Hidden in Plain Sight: Treating Trauma in the Intellectually Disabled

A Review of

Healing Trauma: The Power of Group Treatment for People With Intellectual Disabilities by Nancy J. Razza and Daniel J. Tomasulo
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Reviewed by
John C. Linton

Recently a colleague consulted with me about a young woman he had just evaluated in the hospital who had been traumatized by a sexual assault. He was stuck, unable to plan a course of action because the patient was quite challenged intellectually, and therefore the customary treatments seemed inappropriate. His literature search determined that although hundreds of books and articles have been written about the evaluation and treatment of psychological trauma, there was little guidance about intervention with traumatized patients who were intellectually limited. I suggested that he read this book.

Razza and Tomasulo write that their goal is to “share our hard won lessons with other clinicians” (p. 3) regarding ways to understand and work with those who have intellectual disabilities in addition to psychological disorders, and more specifically those who have experienced psychological trauma through neglect and sexual assault. They make a strong case for providing therapy for this underserved population and then present a way to do it.

On the Margins

Individuals with intellectual disabilities have regrettably been marginalized by society. They have been invisible even to mental health professionals, who often complete graduate training with no exposure to the nature of psychopathology in this population, and never see it in practice. Clinicians have not only been limited in their understanding of emotional disorders in the intellectually challenged, but assumed that such patients lack the necessary abilities to engage in the process of psychotherapy, and have therefore discouraged them from treatment.

In recent years there has been an amplified interest in their mental health needs and treatments that might be tailored to meet them. Research has found that the prevalence of psychiatric disorders in intellectually disabled people is three to four times the rate found in the general population. Yet these disorders are often missed, having been masked by “diagnostic overshadowing,” where professionals ascribe emotional symptoms to the mental retardation and assume they are behavioral manifestations of a cognitive defect rather than independent psychiatric disorders. Psychological problems might be overlooked as well because their symptom presentations can vary from the norm; for example, patients with mental retardation may be more agitated and disorganized than those without cognitive disabilities. Mentally disabled individuals may exhibit traumatic reactions to events that others may not see as traumatic, and low IQs make it harder for them to process these incidents. They also have low levels of social support and poorly developed social skills. Thus, they may relate badly, have difficulty explaining their symptoms, and have no one in their lives to assist them in doing so.
Of particular concern is that sexual abuse is known to correlate highly with the development of many kinds of psychological disorders, including major mood and personality disorders, as well as posttraumatic stress. The intellectually disabled have a much higher rate of victimization by sexual abuse, mostly women with mild mental retardation, but also a small number of men with more severe retardation (Mansell & Sobsey, 2001). Also, men with intellectual retardation are more likely to commit sexual offenses, because cognitive limitations are thought to cause a vulnerability that interferes with the awareness and expression of one’s sexuality. Men who have been abused are known to victimize others, to be self-destructive, or to be victimized again later in life. Given the gravity of this problem, Razza and Tomasulo focus primarily on individuals who have mental handicaps and also suffer psychiatric disorders secondary to sexual victimization, whether due to being a victim or a perpetrator.

**Out of the Shadows, Into a Group**

Group therapy for patients who have been traumatized has been successful in the literature (Young & Blake, 1999). These authors have also found that the best predictor of recovery for traumatized patients who are intellectually disabled is a strong, validating support group, and thus they have developed a group therapy treatment model differentially targeted to the specific needs of their various patients. Seeing one’s behavioral pattern in the lives of others is a benefit unique to group therapy, and this can help those with weak cognitive skills to challenge their long-held notions and self-concepts that are dysfunctional or in error. Attachment has also been shown to be important in the development of, and reaction to, offensive behaviors, so providing a safe and therapeutic relationship for groups of victims and groups of offenders is also considered important for improvement.

The authors illustrate the interactive-behavioral model of group therapy (IBT), which was developed over 15 years and is based on techniques from psychodrama. Patients with mental disabilities have cognitive impairments and typically weak verbal skills. However, strong cognitive and verbal skills are desirable for talk therapy, so insight-oriented treatment calls for the mentally handicapped individual to work in areas of their greatest limitation. To address this dilemma, IBT borrowed from psychodrama to engage such patients behaviorally and, hence, emotionally.

Although the heart of classic social skills groups is the connection between the student, the instructor, and the curriculum, IBT is focused almost entirely on the interactions among the group members. The underlying principle is that faulty styles of interpersonal connection are developed with others, so they need to be repaired with others. Years of experience have shaped intellectually disabled people to pay attention to the teacher, not one another. The IBT facilitator instead calls for group members to listen to and understand their peers, rather than learning to follow a leader’s coaching. The groups strive primarily to strengthen group dynamics and secondarily to share information. Groups run for roughly an hour and are conducted in four stages.

Orientation lasts for 20 minutes and prepares the participants for each group, stresses safety and confidentiality, and focuses on communication skills, because members are used to being ignored and ignoring others. One person begins speaking and the leader then interrupts and asks that feedback be given to the speaker about what was heard by the others. Then the speaker chooses the next member to talk, and the process is repeated. Disclosure is horizontal and superficial, and speakers are given specific positive feedback about, for example, their eye contact or listening skills. Warm up and sharing lasts for 15 minutes; self-disclosure becomes more vertical, with members clarifying issues they want to share that day. In the enactment stage, which lasts about 10 minutes, issues presented are put into action as in psychodrama, which engages both attention and memory and accelerates the emotional involvement of members. A “double” is chosen to stand behind the speaker and relate the thoughts and feelings the speaker might be having. The speaker feels supported, and the double learns empathy. Affirmation continues for the final 5 to 10 minutes and provides feedback to each member about his or her participation in that day’s group. The feedback is all positive, allowing for improved self-confidence, for example, “I am a good listener” or “I am controlling my temper better.” The aim in this stage is to reconnect with others in self-affirming ways, because the authors have learned IQ does not dictate the ability to heal.

The book is organized into chapters on the basis of group member problem, such as sexual survivor or sexual offender, and there is also a group designed to prevent sexual abuse in those at risk, who have typically been referred by others.
rather than self-referred. The authors recommend that a group be made up of individuals with similar problems and intellectual abilities to promote comfort and the universality of their experiences. In addition, a member deviant from the group on such variables is at risk to drop out. Those who are paranoid or clearly antisocial are excluded, and individual contacts are recommended for them.

This book provides excellent instruction concerning how the mentally handicapped patient may present less classical symptoms of psychological disorders. The authors discuss in detail the composition of IBT groups, and through specific clinical examples, including common mistakes and special problems in the initial interview, they offer group therapists who are naïve to this population sufficient information to establish their own IBT groups. Cases are carried from start to finish, with comments about progress and setbacks in the IBT groups, so the reader is left with an appreciation of how to organize and conduct these interventions. Well written and sensibly organized, this book should be required reading for anyone who works with the intellectually disabled or plans to. It also provides an interesting perspective for any reader who treats trauma patients, providing illumination for an area of suffering that has existed in the shadows for too long.

References
