and memory'.)

## Acquiescence and suggestibility

People with intellectual disability tend to be open to suggestions, acquiescence (confirming statements or agreeing to what is asked because they think this is expected of them) and confabulation (reporting imaginary experiences that they believe to be true) (Keilty & Connelly, 2001). In addition, research demonstrates that people with intellectual disability are more likely than others to admit to offences, including ones that they did not commit. It is common for people with an intellectual disability to be easily influenced by external factors.

There are a number of things about the legal context that increase the likelihood of acquiescence and suggestibility. Feelings of frustration can diminish the client's self-confidence and induce them to rely on the suggestions of others. They may also tend to

agree with authority figures because they want to please or placate people in authority. This means that they are more likely than others to be influenced by the suggestions of authority figures such as police officers, judges and barristers. (For more information, see the section: 'Acquiescence and masking'.)

## Questioning styles

To address the issues of acquiescence and suggestibility, great care must be taken with the questioning styles used in consultations with a client with intellectual disability.

Although all people are vulnerable to suggestion when being interviewed, people with intellectual disability tend to be more susceptible to the negative consequences of poor questioning (Milne & Bull, 2001). Kebbell et al. (2001) state that two categories of questions frequently used by lawyers can cause problems for witnesses with intellectual disability: (1) questions that communicate the answer required (including yes/no questions, either/or questions and repeated questions), and (2) questions that confuse the witness (including questions with a negative or double negative, multiple questions, and questions with complex vocabulary and sentence structure). They state that 'all of these unhelpful question types are more likely to be asked by hostile lawyers in cross-examination than by friendly lawyers in evidence-in-chief'. (For more information, see the section: 'Questioning'.)



## Understanding legal terms

Ericson and Perlman (2001) examined the knowledge and understanding of legal terminology used commonly in court proceedings amongst adults with developmental disabilities. They asked the participants to identify which terms they were familiar with and then asked participants to give detail about what they thought the words meant. They found that 75 percent or more of participants with developmental disabilities understood the terms: Court, Jail, Judge, Lawyer, Lie, Police Officer, Truth, Witness.

However, the following terms were not understood by at least 40 percent of participants: Accused, Adjourn, Allegation, Arrest, Case, Charges, Convict, Court Reporter, Crown, Attorney, Defendant, Detective, Evidence, Guilty, Hearing, Interrogate, Objection, Prosecute, Suspect, Swear an Oath, Testimony, Trial, Victim.

The study also found that reporting familiarity with a word was not a reliable indicator of actual familiarity with a word. This is important, because it shows that simply asking 'do you understand?' is not a sufficient way of determining a client's actual level of understanding. It is important to ask clients to explain back in their own words what they understand, and then use that response as a basis to clear up any misunderstanding. The fact that some of the participants were able to provide accurate responses suggests that, if given time and support, people with intellectual disability have the potential to develop deeper understanding of the legal processes affecting them.

In general, questions should be kept as simple and concrete as possible. Abstract questions and concepts should not be used. Ideally, interviewers should consider ways that they can change their own behaviour and adapt their questioning formats to suit the communication needs of the interviewee (Brennan & Brennan, 1994).

Important things to remember when interviewing clients with intellectual disability include:

- Use plain, simple English
- Avoid closed questions
- Think before repeating questions: repeating questions may encourage the client to change their answer or to acquiesce. The client may assume that their first answer was wrong and that they should change it (Brennan & Brennan, 1994)



- Keep questions of choice very simple. Either/or questions tend to elicit more reliable responses, because giving too many choices will be more likely to produce a 'last option bias'. This could be caused by the client's 'difficulty in remembering the choice of replies' (Milne & Bull, 2001)
- Avoid multiple questions (for example: 'As you went into the kitchen, he picked up a knife to defend himself against you? Because you have attacked Adrian in the past, have you not?'). Instead, ask each question separately, and give time for a response to each
- Avoid double-barrelled questions
- Avoid double negatives.

(For further information, see the section: 'Questioning')

### **An example of how repeated questioning may encourage someone to acquiesce**

Lawyer: Do you remember at your house there used to be shovels kept under the house?

Witness: No.

Lawyer: No shovels?

Witness: There weren't any shovels.

Lawyer: No shovels at all?

Witness: I don't think so.

Lawyer: Big long shovels, like this?

Witness: Oh maybe there were some shovels?

Lawyer: Metal?

Witness: Yeah.

Adapted from Kebbell, Hatton, Johnson & O'Kelly, 2001.

## **Narrative interviewing techniques**

According to Powell, Fisher and Wright (2005), all prominent interview protocols recognise that the most useful information obtained in forensic interviews is that which is given in a free narrative response. A 'free narrative' is obtained when interviewees are encouraged to provide an account of the event or situation in their own words, at their own pace, and without interruption. It should be obtained prior to asking any specific questions. Kebbell, Hatton and Johnson (2004) note that, for this questioning style, eyewitnesses with intellectual disability provide accounts 'with accuracy rates broadly similar to those of the general population, although they may provide less information overall'.



Powell, Fisher and Wright (2005) describe the steps of narrative interviewing in the following way:

1. Narrative interviewing generally proceeds with the interviewer asking a broad, open-ended question (for example, 'Tell me everything you can remember about the event')
2. The interviewer then uses minimal, non-verbal encouragers (such as head nods, pauses, silence, 'mmmm,' 'uh-huh' and additional open-ended statements or questions) to steer the interviewee to provide additional narrative information (for example, 'Tell me more about that.' 'What happened then?' 'What else can you remember about that?')
3. Once the interviewee has reached the end of the story, they are usually guided back to parts of the narrative and given an opportunity for further recall (for example, 'You said this ... can you tell me more about it?').

The important aspect of the prompts used in narrative interviewing is that they are general. They focus the interviewee on a particular part of the account, but do not dictate or imply which specific information is required (Power, Fisher & Wright, 2005).

Powell, Fisher and Wright (2005) list the following benefits of encouraging a free narrative:

1. Open-ended questions usually lead to more accurate responses than specific or closed questions. The heightened accuracy of responses to open-ended questions has been demonstrated by research
2. Specific questions can lead interviewers to underestimate the witness's language limitations, especially when a witness adopts strategies to conceal those limitations. For example, interviewees may repeat phrases or words used by the interviewer, provide stereotypical responses, or give affirmative answers to yes/no questions, even when they do not understand the question
3. Open-ended questioning that is conducted at the interviewee's own pace allows the interviewee some time to collect their thoughts and, consequently, promotes more elaborate memory retrieval. Excessive questioning is distracting for witnesses
4. Open-ended questioning is less distracting for the interviewer. Open-ended questions allow the interviewer to focus their attention on listening intently to the answer, rather than focusing on formulating the next question.

## Advice that can be given to the judge

It may be possible for lawyers to give instruction to the judge or magistrate to assist in minimising the problems caused by inappropriate questioning. Kebbell, Hatton, Johnson and Kelly (2001) state that:

The judge is obliged not only to have regard to the need to ensure a fair trial for the defendant, but also to the reasonable interests of other parties to the court process.

This is particularly true of vulnerable witnesses who are obliged to relive the ordeal to which they allege they have been subjected.

Advising judges of the communication needs of the person and appropriate and inappropriate questioning strategies may allow the judge to intervene when necessary and permissible (Kebbell, Hatton, Johnson & Kelly, 2001).

## Capacity to give instruction

Lawyers always begin from the position that adults are presumed to have the capacity to give legal instruction. The law assumes that people over the age of 18 have legal capacity, unless a Court or the Guardianship and Administration Tribunal has ruled they do not have capacity (Guardianship and Administration Act 2000). Having cognitive difficulties will not necessarily negate a person's ability to make decisions about a particular matter.

In order to be considered capable of providing legal instruction, a client should be able to (LSNSW, n.d.; MacDonald, 2008):

- Comprehend the essential elements of the legal matter
- Understand the charges against them
- Respond to those charges with a plea
- Understand the role of the solicitor
- Have a basic understanding of the court process and be able to participate in proceedings
- Understand what impact their instructions will have on the outcome of the legal matter.

If a lawyer has serious concerns about a client's ability to give instruction, it may be possible to ask the client's support person to assist by voicing the needs of the client. However, this depends on the matter and it is important to ensure that the support person does not have a conflict of interest (LSNSW, n.d.).

At its website, the Queensland Criminal Justice Centre states (QCJC, n.d.):  
Where a lawyer is put on notice that there may exist a 'significant relationship' between the actions or omissions that led to criminal charges, and, the possible existence of a relevant disability, the lawyer should invariably seek an adjournment and bail (depending on the circumstances) in order to investigate the matter of the client's mental state and/or cognitive abilities.

Seeking an adjournment to obtain further advice and evidence may be the most useful approach if considering (1) whether the client is fit for trial, (2) whether the matter should be referred to appropriate diversionary courts, and (3) whether to make an adequate submission about mitigating circumstances. Where necessary, advise and assist clients to apply to Legal Aid Queensland to seek funding for a psychiatric assessment and report.



The Queensland Criminal Justice Centre's website also advises that investigations on behalf of a client could include, but are not limited to:

- The QP9 and criminal history, if any, from the prosecution
- Letters from treating doctors detailing the client's condition
- Freedom of Information applications to the Medico-Legal Department of the relevant Acute Mental Health Unit in order to acquire the client's mental health history where the person with intellectual disability also experiences a mental health issue
- Private psychiatric reports
- Psycho-social reports from psychologists
- Character references and details of any social supports in place for the client from relevant social workers and advocates or others.

## References

- Bender, M. (1993). The unoffered chair; the history of therapeutic disdain towards people with learning difficulty. *Clinical Psychology Forum*, 54, 7-12.
- Community Living Association. (2000). *Normal is everyone: Working with people with a learning difficulty*. Nundah: Community Living Association.
- Gallagher, E. (2002). Adult clients with mild 'intellectual disability': Rethinking our assumptions. *Australian and New Zealand Journal of Family Therapy*, 23, 202-210.
- Potter, C., & Whitaker, C. (2001). *Enabling communication in children with autism*. London: Jessica Kingsley Publishers Ltd.
- Thurman, S. Jones, J., & Tarleton, B. (2005) Without words – meaningful information for people with high individual communication needs. *British Journal of Learning Disabilities*, 33(2), 83-89.
- Abbott, S. & McConkey, R. (2006). The barriers to social inclusion as perceived by people with intellectual disabilities. *Journal of Intellectual Disabilities*, 10, 275-286.
- ABS (Australian Bureau of Statistics). (2010). *The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. 470.4. Available: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4704.0/> [Retrieved June 30, 2011].
- AIHW (Australian Institute of Health and Welfare). (2008). *Disability in Australia: Intellectual disability*. AIHW Bulletin No. 67. Cat No. AUS 110. Canberra: AIHW. Available: <http://www.aihw.gov.au/publication-detail/?id=6442468183&tab=2> [Retrieved 27 June 27, 2011].
- Anderson, G. & Kazantzis, N. (2008). Social problem-solving skills training for adults with mild intellectual disability: A multiple case study. *Behaviour Change*, 25, 97-108.
- APA (American Psychiatric Association). (2000). *Diagnostic and Statistical Manual of Mental Disorders (4th Edn)*, Text Revision (DSM-IV-TR). Washington DC: APA.
- Betchley, D. & Falconer, W. (2002) Giving Colin a voice: The challenge of narrative therapy with a client who has an intellectual disability and communication difficulties. *Australian Social Work*, 55, 3-12.
- Blackman, N. (2008). The development of an assessment tool for the bereavement needs of people with learning disabilities. *British Journal of Learning Disabilities*, 36, 165-170.
- Brennan M. & Brennan R. (1994). *Cleartalk: Police responding to intellectual disability*. [Unpublished paper]. Wagga Wagga: Charles Sturt University, School of Education.
- Brown, F. J. & Hooper, S. (2009). Acceptance and Commitment Therapy (ACT) with a learning disabled young person experiencing anxious and obsessive thoughts. *Journal of Intellectual Disabilities*, 13(3), 195-201.
- Carey, L. (Ed.). (2006). *Expressive and creative arts methods for trauma survivors*. London, England: Jessica Kingsley Publishers Ltd.
- Cashmore, J. & Paxman, M. (2006). Predicting after-care outcomes: The importance of 'felt' security. *Child and Family Social Work*, 11, 232-241.
- CDDHV (The Centre for Developmental Disability Health Victoria). (2005). *Challenging behaviour* [Information Sheet]. Available: <http://www.cddh.monash.org/assets/chabev.pdf> [Retrieved July 27, 2011].
- Chenoweth, L. (1996). Violence and women with disabilities: Silence and paradox. *Violence Against Women*, 2 (4), 391-411.
- Collins, K., & Valentine, D. (2003). Discovering women with disabilities: responsive and relevant practice. *Journal of Social Work and Rehabilitation*, 2 (4), 43.



- Community Living Association. (2009). *Substance abuse and people with an intellectual disability*. Submission to Australia's National Drug Strategy Beyond 2009 Consultation. Nundah, Brisbane: Community Living Association.
- Community Living Program. (1994). *Forgotten people*. Nundah, Brisbane: Community Living Program.
- Cooper, S. A., Smiley, E., Allan, L. M., Jackson, A., Finlayson, J., Mantry, D. & Morrison, J. (2009). Adults with intellectual disabilities: Prevalence, incidence and remission of self-injurious behaviour and related factors. *Journal of Intellectual Disability Research*, 53(3), 200-216.
- CPA (The Constellation Project Australia). (2010). *Intellectual disability and grief - for professionals* [website]. Available: <http://constellationproject.org.au/intellectual-disability-and-grief.php> [Retrieved August 22, 2011].
- Craig, D. & Bigby, C. (2010). *Building relationships between people with and without intellectual disability: Insights for contact theory*. Paper presented at the Australian Society for the Study of Intellectual Disability (ASSID) Conference, September 2010, Brisbane. Available: [http://www.asid.asn.au/Portals/0/Conferences/45thBrisbane/Conference%20Papers/Craig&Bigby\\_THU\\_1440\\_Relationsh](http://www.asid.asn.au/Portals/0/Conferences/45thBrisbane/Conference%20Papers/Craig&Bigby_THU_1440_Relationsh).
- CYWHs (Children, Youth and Women's Health Service, South Australia). (2011). *Communication difficulties* [Health topics information sheet]. Available: <http://www.cyh.com/HealthTopics/HealthTopicDetails.aspx?p=114&np=306&id=1877> [Retrieved August 2, 2011].
- DADHC (New South Wales Department of Ageing, Disability and Home Care). (2009). *Intellectual disability mental health first aid manual*. Sydney: Dept of Ageing, Disability and Home Care. Available: [http://www.mhfa.com.au/cms/wp-content/uploads/2011/02/id\\_manual\\_March09.pdf](http://www.mhfa.com.au/cms/wp-content/uploads/2011/02/id_manual_March09.pdf) [Retrieved June 6, 2011].
- Dagnan, D. & Jahoda, A. (2006). Cognitive-behavioural intervention for people with intellectual disability and anxiety disorders. *Journal of Applied Research in Intellectual Disabilities*, 19, 91-97.
- Didden, R., Embregts, P., van der Toorn, M. & Laarhoven, N. (2009). Substance abuse, coping strategies, adaptive skills and behavioral and emotional problems in clients with mild to borderline intellectual disability admitted to a treatment facility: A pilot study. *Research in Developmental Disabilities*, 30, 927-932.
- Dossetor, D. R., Santhanam, R., Rhodes, P., Holland, T. J. & Nunn, K. P. (2005). Developmental neuropsychiatry: A new model of psychiatry for young people with and without intellectual disability? *Clinical Child Psychology and Psychiatry*, 10, 277-303.
- Ellem, K. A. & Wilson, J. (2010). Life story work and social work practice: A case study with ex-prisoners labelled as having an intellectual disability. *Australian Social Work*, 63, 67-82.
- Ericson, K. & Perlman, N. (2001). Knowledge of legal terminology and court proceedings in adults with developmental disabilities. *Law and Human Behaviour*, 25, 529-545.
- Fan, B. (2007). Intervention model with Indigenous Australians for non-Indigenous counsellors. *Counselling, Psychotherapy, and Health*, 3 (Indigenous Special Issue), 13-20.
- Francisco, I. & Carlson, G. (2002). Occupational therapy and people with intellectual disability from culturally diverse backgrounds. *Australian Occupational Journal*, 49 (4), 200-211.
- French, P. (2007). *Disabled justice: The barriers to justice for persons with a disability in Queensland*. Brisbane: Disability Studies and Research Institute for Queensland Advocacy Incorporated.
- Frohman, C. (2010). *Submission to the Australian Government consultation paper: Family violence – Improving legal Frameworks*. Rosny Park, Tasmania: Women With Disabilities Australia.
- Gallagher, E. (2002). Adult clients with mild 'intellectual disability': Rethinking our assumptions. *Australian and New Zealand Journal of Family Therapy*, 23, 202-210.
- Goggin, G. & Newell, C. (2005). *Disability in Australia: Exposing a social apartheid*. Sydney: University of NSW Press.



- Gow, K. (1999). *Cross-cultural competencies for counsellors in Australia*. Paper presented at the Culture, Race and Community: Making it work in the New Millennium International Conference, Melbourne, 19-21 August. Available: <http://www.vtpu.org.au/docs/crc/kathrynmgow.pdf>.
- Griffis, D. (2010). *First submission to the Productivity Commission Inquiry into Disability Care and Support*. First People's Disability Network. Available: [http://www.pc.gov.au/\\_\\_data/assets/pdf\\_file/0006/102795/sub0542.pdf](http://www.pc.gov.au/__data/assets/pdf_file/0006/102795/sub0542.pdf) [Retrieved June 30, 2011].
- Haddock, K. & Jones, R. (2006). Practitioner consensus in the use of cognitive behaviour therapy for individuals with a learning disability. *Journal of Intellectual Disabilities*, 10, 221-230.
- Hayes, S. (2007). *Cognitive behavioural therapy for people with ID who are victims of crime – can it be accessed and does it work?* Paper presented at the 5th World Congress of Cognitive and Behavioural Therapies, Barcelona, 11-14 July 2007.
- Healthy Start. (2011). *Practice point: Child protection*. Sydney: Healthy Start: A National Strategy for Children of Parents with Learning Difficulties (in collaboration with The University of Sydney & Parenting Research Centre). Available: [http://www.healthystart.net.au/images/resources/02-Practice-Points/Practice\\_Point\\_Child\\_Protection.pdf](http://www.healthystart.net.au/images/resources/02-Practice-Points/Practice_Point_Child_Protection.pdf) [Retrieved July 7, 2011].
- Hollins, S. (2006). *Depression in people with learning disability*. Royal College of Psychiatrists. Available: <http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/depression/learningdisability.aspx> [Retrieved August 1, 2011].
- Hoole, L. & Morgan, S. (2008) How to trick 'Angry': Narrative therapy for people with an intellectual disability who have been referred for 'anger management'. *Psychology and Society*, 1, 105-115.
- Horner-Johnson, W. & Drum, C. E. (2006). Prevalence of maltreatment of people with intellectual disabilities: A review of recently published research. *Mental Retardation and Developmental Disabilities Research Reviews*, 12, 57-69.
- Hughes, F. (2009). Better care for people with intellectual disability and mental illness. *Journal of Psychological Nursing & Mental Health Services*, 47, 8-10.
- IATO (International Association of Art Therapy). (2011). *What is art therapy?* [Website]. Available: <http://www.internationalarttherapy.org/whatisarttherapy.html>.
- Irons, L. (2011, April 11). Queensland Public Advocate presentation at the symposium: 'Everybody's business: Stopping the abuse and neglect of people with intellectual disability'. Griffith University International Symposium, Brisbane.
- Jackson, R., O'Connor, M. & Chenoweth, L. (2006). *Journeys of exclusion*. Nundah, Brisbane: Community Living Program.
- Johnson, K., Hillier, L., Harrison, L., & Frawley, P. (2001). *Living safer sex lives. Final report*. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne.
- Kebbell, M., Hatton, C. & Johnson, S. (2004). Witnesses with intellectual disabilities in court: What questions are asked and what influence do they have? *Legal and Criminological Psychology*, 9, 23-35.
- Kebbell, M., Hatton, C., Johnson, S. & O'Kelly, C. (2001). People with learning disabilities as witnesses in court: What questions should lawyers ask? *British Journal of Learning Disabilities*, 29, 98-102.
- Keilty, J. & Connelly, G. (2001). Making a statement: an exploratory study of barriers facing women with an intellectual disability when making a statement about sexual assault to police. *Disability and Society*, 16, 273-291.
- Lambie, G. & Milsom, A. (2010). A narrative approach to supporting students diagnosed with learning disabilities. *Journal of Counseling & Development*, 88(2), 196-203.





- Lamont, A. & Bromfield, L. (2010). *Parental intellectual disability and child protection: Key issues*. Canberra: National Child Protection Clearinghouse, Australian Institute of Family Studies. Available: <http://www.aifs.gov.au/nch/pubs/presentations/2010/lamont.pdf> [Retrieved July 7, 2011].
- Lennox, N. & Edwards, N. (2001). *Lessons from the labyrinth: Views of residential care officers on barriers to comprehensive health care for adults with an intellectual disability*. Brisbane: Developmental Disability Unit, School of Population Health, The University of Queensland. Available: [http://www2.som.uq.edu.au/som/Research/ResearchCentres/qcidd/Documents/lessons\\_from\\_labyrinth.pdf](http://www2.som.uq.edu.au/som/Research/ResearchCentres/qcidd/Documents/lessons_from_labyrinth.pdf) [Retrieved June 6, 2011].
- Lennox, N. & Simpson, J. (2011). *Australian Productivity Commission Submission on the health of people with intellectual disabilities*. National and NSW Councils for Intellectual Disability & Australian Association of Developmental Disability Medicine. Available: [http://www.pc.gov.au/\\_data/assets/pdf\\_file/0012/98796/sub0029.pdf](http://www.pc.gov.au/_data/assets/pdf_file/0012/98796/sub0029.pdf) [Retrieved June 6, 2011].
- LSNSW (Law Society of New South Wales). (no date). *Understanding your clients and intellectual disability* [Young Lawyer Factsheet]. Available: <http://www.lawsociety.com.au/idc/groups/public/documents/internetyounglawyers/023694.pdf> [Retrieved November 29, 2011].
- MacDonald, S. (2008). *Which way is justice? A practice manual for supporting people with an intellectual disability in the criminal justice system*. Nundah, Brisbane: Community Living Association Inc.
- MacHale, R., McEvoy, J. & Tierney, E. (2009). Caregiver perceptions of the understanding of death and need for bereavement support in adults with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, 22, 574-581.
- Matthews, B. & Matthews, B. (2005). Narrative therapy: Potential uses for people with intellectual disability. *International Journal of Disability, Community and Rehabilitation*, 5(1). Available: [http://www.ijdc.ca/VOL04\\_01\\_CAN/articles/matthews.shtml#top](http://www.ijdc.ca/VOL04_01_CAN/articles/matthews.shtml#top) [Retrieved 26 October 2011].
- McCarthy, M. (2011). Prescribing contraception to women with intellectual disabilities: General Practitioners' attitudes and practices. *Sex and Disability*, 29, 339-349.
- McClure, K., Halpern, J., Wolper, P. & Donahue, J. (2009). Emotional regulation and intellectual disability. *Journal on Developmental Disabilities*, 15, 38-44.
- Milne, R. & Bull, R. (2001). Interviewing witnesses with learning disabilities for legal purposes. *British Journal of Learning Disabilities*, 29, 93-97.
- Milne, R., & Bull, R. (2006). Interviewing victims, including children and people with intellectual disabilities. In M. Kebbell & G. Davies (Eds.), *Practical psychology for forensic investigations*. Chichester: Wiley.
- Mirow, R. (2008). 'Going cognitive': CBT for people with learning disabilities. *Learning Disability Practice*, 11, 34-38.
- Mitchell, L. (2011). *Domestic Violence in Australia: An overview of the issues*. Parliamentary Library Background Note. Canberra: Commonwealth of Australia. [http://www.aph.gov.au/library/intguide/sp/Dom\\_violence.htm](http://www.aph.gov.au/library/intguide/sp/Dom_violence.htm) [Retrieved February 3, 2012].
- MMHA (Multicultural Mental Health Australia, National Ethnic Disability Alliance, and Australian Mental Health Consumer Network) et al. (2004). *Reality check: Culturally diverse mental health consumers speak out*. Parramatta: National Ethnic Disability Alliance, Parramatta.
- Morris, J. (1993). Gender and Disability. In J. Swain, V. Finkelstein & M. Oliver (Eds.), *Disabling barriers – Enabling environments* (pp. 85-92). London: Sage Publications
- Murray, L. (2003). Self-harm among adolescents with developmental disabilities. *Journal of Psychosocial Nursing & Mental Health Services*, 41, 36-44.

- Murray, S. & Powell, A. (2008). *Sexual assault and adults with a disability: Enabling recognition, disclosure and a just response*. Canberra: Australian Institute of Family Studies.
- Ncube-Mlilo, N. (2006) The tree of life project. *International Journal of Narrative Therapy and Community Work*, 1, 3-16.
- NEDA (National Ethnic Disability Alliance). (2001). *Racial discrimination and disability*. A response prepared by the National Ethnic Disability Alliance for the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance, Durban, South Africa.
- Newman, E., Christopher, S. R. & Berry, J. O. (2000). Developmental disabilities, trauma exposure, and post-traumatic stress disorder. *Trauma Violence Abuse*, 1, 154-170.
- Nezu, C., Nezu, A. & Arean, P. (1991). Assertiveness and problem-solving training for mildly mentally retarded persons with dual diagnoses. *Research in Developmental Disabilities*, 12, 371-386.
- NHMRC (National Health and Medical Research Council). (1990). *Learning difficulties in children and adolescents*. Canberra: Australian Government Publishing Service.
- NSWCID (New South Wales Council for Intellectual Disability). (2011). *Alcohol and other drugs* [Factsheet]. Available: <http://www.nswcid.org.au/health/se-health-pages/alcohol-and-other-drugs.html> [Retrieved May 30, 2011].
- NSWLRC (NSW Law Reform Commission). *People with and intellectual disability and the criminal justice system* (Report 80). Available: # <http://www.lawlink.nsw.gov.au/lrc.nsf/pages/R80CHP3> [Retrieved April, 3, 2011].
- O'Connor, M. & Fowkes, J. (2000). *Normal is everyone: Some of us have a learning difficulty*. Nundah, Brisbane: Community Living Association Inc.
- O'Driscoll, D. (2009). Psychotherapy and intellectual disability: A historical view. In T. Cottis (Ed.), *Intellectual disability, trauma and psychotherapy* (pp. 9-28). New York: Routledge.
- O'Sullivan, J., Ryan, R., & MacDonald, K. (2003). *Cognitive behavioural therapy* [Factsheet]. Brisbane: Royal Brisbane and Women's Hospital, Metro North Health Service District. Available: <http://www.health.qld.gov.au/rbwh/docs/cbt.pdf>.
- Oaks, P. M. & Davies, R. D. (2008). Intellectual disability in homeless adults: A prevalence study. *Journal of Intellectual Disabilities*, 12, 325-334.
- Ozdowski, S. (2002). *Human rights for people with intellectual disabilities in Australia: Where to from here?* Address by the Australian Federal Human Rights Commissioner and Disability Discrimination Commissioner (former) to the Inclusion International 13th Congress, Melbourne 24 September, 2002. Available: [http://www.hreoc.gov.au/disability\\_rights/speeches/2002/inclusion.htm](http://www.hreoc.gov.au/disability_rights/speeches/2002/inclusion.htm) [Retrieved July 7, 2011].
- Paley, S. (2008). *Self injurious behaviour* [Factsheet]. UK: British Institute of Learning Disabilities. Available: <http://www.bild.org.uk/05factsheets.htm> [Retrieved June 30, 2011].
- Parkinson, G. (2006). Counsellors' attitudes towards disability equality training (DET). *British Journal of Guidance & Counselling*, 34, 93-105.
- Pearson, M. & Wilson, H. (2001). *Sandplay and symbol work: Emotional healing and personal development with children, adolescents and adults*. Melbourne: Australian Council for Educational Research (ACER) Press.
- Powell, M., Fisher, R., & Wright, R. (2005). Investigative interviewing in psychology and the law: An empirical perspective. In N. Brewer & K. D. Williams (Eds). *Psychology and Law: An Empirical Perspective* (pp.11-42). New York: The Guilford Press.
- QCJC (Queensland Criminal Justice Centre). (no date). *Initial options at court*. [Website]. Available: <http://www.qcjc.com.au/practice/econtent/1/2/148/initial-options-at-court> [Retrieved November 30, 2011].



- Riches, V. (2008). Unrecognised and unsupported: Grief among people with intellectual disability. *Grief Matters*, Winter, 48-52.
- Saleebey, D. (2009). *The strengths perspective in social work practice* (5th ed.). Boston: Pearson.
- Sau-Lai Chan, J. & Hing-Min Tse, S. (2011). Massage as therapy for persons with intellectual disabilities: A review of the literature. *Journal of Intellectual Disabilities*, 15, 47-62.
- Schauer, M., Neuner, F. & Elbert. (2005). *Narrative exposure therapy: A short-term intervention for traumatic stress disorders after war, terror, or torture*. Cambridge, MA: Hogrefe and Huber.
- Singh, N., Whaler, R., Adkins, A. & Myers, M. (2003). Soles of the feet: A mindfulness-based self-control intervention for aggression by an individual with mild mental retardation and mental illness. *Research in Developmental Disabilities*, 32, 2690-2696.
- Sobsey, D. (1994). *Violence and abuse in the lives of people with disabilities: The end of silent acceptance?* Baltimore: Paul H. Brookes Publishing Co.
- Spork, H. (1994). *Standing tall: A resource on the development of a self support group for women with a mild intellectual disability*. Woolloowin, Brisbane: Wild Women's Group Project.
- Stenfert Kroese, B., & Thomas, G. (2006). Treating chronic nightmares of sexual assault survivors with an intellectual disability – two descriptive case studies. *Journal of Applied Research in Intellectual Disabilities*, 19, 75-80.
- Taylor, J., Lindsay, W., & Willner, P. (2008). CBT for people with intellectual disabilities: Emerging evidence, cognitive ability and IQ effects. *Behavioural & Cognitive Psychotherapy*, 36, 723-733.
- UIDH (Understanding Intellectual Disability and Health). (2011). *Understanding intellectual disability and health* [website] Available: <http://www.intellectualdisability.info/mental-health/depression-in-people-with-intellectual-disabilities> [Retrieved June 3, 2011].
- UN (United Nations). (2006). *The United Nations convention on the rights of persons with disabilities*. Available: <http://www.un.org/disabilities/default.asp?id=259> [Retrieved July 7, 2011].
- Upton, J. (2009). When words are not enough: Creative therapeutic approaches. In T. Cottis (Ed.), *Intellectual Disability, Trauma and Psychotherapy* (pp.29-44). New York: Routledge.
- West, G. (2011, May 25). Call for radical intervention on juvenile justice. In S. Dingle (Reporter). AM [Radio broadcast]. (Interviewee, from St Vincent de Paul, NSW). Sydney: Australian Broadcasting Corporation.
- White, I., Bull, S. & Beavis, M. (2008). Isobel's images – one woman's experience of art therapy. *British Journal of Learning Disabilities*, 37, 103-109.
- White, P., Chant, D., Edwards, N., Townsend, C. & Waghorn, G. (2005). Prevalence of intellectual disability and comorbid mental illness in an Australian community sample. *Australian and New Zealand Journal of Psychiatry*, 39, 395-400.
- WHO (World Health Organisation). (2007). *ICD-10 (International Statistical Classification of Diseases and Related Health Problems) 10th Revision*. (2007).
- Willner, P. & Goodey, R. (2006). Interaction of cognitive distortions and cognitive deficits in the formulation and treatment of obsessive-compulsive behaviours in a woman with an intellectual disability. *Journal of Applied Research in Intellectual Disabilities*, 19, 67-73.
- Willner, P. (2006). Readiness for cognitive therapy in people with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, 19, 5-16.
- Willner, P., Brace, N. & Phillips, J. (2005). Assessment of anger coping skills in individuals with intellectual disabilities. *Journal of Intellectual Disability Research*, 49, 329-339.
- Wilson, N., Paramenter, T., Stancliffe, R., Shuttleworth, R., & Parker, D. (2010). A masculine perspective of gendered topics in the research literature on males and females with intellectual disability. *Journal of Intellectual and Developmental Disability*, 35, 1-8.

# Index

- Aboriginal and Torres Strait Islander people and intellectual disability 29-30
- Abstract and concrete thinking 40-41
- Access to justice 26
- Accommodation 9-10
- Acquiescence and masking 36-37
- Acquiescence and suggestibility, for legal professionals 89
- Acquiescence, example for legal professionals 92
- Adapting counselling 38
- Advice that can be given to the judge, for legal professionals 93-94
- Alcohol and substance misuse 21-22
- American Association on Intellectual and Developmental Disabilities 4
- American Psychiatric Association 5
- Anxiety during counselling 27
- Artwork therapy 68-69
- Asking questions 39-40
- Assault 15-16
- Assault, sexual 15-16
- Attention and memory 37-38
- Barriers to communication for people with intellectual disability 34-46
- Barriers to community inclusion 14
- Behavioural issues in communication 41-43
- Bereavement 52-53
- Building a team (Exercises) 82-83
- Building the capacity of the support team 56-57
- Capacity to give instruction, for legal professionals 94-95
- Carers, see support people
- Causes of challenging behaviour 42
- Causes of self harm 20
- Causes of speech difficulties 44
- Challenges of accessing multiple services 24
- Challenging behaviour 41-43
- Changes in behaviour 42
- Child protection system involvement and over-representation 22-24
- Cognitive behavioural therapy 64-66
- Common 'lived experience' or intellectual disability 6; 9-26
- Common health problems 18
- Commonwealth Disability Discrimination Act 8
- Communication ability and self harm 19
- Communication and intellectual disability 34-46
- Communication and IQ 34-35
- Communication difficulties 36
- Communication difficulties and physical health 17
- Communication, for legal professionals 88
- Concrete and abstract thinking 40-41
- Confabulation and exotic story telling 43-44
- Confidentiality 45-46
- Considerations for counselling practitioners 47-58
- Contributors to poverty 13
- Contributors to substance misuse 21
- Counselling practitioners, considerations 47-58
- Counselling strategies for people with speech difficulties 45
- Counselling, positions of power 49
- Counsellors' values and attitudes 47-48
- Creative approaches to counselling 38; 40; 53-55; 60-69
- Creative expression 53-55
- Crime and disability 17
- Crime 17
- Criminal justice system over-representation 17
- Crossing the river (Exercises) 77-78
- Cultural awareness 29-30; 30-33
- Cultural diversity 29-30; 30-33
- Cultural understanding 29-30; 30-33
- Culturally and linguistically diverse backgrounds 31-33
- Culturally-appropriate services 29-30; 30-33
- Death, understanding 52-53
- Definitions of intellectual disability 4-7
- Definitions, legal 5
- Definitions, medical 4
- Definitions, self 5
- Development of self harm 19-20
- Diagnosis of mental illness 18-19
- Difficulties for parents 22-23
- Domestic violence 14
- Duty of care and safety 58-59
- Education 11-12
- Employment after school 12
- Ethical issues and duty of care 58-59
- Eugenics 8; 11
- Exclusion from counselling and support services 8
- Exclusion 13-14
- Exercises 70-84
- Exotic story telling and confabulation 43-44
- Experience of living with intellectual disability 6; 9
- Exploitative relationships 10-11
- Exploring feelings through art (Exercises) 72-73
- Family and relationships 10-11
- Family members – see also, support people
- Family, see support people
- Financial security 12-13
- Flowers and rocks (Exercises) 74-75
- Focusing on the client, and support people 56
- Gender and intellectual disability 27-28
- Grief, loss and bereavement 52-53
- Group housing 9-10
- Health problems, common 18
- Homelessness 10
- Housing 9-10
- Human rights 25-26
- Identifying intellectual disability, for legal professionals 85-87
- Identifying trauma 50-51



- Impact of support people's attitudes 57-58
- Independent living 9-10
- Intellectual disability and people from culturally and linguistically diverse backgrounds 31-33
- Intellectual disability myths 48
- Intellectual disability, definitions 4-7
- Intimacy 11
- Involvement with multiple service systems 24
- Kinship ties 30
- Legal definitions 5
- Legal professionals and ...
  - acquiescence and suggestibility 89
  - advice that can be given to the judge 93-94
  - capacity to give instruction 94-95
  - communication 88
  - identifying intellectual disability 85-87
  - memory and recall difficulties 88-89
  - narrative interviewing techniques 92-93
  - poor literacy skills 89
  - questioning styles 90-92
  - support people 87
  - systemic issues 85
  - time and rapport 88
- Lived experience 6; 9-26
- Living situations 9-10
- Masking 36-37
- Medical definitions 4
- Medication and mental illness 18-19
- Memory and recall difficulties, for legal professionals 88-89
- Memory 37-38
- Men with intellectual disability 28
- Mental health 18-19
- Mental illness 18-19
- Methods of questioning 39-40
- Multiple service systems 24
- Myths about intellectual disability 48
- Narrative interviewing techniques, for legal professionals 92-93
- Narrative therapy 60-64
- Narrative-based self-reporting and creative expression 53-55
- Out-of-home care 23-24
- Over-representation in the criminal justice system 17
- Paid support workers, see support people
- Parenting ability 22-23
- Parents with intellectual disability 22-23
- Perpetrators of sexual assault 15
- Physical health 7-18
- Poor literacy skills, for legal professionals 89
- Positions of power in counselling 49
- Poverty 12-13
- Poverty, contributors to 13
- Power imbalance, reducing 49
- Power in counselling 49
- Prejudice 14
- Privacy and consent and support people 56
- Queensland Criminal Code Act 16
- Queensland Criminal Law Code 5
- Questioning styles, for legal professionals 90-92
- Questioning 39-40
- Recognising intellectual disability 35-36
- Reducing power imbalance 49
- Relationships 10-11
- Relationships, exploitative 10-11
- Relationships, sexual 11
- Rights and self-determination 25-26
- Risks of alcohol misuse 21
- Safety and duty of care 58-59
- Sand tray therapy 66-68
- School 11-12
- Self harm 19-20
- Self harm, causes 20
- Self-definitions 5
- Self-determination 25-26
- Sequencing 38
- Sexual assault 15-16
  - and exploitation 15-16
  - and need for companionship 16
  - and share housing 15
  - and supported accommodation 16
  - Sexual exploitation 15-16
- Sexual relationships 11
- Sexuality 10-11
- Significant others, see support people
- Signs of trauma 50-51
- Social disadvantage 9-10
- Social isolation 13-14
- Socio-historical context 8
- Speaking and verbal issues 44-45
- Substance misuse 21-22
- Support people
  - and bereavement 53
  - and confidentiality 46
  - and focusing on the client 56
  - and privacy and consent 56
  - building their capacity 56-57
  - for legal professionals 87
  - impact of their attitudes 57-58
  - working well with 55-58
- Support system reliance 13
- Supporting challenging behaviour 42-43
- Supporting grieving 53
- Systemic issues, for legal professionals 85
- The 10 questions technique (Exercises) 83-84
- The football field activity (Exercises) 75-77
- The relationship ladder (Exercises) 81-82
- Thinking, concrete and abstract 40-41
- Time and rapport, for legal professionals 88
- Time 50
- Tips for legal professionals 85-95
- Trauma 50-51



---

Treatment of mental illness 18-19  
Tree of life (Exercises) 78-80  
Typical communication difficulties 36  
Understanding  
    consequences 38  
    death 52-53  
    emotions 41  
    legal terms 91  
United Nations Convention on the Rights of Persons  
with Disabilities 8; 25  
Using symbols (Exercises) 70-72  
Values and attitudes of counsellors 47-48  
Verbal issues and speaking 44-45  
Victimisation 14  
Victims of crime 14; 17  
Vulnerability to criminal victimisation 14  
Vulnerability to sexual assault 15-16  
Women with intellectual disability 27  
Working with support people 55-58  
World Health Organisation 5  
Young people in care 23-24



# How to Hear Me

A Resource kit for Counsellors and Other Professionals  
working with people with Intellectual Disabilities

The WWILD Sexual Violence Prevention (SVP) Association Inc is pleased to present the How to Hear Me Resource Book and DVD as an important tool in building the capacity of victim support agencies, counsellors and other professionals to work effectively with people with an intellectual disability.

Around three percent of Australians experience intellectual disability and are much more likely to become victims of crime than other members of the population. This Resource Book and accompanying DVD will help counselling professionals to work with people with intellectual disability in their recovery journey.

This book is not intended to instruct professionals in the work they are already trained for, but rather to augment their existing expertise, allowing them to adapt current practice to meet the needs of a wider and more diverse client base. It is designed to support practitioners to gain a deeper understanding of the complex range of issues experienced by people with intellectual disability and offers some techniques to assist in improving practice.

This book is a reflection of WWILD's experience, practice and research. WWILD-SVP is a not for profit organisation based in Brisbane, Queensland, that works with people with intellectual disabilities who have experienced or are at risk of experiencing sexual violence or have been victims of crime.

This project is funded by the Department of Justice and Attorney-General,  
supporting victims of crime in Queensland