TRAUMA AND INTELLECTUAL DISABILITY

Emma Longfellow and Rachel Hicks

Introduction

Several contextual issues impact on our understanding of trauma within forensic Intellectual Disability (ID) populations. One of the most critical is the base issue of identifying who and where the ID population are, as there is immense variation in prevalence of ID in forensic settings noted in existing studies as well as inconsistency in ID definition (Hellenbach, Karatzias, & Brown, 2017; Murphy, Harnett, & Holland, 1995). This fundamental issue in understanding who this group are also limits our understanding of the prevalence and experience of trauma in this population. Although the data are flawed, it is largely accepted that individuals with ID are over-represented in forensic settings (Hayes, Shackell, Mottram, & Lancaster, 2007; Heaton & Murphy, 2013; Hellenbach et al., 2017). We also know that ID populations are more vulnerable than non-ID populations to experiencing trauma, have resiliency deficits (van der Put, Asscher, Wissink, & Stams, 2014), and are at a heightened risk of developing post-traumatic stress disorder (PTSD) (Daveney, Hassiotis, Katona, Matcham, & Sen, 2019). It is therefore reasonable to assume that trauma prevalence in forensic ID populations is likely to be high. This is likely to be further compounded by the trauma of receiving an ID diagnosis itself, or conversely from ID being undiagnosed and unrecognised (García-Largo, Martí-Agustí, Martin-Fumadó, & Gómez-Durán, 2020). Despite limitations in the literature there is a clear need to consider trauma and its sequelae when caring for individuals with ID.

Defining Intellectual Disability and Trauma

An Intellectual Disability is principally defined by three core criteria: a significantly reduced ability to understand new or complex information in learning new skills (evident in lower intellectual ability), reduced ability to cope independently (evident in impaired adaptive functioning), and that these difficulties started before adulthood and had a lasting effect on development (British Psychological Society, 2015). Individuals with ID are not a homogeneous group, which is evident in varied
cognitive and adaptive functioning, co-occurring neurodevelopmental difficulties, personality, environmental stressors (Emerson & Hatton, 2007), and attachments (Smith, 2009). To capture the varying degrees of functioning displayed, ID has been further subcategorised into mild, moderate, severe, and profound to support in identifying individual support needs (Department of Health, 2001).

As well as understanding what we mean by ID, it is important to clarify what we mean by trauma in ID populations. Based on the available literature and drawing from the authors’ clinical experience we have identified two types of trauma for an individual with ID: the trauma associated with having an ID (both recognised and unrecognised) and the broader trauma of adverse life events (whether single or multiple traumas across the life course). These in reality do not exist in silos and regularly co-occur.

There have been several studies over the past 50 years that have explored the impact of diagnostic labels on an individual. In relation to cognitive abilities, labels have been found to have a negative impact on the perception of critical others – such as teachers, carers, and parents – and on self-perception (Daley & Rappolt-Schlichtmann, 2018). Labels associated with special educational needs and ID were noted to be perceived as “shameful”, isolating, impacting on future placements, creating self-doubt, and learned helplessness (Daley & Rappolt-Schlichtmann). Ho (2004) argued that pathologising and labelling individuals based on their intellectual difference was counterproductive and unnecessary. They noted that inclusion was dependent on understanding the range of contexts that influence an individual’s cognitive abilities and learning. They suggested starting from the presumption that all individuals are unique and that, in turn, we should be flexible in our approaches. Pathologising ID can create an “out group” and raises the issue of othering and micro-aggressions in ID populations. One of the critical elements associated with othering is the idea that the dominant group is distant from the other “lesser” group and can dehumanise, discriminate, and marginalise further (Staszak, 2008). In many cases this can occur subconsciously and can become easily embedded in institutions and complex systems. Peternelj-Taylor (2004) noted this as commonplace in forensic psychiatric settings, evident in the use of depersonalising language. This can manifest as micro-aggressions centred on “us” and “them” using blanket statements, being condescending (using a baby voice) and assuming ID means intellectual inability. Conversely those with ID who are not identified or recognised can experience similar difficulties due to a lack of understanding or reasonable adjustment contributing to decreased self-esteem, isolation, and exclusion (Peternelj-Taylor, 2004).

García-Largo et al. (2020) note that not identifying those with ID within forensic settings impacts on provision and contributes to re-traumatisation of an already marginalised and vulnerable population.

People with an ID have been found to be more likely to experience traumatic events and negative life events than individuals who do not have an ID (Catani & Sossalla, 2015; Wigham, Taylor, & Hatton, 2014). Impaired intellectual ability generally is associated with increased risk of exposure to adverse events and development of PTSD (Breslau, Lucia, & Alvarado, 2006; Macklin et al., 1998; Tureck, Matson, Cervantes, & Konst, 2014). The increased likelihood of being exposed to
Trauma and Intellectual Disability

Environmental stressors, including issues such as poverty (Wigham & Emerson, 2015), contribute to people with ID being at a higher risk of having their resilience compromised and developing mental health difficulties. Children with an ID are significantly more at risk of experiencing physical and verbal violence (Jones et al., 2012), emotional abuse (Sullivan & Knutson, 2000), and neglect (Miller & Brown, 2014) than children without an ID. They experience significantly more disruptions in attachment and caregiver bonding as they are less likely to remain with their biological families after birth (Milligan & Stevens, 2006; Smith, 2009), and more likely to be placed on the at-risk register (Spencer et al., 2005), to enter the care system and to struggle to find long-term foster placements. This results in a reliance on carers and systems and contributes to high prevalence of carer perpetrated violence in institutional settings (Wigham & Emerson, 2015). People with an ID are more at risk of exposure to other types of trauma such as systematic abuse and neglect over long periods of time (Hatton & Emerson, 2004; Sobsey & Doe, 1991) compounded further by difficulties in recognising and reporting.

Trauma Prevalence

Brackenridge and Morrissey (2010) published a service evaluation within the National High Secure Learning Disability Service at Rampton Hospital exploring trauma experiences and post-trauma symptoms. They assessed for experiences of multiple types of abuse, including physical, psychological, sexual, institutional, discriminatory, financial and neglect, using information gathered from file information, self- and observer-report. This was repeated by Longfellow and Hicks (2020) who reviewed available file information and existing assessments that identified trauma presence or absence for each patient. Trauma was defined as any experience of physical or sexual violence, psychological or emotional trauma across lifetime and contexts. From this review 98% of patients were identified as having experienced some form of trauma. Eighty-six per cent experienced psychological or emotional trauma, 84% experienced physical violence, and 80% experienced sexual violence. Of the 98% who experienced some form of trauma, all experienced multiple (four or more separate types) forms of trauma suggesting complex chronic trauma experiences within the population.

In a recent meta-analysis, the weighted pooled prevalence of PTSD in people with ID who had accessed non-forensic services was found to be 10% based on 1,381 participants from seven included studies (Daveney et al., 2019). The estimated prevalence rates in the general population have ranged from five to ten per cent (Kessler, Chiu, Demler, & Walters, 2005; Shalev, Liberson, & Marmar, 2017). This would place the estimated prevalence for individuals with an ID towards the upper limit, indicating that there may be a heightened risk of developing PTSD for individuals with ID (Daveney et al., 2019). However, the quality of studies included in the review was low and there was large heterogeneity in the estimates, with a 95% confidence interval of 0.4 to 19.5 per cent (Daveney et al., 2019). Despite its limitations, this study highlights the importance of considering trauma and its sequelae when caring for individuals with ID.
Reason for Under-Representation

There are several factors that contribute to why trauma prevalence is less known in ID populations. Formal diagnosis of trauma-specific difficulties remains rare within the ID population despite evidence to suggest that individuals with ID are likely to be susceptible to the full range of trauma associated psychiatric disorders (Dosen, 2007). Psychiatric assessment of ID is inherently problematic. Impairments in receptive and expressive language make it difficult for individuals with ID to understand and respond to clinicians who typically rely on the person’s identification and description of his or her experiences and emotional states, especially as the level of intellectual functioning declines (Fletcher, Beasley, & Jacobson, 1999; Fletcher, Loschen, Stavrakaki, & First, 2007). Where symptoms and behaviours are observed, diagnostic overshadowing can contribute to the over-attribute of this to ID itself, contributing to a failure to adequately understand or address trauma needs. Moreover, psychiatric symptoms are often expressed differently in persons with ID compared to those without ID (Fletcher, Lyon, Fuchs, & Barnes, 2018). Additionally, there are difficulties for those with ID in recognising the behaviour of others as harmful or neglectful, further compounding any communication of events or impact.

It has been previously noted that trauma understanding, assessment, and interventions for the ID population are limited compared to the general population (Hastings, 2013; Wigham & Emerson, 2015; Wigham, Hatton, & Taylor, 2011) and this is compounded further in the forensic ID population. Failures to appropriately recognise and respond to trauma will likely impact on the length of residence within secure services as well as the inadequate and ineffective intervention for the individual. The Winterbourne View scandal which exposed physical and psychological abuse of people with learning disabilities at a private hospital in England in 2011, and further recent examples, highlights how individuals with ID are at a greater likelihood to be harmed within services that are supposed to be caring for them. This provided a catalyst for a range of subsequent policies, procedures, and guidance on working with ID from the Transforming Care Agenda, including the active closure and reduction in inpatient care settings and increased community placement. Commentary on the appropriateness of this agenda is beyond the scope of this chapter, although there has been much debate within the literature (Hollins, Lodge, & Lomax, 2019). However, to support individuals with ID who have offended or display behaviour that challenges to progress into less secure environments, reintegrate into the community, and live meaningful lives, the factors that contribute to behaviour that challenges and offending behaviour need to be understood to enable appropriate intervention and care. To neglect this is to further neglect an already marginalised and mistreated population (Taylor, McKinnon, Thorpe, & Gillmer 2017). Crucial to this aim is an increased knowledge of the impact of trauma and the consideration of trauma and its sequelae being priority targets for intervention (Lovell & Skellern, 2020; van der Put et al., 2014). Although a recent qualitative analysis of the views of learning disability nurses working in varying levels of secure psychiatric hospitals within the UK demonstrated anecdotal understanding of the significant impact of traumatic experiences on offending behaviour (Lovell & Skellern, 2020), there is still a lack of empirical enquiry.
Impact of Trauma on Behaviour in ID

The link between childhood maltreatment and offending is discussed in detail in Chapter 1. This highlighted that a minority of those exposed to childhood maltreatment will subsequently commit serious or violent offences, although the pathways are complex and not well understood. Despite the growing evidence base on the link between ID, trauma exposure, and over-representation in forensic settings, there is a paucity of research into the link between trauma and offending in those with ID. Research conducted using a sample of justice-involved juveniles in the US compared the history of maltreatment and abuse and the relationship between these experiences and subsequent offending behaviour for those with and without a formal diagnosis of ID (van der Put et al., 2014). As anticipated from the literature, juveniles with ID had a higher prevalence of adverse childhood experiences than those without an ID diagnosis. Furthermore, the relationship between being a victim of abuse and sexual offending was stronger for the juveniles with ID than those without, although for violent offending there was no significant difference between the ID and non-ID individuals. Although causality cannot be inferred because of the correlational nature of this research, this study supported the notion that trauma should be a core consideration when trying to understand the offending behaviour of individuals with ID.

Exploration of trauma and offending in ID populations can be more difficult than other populations. It has been found that individuals with ID are viewed as less accountable for their actions and that carers or staff in forensic services are reluctant to report behaviour to the police (Steans & Duff, 2020). Consequently, there can be a lack of formally recorded offending behaviour. It is therefore useful to consider behaviour that challenges and behaviours of distress when exploring the impact of trauma exposure (Rittmannsberger, Yanagida, Weber, & Lueger-Schuster, 2020). Those with ID who experience maltreatment and adverse events may present with behaviours that challenge at an elevated rate due to the nature of difficulties associated with ID, such as problems in emotion regulation, poorer problem-solving capacities, and difficulties in social communication (van der Put et al., 2014).

Significantly, the National Institute for Health and Care Excellence (NICE) does not formally consider the possibility for behaviour to represent manifestations of trauma responses in their published guidance (NICE, 2018a) for working with behaviour that challenges in individuals with ID (Morris, Webb, Parmar, Trundle, & McLean, 2020). In addition, NICE also neglects to consider individuals with developmental disorders as a population that are more at risk of exposure to adversity in their guidance for psychological trauma (NICE, 2018b), despite Morris, Shergill, and Beber (2019) highlighting that those with ID are disproportionately affected by adverse childhood events. Given that NICE have a key role in providing the guidelines for practice and quality standards for health and social care professionals in the National Health Service (NICE, 2021), these omissions can be considered to further exacerbate the vulnerability of individuals with ID. In doing so they fail to adequately capture the needs of individuals with ID or promote good practice to manage the impact of exposure to adversity within the services designed to care for them (Morris et al., 2020).
Trauma-Informed Care and ID

The concept of TIC was developed in the US in response to the increasing awareness that individuals entering human services have often experienced trauma, and that the services that they rely on for help could often inadvertently be re-traumatising (Fallot & Harris, 2008; Harris & Fallot, 2001; Keesler, 2016; Sweeney, Clement, Filson, & Kennedy, 2016). TIC is a philosophy to guide service culture, service delivery, and individual care with the principles of trustworthiness, empowerment, choice, safety, and collaboration to prevent re-traumatisation and support recovery (Fallot & Harris, 2008; Harris & Fallot, 2001). One core component of TIC is changing the narrative surrounding the individual’s behaviour and preventing pathologising language by asking “what happened to you?” as opposed to “what is wrong with you?” (Harris & Fallot, 2001). This supports in reframing the understanding of the behaviour as being a survival strategy that developed in response to the context and enables clinicians to focus on the individual’s underlying needs (Sweeney et al., 2016). TIC within hospital settings is discussed in more detail in Chapter 20.

Despite the increasing awareness that individuals with ID may be disproportionately exposed to adverse experiences compared to the general population and the fact that many individuals with ID are likely to have contact with support services (Keesler, 2014a), there has been little research into or implementation of TIC within ID services (Keesler, 2014a; 2016). As discussed above, diagnostic overshadowing within ID populations can preclude the exploration of what happened to individuals and the consideration that current presenting behaviour may be the manifestation of previous trauma (Mevissen & De Jongh, 2010). This can be harmful for individuals as the response to the behaviour may fail to account for the potential for interventions to be re-traumatising and evoke the emotional and physiological experiences associated with the original event (Sweeney et al., 2016). If individuals continue to feel unsafe and re-experience trauma, they may continue to rely on the survival responses they developed to cope, such as self-harm or aggression (Sweeney et al., 2016). Practices that have the potential to trigger past trauma or create new trauma may occur within forensic and mental health settings, including restraint, seclusion, enforced medication, being the victim of violence from peers, and coercive practices (Butler, Critelli, & Rinfrette, 2011; Faccini & Allely, 2021; Goad, 2021; Keesler & Isham, 2017; Sweeney et al., 2016) and ultimately not having freedom. Therefore, adopting a TIC approach would support in identification of past trauma, potential triggers for this, and inform decisions on how to intervene when individuals display potentially harmful behaviour (Faccini & Allely, 2021).

Keesler (2014a) has outlined how TIC can be implemented within ID services. One component crucial to effective integration of TIC principles is the training of staff to increase their understanding of trauma and how this can impact on individuals (Keesler, 2014a, 2014b; Sweeney et al., 2016). In addition, Keesler (2014a) proposed that sensitive and consistent approaches, having clearly identified boundaries, adequate staffing resources, incorporating individuals’ perspectives into their care planning, and focussing on individuals’ strengths are all central to trauma-informed ID services.
One of the five TIC principles that has historically been problematic in ID services is *choice*, as staff assumptions that the presence of ID compromises an individual’s ability to make an informed choice can exacerbate a sense of powerlessness (Keesler, 2014a; 2016). Essential to enabling choice and engendering a sense of empowerment will be a focus on supporting individuals’ understanding of their available options and increase their ability to make their own informed choices (Keesler, 2014a). In a survey conducted with staff who support individuals with ID, Keesler (2020a) found that the collaboration principle was the least strongly endorsed by participants. This suggests that more needs to be done to ensure the voices of individuals with ID are heard and that their own preferences are at the core of decisions relating to support (Keesler & Isham, 2017).

Research conducted with non-ID populations has indicated that implementing TIC has had a positive impact, including a reduction in the use of restraint and seclusion in a psychiatric setting for children and adolescents (Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2011). This would fit with the wider strategy for ID services in the UK to reduce the use of restrictive practices. Keesler and Isham (2017) presented the findings from the implementation of a new trauma-informed day service for individuals with ID who had recently exited institutions in the US. They found reductions in behaviours that challenge, aggression, and the use of medication, but an increase in least restrictive interventions that were used as an alternative. The use of TIC has also been found beneficial for staff working within support organisations, among whom there can also be a high level of trauma experiences (Keesler, 2018). A trauma-informed organisational culture in ID services has been found to be associated with increased psychological wellness and reduced burnout amongst staff (Keesler, 2020b). Therefore, TIC may support in staff well-being and retention, leading to greater consistency in the care of individuals with ID who use services which is seen as central in creating a safe environment (Keesler, 2014a).

Implementation of TIC within ID services is dependent on change in organisational culture and for all policies, procedures, and clinical practices to reflect the TIC principles by being sensitive to the trauma experiences that individuals may have been exposed to (Goad, 2021; Keesler, 2016). Organisations that support individuals with ID need to commit to adopting TIC (Keesler, 2020b; Rich, DiGregorio, & Strassel, 2020), which would enable access to interventions that consider trauma when attempting to understand current clinical presentation (Truesdale et al., 2019). Research suggests that staff view TIC as the most beneficial way to progress to ensure that services are effectively meeting the needs of adults with ID (Truesdale et al., 2019). The research base on TIC within the ID field is still in its infancy and studies conducted to date have failed to capture the views of those with ID or their carers. This should therefore be a focus of future research (Rich et al., 2020).

**Case Example: Bob**

We present an example of using a trauma-informed approach with an adult male diagnosed with ID. This highlights how the principles of TIC have informed his care since entering the service.
Bob was born in mainland Europe and was described as being an irritable baby who cried often. He is one of four children from his parents’ relationship, with an older sister, a younger sister, and a younger brother. There is reference in his history to another sibling who sadly died suddenly in infancy, although Bob has never spoken about this. His mother was reported to have consumed up to 70cl of spirit alcohol daily during her pregnancy with Bob and there was some suggestion that he suffered from foetal alcohol syndrome. Bob demonstrated some developmental delay in his speech and was seen by a speech and language therapist from the age of four. He was noted to experience delays in creative play and difficulties interacting with other children. Bob received a diagnosis of Learning Disability and Attention Deficit Hyperactivity Disorder (ADHD) at the age of seven. He accessed a special school within his birth country.

Bob’s family home was characterised by a lack of safety and he experienced multiple adverse childhood experiences. The level of care provided by his parents would have been considered to be neglectful, with Bob describing that he learned to look after himself and his younger siblings whilst his father was at work. Bob’s father alleged that his mother spent time as a sex worker and would bring men back to the house, and that his mother also attempted to arrange for one of his sisters to have sex with men for money when she was nine years old. It is unclear whether Bob witnessed any of this or has any awareness that this occurred. The relationship between his parents was reportedly difficult and Bob witnessed domestic violence within the family home. His mother abused substances and was physically violent towards Bob. When his parent’s relationship ended, Bob and his siblings initially stayed with their mother. However, Bob said that his mother wanted to place him, but not his siblings, in care because his behaviour was difficult to manage, and as a result, he felt unwanted and not part of the family.

Due to the difficulties in the relationship and the care provided by his mother, Bob went to live with his father when he was six years old. He remained in contact with his mother and said that he saw her approximately once or twice a week. Bob reported that his mother attempted to strangle him on one occasion and that, to protect himself, he threatened her with a knife. In response to this incident, Bob spent nine months in a psychiatric unit when he was six years old. Bob’s father was also reportedly physically violent towards him, using this as punishment for unwanted behaviour from Bob. Bob also reported being the victim of unprovoked physical violence perpetrated by his aunt. The relationship between him and his siblings was also characterised by violence, with Bob reporting that on one occasion his older sister threw him down the stairs. He stated that he would retaliate with violence, and that sometimes he would also use violence towards his younger brother when he had become irritated by him.

Bob’s behaviour at school was described as being extreme, including setting fires, which resulted in him twice being suspended from school and subsequently expelled for violent behaviour at the age of seven. After his expulsion, Bob was placed into a children’s home where his education continued. Bob moved to the UK with his father and siblings when he was approximately ten years old and attended a mainstream high school. He reports that he experienced bullying within this high school.
and that one particular individual would make comments about his father and push him. Bob attempted to resolve this by telling teachers but said that he was not believed and therefore decided that he needed to take matters into his own hands. He was subsequently expelled from school for physical violence towards this individual and received one-to-one teaching for a short period of time.

In the UK, Bob’s home life continued to be challenging. He came to the attention of his Local Authority when he was approximately 11 years old following a referral from the Child and Adolescent Mental Health Team. The next year, an investigation took place following statements made by Bob about touching his sisters in a sexually inappropriate manner. He was interviewed by the police and made disclosures about sexual behaviour, but his sisters wrote letters withdrawing the allegations. Shortly after this time, a child protection conference was held, and Bob and his siblings were made subject to a child protection plan. As there were continued concerns, Bob was placed into foster care when he was aged 13. Bob would often abscond so that he could visit his father and siblings as he wished to be reunited with them. His foster placement unfortunately broke down a year later due to reported aggressive behaviour by Bob. He was placed into a children’s home and subsequently a residential unit for adolescents with emotional and behavioural disorders. Bob reported being the victim of bullying by other children. It was within this placement that he committed his index offence of sexual assault on a member of staff, resulting in his transfer to a CAMHS Unit and receiving a Hospital Order. Within hospital placements, Bob has demonstrated physical violence towards staff members and peers. This has resulted in transfers to higher levels of security and to his current placement.

**Trauma-Informed Care and Bob**

In accordance with the principles of TIC, the focus of attempts to understand Bob’s past and current offending and behaviours of distress has been on gaining information on what has happened to him in his life and the meaning he has taken from this. Since entering the service he has been offered opportunities to report any traumatic experiences he may have had and receive validation and support with this.

Bob collaboratively developed a compassion-focused formulation with his current therapist to explore the impact of his past experiences on his current behaviour. The diagrammatic format of this is presented in Figure 6.1. This highlights how the adverse childhood experiences contributed to a lack of experienced safety for Bob, leading him to develop survival strategies in the form of physical violence and hiding any form of vulnerability that he believes could be viewed as a weakness by other people. The frequent placement breakdowns and disruptions to his attachment relationships further exacerbated his lack of sense of safety and opportunities to feel cared for and valued, instead reinforcing his belief that he is unwanted and rejected by other people.

All staff in the National High Secure Learning Disability Service have received a one-day trauma awareness training package to support in their understanding of the impact of trauma and potential manifestation in current clinical presentations. In addition, Bob’s therapist and Clinical Nurse Practitioner facilitated a reflective practice
Compassion formulation

**Historical influences**
Things that have happened to me
- Violence between parents in the family home
- My Auntie and Dad would hit me – this was punishment from my Dad if I did something bad. My Auntie did it for no reason
- Some violence from mother – one time she tried to strangle me
- Mum wanted me in care but not my siblings
- Victim of bullying at school

How I view myself:
- Not part of the family
- Not wanted or cared for

How I view other people:
- Uncaring
- Rejecting
- Abusive

**Key fears**
Things I am scared of
- People don’t care about me
- People will hurt me
- Dad will get angry if I tell him how I feel
- I will not be able to progress
- Being made to feel powerless and out of control

**Safety/defensive behaviours**
Things I do to protect myself

**Unintended consequences**
- Seclusion
- Impacts my progress
- Impacts my relationships

External
- Physical aggression
- Become verbally abusive or argumentative

Internal
- Ruminate about things that have annoyed or upset me

How I think about myself
- I am a horrible person
- Nobody likes me

Figure 6.1 Collaboratively developed compassion formulation
day for members of his clinical team and nursing staff to share his life history and formulation. This space facilitated an enhanced awareness of the factors that could be contributing to his behaviour of distress to support staff in considering sensitive and least restrictive ways to support him with these. One factor that Bob identified as being triggering for him was the tone of voice of the person speaking to him as this could remind him of conflict between his parents. The knowledge gained from Bob has been used to inform his Positive Behaviour Support (PBS) plan (see Figure 6.2)

![Collaboratively developed PBS plan for Bob. Pictures are from Widgit symbols © Widgit Software 2002–2021](image)

A PBS plan is a way to help staff to get to know you, understand your behaviour, and support you to achieve your goals.

Staff can look at your PBS plan to know the best ways to help you to stay well. It will also let them know how to support you in positive ways when you are experiencing distress.

**All About Me**

This is where you can tell people the most important things about you. This could be about some of your favourite things, things that you don't like, your personality, or anything else that you think people should know.

- I like to be busy and active.
- I like to have jokes when I am feeling good.
- I am very chatty.

**My Goals**

This is where you can share what you are currently hoping to achieve and what things you think you might need to change to help with this.

- My goal is to move to a medium secure unit and out of hospital. I am doing my treatment.
- I think I need to work on my anger - for example when I get told something not to react in an aggressive way and to sort it out in a positive way.
### When I am Well

<table>
<thead>
<tr>
<th>Things I will do and what people will see</th>
<th>Doing loads of activities</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Speaking to people</td>
</tr>
<tr>
<td></td>
<td>Interacting a lot</td>
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<tr>
<td></td>
<td>Smiling a lot</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Things that help me to feel well</th>
<th>Playing FIFA</th>
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<tbody>
<tr>
<td></td>
<td>Football</td>
</tr>
<tr>
<td></td>
<td>Board games (e.g. rummikub)</td>
</tr>
<tr>
<td></td>
<td>Gym</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>What other people can do to support me to feel well</th>
<th>Encourage me to get off the ward as much as possible</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Tell me when I am doing well</td>
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</table>

### When I am Becoming Distressed

<table>
<thead>
<tr>
<th>Things that can make me distressed</th>
<th>Falling out with my family</th>
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<tbody>
<tr>
<td></td>
<td>Too much noise around (banging)</td>
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<tr>
<td></td>
<td>If people repeat themselves to me</td>
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</tbody>
</table>

*Figure 6.2 Continued*
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**Figure 6.2** Continued

<table>
<thead>
<tr>
<th>Things I will do and what people will see</th>
<th>Start wandering around a lot</th>
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<tbody>
<tr>
<td></td>
<td>I disengage</td>
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<tr>
<td></td>
<td>I sit quietly</td>
</tr>
<tr>
<td></td>
<td>I stop doing my activities</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>What other people can do to support me to feel better</th>
<th>Have a chat with me – see if they can make me in a better mood</th>
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<tbody>
<tr>
<td></td>
<td>Offer me things to do that might help – for example fresh air or music</td>
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<tr>
<th>When I am Very Distressed</th>
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<table>
<thead>
<tr>
<th>Things that can make me very distressed</th>
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</thead>
<tbody>
<tr>
<td>When people tell me what to do</td>
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<td></td>
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<tr>
<td>If people crowd around me – it makes me feel angry</td>
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<tr>
<td>Having bad phone calls with family or friends</td>
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<table>
<thead>
<tr>
<th>Things I will do and what people will see</th>
</tr>
</thead>
<tbody>
<tr>
<td>I start fidgeting</td>
</tr>
<tr>
<td>Play with my hair (twist it)</td>
</tr>
<tr>
<td>I become rude</td>
</tr>
<tr>
<td>I shout</td>
</tr>
<tr>
<td>I won’t listen</td>
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which informs staff of the most effective ways to support him at different phases of an emotional response. The implementation of plans that are informed by his trauma and his own preferences had a positive impact on his well-being and progress, with a significant reduction in the frequency and intensity of aggression displayed by Bob. This may represent an increased sense of safety and empowerment that has enabled him to relinquish his survival strategies.
Moving forward, Bob is working on his goal to progress to less secure conditions and eventually return to the community. He is being supported to work towards this goal by his clinical team who are supporting him in accordance with his needs and incorporating his views and preferences within his care plans. Bob is currently engaged in adapted Dialectical Behaviour Therapy (I Can Feel Good; Ashworth, Brotherton, Ingamells, & Morrissey, 2018) to increase his capacity to cope with his emotional experiences. He will soon be commencing Compassion Focussed Therapy (CFT; Gilbert, 2005) to explore his offending in a trauma-informed way.

**Conclusion**

Progress has been made in the awareness of the increased victimisation and marginalisation that can be experienced by individuals with ID, particularly the elevated trauma prevalence of those who have contact with forensic services. This still needs to fully translate into policy and systemic change to ensure that adverse experiences are identified and the impact for the individual can be understood. Central to this aim is empowering individuals with ID to have their voice and be heard by asking “what has happened to you?” rather than “what is wrong with you?”. Although we are beginning to recognise and implement TIC within forensic ID services, there is a paucity of research evaluating the effectiveness of this. Available research indicates that successful TIC could reduce the need for restrictive practice and facilitate reintegration and maintenance in the community. This could support a better quality of life for those who have experienced contact with forensic services to be re-traumatising. For others, forensic settings represent stability, care, and safety that they were never

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**My Skill Toolbox**

All the skills I have learned to help me keep well

- Listen to music
- Explain to people how I am feeling
- Use skills I have learned in therapy (such as cold water and paired muscle relaxation)
- Stop and think before acting on my urges

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**Figure 6.2** Continued
able to experience in the community. What cannot go unnoticed is the ongoing need to reduce the victimisation, marginalisation, and stigma of this population way before they encounter forensic services.

**Further Reading**


Goad, E. (2021). Working alongside people with intellectual disabilities who have had difficult experiences: Reflections on trauma-informed care within a service context. *Journal of Intellectual Disabilities*. For readers interested in the use of TIC with ID populations and systems.


**References**


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