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Mental Health Counselors Working with Individuals with Developmental Disabilities: A Phenomenological Investigation

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy in Rehabilitation Counseling

by

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Abstract

Individuals with intellectual and developmental disabilities are often not included in traditional mental health treatment services due to beliefs that these individuals cannot benefit from mental health counseling and that mental health clinicians are not capable of treating this population. Some research exists that discusses techniques and interventions recommended to serve individuals with intellectual and developmental disabilities in mental health; however, there is little information on the specific counselors who are willing and able to support this population. A qualitative methodology was utilized to examine the phenomenon of mental health practitioners with experience serving individuals with intellectual and developmental disabilities. Five clinicians participated in the study. Five rich participant narratives were captured as a result of those interviews. From those, 52 themes were extrapolated to create a composite depiction of counselor experiences, and four exemplary components of these experiences were deduced: adapting to differences, systemic barriers to services, supporting the support system, and universal human value.

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Dedication

This dissertation is dedicated to all the individuals who have been diagnosed with an intellectual or developmental disability who have struggled to access the mental health support necessary to live the highest quality life possible. Your lives are valuable and deserving, and my hope is that this research serves as a tool to increase opportunities for you to live your best possible lives.

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Chapter 1: The Problem

Introduction

For many individuals, the experience of having a disability can cause additional life stress, result in daily life limitations, and exacerbate mental health conditions and concerns (Kanellakis, 2010). Developmental disabilities (DD) occur early in life and may provide longer-term and possibly more significant functional limitations than many non-developmental disabilities (Falvo, 2009). It is not surprising that individuals with developmental disabilities experience a dual diagnosis of a mental health disorders at rates elevated between 30% and 70% compared to individuals without a diagnosed developmental disability (Di Marco & Iacono, 2007). Unfortunately, appropriate community-based mental health services are often not available for individuals with intellectual and developmental disabilities.

Background

Despite vocational rehabilitation programs placing a strong emphasis on serving individuals with the most serve disabilities, individuals with developmental disabilities who access federally funded rehabilitation programs are far less likely to engage in competitive employment than any other groups served (Metzel, Boeltzig, Sulewski, Butterworth, & Gilmore, 2007). In fact, societal expectations are often that individuals with intellectual and developmental disabilities are frequently void of the desire and/or ability to engage in employment activities (Mank, 2008). As a result of such bias, many individuals with developmental disabilities do not receive the holistic-focused approach to rehabilitation services that are considered to be best-practice in the field (Roessler & Rubin, 2006). Therefore,

rehabilitation counselors are less likely to identify mental health needs and make appropriate referrals to mental health practitioners if an individual has a developmental disability.

Mental health counselors often face challenges meeting the psychological needs of individuals diagnosed with intellectual and developmental disabilities, as well. As a result of these challenges, appropriate psychotherapy services are frequently not available to individuals with intellectual and developmental disabilities. Many mental health practitioners take a cognitive-based approach to providing counseling services (Corey, 2005) and may be more likely to believe that disabilities impacting cognitive ability will likely prevent an individual from benefiting from cognitive-based therapies. This lack of appropriate mental health services for individuals with intellectual and developmental disabilities is particularly problematic given the high rates of dual diagnosis of developmental disabilities and mental health conditions (Davis, Barnhill, & Saeed, 2008).

Mental health services are just one area in which individuals with DD often do not receive adequate care. Limited and uncertain funding, increasing demands for services, and increasing restrictions from private insurers, government entities, and communities are all factors that negatively impact health care services for individuals with intellectual and developmental disabilities (Lewis, 2009). Mental health services for individuals with developmental disabilities are often even more deficient than general healthcare services due to cognitive and communicative limitations of clients with intellectual and developmental disabilities and the frequent "need for more intensive, specialized, integrated, and long-term" mental health treatment for this population (Davis et al., 2008, p. 206). Additionally, mental health

practitioners are provided with licensing restrictions that prohibit practitioners from practicing outside of their scope of practice and are encouraged to refer clients to more qualified practitioners when the practitioner is not able or qualified to provide services to a particular client (Corey, 2005). Unfortunately, more qualified mental health providers are often not available for referral.

Exacerbating the existing dilemma of mental health service systems inadequately prepared to provide counseling and psychotherapy services to individuals with disabilities is the on-going shift in daily living services for individuals with intellectual and developmental disabilities from isolated, residential settings to community-based support settings (Hamelin, Frijters, Griffiths, Condillac, & Owen, 2011). As advocacy groups lobby for more community-based services and budget short-falls necessitate individuals with intellectual and developmental disabilities to be supported in more economical, community-based settings, the need for community-based mental health services to be able to support the developmental disabilities population increases.

Despite the challenges individuals with intellectual and developmental disabilities face accessing quality mental health services, there are mental health practitioners who actively provide counseling services to this population and do it well. Unfortunately, research has been more focused on specific interventions and less focused on the characteristics and qualities of these few practitioners who choose and are able to provide mental health services to individuals with intellectual and developmental disabilities. Understanding the experiences of these practitioners is important to determining the appropriate actions needed to improve the overall

mental health service options for individuals with intellectual and developmental disabilities. The existing research base does not include research that explores or defines the specific roles and experiences of the community-based mental health practitioner working with individuals with intellectual and developmental disabilities. This study will attempt to gain a better understanding of these unique practitioners and the experiences they have.

Problem Exemplar

The importance of high quality mental health services for individuals with intellectual and developmental disabilities is well illustrated in Dyann Sutton's story about her son, Ryan. Ryan was a young man diagnosed with cerebral palsy who had significant physical and communicative limitations as the result of his disability. Ryan used a manual wheelchair for mobility, which he was unable to operate himself, he was only able to speak a few words verbally, and he relied on assistive technology to assist with communication and control his environment. Ryan grew up in a very loving and supportive family. When he graduated high school and decided he wanted to move into his own apartment, his parents supported him fully despite all of his limitations (personal communication with Dyann Sutton, September 12, 2011).

The process of transitioning into his own home was difficult at times, often leaving Ryan feeling lonely, frustrated, and isolated. He relied on direct support staff to assist with all aspects of his daily living. Ryan was often very frustrated with his support staff and wanted to have more control over his life. At the suggestion of a friend Ryan attempted to establish a relationship with a mental health professional to assist him in dealing with some of the new emotions and experiences he was facing. Ryan's first experience with a mental health counselor

was less than effective. His counselor was condescending and treated Ryan as if he did not comprehend his surroundings. The counselor spoke to Ryan as if he was a child and, sometimes, as if he were deaf. After several frustrating months of unsuccessful counseling services, Ryan decided to stop seeing his counselor, and his depressive symptoms continued to develop and worsen. (Personal communication with Dyann Sutton, September 12, 2011).

As his life progressed, so did Ryan's stress. With the support of his parents, he eventually purchased his own home, but his sadness and loneliness continued to interfere with his daily life. After living in his new home for a short period of time, Ryan was sexually assaulted by a support provider. Due to his communication limitations, it took Ryan several weeks to be able to inform someone close to him about what had happened. Following this event, Ryan's depression became extreme. He often spent entire days crying uncontrollably. His support team strongly encouraged Ryan to give counseling another try. After consistent encouragement, Ryan re-entered counseling services with a new counseling provider. Ryan's second attempt at counseling was a much more positive and productive experience than his first. (Personal communication with Dyann Sutton, September 12, 2011).

Ryan's new counselor worked with Ryan to establish effective forms of expression for their therapy sessions. She assisted Ryan in processing the overwhelming emotions he was experiencing and assisted him in learning and developing skills to communicate and process his own emotions within the bounds of his physical and verbal limitations. Ryan's depression improved greatly, and after almost a year of treatment, he successfully terminated his therapy relationship. Several years later, Ryan experienced complications from a gall bladder surgery

and became terminally ill. His doctors presented Ryan with the option of extending his life via life support or keeping him comfortable until the end. Ryan relied on the skills he learned in therapy to make the most difficult decision of his life, the decision to allow his life to expire. He spent his remaining time with his family and loved ones. Ryan died at a young age, but he lived a full and productive life despite the limitations from his developmental disability. Ryan's support system credits his successful mental health counseling experience as a contributing factor to his ability to live his life as a strong, empowered person who made an impact on the people he met every day. (Personal communication with Dyann Sutton, September 12, 2011).

Problem Statement

While research focused on developmental disabilities and mental health conditions has been conducted to examine the effectiveness of certain counseling interventions and strategies for individuals with disabilities, (Clute, 2010; Di Marco & Iacono, 2007; Lawrence, 2004; Raffensperger, 2009; Tarver-Behring & Spagna, 2004; Taylor, 2010) little published research has been done, and therefore, very little is known about the experiences of mental health counselors who provide counseling services to individuals with intellectual and developmental disabilities in community settings. Understanding the perspectives of these practitioners can provide a better awareness of what is necessary to effectively support individuals with intellectual and developmental disabilities in need of mental health services. Additionally, understanding the factors that influence mental health practitioners' willingness and ability to provide services to individuals with intellectual and developmental disabilities will provide service agencies with valuable information to influence policy development and continuing education requirements to better prepare and promote the developmental of mental health

practitioners capable of serving individuals with intellectual and developmental disabilities. Likewise, educators in the mental health and rehabilitation fields can utilize this same clarification of experience to better structure academic curriculum to prepare practitioners-in-training to be better able to serve individuals with intellectual and developmental disabilities in areas related to mental health.

Purpose and Scope of the Study

This study seeks to construct a thorough understanding of the experiences of mental health counselors who work with individuals with intellectual and developmental disabilities by capturing the unique stories of a sample of such counselors and identifying collective themes within those stories. This research is of a qualitative nature and, therefore, seeks to understand the practitioners' experiences, not to weigh, measure, count, or compare variables related to the counselor or client.

The purpose and scope of this study necessitate a qualitative research perspective because the focus of this research is on exploring, explaining, and describing the phenomena of mental health counselors working with individuals with developmental disabilities (Creswell, 1994). Because this investigation is a qualitative study, information obtained cannot be generalized to other practitioners and other settings; however, this increased understanding of individuals' experiences can provide insight into ideal characteristics important for successful mental health services within this population.

A heuristic phenomenological investigation will be utilized to capture the unique experiences and the meaning of those experiences of the group of mental health practitioners

who comprise part of a small portion of all mental health practitioners by actively providing counseling and psychotherapy services to individuals with intellectual and developmental disabilities. This heuristic phenomenological inquiry will utilize individual interviews with mental health counselors with experience working with clients with intellectual and developmental disabilities to obtain a more thorough understanding of the unique experiences of this group. This approach will not only seek to capture the experiences of the target population but to also develop an understanding of the meaning of those experiences. For a population of practitioners that many are hesitant to join, this is valuable information for both the fields of Rehabilitation Counseling and Counselor Education.

Assumptions Underlying the Study

Assumptions driving this investigation include the idea that mental health counselors who provide services to individuals with intellectual and developmental disabilities have a unique experience that is different from counselors who only work with individuals without intellectual and developmental disabilities and that better understanding these unique experiences can be beneficial for service providers both in the Counselor Education and Rehabilitation Counseling fields. A heuristic research approach will be employed and implies that the construction of meaning for the individual practitioners can provide larger implication and guidance on a more universal level (Moustakas, 1994). Additionally, this study assumes that participant input is accurate and honest. The research relies on participant self-reports to determine the participant's level of experience and success in working with individuals with developmental disabilities and to accurately share individual experiences.

Research Question

This study seeks to explore, construct, and capture the experiences of mental health practitioners who provide counseling services to individuals with intellectual and developmental disabilities. Specifically, this study will attempt to answer the following questions:

1. What are factors that influence the experiences of mental health counselors who work with individuals with intellectual and developmental disabilities?
2. What are the rewards and consequences of providing mental health services to individuals with intellectual and developmental disabilities?
3. What barriers have to be overcome to provide quality mental health services to individuals with intellectual and developmental disabilities?
4. What resources should be accessed and utilized in the experiences of mental health counselors working with clients with intellectual and developmental disabilities?

Significance of the Study

The Field of Rehabilitation Counseling. The field of Rehabilitation Counseling is particularly interested in effective counseling techniques and approaches to employ working with individuals with disabilities. This is evident by the inclusion of 11 specific required topics addressing counseling approaches and principles included in the General Curriculum Requirements, Knowledge Domains, and Educational Outcomes section of the Accreditation Manual for Masters Level Rehabilitation Counselor Education Program (Council on Rehabilitation Education, 2011). Additionally, the field of Rehabilitation Counseling attempts to develop rehabilitation professionals who understand that positive outcomes cannot be achieved for an individual in the rehabilitation service system if the appropriate supports are not provided

for all aspects of the individual's life (Marini, Glover-Graf, & Millington, 2011). Effective mental health supports can be influential in assisting an individual with a disability to improve work readiness and maintain appropriate social interactions to increase the likelihood of employment.

Another reason effective mental health counseling for individuals with intellectual and developmental disabilities is of significant interest to the field of Rehabilitation Counseling is because rehabilitation counselors have an obligation to prioritize services for individuals with the most severe disabilities (Roessler & Rubin, 2006). These are often the rehabilitation clients who have diagnoses of intellectual and developmental disabilities. Having access to appropriate mental health services for these individuals potentially will increase their ability to process through the vocational rehabilitation services system and exit with a successful closure. Understanding common themes among effective mental health counselors for individuals with intellectual and developmental disabilities can give rehabilitation counselors better insight into strategies and characteristics important in facilitating a good working alliance with individuals with intellectual and developmental disabilities, and such an understanding can also assist rehabilitation professional to view mental health counseling as a potentially beneficial resource for individuals with intellectual and developmental disabilities.

The Field of Mental Health Counseling. Individuals with intellectual and developmental disabilities are transitioning from isolated, residential placements to community-based placements at high rates (Lankin et al., 2007). Additionally, individuals with intellectual and developmental disabilities have an increased likelihood of experiencing a mental health

diagnosis in addition to an intellectual and developmental disability diagnosis (Di Marco & Iacono, 2007). As more individuals with mental health and intellectual and developmental disabilities dual diagnoses live in the community and rely on community-based health-care services, more community-based mental health providers will be required to support and serve these individuals. Learning strategies to effectively provide mental health counseling services to this difficult to serve population should be a priority for most mental health practitioners.

Additionally, for years the accrediting agencies for both rehabilitation counseling and mental health counseling, Council on Rehabilitation Education (CORE) and Council for the Accreditation of Counseling and Related Educational Programs (CACREP), have considered a merger of the fields (Shaw & Kuehn, 2009). While the two entities have been in a process of transitioning, the value of the partnership between the two fields is unquestioned, and a merge will be fully in effective in 2016. CORE curriculum requires that rehabilitation counselors learn appropriate counseling techniques from the mental health counseling field, and the American Counseling Association (ACA), the major counseling professional organization, has a division specifically devoted to rehabilitation counseling, the American Rehabilitation Counseling Association (ARCA) (Neukrug, 2012). Cross knowledge between these two closely-related disciplines is vital to both sides.

The Population of Americans with Developmental Disabilities. As more and more individuals with intellectual and developmental disabilities receive necessary daily supports in community settings as opposed to isolated, residential settings, mental health providers are far more likely to encounter individuals with intellectual and developmental disabilities as clients

(Lankin, Prouty, & Coucouvanis, 2007). Additionally, individuals with intellectual and developmental disabilities experience mental health problems at high rates as the result of life circumstances, limitations resulting from disability, lack of adequate supports, disempowerment, and victimization (Kanellakis, 2010). These factors make understanding the perspective of practitioners who are able to serve this population vitally important. This understanding can also empower potential mental health clients with intellectual and developmental disabilities with information that can allow them to scrutinize potential mental health service providers and make the best, most appropriate choice regarding their mental health services.

Study Delimitations

A qualitative study will provide insight and understanding of the specific participants involved in the study, but findings from this type of investigation cannot be statistically generalized to others (Jones, Torres, & Arminio, 2006). Additionally, this research will be limited to willing participants in Arkansas. Geographical and financial limitations restrict the investigation to participants within the state. Factors that influence an individual's willingness to participate in such research may be vital to understanding the experiences of mental health counselors working with individuals with intellectual and developmental disabilities; however, the research will not be able to capture the perspectives of practitioners who are unwilling or unable to participate.

Definitions and Operational Terms

Developmental disability (DD). Because this research will be conducted in the state of Arkansas, the Arkansas Department of Developmental Disabilities Services definition of developmental disabilities (DD) will be utilized. In Arkansas, developmental disability is

defined as a diagnosis of at least one of the following: intellectual disability (mental retardation), autism, epilepsy, cerebral palsy or other conditions that cause a person to function as if they have intellectual disabilities (State of Arkansas, 2011).

Mental health counselor. Mental health counselor will be defined as any licensed practitioner providing mental health counseling or psychotherapy services, including but not limited to, licensed associate counselors, licensed professional counselors, licensed master social workers, and licensed clinical social workers.

Mental health counseling. While there can be socially-perceived differences in the terms psychotherapy and counseling, essentially each is a description of a similar process of personal exploration in pursuit of emotional well-being, with most distinguishing factors being related to perception and context (Kwiatkowski, 1998). Therefore, counseling and psychotherapy will be used interchangeably throughout this report.

Summary

There is a need for rehabilitation counselors and mental health counselors to understand the experiences of mental health counselors who have provided and continue to provide counseling services to individuals with intellectual and developmental disabilities. This phenomenological study will examine the unique experiences of mental health counselors in Arkansas who have provided mental health counseling services to individuals with intellectual and developmental disabilities. Data will be collected in a phenomenological investigation through a demographic questionnaire and an individual, semi-structured interview, with sufficient safeguards to ensure study trustworthiness, credibility, and dependability. Data will be

analyzed to determine themes and common characteristics in the experiences of mental health counselors who provide counseling services to individuals with intellectual and developmental disabilities.

Chapter 2: Review of the Literature

While little published research has been conducted to specifically address the perspectives and characteristics of mental health counselors working with individuals with intellectual and developmental disabilities, a substantial body of research exists on related topics. A background is presented here, followed by the theoretical basis for the proposed study.

This literature review begins with an exploration of research focused on the expectations of mental health counselors. This information is important in understanding the lack of focus on mental health issues pertaining to intellectual and developmental disabilities. Currently, the field lacks expectations that counselors be proficient in this area and discourages practitioners from practicing beyond their scope of practice. With a lack of expectations related to serving individuals with intellectual and developmental disabilities illustrated, this literature review then focuses on reviewing specific treatment models and therapeutic interventions for individuals with intellectual and developmental disabilities that have been researched, with an emphasis on restrictive treatment environments. These studies provide insight into what strategies and techniques are being utilized by the small number of practitioners who do serve this population and emphasizes the over-reliance on restrictive, out-of-community placements for many individuals with intellectual and developmental disabilities who necessitate mental health services.

The literature review continues to explore the theoretical basis for this investigation by reviewing Hershenson's Systemic, Ecological Model for Rehabilitation Counseling and highlighting the need for mental health practitioners to be included in Hershenson's provider

system. Research is reviewed to address the changing dynamics of support services for individuals with intellectual and developmental disabilities and the increasing need for effective, community-based mental health counseling services for individuals with intellectual and developmental disabilities. Lastly, literature is provided on effective, ethical research protocols for the fields of rehabilitation and mental health counseling that will guide and direct this investigation.

Background

Counselor Expectations. Mental health counselors are expected to be knowledgeable of and able to provide services to diverse populations (Baruth & Manning, 2007). Baruth and Manning indicate that counselors must take an active role in collecting information necessary to provide services to an ever-increasingly diverse population (2007). At the same time, the American Counseling Association's (ACA) Code of Ethics clearly dictates that a counselor should never operate outside of his or her boundary of competence (2014). Section C of the ACA Code of Ethics specifically addressing counseling professional responsibility and provides the following guidance to practicing counselors:

> C.2. Professional Competence:
>
> C.2.a. Boundaries of Competence: Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Counselors gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse client population.

C.2.b. New Specialty Areas of Practice: Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and to protect others from possible harm.

C.2.c. Qualified for Employment: Counselors accept employment only for positions for which they are qualified by education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Counselors hire for professional counseling positions only individuals who are qualified and competent for those positions.

C.2.d. Monitor Effectiveness: Counselors continually monitor their effectiveness as professionals and take steps to improve when necessary. Counselors in private practice take reasonable steps to seek peer supervision as needed to evaluate their efficacy as counselors. (American Counseling Association, 2014, p. 8).

It is the mental health counselor's obligation to effectively serve all clients from a wide variety of cultural backgrounds to the greatest ability possible, considering both individual and environmental factors affecting the individual and to refer the client to appropriate services when unable to provide those directly (Corey, 2005).

Mental health counselors are not always willing and/or able to provide counseling services to individuals with developmental/intellectual disabilities (O'Brien & Rose, 2010). Mental health counselors must understand the complex nature of the limitations associated with intellectual and developmental disabilities while avoiding wholly dismissing the diagnosed

individual's ability to process emotion and meaning. This may often require mental health counselors to make modifications and adaptations to the counseling process and approach the counseling process from a non-traditional perspective (Kanellakis, 2010).

The requirements and expectations of a mental health counselor as they specifically apply to serving the population of individuals with intellectual and developmental disabilities have scarcely been explored. O'Brien and Rose investigated the views of individuals with intellectual disabilities as they pertain to the mental health service system in general and found four major themes: individuals with intellectual disabilities tended to have negative perspectives regarding inpatient treatment, the responses of others (including mental health professionals) were frequently judgmental and hurtful, having meaningful daily activities to participate in is important, and what is needed for mental health clients who have intellectual disabilities is support to assist in addressing the limitations that exist, not full control of the person's life (2010).

Treatment models. A number of treatment models provide guidance to mental health counselors working with individuals with intellectual and developmental disabilities (Davis et al., 2008; Encinares & Golea, 2005; Lewis, 2006; Lewis, 2009). Lewis suggests the use of a simplified multicultural counseling model consisting of three key constructs to guide practitioners working with individuals with disabilities: adjustment to disability, stage of development, and cultural identity (2006). The goals of this model are:

1. Identify who the consumer is based on physical identifiable attributes.

2. Predict who the consumer is in the three domains of disability adjustment, development, and cultural identity.
3. Understand who the consumer really is in all three domains and re-group to make needed adjustments to initial perceptions of the consumer, i.e., modify as needed predictions made in goal 2 above.
4. Assess appropriately the fit between the counselor and the consumer.
5. Act in a way that suits the consumer's best interest. (Lewis, 2006, p. 153)

Davis et al. report a modified treatment model for individuals with intellectual and developmental disabilities that includes modified assessment, multimodalities for treatment, including inpatient, outpatient, and day-treatment settings, and a consistent focus on person-centered services (2008). This model of treatment stresses the complexity of mental health treatment needs of individuals with intellectual and developmental disabilities and also highlights the importance of both public policy and societal attitude changes in order to fully maximize mental health treatment benefits for individuals with intellectual and developmental disabilities (Davis et al., 2008). Additionally, Davis et al. indicate the significant influence of location and resource access on the counseling relationship, and ultimately the quality of counseling services for individuals with developmental disabilities:

> There are many treatment models for individuals with MI-DD. The best programs integrate person centered assessments and provide a spectrum of treatment options. But service availability varies across communities, regions, and county. In areas where universities have a major presence, training health care providers, innovation, breadth and

> availability of quality, comprehensive services contrasts with services available in many rural settings. In rural settings, the population density of clinicians and services may be low. Clinicians and other staff are frequently called upon to perform many roles and struggle to manage in areas outside their areas of expertise or competency (Davis et al., 2008, p. 211).

Specific interventions. A number of researchers have focused their investigative inquiries on specific counseling interventions for individuals with intellectual and developmental disabilities or counseling interventions for specific mental health needs. Lawrence investigated how reality therapy group counseling impacted self-determination of participants with intellectual and developmental disabilities and found that reality therapy group counseling significantly increased self-determination in individuals with intellectual and developmental disabilities compared to general mutual support groups (2004). The reality therapy sessions focused on developing a sense of identity, recognition of five basic needs (survival, love/belonging, power/freedom, and fun), understanding total behavior (acting, thinking, feeling, and physiology), and constructing a personal quality world (Lawrence, 2004).

Clute also found group counseling to be an effective intervention when she examined best practices for bereavement interventions for adults with intellectual and developmental disabilities (2010). She found that several areas of research must be considered when framing bereavement for adults with intellectual disabilities and developing a bereavement intervention, including, “cognitive understanding for adults with DD, stress and life events for adults with DD, palliative and end of life care for adults with DD, bereavement experiences for adults with DD,

research with bereavement counselors, bereavement group evaluation, bereavement group case reports, and bereavement individual case stories" (Clute, 2010, p. 166). The complexity of these areas of consideration is indicative of the level of involvement necessary to develop, access, and implement effective mental health interventions for individuals with intellectual and developmental disabilities.

Restrictive treatment settings. A significant amount of research on counseling and psychotherapy services for individuals with intellectual and developmental disabilities focuses on restrictive, residential settings, not community-based mental health environments. Lunsky et al. examined the various effects of specialized inpatient treatment on individuals with mild and moderate intellectual disabilities and found that inpatient treatment corresponded with clinical improvements for both groups but that only patients with mild intellectual disabilities showed improvements on the Global Assessment of Functioning scale (2010). Lunsky and Balogh found that in Canada during the calendar years 2005 and 2006, individuals with developmental disabilities were hospitalized for psychiatric conditions more often than individuals without developmental disabilities and that individuals with developmental disabilities were more likely to be hospitalized multiple times within a year (2010). Despite the increased rates and frequency of hospitalizations, individuals with and without intellectual and developmental disabilities experienced similar lengths of stay when hospitalized for psychiatric conditions (Lunsky & Balogh, 2010). Additionally, Lunsky and Balogh found that young people with intellectual and developmental disabilities were at the highest risk of hospitalization for psychiatric conditions (2010).

Compounding characteristics. Some inpatient approaches to mental health services for individuals with intellectual and developmental disabilities focus on specialized treatment units for individuals with intellectual and developmental disabilities. White, Lunsky, and Grieve examined the effectiveness of this type of specialized, inpatient intervention for individuals with intellectual disabilities and found that individuals in the specialized inpatient treatment units had significantly longer stays in the hospital, when hospitalized, than similar individuals in generic units (2010). Encinares and Golea found similar patterns for individuals with intellectual and developmental disabilities and mental health problems in corrective institutions and indicated that the most effective form of treatment for this population was a longer-term, interdisciplinary treatment team approach (2005).

Additionally, within the intellectual and developmental disabilities population, treatment challenges can be compounded by a client's membership in a narrowed portion of the population. Tarver-Behring and Spagna report on the complexity of supporting children with intellectual and developmental disabilities who experience mental health limitations (2004). Navigating educational systems in order to access appropriate treatment services can confound the already difficult process of accessing appropriate mental health services for children with intellectual and developmental disabilities, and, again, an interdisciplinary team approach to treatment is reported as an effective treatment approach for children who are dually diagnosed (Tarver-Behring & Spagna, 2004). Marco and Iacono examined existing research and found that individuals with intellectual and developmental disabilities in need of mental health services who also experienced significant communication limitations were unrepresented in previous research

and failed to have access to effective assessment and intervention tools and techniques to modify for the communication deficits (2007).

Characteristics of effective counseling. O'Brien and Rose found individuals with intellectual and developmental disabilities valued and benefited from relationships with mental health counselors who actively listened and assisted with problem solving and those who worked to ensure the individual maintained control over her or his life (2010). Knowing how to engender these characteristics in the therapeutic relationship can be difficult, especially when the client experiences limitations in communication and/or abstract thought, which can often be the case when an individual experiences intellectual and developmental disabilities. Strike, Skovholt, & Hummel found that mental health professionals had a need to develop in the areas of disability awareness, knowledge of disability and disability-related issues, and skills working with individuals with disabilities in order to effectively service this population (2004). Determining how to develop these skills has frequently been problematic, and research suggests that a professional's closeness to and familiarity of specific individuals with disabilities positively influences these competency areas (Thomas, Curtis, & Shippen, 2011). Additionally, Strike et al. found that the more experience a mental health practitioner had with individuals with intellectual and developmental disabilities, the stronger that practitioner was in these areas of need (2004). Unfortunately, Weiss, Lunsky, and Morin found that the majority of a sample of Canadian graduate students in the field of psychology recognized the importance of training and education on issues related to intellectual and developmental disabilities but felt inadequately prepared to serve this population due to a lack of experiential learning opportunities (2010).

Theoretical Basis of Study

Hershenson's Systemic, Ecological Model for Rehabilitation Counseling. For decades, Hershenson worked to accurately capture a theoretical representation of the rehabilitation counseling process, first introducing a model of work adjustment for individuals with disabilities in 1974 and a theory of rehabilitation counseling in 1981 (Hershenson, 1998). Through a continuous process of exploration and adjustment, Hershenson's theory of rehabilitation counseling evolved into the Systemic, Ecological Model of Rehabilitation Counseling (Hershenson, 1998). This model views the disability services field as a macrosystem that is made up for four key systems working together that must be considered and addressed to ensure that quality rehabilitation services are provided. These four systems are the consumer system, the functional system, the provider system, and the contextual system. Figure 1 illustrates the Systemic, Ecological Model of Rehabilitation Counseling (Hershenson, 1998, p. 49).

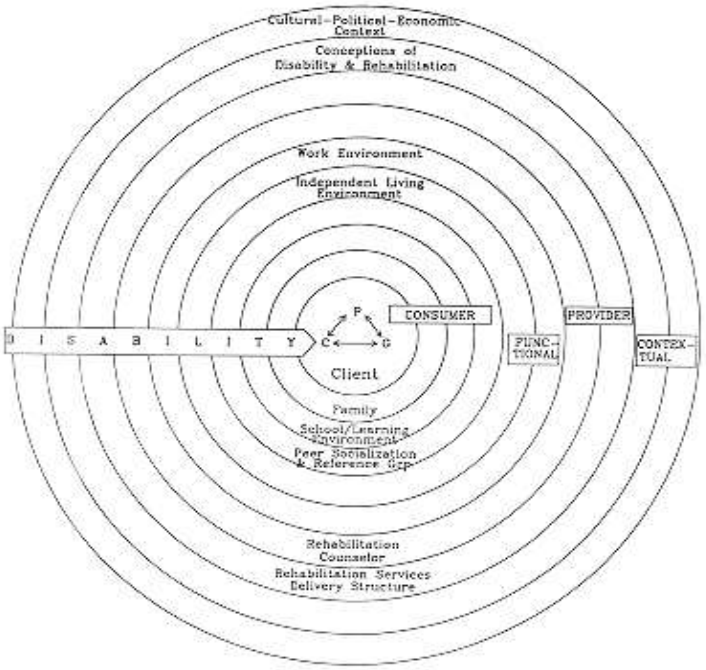


Figure 1: Hershenson's Systemic, Ecological Model of Rehabilitation Counseling

Hershenson suggests that the consumer system is the inner most component of the macrosystem and composed of the consumer, the consumer's family, the consumer's learning environment, and the consumer's peer socialization and reference groups. The functional system is composed of the work environment and the independent living environment. The provider system, as Hershenson defines it, consists of the rehabilitation service delivery structure and the rehabilitation counselor, and the contextual system is made up of the broader cultural, political, and economic context and the conceptions of disability and rehabilitation that are normative with the overall culture (1998). Hershenson's model indicates that each of these systems is interconnected with the other, has significant influence on the other, and that all systems are influenced by the experience of disability (Hershenson, 1998).

While Hershenson does not address mental health counseling specifically, mental health services are appropriate for inclusion and consideration in the provider system of the Systemic, Ecological Model for Rehabilitation Counseling. For effective rehabilitation services to occur, appropriate services must be available in this area for all individuals with disabilities, including individuals with developmental disabilities. According to Hershenson's model, failure to provide effective services on the systemic level will negatively influence the consumer system, the functional system, and the contextual system (1998). Likewise, deficiencies in the consumer system, functional system, and contextual system necessitate effective services from the provider system to assist with coping and adjustment. For example, an individual who has inadequate family support on the consumer level, little to no independence on the functional level, and experiences bias and discrimination on the contextual level must receive appropriate supports and services on the provider level to be able to cope. Therefore, it is essential to include mental health services when considering the provider system.

Increasing Need for Mental Health Services. Individuals who experience intellectual and developmental disabilities often rely on support services to assist with a broad range of activities of daily living, including meal preparation, hygiene and personal care assistance, home care and maintenance, behavior management, transportation, communication supports, and social and emotional supports. Historically, the primary option for daily supports for this population, outside of family provisions, has been services in large, segregated, state-operated institutional facilities (Taylor, 2001) . However, the implementation of Medicaid Waiver in 1981 and the Olmstead Supreme Court ruling in 1999 made community-based services available on the state level and deemed such services a constitutional right of individuals with intellectual and

developmental disabilities (Shapiro, 1994; U.S. Department of Health & Human Services Centers for Medicare & Medicaid Services, 2010).

These legislative events and on-going scrutiny of Medicaid spending have resulted in the population of individuals with intellectual and developmental disabilities living in institutional placements decreasing exponentially and community-based service recipients increasing significantly. In 1992, 104,986 individuals with intellectual and developmental disabilities received support services in large institutional settings in the United States (U.S.) and 62,462 individuals with intellectual and developmental disabilities utilized Medicaid Waiver community-based services in the U.S. By 2006, only 58,195 individuals with intellectual and developmental disabilities continued to utilize institutional services in this country, while 479,392 individuals with intellectual and developmental disabilities accessed community-based support services (Lankin et al., 2007).

Community-based supports have been promoted and advocated for by a wide-range of self-advocacy organizations within the intellectual and developmental disabilities community and have been identified as superior to segregated, institutional placements for promoting higher quality of life and adaptive functioning skills for individuals with intellectual and developmental disabilities (Shapiro, 1994; O'Brien, Thesing, & Tuck, 2001; Lerman, Apgar, & Jordan, 2005; Mansell, 2006; Mansell & Beadle-Brown, 2010; Hamelin, et al., 2011; ADAPT, 2011, TASH, 2011). Such research and advocacy ensures that more individuals with intellectual and developmental disabilities will be participating in community living, as opposed to isolated, residential living, and will be accessing community-based services at increasing rates.

Dual Diagnosis. Service complexity for individuals with dual diagnosis of both intellectual and developmental disabilities and mental health conditions can be vast. Research has found that service needs often include the need for modified attitudes toward dually diagnosed individuals (Kanellakis, 2010). It is important for practitioners to understand limitations but also maintain the ability to recognize and support assets. Mental health providers working with individuals diagnosed with some form of disability must ensure that characteristics of both the disabilities and the mental health condition are considered, recognize that some characteristics of disability are not static and may change or intensify at times, be aware that not all disabilities are visible or obvious, and consider the emotional strain on, not just the individual with the dual diagnosis, but on that person's support system as well (Kanellakis, 2010).

In order for counseling services to be successful, a strong working alliance must be developed between the counselor and client; unfortunately, when the client has a developmental disability, discriminatory attitudes often prevent the consideration of the client as a partner in developing that strong working alliance (Raffensperger, 2009). Raffensperger suggests that it is imperative that the mental health practitioner recognize abilities and assets within the client with intellectual disabilities and mental health limitations, regardless of how significant the person's limitations and impairments might be. Additionally, she stresses the importance of considering and supporting the direct support system of the individual with a dual diagnosis (2009).

While attitudes toward intellectual and developmental disabilities can often limit the traditional counseling possibilities for individuals with intellectual and developmental disabilities, Shaw, Bruce, Ouimet, Sharma, and Glaser found that children with developmental

disabilities and mental health dual diagnoses are often prescribed psychotropic medications aggressively. The treatment focus was often on attempts to alleviate symptoms and not on assisting the individual with a dual diagnosis to process emotions and life experiences to ascertain understanding and develop coping skills (2009). Negative practitioner attitudes influence this failure to see the individual as a capable client.

Appropriate care for individuals with dual diagnosis should include the following quality standards:

1. Accessible services – not just physical access but administrative access (i.e. how appointments are made and followed up)
2. A safe environment
3. Feeling respected as an individual
4. Having one's privacy and confidentiality respected
5. Good communication – appropriate signposting, literature and written communication and complaints procedures
6. Good personal communication – using aids and supports as appropriate; having things explained in a way that is understood
7. Being listened to and having one's opinions sought and respected
8. High quality, evidence-based clinical care. (O'Hara, 2008, p. S156)

McGinty, Worthington, and Dennison suggest that working with families, when they are available, can be an important part of effectively providing services to an individual with intellectual and developmental disabilities and a mental health condition (2008). This reinforces

other findings in the literature that suggest providing support to the client's immediate support system is vital in providing high quality counseling services to individuals with dual diagnoses.

Appropriate Research

Bond provides ethical guidelines that must be considered when researching counseling and psychotherapy. These guidelines are as follows:

Ethical orientation

1. having an adequate knowledge of the Ethical Framework for Good Practice in

Counseling and Psychotherapy

1. ensuring that the research is consistent with the requirements of trustworthiness in the practice of counseling and psychotherapy

Risk

1. a thorough risk assessment of any harm to participants or to the integrity of the research, including the competence of the researcher to undertake the work, is to be undertaken prior to starting the research
2. ensuring that participants are adequately protected from harm and that the researcher is fully accountable for any risks associated with the research
3. ensuring adequate consultations take place about ethical issues prior to and during their search process

Relationships with research participants

1. obtaining participants' consent prior to involvement in research
2. protecting participants' rights to modify, consent or withdraw throughout research process and ensuring that a refusal to participate does not adversely affect services to that person
3. managing and protecting personally sensitive information within the research in ways that are compatible with the service being researched
4. taking reasonable steps to anticipate any conflicts between confidentiality and other ethical obligations
5. taking adequate account of any vulnerabilities of participants
6. ensuring that all participants are treated respectfully and with adequate cultural

Sensitivity

1. adequately protecting the client's interests and vulnerabilities where the researcher is also the provider of services to the client (section 3.5)

Research integrity

1. ensuring fairness and honesty in the collection and analysis of research data
2. communicating any new learning or knowledge effectively to the appropriate audience
3. being competent to undertake the research
4. fostering a research culture that supports the open exchange of knowledge and constructive relationships with other researchers

5. taking adequate account of own needs as researchers for personal safety and being treated ethically
6. making provision for prompt and adequate responses to any complaints Research governance (Bond, 2004, p. 19)

Additionally, Nuttall provides an example of a heuristic approach to researching psychotherapy and notes the appropriateness of this research method for this subject, suggesting that the explorative, abstract nature of heuristic research is a most effective way to investigate such an explorative and abstract intervention as psychotherapy (Nuttall, 2006).

Summary

Despite this theoretical and research background, or perhaps because of it, mental health counselors frequently remain unwilling or unable to provide mental health counseling to individuals with intellectual and developmental disabilities. In a literature review focused on determining factors that influence outcomes for individuals with intellectual disabilities, Raffensperger highlights the importance of the working alliance in all therapeutic relationships, including those that involve clients with an intellectual disability (2009). The research presented here not only suggests that the common approach to individuals with DD who are in need of mental health services is to focus on symptom control, access restrictive, isolating inpatient services, or accept the counselor's deficiencies in being able to serve such a complex client, it also provides a large amount of findings that can effectively guide high quality mental health services for individuals with intellectual and developmental disabilities, such as emphasis on the importance of a strong working alliance, recognition of the damaging nature of unaddressed

negative attitudes, benefits of thorough environmental and historical understanding of the person with the disability, and the specific benefits of certain types of interventions for this population.

While the importance of disability cultural awareness, experiential learning, and a strong working alliance have been documented as important aspects of mental health counseling for individuals with intellectual and developmental disabilities and the perspectives of counselors-in-training and service recipients have been documented, little research evidence exists to represent the perspective of the practitioners who provide or have provided mental health counseling services to individuals with intellectual and developmental disabilities. Understanding this existing perspective on mental health counseling for individuals with intellectual and developmental disabilities and the importance of community-based mental health counseling in the systemic, ecological model of Rehabilitation Counseling (Hershenson, 1998), it is now important to examine how individual counselors live and experience these characteristics in their day-to-day practice.

Chapter 3: Methodology

Research Design

The purpose of this study is to explore the unique experiences of mental health counselors who work with individuals with intellectual and developmental disabilities. The guiding question of this research is, "What is the experience of providing mental health counseling to individuals with intellectual and developmental disabilities?" The phenomenological theory of qualitative research will guide this investigation, with a focus on gaining access to participants' life-worlds and understanding the essence of the experiences of mental health counselors working with individuals with intellectual and developmental disabilities (Jones et al., 2006). This question will be answered with a qualitative design that will consist of individual interviews. The specific methodology, which will guide the method of data collection, analysis and reporting, is heuristic phenomenology (Jones et al., 2006). This methodology is most appropriate to capture the unknown aspects of this unique experience shared by a small portion of the greater mental health field (Finlay, 2009).

To address the research questions posed in this study, it is necessary to take a qualitative approach. Quantitative research of any kind seeks to measure and compare variables on some level (Creswell, 2008). For these particular research questions, the significant variables are not yet known and, therefore, cannot be measured or compared. This qualitative investigation seeks to identify significant variables involved in mental health counseling with individuals with intellectual and developmental disabilities and will utilize individual interviews with mental

health counselors working with individuals with intellectual and developmental disabilities to identify key variables associated with the process.

Other qualitative research techniques were considered by the researcher and ruled out as appropriate options to guide this investigation, data collection, and data interpretation. Case studies were not appropriate to address these research questions because an exemplar individual situation is not known that could embody all the components of an ideal counselor and client with intellectual and developmental disabilities interaction (Berg, 2009). Additionally, focus groups were discarded as a potential tool of investigation for this study primarily due to the researcher's desire to collect rich, thick data on each individual participant (Berg, 2009). The researcher determined that the group dynamic involved in focus groups would influence participant responses and reduce the authenticity and genuineness of the data collected.

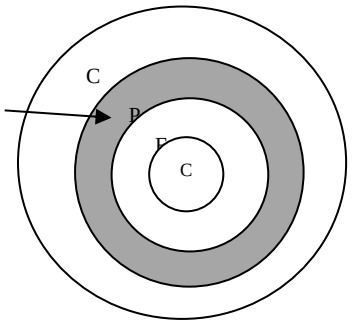
Individual interviews guided by heuristic phenomenology were chosen to provide an opportunity for more thorough understanding of the phenomena of mental health counselors who work with individuals with intellectual and developmental disabilities. Heuristic phenomenological research explores the life-world of participants and involves the researcher and the subject working together to establish meaning of the experiences of participants (Creswell, 1994). This analysis will seek to understand the intent and impact surrounding the experiences of service provision within this population. The researcher will work to establish an interviewing environment where participants can genuinely share their lived experiences through their own personal stories (Creswell, 1994; Finlay, 2009).

Research Questions

Because of its explorative nature, this research design is most appropriate to answer the specific research questions identified in this study:

1. What are factors that influence the experiences of mental health counselors who work with individuals with intellectual and developmental disabilities?
2. What are the rewards and consequences of providing mental health services to individuals with intellectual and developmental disabilities?
3. What barriers have to be overcome to provide quality mental health services to individuals with intellectual and developmental disabilities?
4. What resources should be accessed and utilized in the experiences of mental health counselors working with clients with intellectual and developmental disabilities?

These questions seek to obtain a better understanding of the mental health practitioner's role in the provider system of Hershenson's Systemic, Ecological Model of Rehabilitation Counseling as highlighted in Figure 2.



C = contextual system—society, culture, laws

P = provider system—rehabilitation services, mental health services

F = function system—work, school, independent living

Co = consumer system—individual, family, social support

Figure 2: The provider system of Hershenson's Systemic, Ecological Model of Rehabilitation Counseling

Participants

Chain sampling will be utilized to obtain an adequate sample of mental health counselors in Arkansas who have experience providing services to individuals with intellectual and developmental disabilities. Counselors will be recruited to participate in individual interviews in order to capture their experiences of working with individuals with intellectual and developmental disabilities (Jones et al., 2006). Community-based mental health service providers and state-level professional counseling organizations will be accessed in order to recruit eligible participants for this study. These sampling techniques will ensure appropriate coverage of the population in question and generate a sampling that meets appropriate sampling criteria (Jones et al., 2006). Mental health practitioners who are licensed counselor/psychotherapist in Arkansas and have experience working with more than one individual with intellectual and developmental disabilities in a counseling role will meet criteria for inclusion in this study. Participants who complete all aspects of the research requirements, including member check activities, will be provided a $30 gift card in exchange for their time and effort at the conclusion of the study.

Protection of Human Subjects

A protocol form, provided in Appendix A, and informed consent form, provided in Appendix B, will be submitted to the University of Arkansas' Institutional Review Board for approval prior to the beginning of data collection to ensure the protection of all study participants. Participants will be asked to select pseudonyms to ensure confidentiality in the

reporting process of this research. No anticipated risks exist for participants of this study. Study participants will be free to withdraw from research participation at any time during the study.

Role of the Researcher

The researcher will serve as the primary instrument of data collection and conduct all face-to-face interviews with participants. The researcher has 12 years of experience working in the intellectual and developmental disabilities direct-service field and holds a Licensed Associate Counselor license. While this experience will provide unique insight for the researcher, it is imperative that the research safeguard against personal biases that will arise during investigation due to the experiences she has within each discipline. The researcher will make all attempts to set aside personal bias and be open to the experience and insight of the participants. Memoing and reflective journaling will be employed by the researcher to assist in identifying and controlling personal bias (Creswell, 2007). Consultation with experts in the field of rehabilitation, counseling, and research will be utilized to assist with bias-reduction, along with extensive member-check procedures.

Information Collection

Instrumentation. This study will utilize the researcher as the interviewer and instrument to collect data. Based on Kvale's *Interviews: An Introduction to Qualitative Research Interviewing,* a demographic questionnaire and a semi-structured interview format will be utilized as a guide to ensure that key components of participants' experiences are covered (1996). See Appendix C for the demographic questionnaire and Appendix D for the semi-structured interview questions. Both the demographic questionnaire and the semi-structured

interview questions were developed through consultation with and feedback from professionals with expertise in both the mental health and rehabilitation fields. Questions were developed and modified based on practitioner feedback, and consulting practitioners were in agreement for the finalized versions included in this study to guide the interview conversation (Kvale, 1996). The interviewer will collect responses to the demographic questionnaire for each participant before beginning the semi-structured interview. All portions of the data-collection will be recorded and later transcribed. Interviews will be conducted based on Berg's "10 Commandments of Interviewing", a list of 10 guidelines for conducting successful qualitative research interviews that includes:

1. Never begin an interview cold.
2. Remember your purpose.
3. Present a natural front.
4. Demonstrate aware hearing.
5. Think about appearance.
6. Interview in a comfortable place.
7. Don't be satisfied with monosyllabic answers.
8. Be respectful.
9. Practice, practice, and practice some more.
10. Be cordial and appreciative. (2009, p. 143-144).

Procedures. The researcher will conduct individual interviews with a minimum sample of five mental health counselors with experience working with individuals with intellectual and

developmental disabilities, to ensure appropriate coverage of the population (Jones et al., 2006). The researcher will travel to participants and meet for face-to-face interviews in appropriate, comfortable settings. All interviews will be recorded and transcribed for analysis. Data will be recorded and reported using pseudonyms selected by participants to safeguard participant confidentiality. Participants will review transcripts to ensure accuracy before data are analyzed.

Because this is a qualitative research study, the traditional concepts of reliability and validity are not applicable. Instead, in accordance with guidelines from Lincoln and Guba, the following steps will be taken to ensure trustworthiness, credibility, and dependability: prolonged engagement of all interview sessions and extended contact as long as needed, triangulation with other experts in the field, peer debriefing to ensure that all possible interpretations are being considered, and frequent member check to establish data collection accuracy (Lincoln & Guba, 1985). These research procedures will allow for the most authentic answers to the study's research questions to be recorded in the most unbiased manner possible.

Data Analysis

Interviews will be transcribed, and transcripts will be provided to members for member check purposes to ensure data accuracy (Creswell, 2007). Once transcripts are adjusted and approved by participants, data will be analyzed using Moustakas' three-level coding system for heuristic inquiry: creating a rich narrative for each participant, establishing a composite depiction for all participants, and ascertaining an exemplary depiction of the themes from all interviews (1990). Data will be analyzed using a phenomenological perspective. Themes will be identified, and field experts will be accessed to review transcripts and identified themes for the

purposes of triangulation and to ensure that data analysis is accurate. Figure 3 is a modification of Creswell's data analysis process that illustrates the data analysis process for this research (2008, p. 244).

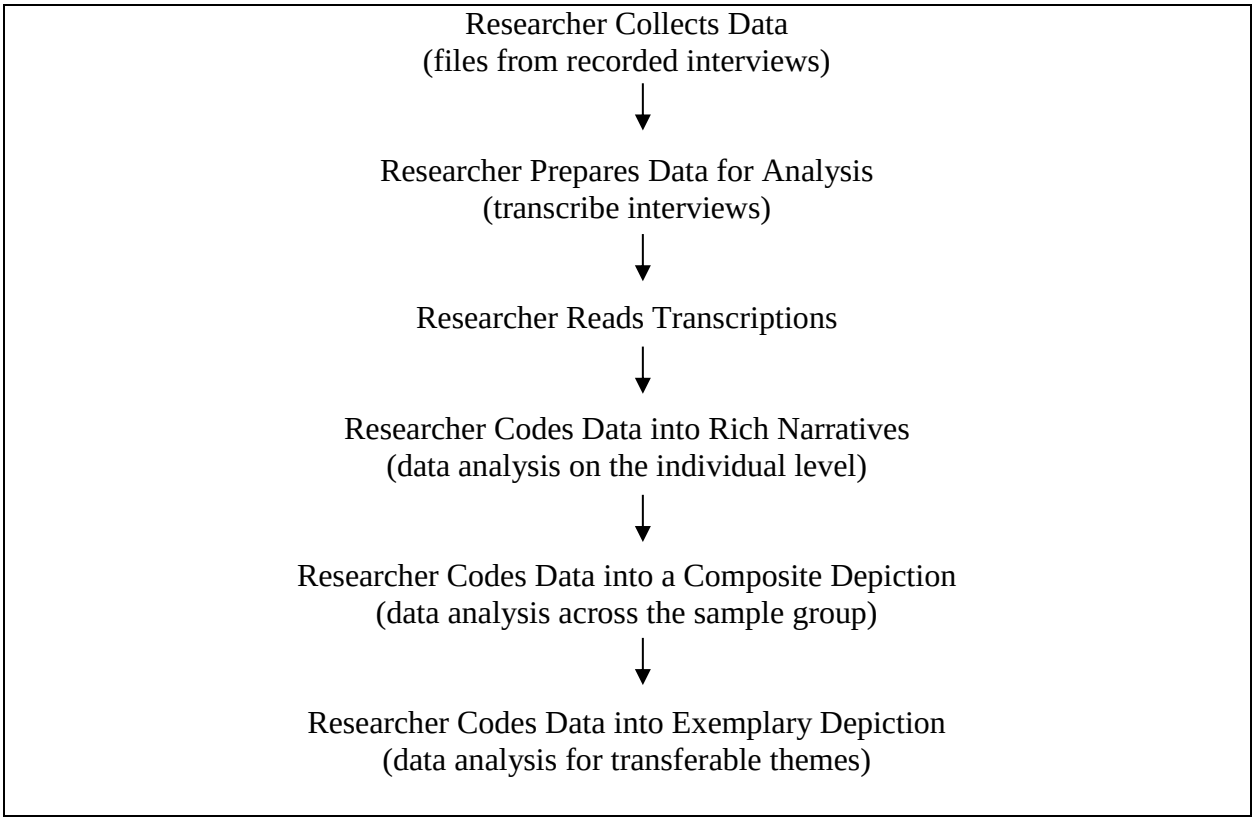


Figure 3: Data Analysis Process

Summary

A heuristic phenomenological investigation will be conducted using a sample of mental health counselors who have experience providing counseling services to individuals with intellectual and developmental disabilities. Participants will be recruited through counseling provider agencies and professional counselor groups. Data will be collected utilizing a semi-structured interview. Research evidence has been provided to suggest that this form of qualitative inquiry is the most appropriate form of investigation for the subject matter being studied and for the research questions involved. Once interviews are completed, participants will be accessed again for member check purposes. Once data has been collected and organized appropriately, data analysis will follow Moustakas' three-level coding system for heuristic inquiry. Data collection and analysis will attempt to answer the question, "What is the experience of providing mental health counseling to individuals with intellectual and developmental disabilities?"

Chapter 4: Results

In order to obtain a better understanding of the experiences of mental health counselors who provide services to individuals with intellectual and developmental disabilities, this study sought out mental health counselors who had such experiences and recorded their experiences for analysis. The researcher contacted community mental health providers in the state of Arkansas and contacted the state's University Center for Excellence in Developmental Disabilities to solicit research participants. The researcher obtained seven names and contact information from this chain sampling approach. Five clinicians responded to the researcher and agreed to participate in the study. The counselors who participated in this research were experienced and licensed clinicians who willingly volunteered to be interviewed. The data obtained from these inquiries provided an opportunity for the researcher to establish rich narratives which thoroughly captured the individual experiences of clinicians, a composite depiction of the collective account, and an exemplary depiction of universal theme found in each scenario. The following results provide insight into this phenomenal segment of mental health counselors that can be used to guide and direct training, best practices, and policy developments.

Demographic Descriptive Statistics

Five independent interviews were conducted with five mental health counselors from across the state of Arkansas. One participant held Licensed Master Social Worker (LMSW) credentials while the other four were Licensed Professional Counselors (LPC) with all interviewees being licensed in the state of Arkansas and working under those state guidelines during the time of interview. All counselors had been practicing counseling for more than 10

years, with the most inexperienced counselor having 11 years of experience and the most experienced practitioner having practiced for 26 years. The five interviewees had an average of 18 years of clinical experience. Four of the interviewed clinicians maintain current caseloads ranging from 10-60 clients with one interviewee not currently having an active case load. Of the five interview subjects, three reported a history of providing mental health services to approximately 20 individuals with developmental disabilities (DD) over the course of their careers, while one clinician reported providing counseling services to 60 individuals with intellectual and developmental disabilities, and one counselor reported serving 100 individuals with intellectual and developmental disabilities in a mental health setting throughout his career. Table 1 provides specific descriptive statistics.

Of the five individuals interviewed, one was male and four were female. One research participant was in her 30s, three were in their 40s, and one participant was in her 50s. All interviewees identified as Caucasian. Two participants identified as "single" with three participants identifying as "married". Three of the counselors interviewed listed Cognitive Behavioral Therapy as their theoretical orientation to counseling, while the other two clinicians listed their theoretical orientation to counseling as Eclectic. Three of the interviewees practiced in nonprofit agency settings, with two of those settings being community mental health providers and one being a private treatment center for youth with sexually inappropriate or problematic behaviors. One clinician operated a private practice, and the fifth interviewee was employed by a research-based organization. See Table 2 for details.

Table 1

Demographic Information on the Interview Subjects

Counselor Pseudonym	Theoretical Orientation	License	Length of Practice (Years)	Current Average Caseload	Total Clients w/ DD
Cimarron	Eclectic	LPC	26	n/a	60
Yoda	Eclectic	LPC	21	40-60	20
Jane	CBT	LPC	11	10-12	20
Dave	CBT	LMSW	18	30	100
Sally	CBT	LPC	14	20-30	20

Table 2

Demographic Information on the Interview Subjects

Counselor Pseudonym	Identified Gender	Age	Relationship Status	Race/ Ethnicity	Practice Setting
Cimarron	Female	57	Single	Caucasian	Other
Yoda	Female	46	Married	Caucasian	Private Practice
Jane	Female	36	Single	Caucasian	Nonprofit Agency
Dave	Male	44	Married	Caucasian	Nonprofit Agency
Sally	Female	46	Married	Caucasian	Nonprofit Agency

Data Analysis

Rich Narratives. Rich narratives seek to capture a whole and thorough depiction of a participant's unique experience in order to examine the complexity and immensity of the interviewee's lived experience. Each interview in this study yielded an individual narrative of the clinician's experiences supporting individuals with developmental disabilities in mental health services and the conclusions the practitioners took away from their experiences. These rich participant narratives are documented fully to illustrate the density and enormity of the experience of a mental health counselor providing services to individuals with intellectual and developmental disabilities. Each experience provided valuable information to consider when attempting to determine why mental health counselors engage in counseling relationships with individuals with developmental disabilities, what factors influence those decision, and what barriers and resources exist for mental health clinicians serving this population.

Cimarron. At 57, Cimarron was the oldest and most experienced clinician interviewed. She was also the most closely connected to the developmental disabilities community as an employee of the Arkansas University Center for Excellence in Developmental Disabilities Education, Research, and Service at the time of her interview, with much of her clinical experience coming from her tenure at the Child Study Center. The information she provided was based on her past experiences, as she was not actively providing mental health counseling services at the time of the interview.

From the very beginning of her interview and throughout, Cimarron emphasized the importance of adapting counseling techniques to individuals with developmental disabilities.

She expressed significant concerns with the way in which traditional mental health counseling is structured to rely on evidenced-based techniques that are rarely, if ever, tested and researched utilizing clientele with intellectual and developmental disabilities:

> Interviewer: Ok. Working with that population, what would you describe as being the biggest challenges?
> Cimarron: {pause followed by a deep exhale} Um, most of the therapeutic interventions that are evidence-based, are done on populations that are, that do not really include individuals with intellectual and developmental disabilities. And so the assumptions of evidenced-based, {pause}, you can't always take an evidence-based approach and work with a person with a developmental disability and think that you're going to get the same outcome. And so, adaptations when you're doing counseling with people with developmental disabilities are really critical.

She expressed fear that the rigidity of some evidenced-based treatments were not only ineffective for individuals with intellectual and developmental disabilities, but also potentially harmful:

> Cimarron: My fear is now. You know what my fear is? My fear is now is that we have a lot of people who are going through evidence-based training , you know Cognitive Behavioral Therapy, and, well, that is an evidenced-based intervention, and it's not the only intervention. And the protocols for that are pretty rigid as to what you do with it, um, so just in my experiences in some of those setting, in some of the things that are happening with kids with disabilities are pretty frightening {laughs}.

As she discussed adaptations, Cimarron provided many examples of specific adaptations and techniques she has found productive in therapy relationships with individuals diagnosed with intellectual and developmental disabilities:

> Cimarron: [I] did a lot of visual scheduling; just showing them what they were going to be doing on a particular day that they might come in. We used Time Timers to show the passage of time. A lot of times…I would visit with children in their homes. I would take materials there and see them there. I have seen kids when they've been swinging on swings and talked with them in that kind of setting, so to help regulate their sensory systems. Um, and actually that's worked out pretty well because they would be able to talk a lot clearer when they were engaged in some kind of sensory experience…Just from the stand point of an intervention, I've worked with families members to know how to provide information to their child in order for them to know what to expect. Uh, divorce

> seems to really mess up a lot of kids with autism spectrum disorders, and if you understand it from their perspective you see kids who have one home and then all of a sudden they have two homes, and then people are referring it to them as "You're going to go home with mom" "You're going to go home with dad", and that makes no sense to them at all. So you have to put a framework around it so that they can understand that. [I] used a lot of visuals, concrete kinds of emotion cards…

Additionally, Cimarron discussed the problems with mental health therapists not preparing to or being willing to serve individuals with intellectual and developmental disabilities and the consequences that unwillingness may create:

> Cimarron: …as long we start to create separate systems to provide services, then we're kind of moving into something that's counterproductive to what the purpose of the Americans with Disabilities Act and inclusion is all about because a lot of the programs that then set up mental health services are located in agencies that have quite a bit of control over individuals' lives. I think when you end up with one agency having control over an individual's life quite that much, then you end up with not a lot of richness. You end up with kids whose reputations have followed them. People who are, maybe kind of, tired of dealing with them, who don't take them as seriously in the same way. So for mental health professionals, um, it's kind of a double-edged sword, though. Because they don't like to practice outside of their area of expertise, yet at the same time, when they are not serving someone with a developmental disability because of the disability then where does that person get services? Um, we have that now with people who are sexual assault victims. Counselors are not feeling particularly comfortable to serve people with disabilities who have been sexually assaulted. So they don't serve them. They use the thing that "they're not trained in that area". Which that could very well be. Yet at the same time, [these individuals have] also been sexually assaulted, and so they're sort of denying services to the individual based on the lack of information that they, the counselor, could very well have already.

Cimarron shared the important and impactful benefits she experienced from being able to work with a team of cross-discipline professionals and rely on one another when faced with the challenges of providing mental health services to individuals with intellectual and developmental disabilities:

> Cimarron: We had a core group of people that worked together to consult with each other, um, as well as psychiatrists who were on staff, and we did some really, really good work during those two years…Um, but we continue even today to reap the benefits of

> some of the work that we did when we were all together, doing that, when we were blending the field of developmental disabilities and the field of mental health together.

She spoke about her personal motivation to get involved in mental health services for this population, once again emphasizing the value of a strong support system for the clinician:

> Interviewer: What got you personally into this?
> Cimarron: Well, the other thing is that doing work around violence, I saw the need, and I was getting calls from people who were not able to get in to see people, and so I felt the need to help increase the capacity to do that. I talked with the management of our agency about what we could do around it. Um, we started off with an informal group of people from the mental health field and from the developmental disability field looking at what the issues were that people were seeing in schools and from that then we developed some action steps. We met for a couple of years, actually, sharing information, identifying professionals who were willing to do the work.

And while she identified her theoretical orientation to counseling on her demographic questionnaire as Eclectic, Cimarron described why it was important to be more dynamic in their approach to counseling and illustrated a range of ideologies and approaches she had taken to providing therapy:

> Interviewer: Or, you know, explain your approach.
> Cimarron: Ok, ok. Well, uh, at the time that I went to school, you know, there were a lot of theoretical approaches that were taught at that period of time: Reality Therapy, all of that kind of stuff, um, Rational Emotive Therapy, all of that. Um, Eclectic really fits me because it sort of takes the best of the various pieces and puts them in together. Um, I'm trained actually in hypnosis, and so a lot of the work that I do now and some of the work that I actually did then, incorporated Rapid Resolution Trauma, which is a methodology, not particularly as evidenced-based as some of the others. Um, that methodology has been effective in treating a lot of people with trauma in a very short period of time rather than in bringing people in for week after week after week to often times, sometimes, re-traumatize them…I use a lot, I used a lot of play therapy seeing kids…there's also a lot of variety within play therapy. Child-centered play therapy, I did a lot of child-centered play therapy. Um, I did a lot of filial therapy with kids or modified versions of it because I never really stuck with any of those things for very much time. It just depended on what the child was presenting with and what I thought might be best.
> Interviewer: So, really more of an individualistic approach to each individual.
> Cimarron: Very much so. Very much so.

When asked to reflect on potential incentives mental health counselors may have for providing therapy services to individuals with intellectual and developmental disabilities, Cimarron relayed the important influence of personal connection, having a 'heart for the work', and a willingness to address the obvious need:

> Cimarron: {laughing} Um, you know the people who have been the most committed to this have been people who have children with developmental disabilities, people who have family members, who understand the need from a totally different perspective. Um, I've always said that if you can, um, if you run across somebody who has the heart for the work that they're doing, then they see the need regardless of whether the person has a disability or not. Um, and they attempt to meet that need in the best possible way that they can.

Cimarron also was direct in stating that incentives for individual counselors are lacking and the consequences of the system that is in place:

> Cimarron: Um, at the same time that I say that, there's just not a lot of incentives, because at the moment we have agencies who are setting up their own mental health programs or coming to bill that way. And as that happens then kids will continue to be shifted to some of those programs, and while it may be meeting an immediate need, it has some long-term implications that are concerning
> Interviewer: Segregating?
> Cimarron: Correct. And, not all programs are going to be able to do that, and so they're going to have to rely on the programs that exist within their communities, or, um, private counselors, or whatever. So, I don't really see a lot of, I don't really see a lot of incentives, because it's actually, frankly, it's hard work, and sometimes the systems that are even set up to supposedly help, don't. Um, there were some creative things that we did with CASSP but when you had some of the agencies who represented the disability community participate who weren't particularly helpful, then it doesn't really set up much of a desire for those programs to continue covering or serving those children and there's not the support coming from the agencies. Um, the other thing that I don't think really gets the attention it deserves is, um, the whole aspect of being a trauma-informed. Developmental disability services really don't get that, generally, period. And so, without that piece then I think there's a lot of unrecognized mental health needs that people with disabilities experience.

And she identified a lack of adequate resources and supports as a significant disincentive for therapists interested in working with this population:

> Interviewer: What disincentives exist?
> Cimarron: Disincentives?
> Interviewer: For the individual practitioner.
> Cimarron: {laughing} Um, disincentives. There's not really a network of mental health professionals that can help to support, um, their interest in and their knowledge of the work.

While acknowledging a lack of resources and a limited understanding of individuals with intellectual and developmental disabilities, Cimarron also points out that this weakness in the mental health field presents a significant opportunity for research and development:

> Cimarron: Um, sometimes when you read [mental health research] you can see that, uh, the practitioner has looked only from one lens to the individual and made some assumption about the person's progress, sometimes based on attributing that progress to therapy when in fact some of it was related to sensory activities that were happening in the therapy session. Um, so as long as you have misinformation that is being promulgated, you're going to have folks who are struggling to find the best practice kinds of work for people with developmental disabilities. So, since there's not a lot of, in my experience anyway, not a lot of really good resources for counseling people with developmental disabilities. And so, that's kind of disincentive for people to get involved in it. Um, on the other hand, it's ripe for research, it's ripe for development.

When asked about what was important to facilitate successful therapeutic interactions with individuals with developmental disabilities, Cimarron stressed the importance of the clinician's comfort level and recommended clinicians expose themselves to individuals with intellectual and developmental disabilities regularly to increase comfort:

> Cimarron: I think the first thing, probably, um, it seemed to me that at the mental health center, children had radar as to who was comfortable with them and who was wasn't. And, I think any mental health professional who is going to work with people with developmental disabilities needs to spend some time around individuals with developmental disabilities in other settings first in order to get a little bit more relaxed. Um, my experience was that people just had, like, radar for people who were uncomfortable around them. Um, and the families actually had pretty good radar for who was uncomfortable around them, as well. Um, so I think some exposure is important.

Much in line with her Eclectic approach to counseling, Cimarron also stressed the importance of flexibility in the counseling engagement and cites her experience of not having flexibility as evidence of its importance. She also advocates for a holistic approach to supporting individuals and families:

> Cimarron: I think flexibility is a real key. I, I think if you're really going to serve this population that you need to be able to have some flexibility in the methodologies. Um, when I was working with the family treatment program doing counseling for people who were sexual assault survivors, I didn't have that flexibility. It had to be in an office setting. It had to be at a set, determined time, and, uh, in that setting family members who were already dealing with a lot of difficulty have a hard time providing transportation to a location. So, I think you have to look at some of the holistic factors, and where that service delivery can happen with the most consistency. Um, and not blaming the family, nor the child, for missing a therapy appointment. So flexibility, I think, is a real key.

When asked about specifically what her experiences serving this population had taught her, Cimarron underscored a need to avoid judgements, trust instincts, be flexible, be creative, and be knowledgeable about disability:

> Interviewer: Okay. What do you feel like, as a counselor, you've learned working with this population, with your personal experiences?
> Cimarron: Probably to suspend your judgements about what you think is going on. I think you have to stay open to the information that you're getting because, immediately, once you've latched on to what you think it is, you miss, a lot of times, about what it really is. Um, the aspect of needing to be flexible and creative. Some of the best work that I've done with people has been with a gut instinct that I've gotten when I've been working with them about where to go next. Um, and that comes from a broad base of knowledge of whatever disability it is that they're presenting with.

She suggested that clinicians consider oppression, segregation, and trauma when seeking an understanding and working knowledge of disability and how those historical experiences and roles may interfere with establishing a therapeutic relationship:

> Cimarron: Um, the other thing that I think you have to be aware of when working with this population is the effects of oppression and discrimination, and the settings in which they live, some of their historical experiences. Especially when you're working with

> adults, um. I think the other thing that's important to realize is that just because, uh, you feel like you're there to help them, they don't always feel like you're there to help them, and so the aspect of building trust with them is a lot more imperative.

Cimarron offered additional advice to clinicians to remain confident in their abilities, utilizes the things that they know, and remember that, despite disabilities, people are generally more alike than different:

> Cimarron: Gosh, there is just so many things I've learned. That people are a lot more alike than they are different, and while a child or adult might have a disability, whatever the victimization that they experience, there's a lot of similarities that happen. And not to forget what you already know. Um, and not to forget that people who are sexually assaulted have certain behaviors that you sometimes see. Sometimes people with disabilities might manifest them in a different way, um, but they're going to be there usually.

She also cautioned mental health therapists and developmental disabilities providers about an overreliance on behavior modification for individuals with intellectual and developmental disabilities, a practice common in the field:

> Cimarron: Um, the other thing that I've learned is that we do address a lot of behaviors with people with disabilities without addressing the underlying causes of what's causing the behavior. And that actually is a disservice because a lot of times you can modify a behavior but if you don't really know what the underlying root cause of it is then you're not acknowledging the person's experience in the process of that.

Cimarron's experiences were notably influenced by her background working in the field of developmental disabilities. Her previous exposure afforded her a level of comfort in supporting this population that other clinicians often lack. Additionally, her personal and work experiences with individuals with developmental disabilities armed her with tools and strategies to utilize in the process of modifying and adapting traditional counseling techniques and practices to meet the communication and learning differences of clientele in this population. Cimarron also shared concerns of the systemic restriction of access to mental health services that

often occurs in the developmental disabilities community and noted the value of flexibility in service delivery and service setting.

Yoda. Yoda was the only clinician interviewed who operated a private practice. At 46 years of age, she had more than 20 years of clinical counseling experience. Within the first minute of her interview, she disclosed her primary motivation and greatest incentive for providing mental health counseling to individuals with intellectual and developmental disabilities, which was that she is a mother of a child with a developmental disability:

> Yoda: Um, it wasn't until I, uh, gave birth to a son 18 years ago who 3 years later was diagnosed with autism and verbal apraxia and didn't speak a word until he was 4. So, um, I kind of hit the ground running when it came down to understanding what developmental disability was. I think, in kind of being on the front line of that as a mother has increased my knowledge base more in a real, straightforward way rather than kind of coming at it from a clinical aspect of best options. I was living, breathing, and sleeping it.

Yoda accredits her experiences as a parent for allowing her to see past a disability label and connect to her therapy clients on an individual basis and be a better therapist:

> Yoda: I think having a child with a developmental disability has really made me a better therapist. It's made me a better advocate. Um, and, because of that, I also recognize that [my son] is just, he's 18 now, but he's just a boy who has a, a different learning style or learning differences. And so, if I can look at it in that process, then I can come across in working with somebody in a way where I'm not going to see a disability first. I don't, um, my theory is a lot of therapists out there get trapped or get lost in the idea of a disability first before looking at the person behind the disability.

She also shared a previous work experience as a job coach for a developmental disability services provider prior to entering graduate school, where she states there was no mention of intellectual or developmental disabilities in her formal education:

> Yoda: My initial first experience was being a job coach at, um, Abilities Unlimited up in Northwest Arkansas when I was just a bachelorette student, and then I left there and went on to graduate school, and, um, my experience from that point was very little to none. Um, [developmental disability] was not a discussion in graduate school, of working with folks with developmental disabilities.

Yoda indicates that as her exposure to developmental disability increased, her comfort level with supporting that population also increased, and her focus became supporting the support system and working directly with families:

> Yoda: Basically. So, that's my experience of how I came to it, and because my comfort level developed, um, and I started working with children that went to school with my son, or families would connect with me because I had a child with autism, and they, the word was out that this is a therapist who has a child with autism. So, I started more working with the families and kind of giving them a supportive situation or supportive, um, services, and then just kind of used some of the stuff that I worked with my son on with my clients and with their families. So, that's where I come from, in kind of, full circle of working with clients with developmental disabilities.

Yoda's approach to serving individuals with intellectual and developmental disabilities in a mental health setting emphasizes understanding the individual's communication methods and understanding that all individuals utilize behavioral expression as communication:

> Yoda: …first and foremost to me is figuring out how they communicate their wants, their needs, their emotions. Um, how they communicate to their environment, how they communicate to their family members, because it can be quite different, um, say if they're in a day treatment program versus living at home with mom and dad or living in their own apartment. Um, so, understanding what their communication base typically, 9 times out of 10, it's behavioral content first. And it is a basic theory of mine, or belief, I should say belief, not just theory. It is a belief of mine that any behavior is a form of communication. So, I kind of go from that aspect, um, and then just try and figure out what they're trying to tell me. So, I need to get a feel for where they're coming from with communicating across to me.

While identifying her currently theoretical orientation to counseling as Eclectic, Yoda acknowledged value in her early cognitive behavioral orientation to counseling and expressed the value in adaptability when supporting this population:

> Yoda: I kind of started more from a sort of cognitive behavioral background, and I think that's kind of helped me cross over into looking at understanding thoughts and feelings and actions and how they relate to the person. I know that that particular, according to, you know, research or theory, they determine that there's kind of a limitation of cognitive behavioral, um, theory, but I, I have, in my mind, kind of adapted it, kind of made it, break it down to more of a basic aspect to kind of get across to folks and get it, um, to the families, looking at those thoughts and those feelings and the actions and how, how they respond to each one of those pieces.

Based on her personal experience as a parent and as someone whose comfort level supporting individuals with intellectual and developmental disabilities as her exposure increased, Yoda communicated that she found no reason for a mental health counselor to avoid working with this population:

> Interviewer: What, what reasons should a counselor engage in a therapeutic relationship with a client who has a developmental disability, and what reasons exist why they shouldn't?
> Yoda: Um, I can't think of a reason why they wouldn't want to. I mean, if you're, if you're open to working with individuals and if that's your calling, then you need to give it a try, give it a shot, and if you can't, say work with the individual, per se, then you know for a fact that you can work with the family.

Supporting families is a major emphasis of Yoda's practice and an intervention she finds significant value in from very early in her practice. Through supporting families, she found communication methods to address the individual with the disability and was able to develop effective interventions from there:

> Yoda:…in the first part of my practice when I was working with individuals with developmental disabilities, I worked a great deal with families that were getting those initial diagnoses of, you know, developmental delay or Down's or autism, and that was a real shock to their systems. And so, I think it was really important for them to kind of get a grasp on how they're defining, um, their family dynamic in relation to this disability. And then it kind of expanded from that of "what techniques and tools can I as a therapist use to reach the family member who has a diagnosis?", and expand either their communication or expand their learning process or give them the ability to understand or process, um, the challenges that are put before them in ways that are less abstract and more concrete or less auditory and more visual.

Additionally, Yoda acknowledged that personal perspective has allowed her to view an active family's role in an individual's life as a tool and allowed her to utilize the family unit as an extension of an intervention:

> Yoda: I believe that, I believe in the idea that when you have a family that's involved, you're looking at the person's first teacher, you're looking at the person's first therapist. You're looking at the first person, the person's first primary female role model and the primary male role model. Those are all very strong power positions to be in; so if we can kind of get an idea of where they're coming across, what their strengths and weaknesses are in relation to the person with a disability. If I can possibly reinforce them, then it may help them in the long run of things in working with that person with a disability. I'm not coming, uh, I think the uniqueness with me is I, I wasn't trained in this. I'm coming more from a life application, hands on background.

It is this real-world experience with developmental disability that Yoda attributes her success as a mental health therapist supporting this population, and she questions whether a more significant formal education on the subject would have hinder her success or not:

> Yoda: I think it is more kind of thinking on your feet, rather than going through and maybe learning from a book what developmental disability looks like and the process of it or how it is diagnosed and how it's tested. I just, I don't have any of that, and I don't know if maybe I would have been a better therapist, or maybe, you know, I don't know, maybe less of a therapist if I got caught up in rehab, and you know, I don't know.

Yoda describes the counseling process with individuals who are diagnosed with developmental disabilities as an exciting sort of mystery, and the excitement beams through in her voice and her eyes communicates this in her interview:

> Yoda: I think again, figuring out where they are coming from, um, how willing they are to participate. How willing is the family. Where is the family coming from? I enjoy the mystery of it. I enjoy the, the trouble shooting of it. And if you're willing to kind of put aside, you know, exactly what, "ok, this is what is the treatment plan, and this is what we are going to look for", but if you are just kind of willing to look at what are some of the things that keep coming up and working at that and observing that. I think, that for me it's the challenge you face. It's the mystery. It's the search. Trying to, um, connect with these people in a way that works for everyone involved. That, for me, is the positive. That's where I get my, my feel good or pat on the back.

However, when asked about resources that exist for mental health providers supporting individuals with intellectual and developmental disabilities, Yoda quickly pointed out that there are very few resources and that the service system not only provides limited resources, it also creates significant barriers to serving this population:

> Interviewer: What resources do you feel like exist for mental health counselors providing services to this population?
> Yoda: {pause} There's not a whole lot. I mean you, you hook in with some of the organizations that work with people with disabilities, and you connect them to, you know, for services for certain options, for funding, for housing, um, for day treatment, for transportation, but for mental health, there's not a whole lot out there. I don't think, um, the mental health needs of a person with a development disability are taken serious enough. Um, they are not taken serious, in my opinion, by the insurance companies. I mean, my son has autism, but he cannot, he cannot be treated for depression just basically under a diagnosis of autism. He has to be labeled depressed.

She went on to discuss her concerns regarding the mental health component of having a disability being overlooked or not acknowledged for individuals with developmental disabilities:

> Yoda: There's emotional issues involved with a developmental disability. You know, how they, how they understand themselves, how they reach out, how they connect with others. That's tied to the disability. I don't think it's just a mental health issue…You know, um, there's a lot of disability organizations that do excellent work but sometimes those organizations don't think out the emotional piece of a person with a developmental disability, just more kind of shaping them into the mold that they already have established in this program. And if they don't fit in this program, they refer them over here.

During the interview, Yoda reflected on how her practice with individuals with intellectual and developmental disabilities had strengthened and improved her ability to provide therapy services to individuals without developmental disabilities:

> Interviewer: Um, what would you say that you've learned working with this population that's impacted you as a therapist in general, overall?
> Yoda: Um, that there are, there are other forms of getting people to connect within themselves. Um, like some of the techniques that I like to use, I like to use video, like

> videotaping somebody while they're speaking. Um, scripting for them, social skills, I mean, Social Stories. Finding alternate ways for the client to process a situation that may be stressful for them or getting a clear picture of their environment and giving them a sense of empowerment as we go through that. I mean I have a whole bag of tricks that I, I kind of fall back on. Um, and I wouldn't have known about any of them if I hadn't had a child with a disability. And I have found that I have used them so much more with my non-developmental disability crowd. Um, some of the best stuff that I've found out there is like working with occupational therapists. Sensory issues, sensory integration, sensory dysfunction. I have used that across the board with so many different client levels out there. It, it's amazing. And it has helped them.

When asked about specific interventions, Yoda shared the process she goes through in assessing and engaging with an individual with a developmental disability in a counseling relationship and identified important questions she arms herself with in order to begin to make sense of the presenting emotional and behavioral challenges:

> Yoda: Um, you know, I was kind of thinking about what do I, what do I normally kind of put in the back of my head when they come in? I'm like, "ok, I need to observe their social skills, um, or examine the interactions that they have with the family members. Um, observe the power structure, or, within the family. Um, what role does the disability play with the power, uh, family structure? Um, does, does the family appreciate the disability; does the family acknowledge the disability? Does the disability play such a role that the family uses it as a sense of definition?" Um, with the family I address grief, and um, realistic beliefs of the disability versus possibly the unrealistic beliefs of the disability. Um, looking at the sensory issues, and the effects, and the understanding.

And she shared specific interventions which focused on body movement and utilizing sensory input to address anxiety that she found beneficial, while pointing out that many people overlook the natural relationship between having a disability and the anxiety that functional limitations will produce:

> Yoda: Um, some of the more hands-on stuff that I use, uh, I use Brain Gym, it's a really good program when interacting with, uh, using exercise and using body movements to increase their focus and increase their processing. Yoga is a really good way of kind of conveying a sense of interaction, I mean, relaxation, but also it helps kind of bring them more into the moment and, and to their bodies and to who they are at the moment. I like to have sensory toys. I keep a basket of sensory toys under the chair that you're sitting in right now. Um, not just for the person with a disability but, uh, I have other clients that

> automatically pull it out and kind of use it to reduce some of the anxiety. That is one piece of developmental disability that people don't acknowledge, that there's a lot of anxiety involved. When you're put into a world that you don't understand. And, you know, that is always an underlying key that I look for. How they manage their anxiety. How they, um, calm themselves.

As she continued to elaborate on specific techniques she utilized, highlighting the value and influence of her parent role on her practice:

> Yoda: So, and then, um using comic strip communications have been effective. Um some folks don't like to do it, but I find it helpful, videotaping the person within the environment that they may be having difficulty, and then videotaping the environment without them in it. And then having the two of us sit down and kind of observe it and look at it, and it gives that sense of separation from their own self-perception. Um, and I do a lot of scripting. A lot of, having them correct their statements. Um, one thing I noticed with my son is, because of his verbal stuff, he was getting a lot from television or videos, and so I was hearing the statements coming out of his mouth that I had heard on the Sponge Bob cartoon the week before. And I thought, oh my god, that's a really valuable thing. I need to figure out what to do with that; so I ended up scripting for folks, you know, of more effective statements, you know of, "how would you change that to make it sound better?" "Let me now say back to you what you just told me". I mean I'm sure there's a title for that, and speech therapists, my speech therapist would probably pull out all of their stuff and tell me better ways of doing it, but that's what I end up doing.

Yoda also addressed the importance she has found in being confrontational, direct, and firm, despite her clinical training steering her to be more supportive and nurturing:

> Yoda: I think as a therapist, you have to be comfortable with being, with making people uncomfortable. So, if someone is being rude, you have to get straightforward with them and say, "that sounded very rude. I'm going to repeat back to you what you just said to me." Um, to somebody on the outside, that's rude. That's inappropriate. How dare you do that? You know, do the soft approach. The soft approach doesn't work. The direct approach is what you have to do. And so, coming from a mental health background, we're not trained for that.

In further exploring this concept, Yoda elaborated on the need for mental health clinicians supporting individuals with intellectual and developmental disabilities to be extremely concrete in a profession that deals more so with abstract concepts:

> Interviewer: What I, in that, what I hear you describing really is the, um, the concreteness of communication that the disability community really grasps and understands that you don't necessarily hear, I mean in the mental health community we tend to be more abstract.
> Yoda: Yeah, absolutely. And I think, I think mental health therapists on some level need to be taught how to be concrete first before they can be abstract. You know when we learned algebra or higher level math that you have to take to pass to get your bachelor's degree or that statistics class, we had to learn simple, basic math first before we could get there. Why not think about the same thing with the communication piece when talking about that in graduate school? I mean that sounds probably pathetic, um, but I think we have to start somewhere, you know, on the most basic level. I think we got more, I think I got more from maybe the classes working for child therapy and play therapy, in that realm. On an overall thing, I think we have to start somewhere.

Yoda's experiences as a mental health clinician supporting individuals with developmental disabilities were most significantly impacted by her role as a parent of an individual with a developmental disability. She specifically pointed to the diagnosis of her young son as a turning point in her knowledge and awareness of this population. Yoda referenced specific strategies she utilized with her counseling clients to facilitate communication and address sensory dysfunction and explained how she acquired those tools and resources through interactions with her son. Additionally, Yoda shared how learning to support individuals with intellectual and developmental disabilities had improved her skills as a counselor and increased her ability to effectively support individuals without an intellectual or developmental disability.

Jane. At 36 years of age and with just 11 years of clinical experience, Jane was both the youngest and least experienced practitioner interviewed. She was employed by a nonprofit community mental health clinic and worked specifically with children in the foster care system. This environment was the setting for much of her clinical experience.

> Jane: Um, I have been working in therapeutic foster care, uh, for about 8 years. Uh, and when I was carrying a full-time caseload, kids would come into our program who had, um, diagnoses like most of the kids had post-traumatic stress disorder diagnoses, um depressive disorders, anxiety disorders, ADHD, ODD, but we also have kids who have a lot of developmental delays, who, um, most of our kids' average IQ is around 75, and then, there was, there were children who also had Asperger's diagnosis as a secondary diagnosis.

Jane worked with directly with the client, the child, but also with the support system, including foster families and biological families:

> Jane: And so, in therapeutic foster care, as a counselor. I would provide individual therapy for the child, family therapy with the therapeutic foster parents, and then also family therapy with the child's family of origin, if that child was working on reunifying, uh, and going back home with that family. Um, those are the kinds of services that the kids receive and that I would provide.

When asked to describe some of her major challenges supporting individuals with intellectual and developmental disabilities in a counseling setting, Jane described feeling like she lacked training and not being able to be as effective with this group utilizing traditional approaches and techniques:

> Jane: Um hm. You know, I often felt like I-I, um, these kiddos always stood out, have stood out to me when I was working with them and even now because it was different than working with kids who didn't have any of these kinds of diagnoses, who were just purely Axis I mental health, no DD. Um, and I always felt like I needed more training. Uh, I, I wasn't, they didn't quite respond in the same ways as other children did, and I couldn't quite do the same kinds of things and be as effective. So, I frequently felt like I needed more training.

She went on to describe some specific instances of ineffectiveness and disconnect she found related to concreteness of language or lack thereof:

> Jane: When I was doing a lot of play therapy, some of the kids who had Asperger's, their play was a little different, and I struggled to see any kinds of changes in things. There was a lot of perseveration on "good guy, bad guy" kinds of stuff. Uh, we had to learn how to communicate with our little guys who had Asperger's. Um, an example is like,

> uh, this young guy came in and was a 9-year-old fella, and he had gotten a certificate at school for perfect attendance. He was really excited, and he showed me, and he wanted to show his paraprofessional. So, I said "let's go down there, and let's show her", you know. "Ok". He says, "Ok". And so we go down there, and I said, "Hey, look at what he's done. Show her. Look at what he's done". And he holds it out and shows the case manager, and the case manager says, "Oh, get outa here. Get outa here." So, he starts backing up with this horrified look on his face. "Ok. Ok. I'm going." And I'm going, "It's ok", you know.

To address the deficit she felt in her ability to support individuals with developmental disabilities, Jane sought out training specifically in the area of autism and Asperger's:

> Jane: I was able to go to some workshops and seminars, uh, and things like that that helped. Learning ways to communicate when I went to a workshop that talked about social skills, and role playing, and scripts, and things like that I felt like then I had some tools.

Jane found that being able to recognize the overly concrete nature of her client's communication and assist him in 'translating' the vague and abstract communication of others was one of the most beneficial therapeutic tools she could use. Additionally, she found that success extremely rewarding:

> Jane: And, um, one of the particular fella, he, uh, would perseverate on different things, and he was having difficulty in the school setting. Kids were getting annoyed with him, and teachers weren't understanding, and everybody was frustrated. Foster parents were tired of hearing about Pokemon, and he didn't get it. And he was feeling frustrated about it, and so we had to learn how to communicate about what it means to perseverate on something. So, we, we kind of developed this saying, he and I, about, he would come and tell me "I'm stuck on it. I'm stuck on this, Miss Jane. I'm stuck on it." And so, that's how I knew he was sort of perseverating on something. And he could start to identify that and start to identify how other people were, kind of, impacted by that. Um, so it was like learning a different language and learning a different tool set. Um, which was, for me, really exciting. I enjoyed it.

And the benefits of improved communication were relayed and applied to the support system, as well:

> Interviewer: With that kind of knowledge of processing, is that stuff you employed within that family therapy as well?
> Jane: Yeah, it then began, it then became helping the foster parent understand his language. Interestingly, he was working with his biological parent as well on reunification; so, biological mom would come in and, she was able to help me understand his language and how to work with him. And soon he was telling his foster mom he was stuck on things and his mom he was stuck on things. Um, yeah, incorporating those things with other individuals, um, who were working with him became important, I think, in a, in a wrap around, kind of way, so that he felt understood, that he was understood, in, in more places than just a therapy office.

When asked about her reasoning for supporting individuals with developmental disabilities, Jane provided an explanation of the importance of connecting with an individual for the purposes of discovering and understanding underlying issues, regardless of the challenges a clinician might face in that process. She identified this process of discovery as valuable and indicated a belief that everyone is capable of it, regardless of cognitive functioning:

> Jane: That's a good question. I think that, um, regardless of what language, I guess, a person speaks, there's some underlying needs and desires to be heard and understood, and when you're not, you're not feeling as though you're heard and understood, it's going to impact your overall mental health. You know, frustration, irritability, anxiety, um, disconnection from others, all those kinds of things. So, I think that there's value to, um, learning to, to speak the language and letting the child teach us so that we can help them feel better about their connections with others, and it's hard for me to understand why those things wouldn't happen regardless of a person's developmental disabilities or their IQ. It's just connecting with them in a, in a different manner than what we are, maybe, traditionally used to. {pauses} And I think that people do do their own work, regardless of whether their IQ is 90 or 70. I, I think sometimes, in my experience, I've seen kiddos with, you know, a 95 IQ do a whole lot less work, clinical work, you know.

Jane surmised that the clinician has a responsibility to treat the client, regardless of the client's IQ, and this belief strongly influenced her practice and the way she approached it:

> Jane: I work with kids who have experienced a lot of trauma. And, just because a kid has a developmental disability does not mean that suddenly, they do not need to work on their trauma. We just, it is, it's our responsibility as practitioners to learn how to figure

out how to help them work on their trauma. Not, "Oh you have this other diagnosis, so we're just going to ignore your mental health stuff. We're going to ignore the trauma". You can't do that. That's not treating a person.

On her demographic questionnaire, Jane listed Cognitive Behavioral Therapy as her clinical orientation to counseling, yet when asked about her theoretical orientation to counseling, communicated a fluid focus in her practice that emphasized meeting the client where he or she was at and making therapeutic decisions based on the individual needs of the person:

> Interviewer: What's your theoretical orientation to counseling, and how do you feel like that influences working with this population?
> Jane: Um, I guess I would say, uh, that, that I do a lot of work now related to trauma, and there's a lot of CBT stuff that I do, but I also do a lot of directive and non-directive play therapy. Um, and when I think of the kiddos that I've worked with, um, definitely in this kind of realm, there was more role play. We did more role play. We didn't do a lot of CBT kinds of stuff. When there was play therapy going on, it was more like directed play therapy. Almost like, "Ok, we're going to play out what happens in the classroom". Um, because, you know, little guy's having trouble in the classroom, we're going to set up a little room and pretend we're in a classroom. We're going to play it out, and then I'm teaching him how to function in that, in that environment where it was bothering him. So we did, we did a lot of directed play. And I don't typically, with other clients, I don't typically do a lot of directed play. I'm a little, I'm a little less directive. I think with [clients with developmental disabilities], I was more directive, and skill-building oriented that I typically would be, um, with some of my other kids.

Jane was asked to describe the seminar she attended that she felt was beneficial to her practice with individuals with intellectual and developmental disabilities:

> Jane: Um, it was extremely helpful. Uh, there was a lot about the brain and understanding all of that important stuff, but also, um, how to relate and how to help with the functional and kind of adaptive skills. So I took from that into some of these sessions, and that's where I was able to start learning things with these kiddos. They talked a lot about note cards and scripting. I don't even know if that's still used anymore, because, I, this was a long time ago. But we would play, "How do you meet somebody?" {gestures as if pulling note card from pocket} And the kiddo would have a little card in his pocket of how to meet people. And we'd practice it and play it out. We'd set up the classroom, and play "How do you raise your hand?", "How do you..." {laughs} I think those are the things that I can remember, that I can remember learning.

However, she was not able to identify resources specifically focused on supporting individuals with intellectual and developmental disabilities available to therapists in her experience beyond the training she had attended:

> Interviewer: Are there any other resources that you've relied on or come across and utilized in serving this population?
> Jane: No, I think I've found myself to be resource empty. Like, I think, I think we as counselors and social workers and what not, need more resources to help understand this population. I mean that was one training, you know what I mean?...that was helpful. {pause} I work a lot with kids, um, trying to help them facilitate a trusting relationship with, an attachment with therapeutic foster parents. And I feel like, um, {pause} I feel like some of the developmental issues, the DD issues really impact attachment. I am sure there are books out there; I'm sure there is something that would help sort of back up that feeling that I have about it, uh, because of the social issues, because of the social deficits of kids with Asperger's. All of that impacts attachment. So, I think I would like more resources related to those things.

Jane also communicated a lack of information on serving this particular population in her formal training and education:

> Interviewer: Do you feel like in your educational preparation on becoming a mental health counselor was there ever any point that these types of issues were addressed or any preparation that you received in this area?
> Jane: Not that I can recall. You know you, in undergrad and then Masters, I seem to recall a traditional kind of child development class. Um, which is very basic. Even for something as important, I think, as attachment there's like, "You know there was Bowlby" and then you move on. But nothing specific, nothing, nothing advanced. I don't think there was even, uh, a little bit about how trauma impacts development, but nothing related to these issues at all, that I can recall.

Jane cited the services system as the sources of barriers and disincentives for mental health clinicians willing to serve individuals with intellectual and developmental disabilities, along with a lack of confidence and preparation of clinicians:

> Interviewer: Ok, in you experience, what disincentives exist for a mental health counselor serving this population?

> Jane: Um, I think there's, uh, Medicaid puts some restrictions on services. Um, and maybe I don't understand Medicaid the way it really is, but I've always been told, if a kiddo's primary diagnosis is Asperger's, we can't treat them. Um, so if it's secondary to something else, we can. So, I think Medicaid puts some limitations. Um, but I think another, I guess, disincentive is that as clinicians, we don't feel equipped. And I think the reality is, we're not. Um, but I don't think it would be, I don't think it would be impossible to become equipped. And I don't think a kid should not be treated. I think it's a responsibility of, um, us as practitioners to figure out and treat them.

And for Jane, her personal connections with individuals she has worked with provide the greatest incentive for taking on the additional challenges associated with providing mental health services to individuals with intellectual and developmental disabilities:

> Interviewer: Are there any incentives that you can identify? Any "pros" specifically to working within this population?
> Jane: Well, it would become a personal thing, but, uh, my favorite clients. I'm going to say two of my very favorite clients in the entire world were kids who had secondary diagnosis of Asperger's. I mean just fabulous, amazing little people. So, that's the incentive to mean that I love them, but you know. I love them. They're great. They're fabulous. And a lot of our foster parents do as well. I mean you know you're not supposed to have favorite clients {laughs}. But, I'm just sayin'.

Based on this perspective, it was not surprising that Jane recognized the therapeutic relationship as the most important component of providing therapy to individuals with developmental disabilities and cited the counselor as being responsible for establishing positive rapport:

> Interviewer: What do you feel like are some of the most important components of having a positive counseling interaction with someone with a developmental disability?
> Jane: Gah, just, absolutely, the relationship. For them to feel that you get them, um, and that you're with them. And that they're okay, whatever they do, and whatever they say, whatever they're doing, they are okay, because they are. You know, that's the most important thing. I think. And I think that becomes the job of the counselors to understand them, and to be with them, and to help them know that you're with them.

While Jane was the youngest, least experienced, and had the least amount of previous connection to intellectual and developmental disabilities, she communicated her passion for supporting this population more resolutely and passionately than any of the other therapists. She

communicated substantial deficits in education and resources available for mental health clinicians when serving individuals with intellectual and developmental disabilities and provided examples of significant restrictions in funding access for mental health services for individuals with developmental disabilities as a primary diagnosis. However, she maintained a high level of passion and excitement for treating this population and communicated a desire for increased opportunities to serve this population.

Dave. Dave was the only male clinician interviewed and the only clinician providing therapy services as a Licensed Master Social Worker. At 44 years old, he had 18 years of clinical experience and reported serving the largest number of individuals, over 100, with intellectual and developmental disabilities as a mental health practitioner. Additionally, Dave had experience providing the most diverse range of services to individuals. In additional to individual, group, and family therapy, Dave had experience working with day treatment, supported employment, and para-professional interventions:

> Dave: I work primarily with clients who have a serious mental illness, uh, and often, I'd say about maybe a third of our clients, have some co-occurring developmental disorder. So, we're working with clients and providing services in terms of individual counseling, group therapy. We have day services. Also para-professional interventions in the community. We try to help link them with employment resources. We briefly provided supported employment. We were an employment network briefly also, and we had clients with DD who were working with us in that capacity.

Dave highlighted the value and benefit of having mental health para-professionals available to work in community-based settings and support skills in real life environments for individuals with intellectual and developmental disabilities and the necessity for individuals with

developmental disabilities to make concrete connections and applications of concepts in order for them to be mastered:

> Dave: We have mental health professionals and those are licensed, traditional, credentialed professionals. We also have bachelor level providers who work as mental health professional extenders, and so they help clients with functional skill development, activities of daily living, coping skills, social skills, uh you know, stuff from budgeting to hygiene to apartment maintenance to, um, how to interact in a social setting, like how to join a bowling league, how to go to a theme park, things like that.
> Interviewer: What types of environments do those services take place in?
> Dave: Primarily, the community. You know, we operate within a recovery model and, um we were a traditional clubhouse when I first got here. Actually, we were more of a modified clubhouse and there was an emphasis on promoting community integration, there still is, but we did more things like camping trips when I first got here, um, more activities in the community like bowling and, um. I'm a big believer in Vygotsky and more capable peer learning. So we definitely were trying to help the clients acquire skills in those more natural environments and in a more meaningful way than me kind of telling how great it would be to structure their day and how great it would be to have a healthy recreational activity, um, which doesn't have a whole lot of connection for them in session, but when they go out into the community and see it done by somebody, it definitely resonated with them.

The individuals receiving support from Dave who are dually diagnosed primarily had a developmental disabilities diagnosis of Mild to Moderate Mental Retardation:

> Interviewer: Okay. And with the DD diagnoses that are secondary for the clients that are in these programs, what are some of the typical diagnoses that you would see in that DD realm?
> Dave: Really, it's, often times, it is mild to moderate MR, and sometimes we get children with a pervasive developmental disorders. Um, and maybe some autism spectrum disorder, but primarily, mild to moderate MR, is what we see clients diagnosed with.

When asked to discuss barriers that mental health providers face when serving individuals with intellectual and developmental disabilities, Dave relayed systemic barriers as being a primary challenge to supporting people appropriately:

> Dave: A lot of [barriers] are external; so I'll address those first. Um, with clients who have a diagnosis of mental illness and also a, let's say mild MR, let's say the client's been diagnosed with, and this is a common presentation, bipolar disorder and MR or schizophrenia, but more commonly bipolar, we can provide services only so long as the mental illness is primary. So, sometimes the more relevant services to the client, the services that are helping them integrate into the community or perhaps the underlying supports that they would have, um, we cannot provide if the primary diagnosis is developmental. Now, it's kind of an interesting phenomenon, because, you know, we would like to keep them services as long as they need care and then transfer out when they don't need care. Um, sometimes, I have clients in Eureka, and there's no place to transfer the clients to when they are no longer needing our services from a psychiatric standpoint.

Dave also discussed the problem with a system that silos mental health and developmental disability services and supports, when the reality of an individual's experience is that there is significant overlap in functional limitation and support needs. He emphasizes that, regardless of the cause of a person's functional limitation, the person still needs supports:

> Dave: ...if we had seen a client in child services for a long time, they may have not applied for [disability services] or helped coordinate that, and so, it's a long wait, and so you're left with some, I'm left with what I feel are some ethical considerations about denying care to someone who is in need and also there not being another resource to pick the client up. That, that's a primary challenge. Also, in teasing out what the functional skill deficit is due to. Because you have to make these convoluted arguments that the deficit is due to depression and not to the MR, and how do you know that that? And you know, they can't get out of bed because they are too depressed, or they can't follow a schedule because they can't concentrate and they can't focus. And also, I think sometimes we get referrals who may be, you know, mis-diagnosed in an effort to secure them services; so, someone who has MR may be diagnosed with bipolar if they exhibit some aggression, um, and then they call that, you know, mood swings. So, there's some difficulty maybe in even finding accurate diagnosis, uh, initially.

Dave notes clinician bias and concerns regarding clinician competency as being significant internal barriers to providing mental health services to individuals with intellectual and developmental disabilities and the importance of educating clinicians that individuals with intellectual and developmental disabilities have rich lives and are capable of growth and development:

> Dave: Internally, I would say that there is some clinician bias. Um, I think some clinicians are reluctant to take on clients who have cognitive issues, cognitive deficits. Their assertion may be that [the clients] cannot function in a process group or they may not benefit from individual therapy, which I know they can. I know these clients have very rich, very rich internal lives, and are capable of growth and change. So, uh, that's been a role, I guess, I have in education with the staff is to help them to, oh, not value, but appreciate the fact that these clients can grow and change just like everybody else can. Because I think that they're often not considered eligible or benefiting from counseling or group therapy or other core services. So that's the primary internal, I guess, clinician bias that we have. There's also a belief that there are issues with competency. Um, you know, providers don't want to practice beyond their scope of competency, and so when, I have brought up that perhaps we want to do both services. We want to be, um an MR provider, I mean a developmental disability provider, and also a mental illness provider. Um, the response back is that we don't have enough psychiatrist or providers to cover that semi-population. We don't have the training or competency, you know, to work with the MR populations, and so we can't do it. But, of course we are doing it, we just, you know, may not be nearly as effective as we could.

When asked about the reasons why he has actively and passionately committed to providing mental health supports to individuals with intellectual and developmental disabilities, Dave cites his early professional experience and the influence it had on his view of individuals in this populations as worthy and valuable:

> Dave: Well, you know, I don't know if it was an active decision. My background is in medical social work, transplant social work, and I've been in mental health for about a decade. Um, I think a lot of our clients, a lot of the clients I work with in the hospitals, you know we did work with clients who had developmental disorders, and so I guess I'll say that my early exposure to clients was in that setting, and I learned to enjoy working with that group, and, um. So I guess early positive experiences working with that populations, um comfort working with the serious mentally ill population, and there being a natural link of, um, there are people in that population who have DD… And I worked with a lot of families when I was in transplantation, uh, and many of those had developmental issues, and, I guess I would say one of the first articles I published was dialyzing the institutionalized, seriously mentally ill populations. We were the only facility in the state who dialyzed the prisoners and the people from the state institutions. So, some of my clients were, um, had major developmental disability problems, and it became quite a process getting the family together and talking to the team about why it's meaningful to help them and not just let them die. So, thinking back now, that was a very profound, I guess, impactful experience that I had early on. And

> seeing the benefit of them having that, um, access to a totally lifesaving, you know, with dialysis you went from a totally fatal disease process to, you can treat it, and they can live. And, um, so seeing the clients, the clients who had MR benefit from that and have, you know, just full rich lives.

Dave notes a reliance on a Cognitive Behavioral Therapy orientation to counseling when supporting individuals with intellectual and developmental disabilities and the importance of working with families:

> Interviewer: What's your theoretical orientation to counseling and how do you feel that influences your work within this population?
> Dave: Well, you know, when I was in school, and early on, I would think I was more Rogerian or eclectic, but I think probably, I'm more fundamentally CBT. Um, you know, we've had internal trainings by people from the Beck Institute, and I tend to use a lot of behavioral activation and activity scheduling in my treatment of clients with SMI and also I find that to be very effective with clients who have developmental disorders in helping them structure their day and helping them identify healthy recreational activities and trying to get to the mood components from that end. And also, I guess, working with families.

Dave struggled to identify reasons other mental health practitioners might be willing to work with individuals with developmental disabilities, beyond personal motivations, and, instead, provided a number of disincentives that exist in the structure of community mental health environment that prevent some practitioners from being willing to serve this population:

> Interviewer: What reasons do you think practitioners do work in this realm?
> Dave: I mean, I think there are some individuals, personal, I guess reasons for wanting to work with this population. Um, you know, I think a lot of the clinicians here will gravitate towards the child services populations because they feel like the can see the most change, and um, when you can't see change rapidly, you become, I think, more disheartened; so, in turns of an incentive, um, you know, we have not incentivized the work with these clients, and I really don't know how to answer that better. And not even, there's not a whole lot of external incentives. I mean one of the things that's a barrier, I think, in most mental health centers to providing care in maybe the ways that the therapist would want to is the issue of productivity. Most places now have pretty high productivity expectations for clinicians. Now that's more of a disincentive. But, you know, if a client is not reliable or consistent and misses appointments, then the clinician will take the hit and maybe not make their productivity, and will have some pretty serious consequences,

> including termination. So, that would be a reason to not want to work with a population that may not be as reliable or, um, or seen as reliable. You know we talked about incentivizing different providers based on their ability to bill certain third-party payers, uh, so we would get more people who bill Medicare and adult services, but that's not really an incentive to necessarily work with the clients with DD because they're often Medicaid. So, I'm fumbling here, I can't think of, we haven't provided any kind of coherent incentive internally to work with this population.

After acknowledging the obstacles productivity expectations can impose on clinicians who might be willing to work with this population, Dave explores the possibility of using reduced productivity requirements as a potential incentive to encourage otherwise willing therapist to commit to provide services to individuals with intellectual and developmental disabilities. He also acknowledged his inability to answer the question more effectively was due to his agency's lack of previous interest in providing incentives to support this population:

> Dave: So, you know, we have different productivity standards for people who are working in office-based settings versus field. So, I think a lowered productivity setting and maybe the ability to go out and do more field work, that could be a potential incentive for someone who wanted to do that. Uh, yeah, it's just that when you say incentives, you know, the organization has not expressed desire to treat this population to be thinking about how we would incentivize individual clinicians is a little difficult to kind of wrap my head around.

Dave communicated that, for therapists to be successful supporting this population, the clinician must believe in the client's ability to grow and change, must be able to establish a healthy therapeutic relationship, and, ideally, must be able to work with the client in real world settings:

> Interviewer: What do you feel like are important components to facilitate an effective and positive interaction as far as therapy is concerned?
> Dave: I think the clinician has to fundamentally believe that people with DD are capable of growth and change. You know, without that belief and that value of that relationship and that potential, that's, I think the client will pick up on that, and, the client will not invest in the relationship. So, I think being able to establish a positive therapeutic alliance is based on that positive regard and belief in ability. The clinician must be able to break down change into various small components that are measureable and that you're

> able to communicate to the client and share successes with the client. The client can see that they're improving. You know, and I think the therapeutic relationship really, for clients who may have functional skill deficits, has to include the ability to, um, to model behavior and demonstrate behavior, and, ideally, it would be in the community, and not strictly in an office setting. Um, I think working with the families is essential, so that they can help you coordinate whatever. A lot of our clinicians are, a lot of our MHPPs will develop schedules for managing household chores or schedules for when to get up and take your medicine or brush your teeth and take a shower. And often the families, we get them involved in that. That's definitely going to help the whole process. And these are long-term relationships often times. So, the ability to not foster dependency in a long-term relationship and the ability to be able to set and maintain appropriate boundaries and, uh, not fall into the role of doing for rather than teaching how and doing with. I think those are huge things. So, you know, having a solid ethical foundation, having a belief that people are capable for change, being able to provide services outside of the office setting, and work with the families.

Additionally, Dave stressed the importance of clinicians having access to training, resources, and, most importantly, support and supervision to reinforce that the skills they have are valuable and sufficient to serve this population:

> Dave:…having someone, again, internal ongoing supports for training because, I don't think anybody here has felt that they had mastery or maybe even competence in providing care to this population. So, I think a lot of clinicians when they're doing this, they're kind of questioning themselves, you know, "Should I be doing this?" or you know, "I don't really know what I'm doing" {laughing}. Um, and it makes them uneasy, and it makes them, I think, not even trust in the skills that they have that they bring to bear with the client. They think, "I must need a whole set of different skills to work with this population. I can't use anything from CBT that I know or anything that has worked with other clients because, this is a big black box, and I don't know anything about it."… You know, I think having a supportive, cohesive team is an internal resources. People, you know, I know my clients are getting it, so I don't have to worry about them because I know that the para-professionals have been trained. So trusting, trusting your team members, knowing that you have the support of your psychiatrist and staff. Um, I think that we've got to do a better job with, with providing on-going training, and we've got to do a better job with figuring out how to, how to get the people who need the resources applying for the resources in a timely fashion.

And the importance of relevant training and resources with fidelity measures for clinicians:

> Dave: Um, I think the challenge we have now is finding a way to measure fidelity to whatever we're using. I think clinicians will sometimes get defensive and sometimes say, "Well, I know I'm doing good work". Well, how do you know and how do you know

> what the fidelity measures are? And what are you doing to ensure that you are true to the model or true to the, um, theory? So, we just need to, we're working on that now. So, I know like ACT has fidelity measures, supported employment does, illness management recovery does. We're working on either finding external trainers or doing team meetings. It's, it's just a challenge carving out time so you're not interfering in the productivity of the individual therapists. But I think they will be more accepting of that than a child clinician going to an adult training on CBT or someone, you know, an adult trainer on suicide assessments, so. Definitely, making it relevant to clinicians.

Dave points to work with individuals with intellectual and developmental disabilities as providing some of the most significant transformations for therapists to be a part of and recognizes that supporting this populations positively impacts therapists' skills in all areas of their practice:

> Dave: I guess we've had some of our more, um, our bigger successes with clients, in terms of getting jobs and integrating in the community. We've seen pretty, pretty huge transformations in some clients' lives, and successes in ways we would not have initially. Or, some clients, some clinicians would not have imagined what's possible. So, just knowing that the models and the therapies that we use with our clients who have mental illness are effective with clients who have DD, and we can support them in the community. Um, I think that's biggest, you know seeing some positive outcomes… You're talking about really identifying those skills and, um, and kind of inherent qualities that are effective across a broad spectrum of diagnoses. And I think that, so I was Rogerian initially, but having that unconditional positive regard and belief in potential for people. Again, I think that is the foundation for effective work with a client. You know, certainly having the tools and the training, um, you know whatever model that you want to use, whether it be systems or CBT or, having some facility in the use of those therapeutic techniques.

Dave reported treating the most individuals with intellectual and developmental disabilities in a mental health setting. He communicated the importance of para-professional level support on mental health team supporting this population and the need for services to occur in real-world environments in order to be the most effective. Throughout his interview, Dave repeatedly emphasized his belief that individuals with intellectual and developmental disabilities have rich, valuable lives and were capable of growth and change. He communicated that these

beliefs are essential for clinicians to have in order to be able to effectively treat this population. Dave provided further evidence of systemic barriers to treatment in regarding to primary diagnosis restrictions but also in the structure of mental health practices. He communicated that many clinicians are deterred for treating clients with developmental disabilities due to high productivity expectations and a lack of resources and support.

Sally. Sally was a 46 year old clinician with just under 15 years of clinical experience. She provided mental health services at a nonprofit, residential treatment center for juveniles with sexually inappropriate or maladaptive behaviors. Sally was also the parent of a child with a developmental disability. Sally's experiences supporting individuals with intellectual and developmental disabilities focused primarily on individual and group counseling and supporting the support system in the residential environment, with occasional opportunities to work with families and outside support systems:

> Sally: I've done one-to-one, individual therapy, weekly, for as long as they were there, and for some of those individuals I would break it up into two sessions, a shorter amount of time. Also, group therapies, 3 to 4 times a week. I would also, if they were having difficulties on the unit, go on the unit and work with them, try to work through issues in the moment with them also. Also, depending on if family was still involved with them, I would also do family therapy sessions and also do coaching with the staff on how to work with residents with developmental disabilities. For a lot of my residents, we would develop some type of behavioral contract with them, in additional to what we normally do.

Within the residential environment, Sally stressed the importance of having a concrete and individualized behavioral contract for the individuals she supported who were diagnosed with intellectual and developmental disabilities:

> Sally: I think [behavioral contacts] are really important, especially with developmental disabilities or children with developmental disabilities, that, in the moment, it's especially

> important, especially in a residential setting, working with staff members that maybe aren't as educated that they also have a guide that they understand, along with the client where if I do this I can obtain this type of privilege, or in some cases responsibilities. Some of them felt really good earning different special responsibilities. I think it was good for them, in the moment, it was something concrete. Concreteness is very important when working with kids with disabilities, that they could not only hear it but see it. Um, sometimes we would come up with tactile cues or visual cues for some of the kids that, maybe, were better able to understand it visually versus auditory. So, it just, it really depended on each resident and what needs they had.

When asked about the challenges that she's experienced providing supports to individuals with intellectual and developmental disabilities, Sally admitted that, initially, she did not enjoy providing supports to this population:

> Interviewer: What challenges have you encountered working with this population?
> Sally: It's kind of funny, when I first started working residential, I did not enjoy working with the individuals with developmental disabilities as much. I preferred working with the more ODD or conduct disordered adolescents. I think part of that had to do with I didn't feel as comfortable working with kids with developmental disabilities because of my lack of knowledge. Um, but I have found, throughout the years, some of my most favorite kids to work with have [developmental disabilities]. Um, I've learned that I learn a lot from them, plus, a lot of times they're, a lot of them tend to be really sweet, and they're honest, and they want to do well. And, it's not as exhausting for me as it is if I'm working in session, you know, with an adolescent that's just trying to be manipulative or they're not motivated to make changes. So, I love working with them now.

She acknowledges that, in addition to setting personal goals to improve her comfort level and ability to serve this population, her clinical development as it relates to supporting individuals with developmental disabilities was largely influenced by her life experience of becoming a parent of a child with a developmental disability:

> Sally: I think part of it was just, it was always one of my professional goals to get more knowledge working with them. But, um, I think part of it was personally motivated also because, you know, I have a young son, well, he just turned 10, who has a developmental disability of high functioning autism. And that, starting from the age of 3, really somewhat opened up my eyes to, I couldn't say I wasn't comfortable with it anymore

> because I have to deal with it on a day-to-day basis in my personal life. So, I think part of that was my motivation, and also, just the more I started working with them, the more, I don't know, a sense of, it was just more satisfying for me. And plus, especially kids on the [autism] spectrum, they're so misunderstood and there just isn't much knowledge out there. But, I don't know, I felt like it was part of my personal mission to educate other people and to get them as many services as I could because it's so hard to get on [disability services] with mountains of paperwork and anything that I could do to also make it fair for the kids and for them to be as inclusive, well, not inclusive, well I want them to be more mainstreamed. So, anyways, it just became both a personal and a career type of situation… I just, um, yeah, I can't explain it, and I don't even know if, I'm guessing it has to do partly with my son. Um, I also had a still born baby girl. She had a genetic birth defect. Um, and so, I just, I don't know if it's just related to this internal drive of somehow the things that have happened in my life, that somehow I can affect somebody else in a positive way.

Sally identified her theoretical orientation to counseling as Cognitive Behavioral Therapy but acknowledged her reliance on Reality Therapy and emphasizing a present-focus to therapy with individuals with developmental disabilities:

> Sally: Well, I'm a Cognitive-Behavioral, but I do like Reality Therapy, and a lot of in the moment, you know, "How are feeling right now?" But a big part of it is I believe how we think affects how we feel and how we feel affects how we behave, and so even if they're not developmentally delayed, we talk a lot about thinking positive and reframing situations. Um, but it's also about being in the moment, um, and "This is what we have to work with", and, you know, "How can we make things better?"

When ask about potential incentives for therapist to work with individuals with developmental disabilities, Sally alluded to the rewarding nature of the relationships therapists develop with clientele in this population and the ability to feel like a difference has been made:

> Interviewer: In your experience, not just for yourself for but for other practitioners, what incentives exist for a counselor to work with this population?
> Sally: Well, I don't think they're monetary, for sure. I think a lot of it has to do with, again, internally an accomplishment and feeling like, I don't know, I think being an advocate is a huge, huge part of what I do and why I do it, uh, because there are so many kids who aren't advocated for, I think, and especially kids with special needs. And so, I don't know. For me, it's just what motivates me. I think for a lot of the therapist that I work with, I don't know if you can put it into words, but you just, there's this feeling of feeling connected in some ways, and um, I think for any therapist, if you're not motivated

> internally, all the money in the world's not going to make a difference. So, I think it's just about feeling good as a person and feeling like, it sounds kind of dorky, but helping somebody's life be better and for them to be as productive and happy and feel good about who they are.

Sally discussed lack of supports, resources, knowledge, and understanding as the primary disincentives that prevent therapists from supporting individuals with intellectual and developmental disabilities:

> Interviewer: Okay. Uh, what about disincentives? What challenges do you see facing a mental health practitioner that might deter them from working with this population?
> Sally: I think it's going to be, I think that if they were in an individual practice where they didn't have support of a team around them. I think it's really important to continue to get education and to continue to feel support, you know, especially with individuals with developmental disabilities. You're maybe not going to see the huge "Ta Da" changes that you might see in the quote-unquote "normal" population, and I think it's realizing that a little thing, such as them looking you in the eye or saying "thank you", you know, or, uh, taking care of their hygiene for the day is a huge step, you know. But for some people they might not feel like they are being very successful, but they're not realistic with what they expect.
> S: So a lack of knowledge and understanding just about developmental disability?
> A: Correct, and also, again, I think it's going to be really important for support and for other professionals to be able to bounce ideas off of and to kind of like, make sure, um, "Okay, yeah, I'm on base with this" and there are positive changes being made. Because sometimes it's almost like, "Um, am I making a difference here" or "Are things ever going to change for this individual?" because the changes are so small.

Sally emphasized the importance of positive rapport and a strong therapeutic relationship for successful outcomes in therapy with this population:

> Sally: I think, like any population, you know the positive regard, all those treatment lingoes we hear in school, but if you don't have a, some type of connection with your client, I think it's, you can throw all the theories out and try all the fancy techniques, but if you don't have some type of relationship where they can tell that you care and that you believe in them, then nothing else is really going to matter. And so I try to work on developing a relationship with them. Level work and therapy assignments, you know, are important, and certainly, there are assignments to do but you make sure they're individualized, but again, I think a lot of it has to do with the relationship and at the same time, you need to set limits and be firm, because even though they are developmentally delayed, many of them are very smart when it comes to manipulating, or, or trying to get what they want without necessarily putting the work or effort into it. All at the same time it's being firm, consistent, I think consistency is huge, but also, they can tell if a person

truly cares or believes in them, and I think, if you don't have those two things, you got nothing when it comes to working with them.

When asked about resources and education that clinicians could access to support their practice with individuals with intellectual and developmental disabilities, Sally indicated that all the learning opportunities she had experienced were self-sought or based on life experience:

> Sally: Definitely, again, I think it's important to reach out to other professionals. I tend to buy books, and I do tend to look on the internet at times, you know there's certain information you can find on the internet, but I do think it's also important to go to trainings. But again, a lot of it has to do with self-education, and part of it has to do with experiencing that. But I think it's a combination of conferences and reading, and reaching out to people and having conversations. And part of it is life experience.

And she seemed surprised when asked to consider how her work with individuals with intellectual and developmental disabilities had influenced her work with clients without this limitations:

> Interviewer: What have you learned working with this population that has been able influence and benefit your practice with patients who do not have a developmental disability?
> Sally: Um, good question. Definitely, patience. Um, I think I've become more patient working with them. Also, understanding that maybe not everybody has the same type of potential but we're all very worthwhile and have a lot to bring to the world. Um, and empathy. I'm feeling, for me, I guess, it's feeling grateful and trying to have my other clients really take a look at, you know, how bad is your life really and focusing, again, on the positives versus the negatives. That's a good question. I don't think I've ever really thought about that before.

When asked if there was any information she felt was important that she was not asked about, Sally explained that self-care was vitally important for all therapists, but especially therapists supporting this population:

> Sally: I think it's, along with any type of therapy, I think taking care of ourselves as individuals. Um, monitoring for stress. Um, you know, I think back to a couple of individuals, and maybe I shouldn't feel this way, but I feel more of a sense of sadness a lot of times when I work with kids with developmental disabilities, and maybe that's

> because it seems like they've been thrown away by so many people in their lives or that they've been mistreated or that somebody hasn't advocated for their needs. So, right, wrong, or otherwise, and again, maybe it's my issues, I feel a, a different type of sadness sometimes for them. And maybe it's just my experiences but a lot of the kids that I've worked with, and again, maybe they're at the further end of seriousness than maybe somebody else does, but they just seem to have gone through a lot of traumatic events, and they've been taken advantage a lot, and that hurts me deep in my soul, and I think it's just important, again, for somebody to be able to, there's work then there's work, but somehow to be able to not be sad so much.

Sally's experiences differed from the other four clinicians interviewed in that her counseling experience working with individuals with intellectual and developmental disabilities came in an inpatient, residential treatment facility. Despite this difference in setting, she echoed other interviewees' focus on importance of supporting the support system. For Sally, often times she found it most effective to work with the support staff in the residential facility to help bridge the gap between the client's communication and learning differences and the world around her or him. Sally's shared that, initially, she was not comfortable and found significant challenges serving this population. However, just as Yoda experienced, Sally's perspective and understanding of individuals with intellectual and developmental disabilities was significantly changed when she had a child who was diagnosed with a developmental disability.

Composite Depiction. When looking at all of the interview transcripts collectively, a list of 52 themes emerge at a regular frequency that create a composite depiction of the experiences of these five clinicians providing mental health services to individuals with intellectual and developmental disabilities. These themes are depicted in Table 3.

Table 3

Themes Present in Composite Depiction

THEME	NUMBER OF CLINICIANS MENTIONED	NUMBER OF TOTAL TIMES REFERENCED
ADAPTING & MODIFYING TRADITIONAL RESOURCES	5	33
ADVOCACY	5	13
CLINICIAN INSECURITIES	5	12
CLINICIAN'S RESPONSIBILITY TO UNDERSTAND	5	36
COGNITIVE BEHAVIORAL THEORY	5	5
COMMITMENT TO SERVE	5	13
COMMUNICATION & LEARNING DIFFERENCES	5	25
CONCRETENESS IS IMPORTANT	5	25
DD RESOURCES ARE ASSETS	5	10
DEVELOPING FUNCTIONAL SKILLS	5	20
LACK OF CLINICAL EDUCATION OR TRAINING	5	21
MEETING PEOPLE WHERE THEY ARE AT	5	23
MENTAL HEALTH IS A PART OF DD	5	19
OPEN MIND	5	14
SEEING THE PERSON FIRST	5	9
SPECIFIC TECHNIQUES TO USE	5	35
SUCCESS IS REINFORCING	5	9
SUPPORTING THE SUPPORT SYSTEM	5	30
SYSTEMIC BARRIERS TO TREATMENT	5	27
VALUE & WORTH	5	18
BEHAVIOR AS COMMUNICATION	4	10
EXPOSURE INCREASED COMFORT	4	10
INDIVIDUALS WITH DD ARE CAPABLE	4	9
LACK OF INCENTIVES	4	12
LACK OF RESOURCES	4	15
MH NEEDS FOR DD NOT TAKEN SERIOUS	4	11
PERSONAL EXPERIENCE	4	10
RELATIONSHIP IS MOST IMPORTANT	4	15
SOUGHT OUT ADDITIONAL INFORMATION	4	7
ACCESSING APPROPRIATE SUPPORTS	3	13
CLINICIAN BIAS	3	6
CLINICIAN SUPERVISION IS VITAL	3	4
ECLECTIC THEORY	3	3
FUN POPULATION TO WORK WITH	3	6

Table 3 Continued

Themes Present in Composite Depiction

THEME	NUMBER OF CLINICIANS MENTIONED	NUMBER OF TOTAL TIMES REFERENCED
INTERVENTIONS USED	3	9
PARENT OF CHILD WITH DD	3	10
POTENTIAL INCENTIVES	3	7
PREVIOUS WORK EXPERIENCE	3	8
TRAINING & SUPPORT MUST BE EMPHASIZED	3	10
COMMUNITY-BASED SERVICES	2	8
EVERYONE CAN DO THEIR WORK, DESPITE LIMITATIONS	2	2
INCLUSION IMPACTS QUALITY OF LIFE	2	2
REINFORCED BY CHALLENGE	2	3
SCOPE OF PRACTICE CONCERNS	2	4
SELF-EDUCATED ON DD	2	3
SENSORY ISSUES	2	6
SERVING THIS POPULATION MAKES ME A BETTER THERAPIST	2	6
BENEFITS OF TECHNOLOGY	1	1
FELT DRAWN TO CLIENTS WITH DD	1	1
IMMERSED IN DD	1	1
PROBLEMS WITH EVIDENCE BASED FOR DD	1	3
ROGERIAN	1	1
SELF-CARE IMPORTANT FOR CLINICIAN	1	2

While the “importance of clinician self-care”, “concerns regarding a lack of research focused on evidenced-based interventions specifically targeted at individuals with intellectual and developmental disabilities”, the “benefits of being immersed in a population of individuals with developmental disabilities”, “feeling drawn to clients who have a diagnosed developmental disability”, and “the benefits of technology in supporting individuals with intellectual and developmental disabilities” were themes that were only documented in the experiences of a single clinician interview, they were prominent themes that were discussed at length and provided valuable information and insight, despite the lack of repetitiveness across clinicians. Specifically, “importance of clinician self-care” speaks directly to the research question in this study that asks, “What are the rewards and consequences of providing mental health services to individuals with intellectual and developmental disabilities?” Only one clinician identified a consequence of supporting this population, and that was a heightened sense of sadness that required a focus on clinician self-care. Due to the specific relevance to the research questions, themes provided by only one clinician have been in included in the analysis of this research.

For the clinician who emphasized the importance of self-care, the recommendation came from a lengthy discussion of the profound sadness she felt when providing mental health services to some individuals with intellectual and developmental disabilities. The discussion focused on the mental health field’s emphasis on evidence-based interventions highlighted the exclusionary nature this requirement has on the population in question due to the lack of research, or evidence, being generated focusing on interventions for treating individuals with intellectual and developmental disabilities. The opportunity to experience immersion in a group of individuals with developmental disabilities was one that only one of the clinicians interviewed had; however,

the value and benefits were significant and reinforced the theme of exposure to this population increases comfort. While only one clinician communicated a sense of feeling drawn to this population, that sense of connection was valuable and mirrored other clinicians' personal and professional connections of other kinds. And the emphasis on the importance of technology in supporting individuals with intellectual and developmental disabilities was only introduced by a single interview subject, the discussion provided significant evidence that technology tools, such as the iPad, could be valuable resources in facilitating connection and communication in a therapeutic environment. For all these reasons, these themes are considered valuable insights, despite only being identified in one of the five source interviews.

Similarly, "community-based services", "everyone can do their work despite limitations", "inclusion impacts quality of life", "reinforced by challenge", "scope of practice concerns", "self-educated on developmental disability", "sensory issues", and "serving this population makes me a better therapist" were all themes identified in two of the five interview transcripts, yet each of these themes offers valuable comprehension of the experiences of clinicians supporting individuals with intellectual and developmental disabilities.

Those clinicians discussing the importance of community-based services emphasized the frequent need for individuals with intellectual and developmental disabilities to learn skills in the environment of application and avoid unsuccessful attempts to acquire transferable skills in a false environments. The clinicians who offered the conclusion that despite limitations, everyone is capable of doing their own work passionately attempted to dispel the myth that some limitations are so significant that they prevent individuals from being able to effectively process

emotions. The impact of inclusion on an individual's quality of life served as a guide for the therapists who contributed that theme. They both used it to focus their counseling efforts on supporting their clients' inclusion to the greatest degree possible. The therapists who revealed their positive response to the challenges associated with supporting an underserved and poorly understood population provide a potential opportunity to highlight incentives for some that may be assumed to be barriers to others. Scope of practice concerns are well documented for mental health practitioners with many populations. Identifying those concerns in the shared experiences of the interviews conducted reinforces the concept as an ongoing barrier to quality mental health treatment for individuals with intellectual and developmental disabilities. The clinicians who identified the importance of being self-educated on developmental disability illustrate a barrier in clinician supports and resources while addressing the innovative ways they overcame the lack of education resources provided in the traditional education process. The practitioners who focused on sensory issues in their mental health practices both identified this need and offered specific interventions for how to address this client need. And the clinicians who suggested that serving this population makes them better therapists offer a hopeful incentive to work that is often view as significantly lacking incentives.

The collective narrative of the clinician interviews indicates that "emphasizing training and support" is important to clinicians working with individuals with intellectual and developmental disabilities. It is a theme that clinicians identified as being both a positive contributing factor to their success with this population and a necessary component for other clinicians willing to serve this population. Over half of the practitioners interviewed had been influenced by "previous work experiences" that facilitated their willingness and ability to support

this population. In each case, this previous work experience with individuals with intellectual and developmental disabilities were positive experiences and provided the opportunity for the clinician to-be to see the value and worth of individuals in this group. While they vary across environments and situations, over half of the clinicians interviewed were able to identify "meaningful incentives to supporting this population"; however, all of these incentives were personal, such as being rewarded by the relationships and substantial progress seen when supporting this population, yet no incentives were identified on an agency or systemic level.

In addition to previous work experiences being identified as a key factor in a clinician's ability to treat this population, clinicians who were parents of children with intellectual and developmental disabilities were also a strong focus. Two of the five clinicians interviewed for this study were parents of children with developmental disabilities and an additional clinician, who had no children, communicated that the clinicians she had known who understand this population best were individuals who were parents or family members of an individuals with an intellectual or developmental disability. The collective experiences of the interviewees captured the importance of having a connected, nurturing relationship with an individual with a developmental disability and being able to see individual in a more diverse role than simply "an individual with a developmental disability" in facilitating clinician comfort and success in supporting this population. The two parents of children with intellectual and developmental disabilities interviewed frequently cited ideas and techniques they utilized in therapy settings that were developed based on interactions with their own children.

Many clinicians provided examples and descriptions of specific techniques they found to be beneficial in providing mental health services to individuals with intellectual and developmental disabilities. Specific techniques and interventions reported often focused on sensory processing needs, such as utilizing physical movements like yoga or Brain Gym, providing sensory input through props and toys, and giving opportunities to incorporate movement into therapy through things like swinging. Direct proprioceptive sensory input was reported to be utilized in certain situations in the forms of the Wilbarger brush technique, rug wraps, and bodysoks. Additionally, documented techniques utilized to support this population focused on concreteness and strategies to translate situations and settings that prove confusing to clients with intellectual and developmental disabilities. Clinicians reported using concreate behavioral contracts, visual scheduling, scripting, role play, directed play, social stories, comic strip conversations, and situational/environment videotaping to assist their clients with intellectual and developmental disabilities to better understand the world around them and develop more effective means of interacting with that world. To some degree, clinicians indicated using these types of tools to assist individuals with intellectual and developmental disabilities to "speak the language" of the people around them who do not have developmental disabilities.

More than half of the clinicians interviewed specifically stated that they found joy and/or satisfaction in working with this population, and several clinicians displayed endearing emotional responses when describing specific individuals they had supported and reporting the enjoyment they experienced working with those individuals. All clinicians interviewed reported the importance of remaining flexible and fluid when supporting individuals with intellectual and

developmental disabilities. Many clinicians specifically praised the value of having a close supervision relationship to rely on when supporting this population and highlighted the importance of a strong supervision or support team relationship for any clinician working with this population, regardless of the clinician's tenure or years of experience. Throughout the interviews, clinicians repeatedly cited the negative thoughts and opinions of mental health practitioners, or clinician bias, as a barrier to services for individuals with intellectual and developmental disabilities. Examples of clinician bias ranged from clinicians' beliefs that the individual with a developmental disability was unable to learn, grow, and change to a lack of confidence on the part of clinicians in their ability to treat and benefit a client with an intellectual or developmental disability. Additionally, many of the counselors interviewed talked at length about the challenges individuals with intellectual and developmental disabilities face when it comes to access appropriate developmental disability support services. Interviewees described their roles in advocating for and assisting individuals to learn about and access disability supports that provided better support options for day-to-day needs in the area of activities of daily living and noted the lengthy and cumbersome process involved in connecting with and access such supports. Some clinicians admitted to continuing mental health services past the point of therapeutic benefit due to the lack of appropriate support services available and the client's ongoing need for support, though no longer of a mental health nature.

Almost every clinician interviewed gave personal examples of times in their practice supporting individuals with intellectual and developmental disabilities when they took the initiative to seek out additional training, information, and/or resources to assist them in supporting a particular client in this population. These practitioners described reaching a point in

a therapeutic relationship where they found themselves stumped based on the presentation and lack of progress of a client with an intellectual or developmental disability and engaging in a problem-solving process to seek out additional information and resources to address the lack of progress. Clinicians mentioned attending local seminars and trainings focused on developmental disabilities, connecting with local developmental disability service providers, and seeking counsel from other clinicians familiar with this population as valuable resources and supports in their work. While describing their own personal commitments to supporting individuals with intellectual and developmental disabilities and the lengths they had gone to secure the resources necessary to be effective counselors to this population, most clinicians interviewed also acknowledged that, for the field in general, there is a significant lack of resources and incentives for clinicians who might be willing to provide mental health services to individuals with intellectual and developmental disabilities.

The therapists interviewed frequently described situations in which the mental health needs of individuals with intellectual and developmental disabilities were not taken seriously or acknowledged as being an actual mental health need. Emotional distress and struggles to manage emotional wellbeing for individuals with intellectual and developmental disabilities were regularly explained away as problematic behavior and efforts were put in place to extinguish the negative behaviors with no considerations given to the underlying causes of those behaviors. These therapists were all able to recognize negative behavior as a powerful form of communication in this population that often struggles to access and utilize other functional forms of communication. The counselors interviewed reported situations involving individuals with developmental disabilities experiencing significant trauma, loss, and grief without any

consideration given to the individuals' needs for emotional support in understanding and processing such complex and profound emotions.

When asked about factors which facilitate successful therapy experiences for individuals with intellectual and developmental disabilities, almost every clinician interviewed specifically stated that the therapeutic relationship was the most important factor involved. These clinicians stressed the importance of connecting with the client in a way that made the individual feel heard, supported, understood, and believed. They also acknowledged that to establish this type of positive rapport, it was necessary for therapists to meet the individual where he or she was in terms of communication, social interaction, and information exchange. In addition to a therapeutic relationship that was supportive and nurturing, interviewees stressed the importance of a therapeutic relationship that was consistent, set and enforced concrete boundaries, and avoided providing more support for the individual than was needed.

The majority of interviews conducted contained specific examples of prolonged exposure to individuals with intellectual and developmental disabilities as being a productive developing factor in increasing a clinician's comfort level supporting this population, and many therapists interviewed specifically recommended spending time with individuals with intellectual and developmental disabilities outside of the counseling environment in order to improve a clinicians comfort with these clients and confidence with self. Additionally, an important theme that was perpetuated across the collective narrative of these clinicians supporting individuals with intellectual and developmental disabilities was a fundamental belief in the abilities of individuals in this population. Clinicians reported firm beliefs that individuals with

developmental disabilities were capable of making progress, achieving goals, managing emotions, and connecting with the world around them.

All of the remaining themes discussed in this section of results were documented throughout all five interviews. Across five unique experiences, these themes were identified as important in each clinician's report of their personal and professional experiences: the need to adapt and modify traditional resources and techniques, advocacy for the client with a developmental disability, clinician insecurities, the clinician's responsibility to understand, Cognitive Behavioral Therapy, a commitment to serve, communication and learning differences, the importance of concreteness, developmental disability resources as assets to the mental health counselor, developing functional skills for the client, a lack of clinical education or training for clinicians on developmental disabilities, the importance of meeting people where they are figuratively and literally, mental health is a part of developmental disabilities, open-mindedness, seeing the person first not the disability, success is reinforcing, the importance of supporting the support system, systemic barriers to treatment, and seeing the value and worth of individuals with intellectual and developmental disabilities.

All clinicians interviewed acknowledged that in one way or another, providing mental health services to individuals with intellectual and developmental disabilities requires clinicians to adapt and modify traditional counseling techniques and practices in order to fit the needs and abilities of the client. These clinicians approached such modification as a matter of fact and did not seem to struggle with or be discouraged by the challenges of making such adjustments. Additionally, all therapists involved in this investigation reported engaging in advocacy activities

on behalf of their client with an intellectual or developmental disability. Therapist indicated that advocacy is often required when treating this population well beyond what it would be when providing services to individuals without developmental disabilities. The advocacy activities often required clinicians to seek out additional information regarding aspects of intellectual and developmental disabilities and the developmental disabilities service system.

Each of the participants in this research study discussed the influence of clinician insecurities on the therapeutic process when supporting clientele who have developmental disability diagnoses. These clinician shared their own personal experiences of insecurity, how they addressed those feelings, and examples of times when other clinician have avoided supporting this population due to clinician insecurity. Collectively, this group of five counselors all operated based on the belief that the counselor has a responsibility to understand or make sense out of what is being presented. The focus of these individuals was on investigating the information and symptoms that were presented and the way in which the client presented these things to gain a better understanding of what was occurring and how to intervene appropriately. All five clinicians also reported, at least some, benefits associated with Cognitive Behavioral Therapy when supporting individuals with intellectual and developmental disabilities even if that was not the therapist's personal theoretical orientation to counseling. However, many therapists also acknowledge limitations with the rigidity sometimes associated with this theory of counseling. And for each of the clinicians interviewed, their personal commitment to serve the client, regardless of the client's limitations, was a driving force in motivating and propelling the counselor to overcome practical challenges and limitations in the therapeutic process with this population.

All of the therapists interviewed discussed the communication and learning differences they had experienced when working with individuals with intellectual and developmental disabilities. The example of differences were varied, but each account was consistent in documenting that for their clients with developmental disabilities, it was expected that there would be differences in these areas. One of the most significant factors described when considering how to best address the potential differences that would occur when supporting this population was a strong emphasis on concrete information and communication. Therapists relayed the value in breaking complex, abstract concepts down into smaller components that could be made concrete and tangible. These benefits were not only seen in the treatment setting but were also recognized as beneficial factors in facilitating family and support system interactions. This notion reinforced the idea that, in order to be successful with this population, clinicians must meet the person where they are at, meaning: discover how the individual processes information and communicates and engage the person on that level initially. These clinicians recognized through their experiences that, when providing mental health services to individuals with intellectual and developmental disabilities, it is often necessary to first and foremost invest in learning about the individual and how that person operates opposed to beginning with traditional clinical engagement. And one of the most significant interventions discussed across all five narratives was supporting the support system. In some instances, clinicians communicated that the family or support system was the valuable resource and tool the therapist could access to connect with the individual with a developmental disability. In other cases, the primary goal of the therapeutic interaction was to facilitate a greater connection and better understanding between the individual and her or his support system. Regardless, every

clinician interviewed relayed the value and importance of focusing clinical efforts, not only on the specific individual, but also on supporting the support system in place to better understand and respond to the needs of the individual receiving services and vice versa.

Each counselor involved in this research communicated a recognition and reliance on the value of developmental disability service providers and resources in better supporting the mental health needs of individuals in this population. Utilizing learning opportunities from developmental disability providers and resource from the developmental disabilities field, clinicians were better able to support their clients to develop functional skills and operate more productively in their daily lives. This development of functional skills was identified as a valuable adaptation for clients with intellectual and developmental disabilities by all research participants. All participants in this study indicated that this knowledge and these resources had to be sought out after entering their practice because information and resources regarding individuals with intellectual and developmental disabilities was not provided in traditional clinical education or training provided to general mental health practitioners.

It was emphasized by every person interviewed that mental health challenges are a natural component of experiencing intellectual and developmental disabilities, and the need for mental health services and supports for people with these diagnoses should be anticipated by all mental health and developmental disability professionals. It was expected by those interviewed that possessing functional limitations in the areas of communication, information processing, and self-care combined with isolation and the lack of control often experienced with intellectual and developmental disabilities would produce symptoms of anxiety, depression, trauma, and

challenges with emotional management. These clinicians took the matter-of-fact approach to their practice that suggested these individuals have an increased likelihood of needing mental health counseling, so as mental health providers, it should be expected that they receive services.

Clinicians reported the value of maintaining an open mind in every situation and avoiding jumping to conclusions that might be appropriate in a more traditional mental health relationship. Success for each person interviewed involved being able to truly understand the individual with an intellectual or developmental disability as a unique human being, separate from simply a diagnosed disability. While this seemed like a straightforward way for a clinician to operate, many interviewees reported having to actively guard against making treatment decisions based on an individual's diagnosis as opposed to the individual as a whole person. Participants conveyed the need to maintain a fine balance, required by clinicians treating this population, of understanding, accommodating, and adapting for an individual's functional limitations while not allowing a formal diagnosis to overshadow the person's humanity and complexity as a human being. The clinicians interviewed all expressed the ability to identify value and worth in the individuals they served and emphasized the importance of maintaining focus on value and worth in working with mental health clients with intellectual and developmental disabilities.

One of the most frequently and thoroughly discussed themes across all five clinician accounts was the systemic barriers in place that hinder mental health services for individuals with intellectual and developmental disabilities. All clinicians interviewed reported encountering insurance restrictions related to primary diagnosis that prohibited individuals with intellectual and developmental disabilities from access appropriate mental health services.

Therapists shared experiences of individuals receiving incorrect diagnosis for the purposes of qualifying for necessary supports, and interviewees pointed to the structure of the mental health service system as imposing significant disincentives for mental health practitioners to serve individuals with intellectual and developmental disabilities, such as productivity requirements and restrictive settings of service. And all participants in this research study expressed a desire for such systemic barriers to be removed to allow for more individuals with intellectual and developmental disability diagnoses to access the mental health treatment system as necessary. Each of the clinicians interviewed for this study provided examples of times when they were successful in treating individuals with intellectual and developmental disabilities to reach their therapeutic goals, and all clinicians shared a similar response to that success. For them, and they believe for their mental health colleagues as well, success is reinforcing.

Exemplary Depiction. In analyzing the collective depiction established from the themes documented in the five clinician interviews, it is possible narrow the focus of the data obtained to four overarching revelations provided by the subjects of this investigative inquiry: adapting to differences, systemic barriers, supporting the support system, and universal human value. These four overarching themes establish an exemplary depiction of the unique experiences of the mental health counselors involved in this study who have experience providing mental health support services to individuals with intellectual and developmental disabilities. This exemplary depiction was documented based data analysis by the researcher and triangulation provided from two research colleagues.

Adapting to differences. Throughout this research, clinicians provided detailed accounts of the differences associated with providing mental health services to individuals with intellectual and developmental disabilities, such as communication and learning differences present in clients who have diagnoses of intellectual and developmental disabilities, the need for and involvement of mental health clinicians in a greater advocacy role, the significant benefits associated with community-based therapy and providing services in real-world environments, and the necessity of reducing complex, abstract concepts to more simplified, and concrete components. Additionally, clinicians shared specific strategies employed to address this differences, including concreate behavioral contracts, scripting, social stories, comic strip conversations, videotaping, direct confrontation, sensory supports, establishing relationships with developmental disability services providers, and seeking out supervision and resources to assist in the on-going investigation and adaptation process.

Systemic barriers to services. Both in the individual accounts of clinician experiences and the collective narrative of the research participants, systemic barriers to mental health services for individuals with intellectual and developmental disabilities are well documented throughout this research. Clinicians shared the restrictive effects of insurance systems requiring individuals to have a primary mental health diagnosis in order to be approved for funding for mental health services. Practitioners complained that this primary diagnosis requirement failed to acknowledge the mental health components of intellectual and developmental disabilities and limited clinicians' abilities to treat and support clients that they would otherwise choose to serve. Additionally, clinicians expressed frustrations with the restrictive nature of service settings, often requiring services to be provided in the office setting, and clinician productivity requirements

implemented to maximize billable time citing these requirements as preventing counselors from investing the extra time often necessary to effectively support clients with intellectual and developmental disabilities and preventing them from accessing the most productive treatment settings and environments appropriate to meet individuals' needs.

Supporting the support system. Practitioners involved in this study conveyed the importance of accessing, utilizing, developing, and supporting the families and support systems that exist for individuals with intellectual and developmental disabilities. These systems are often looked to to assist clinicians in learning about the unique aspects of the individual in services, including communication methods, existing coping mechanisms, and information processing strategies. Additionally, research participants revealed a regular need to mediate and facilitate a better understanding between the individual with a developmental disability and the support system in that person's life, whether that be family members, support staff, coworkers, or educational personnel. Several examples were provided to illustrate the benefits of interventions targeted at the support system as a whole when individual interventions were not possible due to the functional limitations of the individual with a developmental disability.

Universal Human Value. The clinical success of this phenomenal group of therapists in supporting individuals with intellectual and developmental disabilities is likely most closely connected to each practitioner's fundamental belief in the universal value and worth of human beings and their ability to attribute this value and worth to individuals with intellectual and developmental disabilities. Successful counseling relationships began with a belief in the ability of the individual with a developmental disability to grow, develop, and change. Counselors

reported engaging in these therapeutic relationships due to personal beliefs that all individuals deserve support and services, regardless of functional limitations, and clinicians acknowledged significant feelings of satisfaction, connection, and joy as the result of their therapeutic relationships with individuals with intellectual and developmental disabilities. In short, these therapists reported being willing and able to treat mental health clients with intellectual and developmental disabilities because they were able to view them as individuals separate from their diagnoses and able to connect with them as valuable human beings.

Summary

While the data generated in this research is qualitative in nature and does not provide any comparative or projective capability, the rich depictions of the lived experiences of mental health counselors providing services to individuals with intellectual and developmental disabilities are valuable in developing understandings of the experiences of these clinicians and, therefore, the service systems they attempt to operate within. The narratives, depictions, and themes captured here allow interested parties the opportunity to explore concepts further and begin to investigate further how each of these factors and components influence mental health services for individuals with intellectual and developmental disabilities. The clinicians included in this study are representative of many mental health clinicians in the state of Arkansas and others across the United States. While some of them have personal experiences that influenced their participation in providing services to this group, some of the interviewees lacked those types of connections prior to engaging individuals with developmental disabilities in their mental health practice.

This suggests that more mental health providers can learn and benefit from the experiences of these practitioners and become better able to serve this population.

Chapter 5: Discussions

The lack of knowledge about the experiences of mental health counselors who provide counseling services to individuals with intellectual and developmental disabilities in community settings was the primary catalyst for this investigation. This group of practitioners makes up a small minority of practicing counselors, and components of the licensing and service structures, such as mandates to avoid practicing beyond scope of practice, are known to deter counselors from working with this population (Corey, 2005). Understanding the perspectives of these practitioners provides a better awareness of what is necessary to effectively support individuals with intellectual and developmental disabilities in need of mental health services. Additionally, understanding the factors that influence mental health practitioners' willingness and ability to provide services to individuals with intellectual and developmental disabilities offers service agencies valuable information to influence policy development and continuing education requirements to better prepare and promote the development of mental health practitioners able to treat individuals with intellectual and developmental disabilities. Additionally, educators in the mental health and rehabilitation fields can benefit from a more thorough consideration of such experience to better structure academic curriculum to prepare practitioners-in-training to be better able to serve individuals with intellectual and developmental disabilities in areas related to mental health. All of this is important because individuals with intellectual and developmental disabilities are increasingly being included in community living placements, as opposed to isolated, residential settings that have traditionally kept individuals with these functional limitations isolated from their communities and from traditional mental health services (Hamelin,

Frijters, Griffiths, Condillac, & Owen, 2011). The need to provide mental health services to the already underserved group will only increase in the future.

Purpose of the Study

The primary purpose of this study was to construct a thorough understanding of the unique experiences of mental health counselors who provide services to individuals with intellectual and developmental disabilities by capturing the lived experiences of a sample of such counselors and identifying collective themes within those individual and collective experiences. By identifying and understanding the factors that influence these counselors' experiences, there is potential to extrapolate important components to consider in mental health counselor development, in the structure of the service system, and in the need for public policy interventions. The counselors who participated in this investigation have been able to serve a difficult population that has been traditionally left out of the mental health service system while simultaneously operating as clinicians within that traditional system. Understanding how and why they have been effective in supporting this population can potentially inform the larger system of necessary actions to take to become more accessible and better equipped to support mental health clients with developmental disabilities.

Statement of the problem. Within the field of Counselor Education, little published research exists, and therefore, very little is known about the experiences of mental health counselors who specifically provide counseling services to individuals with intellectual and developmental disabilities in community settings. Understanding the perspectives of these

practitioners can provide a better awareness of what is necessary to effectively support individuals with intellectual and developmental disabilities in need of mental health services.

Statement of the procedures. To begin the process of developing a better understanding of this valuable area of clinical services, this research attempted to illustrate a more thorough understanding of the unique lived experiences of clinical mental health practitioners who have experiences providing mental health services to individuals with intellectual and developmental disabilities by conducting a heuristic phenomenological investigation. Individual interviews were conducted with five clinicians who had experience treating individuals with intellectual and developmental disabilities in a mental health setting. Interviews were transcribed by the researcher, coded by the researcher utilizing NVivo11 analytical software, and triangulated by two research colleagues. While NVivo11 is a research software designed to support all types of qualitative research, it was used in this research to organize the researchers coding and not used to conduct automated coding or analysis (NVivo, 2014). Data was coded into individual rich narratives for each participant, a composite depiction of themes across the collective narrative of all five clinicians, and an exemplary depiction of those themes that were most significantly and universally illustrated across the collective narrative as they pertain to the specific research questions of this investigation.

Research questions. This inquiry sought to answer these specific questions:

1. What are factors that influence the experiences of mental health counselors who work with individuals with intellectual and developmental disabilities?

2. What are the rewards and consequences of providing mental health services to individuals with intellectual and developmental disabilities?
3. What barriers have to be overcome to provide quality mental health services to individuals with intellectual and developmental disabilities?
4. What resources should be accessed and utilized in the experiences of mental health counselors working with clients with intellectual and developmental disabilities?

Discussion

What are factors that influence the experiences of mental health counselors who work with individuals with intellectual and developmental disabilities? The data reported in this investigation provided a wide range of specific and general factors involved in the counseling relationship between a mental health counselor and a client who is diagnosed with an intellectual or developmental disability. Fifty-three themes were identified and captured in the composite depiction of the clinician experiences, with 14 of those themes addressing factors that influence counselor engagement with this population: clinician insecurities, clinician's sense of responsibility to understand, commitment to serve, open mind, success is reinforcing, value and worth of individuals with DD, exposure increases comfort, personal experience, clinician bias, parent of child with DD, previous work experience, reinforced by challenges, scope of practice concerns, felt drawn to clients with DD. See Table 4. The exemplary depiction of data resulted in four overarching revelations provided by the subjects of this investigative inquiry, two of which specifically spoke to factors that influence whether or not a counselor will engage in a

therapeutic relationship with an individual with a developmental disability: systemic barriers and universal human value. Every counselor interviewed in this report shared either observing or experiencing some type of systemic barrier that hindered a mental health clinician's ability to serve individuals with intellectual and developmental disabilities. Funding restrictions put in place by insurance companies that only allow individuals with a primary mental health diagnosis to be approved for services significantly limited individuals access to mental health services. Additionally, some clinicians reported work environments that required productivity expectations that forced clinicians to avoid counseling relationships that might require additional time in preparation and service delivery due to significant consequences of failure to meet productivity.

What are the rewards and consequences of providing mental health services to individuals with intellectual and developmental disabilities? Clinicians identified a number of personal and existential rewards they experienced providing mental health services to individuals with intellectual and developmental disabilities, including a deep sense of satisfaction, strong, endearing, and rewarding relationships, and professional development as a result of these interactions that improved the clinicians overall abilities to provide good mental health services. See Table 4 for a complete list of the specific themes related to rewards and consequences identified in the composite depiction of the research data. Additionally, clinicians reported enjoyment and appreciation for the universal human value of individuals with intellectual and developmental disabilities identified in the exemplary depiction of the research and communicated this value as a type of reward of their clinical work. While the interview participants communicated a wide range of challenges and barriers to treating this population in a

mental health setting, only one of the clinicians reported personally experiencing a negative consequence for engaging in these treatment relationships with individuals with intellectual and developmental disabilities, and that was the consequence of experiencing a more significant sadness when serving this population compared to others.

What barriers have to be overcome to provide quality mental health services to individuals with intellectual and developmental disabilities? Interview subjects reported a wide variety of barriers that must be navigated to successfully service this population, including accessing lacking information and resources, navigating differences in information processing and communication methods, and addressing and overcoming clinician bias. See Table 4 for a complete list of the eight themes related to barriers that clinicians must overcome to support this population identified in the composite depiction of interview data. In all interviews, the most prominent and significant barriers clinicians reported experiencing when supporting individuals with intellectual and developmental disabilities were the restrictions placed on clinicians by funders and employers, themed as "systemic barriers", which silo behavioral health services and developmental disabilities services. Interviewees expressed frustration with not being able to support more individuals with intellectual and developmental disabilities due to primary diagnosis requirements and productivity expectations of clinicians. Additionally, interviewees communicated knowledge of other mental health professionals who do not serve this population because of these types of systemic barriers.

What resources should be accessed and utilized in the experiences of mental health counselors working with clients with intellectual and developmental disabilities? Research

participants reported accessing the individual's support system, developmental disabilities services providers, training and information resources pertaining to developmental disabilities, clinical support teams, and clinical supervision as valuable resources necessary to facilitate the success of mental health services for individuals with intellectual and developmental disabilities. In all, 26 of the 52 themes identified in the composite depiction of clinician experiences were identified as resources clinicians have used and feel important to the success of mental health clinicians supporting individuals with intellectual and developmental disabilities. See Table 4 for a complete list of the specific themes related to resources identified in the composite depiction of the research data. The exemplary depiction analysis of this research yielded the importance of the clinician's ability to adapt to differences clients with intellectual and developmental disabilities present in the therapeutic process. A wide range of differences were identified, included communication differences, learning differences, therapeutic setting differences, sensory needs differences, and functional skill development differences. Additionally, the exemplary depiction highlighted the importance in supporting the support system when working with individuals with intellectual and developmental disabilities, whether that support system consists of family, paid support providers, school personnel, co-workers, or the need to develop a person's lacking support system. The support system and goals targeting the support system were identified by all study participants to be positive resources in the counseling relationship with individuals with intellectual and developmental disabilities.

Table 4

Themes Categorized by Research Question

Influence Factors	**Rewards & Consequences**	**Barriers**	**Important Resources**
Clinician Insecurities	Fun Population to Work With	Communication & Learning Differences	Adapting & Modifying Traditional Resources
Clinician's Responsibility to Understand	Potential Incentives of a Personal Nature	Lack of Clinical Education or Training	Advocacy
Commitment to Serve	Serving Clients with DD Makes Me a Better Therapist	Systemic Barriers to Treatment	Cognitive Behavioral Therapy
Open Mind	Clinician Self-Care is Important	Lack of Incentives for Counselors	Concreteness is Important
Success is Reinforcing		Lack of Resources for Counselors	DD Resources are Assets
Value & Worth of Individuals with DD		Mental Health Needs for Clients with DD Not Taken Seriously	Developing Client Functional Skills
Exposure Increases Comfort		Accessing Appropriate Supports	Meeting People Where They Are At
Personal Experience		Problems with Evidence Based Practices for Clients with DD	Mental Health is a Part of DD
Clinician Bias			Seeing the Person First
Parent of child with DD			Variety of Specific Techniques
Previous Work Experience			Supporting the Support System
Reinforced by Challenges			Behavior as Communication
Scope of Practice Concerns			Individuals with DD are Capable
Felt Drawn to Clients with DD			Relationship is Most Important
			Seek Out Additional Resources
			Clinician Supervision is Vital
			Eclectic Approach to Counseling
			Variety of Interventions Used
			Training & Support Must be Emphasized
			Community-based Services

Table 4 Continued

Themes Categorized by Research Question

Influence Factors	Rewards & Consequences	Barriers	Important Resources
			Everyone Can Do Their Work, Despite Limitations
			Inclusion Positively Impacts Quality of Life
			Self-Education on DD
			Sensory Issues
			Benefits of Technology
			Rogerian Approach to Counseling

Limitations

While this study provided a significant amount of dense data, due to the qualitative nature of this inquiry, the findings are not generalizable. They offer valuable insight that can be applied to current practice, but they are not generalizable. The small sampling of participants also serves as a limitation to the research. A more robust sampling would yield more detailed results. The lack of cultural diversity amongst the research participants limits the thoroughness and applicability of the findings. Additionally, only one research participant was male, resulting in the majority of the data being delivered from the female perspective. All participants were practicing in the state of Arkansas under Arkansas licensing guidelines. The systemic barriers, resources, and requirements documented in these results may be limited by the geographical restriction.

As with all qualitative research, the data analysis conducted by the researcher can be vulnerable to researcher bias. The process of data analysis requires subjective interpretations that can have poor inter-rater reliability. While member check and research colleague review were utilized for the purposes of triangulation and to guard against researcher bias, it is important to acknowledge the potential interference and limitation such bias and human error may present.

Summary

This investigation yielded detailed responses to the four research questions. Fourteen themes immerged in response to the question of influencing factors involved in providing mental health services to individuals with intellectual and developmental disabilities. Four themes were captured as they relate specifically to the rewards clinicians experience when supporting this

population. There were eight significant barriers that were recorded in this investigative process that interfere with counseling services for individuals with intellectual and developmental disabilities, and twenty-six themes that were identified as resources available for counselors supporting this population. Additionally, the exemplary depictions, adapting to differences, systemic barriers, supporting the support system, and universal human value, provide important insight for each of the four research questions as well. The implications of these findings are discussed in detail in the following chapter.

Chapter 6: Implications

Outcomes of the Research

This heuristic phenomenological investigation produced five rich participant narratives of mental health clinicians' experiences providing services to individuals with intellectual and developmental disabilities which yielded a composite depiction consisting of 52 themes that influenced the clinicians' experiences treating this population, see Table 4. From that composite depiction, further deductions were made to compose an exemplary depiction of the unique lived experiences of mental health practitioners serving individuals with intellectual and developmental disabilities. That exemplary depiction consists of four overarching revelations provided by the subjects of this investigative inquiry: adapting to differences, systemic barriers, supporting the support system, and universal human value. While, due to the qualitative nature of this data, these findings cannot be compared or projected to other data, this information provides significant insight into a group of mental health practitioners consider a phenomena due to the large number of clinicians unable or unwilling to support this population. However, the clinicians included in this study did not present as odd or remarkable clinicians for any other reason of practice outside of their experiences working with individuals with intellectual and developmental disabilities in traditional services settings. Utilizing the themes associated with the experiences of this phenomenological group, both counseling and developmental disability professionals can begin to explore factors that have facilitated successful clinical services for individuals with intellectual and developmental disabilities and those that have hinders such services. Educators can consider how clinical training and preparation has failed to prepare these

clinicians with resources necessary to support this population, and potential service recipients can be encouraged by the small group of mental health providers who have experienced successful therapeutic relationships with individuals with intellectual and developmental disabilities. The knowledge of the importance of adapting to differences, supporting the support system, encountering systemic barriers, and recognizing universal human value in clinical relationships provides opportunities for educators to emphasize educating and training to prepare future clinicians in these areas, it provides supervisors and licensing bodies insight to implement strategies that address these areas of need as best practices, and it creates opportunity to scrutinize existing policies that influence barriers and hinders services provided in line with these factors.

Application Opportunities

Influencing Factors. The study provided clinician insecurities, clinician's sense of responsibility to understand, commitment to serve, open mind, success is reinforcing, value and worth of individuals with DD, exposure increases comfort, personal experience, clinician bias, parent of child with DD, previous work experience, reinforced by challenges, scope of practice concerns, felt drawn to clients with DD as answers to what factors influence mental health counselors as to whether or not they will serve this population. This information is valuable to educators and creates opportunities for a greater focus to be made on addressing clinician insecurities, providing opportunities for exposure to individuals with intellectual and developmental disabilities as a part of the training process, facilitating counselor education that requires and reinforces maintaining an open mind in the counseling process, and providing

clarification regarding scope of practice requirements as they pertain to supporting a population that they majority of clinicians have no experience supporting. These influencing factors allow educators to better understand how and why some counselors will determine early on in their training that supporting this population is or is not an option. From that, educators can take steps to ensure counselors-in-training are afforded experiences to help them develop an identity of a counselor who is capable of supporting individuals with intellectual and developmental disabilities.

Specifically, this research suggests that counselor educators should provide exposure opportunities for clinicians-in-training as a part of their curriculum. Courses such as Multicultural Counseling, Marriage and Family Counseling, and Counseling Techniques can all benefit from adding reading and assignments specifically focused on serving clientele with intellectual and developmental disabilities. Understanding how intellectual and developmental disabilities affect families, communication strategies, and information processing will allow future counselors better opportunities to effectively support this population. Additionally, providing assignments that require students to engage and interact with individuals with intellectual and developmental disabilities will allow for a larger population of counselors who have some exposure experiences with this population.

Rewards and Consequences. The revelation that fun population to work with, potential incentives of a personal nature, serving clients with DD makes me a better therapist, and clinician self-care is important are the primary rewards associated with providing mental health services provides an opportunity for provider organizations and licensing bodies to create a

better incentive system to encourage clinicians to serve this populations. Additionally, educators have an opportunity to teach skills and techniques that are effective in supporting individuals with intellectual and developmental disabilities that can be beneficial for other populations and improve a clinicians overall ability to provide counseling services.

Barriers. The barriers identified for counselors working with individuals with intellectual and developmental disabilities were communication and learning differences, lack of clinical education or training, systemic barriers to treatment, lack of incentives for counselors, lack of resources for counselors, mental health needs for clients with DD not taken seriously, accessing appropriate supports, and problems with evidence based practices for clients with DD. From these, educators can understand and adjust their curriculum to address the importance of providing information and opportunities for exposure to individuals with developmental disabilities. Providers and licensing agencies can work to address the missing incentives for serving this population. Developmental disability providers can work to better understand and educate themselves on the importance of mental health supports for individuals with intellectual and developmental disabilities, and the most important revelation from learning about the barriers to providing mental health services to individuals with developmental disabilities is that there must be policy changes to remove the systemic barriers mental health counselors face when attempting to serve this population.

Resources. The research question that generated the most themes in this investigation was the question of what resources do counselors utilize when providing mental health services to individuals with intellectual and developmental disabilities. The results included adapting and

modifying traditional resources, advocacy, Cognitive Behavioral Therapy, concreteness is important, DD resources are assets, developing client functional skills, meeting people where they are at, mental health is a part of DD, seeing the person first, variety of specific techniques, supporting the support system, behavior as communication, belief that individuals with DD are capable, relationship is most important, seek out additional resources, clinician supervision is vital, Eclectic approach to counseling, variety of interventions used, training and support must be emphasized, community-based services, everyone can do their work despite limitations, inclusion positively impacts quality of life, self-education on DD, sensory issues, benefits of technology, and Rogerian approach to counseling. This list provides educator, licensing bodies, and policy makers a sound beginning to the development of best practices for mental health counselors providing services to individuals with intellectual and developmental disabilities. Ensuring that counselors are knowledgeable in these areas and know how to access these resources will facilitate more positive therapeutic relationships within this population and lead to more favorable outcomes.

Suggested Further Research

Due to the small sampling of five clinicians and the restrictive geographical area of the sampling, additional heuristic phenomenological investigations could produce an even richer depiction of the experiences of mental health counselors who serve individuals with intellectual and developmental disabilities. Additionally, qualitative investigations should be utilized to test the reliability and validity of the themes presented here in the composite and exemplary depictions. Research should be focused on testing commonly used techniques and interventions

in counseling with individuals with intellectual and developmental disabilities. And, likely, the most important investigations to follow this research are to explore the policies in place that impact and influence the systemic barriers so thoroughly noted as hindrances to productive mental health services for individuals with intellectual and developmental disabilities based on the experiences of the five clinicians interviewed in this investigation.

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Appendix A

UNIVERSITY OF ARKANSAS INSTITUTIONAL REVIEW BOARD
PROTOCOL FORM

The University Institutional Review Board recommends policies and monitors their implementation, on the use of human beings as subjects for physical, mental, and social experimentation, in and out of class. . . . Protocols for the use of human subjects in research and in class experiments, whether funded internally or externally, must be approved by the (IRB) or in accordance with IRB policies and procedures prior to the implementation of the human subject protocol. . . Violation of procedures and approved protocols can result in the loss of funding from the sponsoring agency or the University of Arkansas and may be interpreted as scientific misconduct. *(see Faculty Handbook*)

Supply the information requested in items 1-14 as appropriate. **Type** entries in the spaces provided using additional pages as needed. In accordance with college/departmental policy, submit the original **and** one copy of this completed protocol form and all attached materials to the appropriate Human Subjects Committee. In the absence of an IRB-authorized Human Subjects Committee, submit the original **and** one copy of this completed protocol form and all attached materials to the IRB, Attn: Compliance Officer, OZAR 118, 575-3845.

1. Title of Project: **Mental Health Counselors Working with Individuals with Developmental Disabilities: A Phenomenological Investigation**

2. (Students **must** have a faculty member supervise the research. The faculty member must sign this form and all researchers and the faculty advisor should provide a campus phone number.)

	Name	Department	Email Address
Principal Researcher	**Syard Evans**	**RHAB**	**evans@uark.edu**
Faculty Advisor	**Brent Williams**	**RHAB**	**btwilli@uark.edu**

3. Researcher(s) status. Check all that apply.

   X Graduate Student

4. Project type

   X Dissertation

5. Is the project receiving extramural funding?

X No

6. Brief description of the purpose of proposed research and all procedures involving people. Be specific. Use additional pages if needed. (**Do not** send thesis or dissertation proposals. Proposals for extramural funding must be submitted in full.)

Purpose of research:

This research seeks to explore the experiences of mental health practitioners who have experience providing counseling services to individuals with developmental disabilities.

Procedures involving people:

This research will conduct individual interviews with mental health practitioners who have experience providing counseling services to individuals with developmental disabilities. Measurements will be collected via face-to-face contact, and participants will be asked to review transcriptions post-interview via e-mail or mail communication to ensure accuracy of data collection.

7. Estimated number of participants (complete all that apply)

0 Children under 14	0 Children 14-17	0 UA students (18yrs and older)	**10 or less** Adult non-students

8. Anticipated dates for contact with participants:

First Contact: **December 2011** Last Contact: **March 2012**

9. Informed Consent procedures: The following information must be included in any procedure: identification of researcher, institutional affiliation and contact information; identification of Compliance Officer and contact information; purpose of the research, expected duration of the subject's participation; description of procedures; risks and/or benefits; how confidentiality will be ensured; that participation is voluntary and that refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled. See *Policies and Procedures Governing Research with Human Subjects*, section 5.0 Requirements for Consent.

X Signed informed consent will be obtained. **See attached copy of form**.

10. Confidentiality of Data: All data collected that can be associated with a subject/respondent must remain confidential. Describe the methods to be used to ensure the confidentiality of data obtained.

    Participants will be asked to select a pseudonym at the beginning of the study. All information will be recorded utilizing the selected pseudonym. Only the researcher will know participant names for the purposes of contact. Participant information will not be divulged to anyone. All information will be held in the strictest of confidence. Results from the research will be reported using participant pseudonyms.

11. Risks and/or Benefits:

    Risks: Will participants in the research be exposed to more than minimal risk? **XNo**
    Minimal risk is defined as risks of harm not greater, considering probability and magnitude, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests. Describe any such risks or discomforts associated with the study and precautions that will be taken to minimize them.

    There are no anticipated risks to participating in this study. The researcher will minimize any unforeseen potential participant risks by ensuring strict confidentiality for every participant and ensuring that all participation is voluntary.

    Benefits: Other than the contribution of new knowledge, describe the benefits of this research.

    By identifying shared themes and characteristics in mental health counselors who work with individuals with developmental disabilities, an understanding of characteristics, skills, and experiences that are beneficial in potential mental health counselors can be developed. Thus this research has the potential to improve the education and training process for future mental health counselors to increase the quality and availability of counseling services to individuals with developmental disabilities.

12. Check all of the following that apply to the proposed research. Supply the requested information below or on attached sheets:

    N/A

13. Checklist for Attachments

    The following are attached:

X Consent form (if applicable)

X Data collection instrument

14. Signatures

I/we agree to provide the proper surveillance of this project to insure that the rights and welfare of the human subjects/respondents are protected. I/we will report any adverse reactions to the committee. Additions to or changes in research procedures after the project has been approved will be submitted to the committee for review. I/we agree to request renewal of approval for any project when subject/respondent contact continues more than one year.

UNIVERSITY OF ARKANSAS

Office of Research Compliance
Institutional Review Board

April 17, 2012

MEMORANDUM

TO:	Syard Evans Brent Williams
FROM:	Ro Windwalker IRB Coordinator
RE:	New Protocol Approval
IRB Protocol #:	12-04-646
Protocol Title:	*Mental Health Counselors Working with Individuals with Developmental Disabilities: A Phenomenological Investigation*
Review Type:	☒ EXEMPT ☐ EXPEDITED ☐ FULL IRB
Approved Project Period:	Start Date: 04/17/2012 Expiration Date: 04/16/2013

Your protocol has been approved by the IRB. Protocols are approved for a maximum period of one year. If you wish to continue the project past the approved project period (see above), you must submit a request, using the form *Continuing Review for IRB Approved Projects*, prior to the expiration date. This form is available from the IRB Coordinator or on the Research Compliance website (http://vpred.uark.edu/210.php). As a courtesy, you will be sent a reminder two months in advance of that date. However, failure to receive a reminder does not negate your obligation to make the request in sufficient time for review and approval. Federal regulations prohibit retroactive approval of continuation. Failure to receive approval to continue the project prior to the expiration date will result in Termination of the protocol approval. The IRB Coordinator can give you guidance on submission times.

This protocol has been approved for 10 participants. If you wish to make *any* modifications in the approved protocol, including enrolling more than this number, you must seek approval *prior to* implementing those changes. All modifications should be requested in writing (email is acceptable) and must provide sufficient detail to assess the impact of the change.

If you have questions or need any assistance from the IRB, please contact me at 210 Administration Building, 5-2208, or irb@uark.edu.

210 Administration Building • 1 University of Arkansas • Fayetteville, AR 72701
Voice (479) 575-2208 • Fax (479) 575-3846 • Email irb@uark.edu

The University of Arkansas is an equal opportunity/affirmative action institution.

Appendix B

INFORMED CONSENT

Title: **Mental Health Counselors Working with Individuals with Developmental Disabilities: A Phenomenological Investigation**

Researcher:

Syard Evans, M. S., Graduate Student
Department of Rehabilitation
College of Education and Health Professions
University of Arkansas
101 Graduate Education Building
Fayetteville, AR 72701
evans@uark.edu

Administrator:

Brent Williams, Ph.D., Dissertation Chair
Program Coordinator
Department of Rehabilitation
College of Education and Health Professions
University of Arkansas
154 Graduate Education Building
Fayetteville, AR 72701
479-575- 8696
btwilli@uark.edu

Description: The present study will explore the experiences of mental health professionals who have experience providing counseling services to individuals with developmental disabilities. You have been identified as a mental health professional with experience counseling individuals with developmental disabilities for the purposes of this study. You will be asked to participate in a one-on-one interview with the researcher, review interview transcripts to ensure accuracy of information collected, and provide clarifying information as needed post-interview.

Risks and Benefits: The benefits of this research include contributing to the knowledge base mental health services for individuals with developmental disabilities and potentially improving mental health services for individuals with developmental disabilities. There are no anticipated risks to participating in the study.

Voluntary Participation: Your participation in this research is completely voluntary. Individuals who fully participate with all components of this research will receive a $30 gift card at the conclusion of the study.

Confidentiality: You will be asked to select a pseudonym at the beginning of the study. All data collection and reporting will utilize your pseudonym. Only the researcher will know your real name, and no data will be recorded or reported using your real name. All information will be held confidential to the extent allowed by law and University policy. Results from the research will only be reported using participant pseudonyms.

Right to Withdraw: You are free to refuse to participate in this research and to withdraw from this study at any time.

If you have questions or concerns about this study, you may contact Syard Evans or Dr. Brent Williams at (479) 575-8696 or by e-mail at evans@uark.edu. For questions or concerns about your rights as a research participant, please contact Ro Windwalker, the University's Compliance Coordinator, at (479) 575-2208 or by e-mail at irb@uark.edu.

Informed Consent: I, _____ (please print), have read the description, including the purpose of the study, the procedures to be used, the potential risks and side effects, the confidentiality statement, as well as the option to withdraw from the study at any time. The investigator has answered all of my questions regarding the study, and I believe I understand what is involved. My signature below indicates that I freely agree to participate in this experimental study and that I have received a copy of this agreement from the investigator.

Signed: _____ Signature Date: _____

Appendix C

Demographic Questionnaire

What pseudonym would you like to use during this study? _____

How old are you? _____

What is your gender? _____

What is your relationship status? _____

Do you have any children? _____

What is your ethnicity? _____

What type of license do you have? LAC LPC LMSW LCSW LMFT LMHC
Other (specify) _____

What is your counseling theoretical orientation? _____

Where did you complete your master's degree? _____

What type of setting do you practice in? private practice nonprofit agency for-profit agency
Other (specify) _____

How long have you been a practicing counselor? _____

How large is your average caseload? _____

Approximately how many individuals with developmental disabilities have provided counseling services to? _____

Appendix D

Suggested Semi-structured Interview Question Guide

- Please describe your experience as a mental health counselor working with individuals with developmental disabilities.
- What challenges do you face as a mental health counselor working with individuals with developmental disabilities?
- Why do you provide counseling services to individuals with developmental disabilities?
- What led to you working with this population?
- What is your theoretical orientation to counseling?
- In your experience, what incentives exist to providing counseling services to individuals with developmental disabilities?
- In your experience, what factors are important to ensuring positive counseling interactions and outcomes for clients with developmental disabilities?
- What resources exist for mental health practitioners working with individuals with DD?
- What have you learned working with individuals with developmental disabilities?
- Is there any additional information that you feel is relevant to understanding the experience of providing mental health counseling services to individuals with developmental disabilities?