TREATING THE SEQUELAE OF ABUSE IN ADULTS WITH LEARNING DISABILITIES

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Introduction

Over the last decade huge advances have been made both in the recognition that abuse of vulnerable adults is a common occurrence (Turk and Brown, 1993), and that it can have a significant impact on their psychological health thereafter (Cooke and Sinason, 1998). The role of abuse in the aetiology of mental illness, challenging behaviour and other manifestations of psychological distress has been well documented (McCarthy, 2001; Beale and Warden, 1995).

The dictum that a degree of sophistication of intellect and communication is required in order to participate in psychotherapy has been well and truly disproved (Sinason, 1992), and a variety of psychotherapeutic approaches, e.g. cognitive (Lindsay, 1999), psychoanalytic (Hollins et al, 1994) and group therapies (Barber et al, 2000) have been used in this population.

A difficulty for practitioners working in services for people with a learning disability is that those approaches, though successful, can be very time consuming. This paper describes the development of a time-limited psychotherapeutic intervention, which has been adapted to make it suitable for use with people with varying degrees of learning disability.

Solution Focused Therapy

Solution-focused therapy is a technique that has been used successfully in abuse survivors without a learning disability (Dolan 1991). The principle underlying it is that someone who has been abused will use dissociation as a psychological mechanism to cope with the overwhelming trauma and distress. This enables them to continue functioning cognitively and emotionally, albeit at a reduced level and with maladaptive responses. In order for them to regain psychological health, they need to acknowledge the part of their psyche which has been “split off” and integrate it back into the whole. This acknowledgement can be very difficult and
painful, and involve reliving experiences that have been repressed. It is vital therefore that it is done in a way which will not be overwhelmingly traumatic. The basic principles of solution-focused therapy are those of “safe remembering”, restructuring of negative concepts, and empowering the survivor to regain their quality of life. The techniques involved are particularly suitable for people with learning disabilities, as they are based on clear, structured and practical tasks, as well as 1:1 support.

**Assessment**

As with all therapies, an accurate diagnosis and assessment of suitability for the particular form of treatment is required. The level of learning disability should not be a bar to participation in therapy. Although a degree of verbal fluency and comprehension is required, this can often appear deceptively limited in someone with psychological damage - “emotional stupidity” (Sinason, 1992) - and can change dramatically during treatment. If the person is suffering from a severe psychiatric illness, such as severe depression or psychogenic psychosis, treatment with medication may be necessary prior to the commencement of therapy, and may need to continue during it.

Effective treatment of survivors is dependent on the availability of 24-hour emotional support outside the therapeutic sessions. The therapist needs to ensure that this will be in place, either from carers or from other professionals such as community nurses or outreach workers. While confidentiality within the sessions is respected, it is important that the supporting person knows what possible reactions to expect during the course of the therapy, and how to respond to them.

**Planning Therapy**

The technique described is based on six hourly sessions at weekly or fortnightly intervals, with another follow-up session approximately six weeks after the end of treatment. As with other forms of psychotherapy, it is desirable for the time and place of the sessions to be constant and protected, and the environment as conducive as possible. It may be helpful to have other aids to communication available, e.g. anatomically correct dolls, pens and paper for drawing.

The first session should start with an explanation of the purpose and nature of the therapy being undertaken. It should be explicitly stated that the purpose is to discuss the abuse and its impact on the person, and to work together to enable them to start to recover and move forward. It may be helpful to identify the particular problems they are experiencing and draw up a list of goals to work towards, e.g. “I want to be confident when I meet new people”, or “I want to stop losing my temper”. The progress being made can then be regularly reviewed by reference to these.

A variety of techniques can be used to facilitate “safe remembering”. These must include giving the person control of the therapeutic relationship. They can be invited to talk about the abuse, but only as much as they want to tell. The therapist should use phrases like “Tell me everything you feel I need to know”. The person receiving therapy must be able to terminate the interview at any point they
wish to and how they can do this should be discussed before commencing. This may include the use of gestures as well as, or instead of, words. If they become distressed they should have some comfort to focus on, such as a familiar and loved possession which can be identified as a symbol for the present time.

An important part of the therapy involves taking a cognitive approach to identify and reframe the negative concept caused by the abuse. Feelings of guilt and self-blame are common, as are negative emotions regarding oneself - “I must be bad/dirty to have caused someone to do this to me”. Identifying and challenging these concepts, and highlighting the reasons why the abuse occurred – imbalance of power, problems of communication, lack of knowledge etc. in my experience can be enormously beneficial. Indeed, it can be the first vital step towards recovery.

The setting of the therapeutic tasks to be done outside the sessions can provide a reassuring link between the sessions and what happens outside them. It is also a way in which the supporting professional or carer can be involved in assisting the person with them. Examples of these are:

a) Making a list of positive things in life. This can be used when the person is feeling sad, angry or distressed, either to remind them of good things in their life, or as a prompt of enjoyable activities to choose to do.

b) Bodywork, e.g. massage, to help release “bad feelings” and develop an awareness of touch as a pleasurable, but non-sexual medium.

c) Artistic self-expression - finding a medium such as art or music through which to express emotions and experiences.

d) Identifying a “healing symbol” such as a plant, to be nurtured and act as a symbol of the person’s emotional and psychological growth.

e) Self-nurturing rituals - being given permission to “spoil oneself” with pleasurable activities, e.g. beauty treatments.

f) Engaging in a “present-focused” activity such as learning a new skill.

g) Keeping an “anger diary” to record episodes of anger for later discussion with the therapist. In someone without literacy skills, a tape recorder may be a useful alternative.

These activities can be introduced at various stages of the therapy, as and when seems appropriate.

An important part of the healing process is “reclaiming the body”. After an abusive experience, the survivor often perceives their body as being dirty or ugly and having betrayed them in some way. It may be helpful to elucidate this by asking them to draw an outline of their body and colour different parts “good” or “bad” and then draw “heart of healing” in another colour on the bad areas. Other activities such as massage and dance or other forms of exercise can also help to “reclaim the body” and feel pride in it again.

Towards the end of the therapeutic process the issue of safety must be introduced. It should be ascertained whether the person feels safe now, or if not, in what way they could be safer. This may include rehearsing some responses to inappropriate advances by other people or discussion on how to avoid potentially abusive situation.

In order to enable healing to continue between and after the end of the therapeutic sessions, some techniques can be taught to help overcome painful memories and prevent dissociation from
recurring. Imagining the therapist’s voice, using cues for comfort and security using the list of positive things, and practising pattern interruption of painful thoughts and their replacement can all be helpful.

**Supervision**

As with all types of psychotherapy supervision is desirable. However, when doing psychotherapy with people with learning disabilities it is often difficult to find a supervisor with the necessary experience. As this technique was being newly developed, it was found helpful to video record the sessions and play them back afterwards for analysis to aid supervision by a colleague. Those involved did not find the camera intrusive and appeared to completely ignore it.

**Illustrative Case Histories**

**Case History 1**

A was a 30-year old lady with a moderate degree of learning disability. She presented with a four year long history of increasing withdrawal, loss of skills, low mood with disturbance of sleep and appetite, almost complete loss of speech and “outbursts of temper”. She was known to have been a victim of sexual abuse in late adolescence and early adulthood. A diagnosis of depression was made and her mental state showed an improvement with anti-depressants, art therapy and intensive nursing and occupational therapy input, but the improvement “plateaued” and she had not regained her formal level of functioning.

It was therefore decided to use solution-focused therapy after discussion by the multidisciplinary team. During the course of therapy she appeared very keen to engage and communicate and was able to talk about the abuse. Her speech improved dramatically, becoming much more audible, with the use of complex sentences. She was able to participate in therapeutic tasks with the aid of her key worker and became livelier and more communicative outside the sessions. She also appeared to be much happier. This improvement was sustained following cessation of the therapy.

**Case History 2**

B was a 20-year-old man with a mild degree of learning disability. He presented with verbal and physical aggression, frequent outbursts of temper, anti-social behaviour, sleep disturbance and a belief that he had “a remote control device inserted in his head through which he could be controlled at night”. He was known to have a history of sexual abuse in childhood and had had a disrupted and deprived childhood and adolescence. A diagnosis of “reaction to stress” was made and he agreed to participate in solution-focused therapy. He was supported during the course of therapy by very caring foster parents. During the sessions he was very co-operative and communicative, and seemed particularly to enjoy using concrete images and practical tasks. There was a significant improvement in his self-image and self-esteem and his nightmares and delusional beliefs disappeared. By the time of his follow-up sessions he had acquired a girlfriend and
started a course at Further Education College.

**Discussion**

It is always difficult to evaluate psychotherapeutic interventions in a systematic way, and the technique described above would need to be used on a significantly sized cohort before it could be properly assessed for effectiveness. However, the cases described would indicate that it may be an effective therapy for people with varying degrees of learning disability who have experienced the trauma of abuse. The fact that it is focused on practical tasks, and that the therapist and survivor work together on the solutions may help to overcome some of the issues of transference and counter transference which can make working with abuse difficult and painful for both (O’Connor 2001). However, the positive elements of the therapeutic interaction such as protected, guaranteed time in a 1:1 relationship that is supportive and caring are preserved.

The fact that the therapy combines a cognitive approach with the use of techniques in other sensory modalities, e.g. touch, to aid healing may appeal to those who subscribe to a holistic approach. People with learning disabilities may have been deprived of the experience of expressive touch (Gale and Hegarty 2000) and may benefit significantly from its use as a therapeutic medium.

Because it is relatively short in duration, it is more accessible to practitioners working in the field who do not have time to practise longer psychotherapeutic interventions, and therefore may enable psychotherapy to be available to a wider clientele than it is at present (Hollins and Sinason 2000). It is a technique that could be used by both psychologists and psychiatrists, and provide a satisfying role for the latter as an adjunct to treating the mental health problems in more traditional ways (Cooke 1997).

**Summary**

There is growing acknowledgement that psychotherapy may be beneficial for people with learning disabilities, particularly if they have suffered a trauma such as abuse. The adaptation of solution-focused therapy for use in this population is described, and illustrated by two case histories. Experience so far suggests that this may be a useful form of therapy for this population, and further evaluation is merited.

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**References**


