Adapting Anger Management Group Counseling for People with an Intellectual Disability

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Abstract

Anger management concerns are a primary reason people with Intellectual Disabilities (ID) are admitted to or remain living in a restrictive setting (Modi, McMorris, Palucka, Raina, & Lunsky, 2015; Taylor & Novaco, 2005). The use of anger management groups for people with ID has demonstrated some promise (Benson, 1992; Taylor, Novaco, Gillmer, Robertson, & Thorne, 2005), yet there remains a limited number of programs available for counselors to implement. An established anger management curriculum was modified to accommodate clients who have mild ID. Behavioral data demonstrated that people diagnosed with an ID who participate in an anger management group were able to reduce instances of aggressive behaviors while participating in the group. Those positive results, however, did not translate to long-term behavior changes. Possible explanations for treatment outcomes as well as, suggestions for counseling practice and future research are provided.

Key words: Anger Management, Intellectual Disability, Group Counseling

Adapting Anger Management Group Counseling for People with an Intellectual Disability

In 2005, Sturmey suggested there was a lack of empirically based research that supported the use of individual or group counseling as an effective treatment for people who have an intellectual disability (ID). Since that time, there remains a shortage of research to support the use of group counseling to help people with ID who struggle with anger management issues. While empirical data is sparse, limited research does demonstrate that group counseling for people diagnosed with mild ID can positively affect behavioral and emotional change (Benson, 1992; Lishman, Lay, & Steward 2008; Rose, 1996; Rose, West, & Clifford, 2000; Taylor et al., 2005; Willner, Brace, & Phillips, 2005; Willner, et al. 2011). Anger management treatment is important to address as aggression remains a primary reason people with ID are admitted to or reside in a restrictive setting (Modi et al., 2015; Taylor & Novaco, 2005). Furthermore, people with ID have the right to evidence-based treatments that are empirically validated for use with the general population (Beail, 2005; King, 2005). Additionally, this anger management group was developed and implemented as partial fulfillment of a settlement agreement between the State of Iowa and The Federal Department of Justice. In the years following that settlement agreement, during an oversight visit, it was mandated that the facility provide counseling approaches typically utilized with the general population (The United States of America v. The State of Iowa, 2004). Therefore, treatment modalities, which are currently practiced with the general population, should be further explored for their specific application for people with ID (Beail, 2005; Katz, 1972). Unfortunately, for addressing anger management concerns, there

remains no accepted group format or program that counselors can utilize to support people with ID.

Group Counseling

Group counseling is a popular format of treatment whereby counselors and group members serve as a support for individual behavior change (Gladding 2019; Yalom & Leszch, 2020). Group members provide feedback, support, and help meet each other's social and mental health needs. A great advantage of group counseling is that one counselor can reach multiple clients, usually 8-12 members, during the same time span they would typically see only one client in traditional individual counseling (Gladding, 2019; Corey, 2016).

Group counseling provides a unique environment known as the social microcosm for processing the underlying issues revealed through the behaviors of the clients. Yalom and Leszcz state that "in this living drama of the group meeting, the trained therapist has a unique opportunity to understand the dynamics of each client's behavior and address the familiar negative interpersonal cycle" (2020, p. 61). A necessary requirement for processing within this environment is that if maladaptive thoughts, thinking, and behaviors are to be changed, group members must be willing and able to receive and process feedback from their peers and the counselor (Yalom & Leszcz, 2020).

The limited research addressing anger management group counseling for people with a diagnosed intellectual disability supports that Cognitive Behavioral Therapy (CBT) principles could serve as an effective framework for developing a group counseling intervention (Lishman et al., 2008; Rossiter, Hunnisett, & Pulsford 1988, Willner, et al. 2011). Additionally, group effectiveness should be measured by client self-report (Walker & Cheseldine, 1997), assessments (Hagiliassis, Gulbenkoglu, Di Marco, Young, & Hudson, 2005), behavioral checklists (Modi et al., 2105), and by qualitative experiential feedback interviews (Lishman et al., 2008). Other group counseling interventions, for people with ID, focused on single components typically associated with anger management programs, such as, mindfulness (Jones & Finch, 2020; Robertson, 2011) or coping skills (Willner & Tomlinson, 2007). These studies support a potential for group counseling curriculum to be effectively adapted for people with ID and anger management issues.

Anger Management

Anger is an emotional state with a wide range of expressions (Spielberger, 1996). Anger and the healthy expression of anger is normal; however, anger can quickly become problematic when expressed inappropriately or with high intensity or duration (Hagiliassis et al., 2005). Poor anger management can also inhibit social relationships, limit personal opportunities, or reduce self-esteem (Hagiliassis et al., 2005). In addition to the self-directed impacts of poor anger management, anger expressed negatively can have harmful effects upon the individual's family and social supports (Hagiliassis et al., 2005). Anger expression was identified and defined in each group participant's Behavior Support Plan (BSP). For the purposes of this study, anger expression was comprised of the following behaviors as defined in participant's BSP. Aggression involved the use of physical force to make or attempt physical contact with another person. Verbal aggression was defined as using curse words directed towards another person or using language intended to threaten harm to another person. Property destruction was defined as

the destruction of another person's personal property or shared property, such as a community TV located in the living room.

The Treatment Program

The anger management program utilized and adapted for this study was developed and published by the Department of Health and Human Services (Reilly, Shopshire, Durazzo, & Campbell, 2002). It was designed for anger management of individuals with substance abuse and mental health issues. The program consists of 12 sessions covering the following topics: an overview of group anger management treatment, discovering triggers and cues, developing anger control plans, understanding the aggression cycle, learning Ellis' A-B-C-D Model, assertiveness training, understanding anger and family of origin issues, and a closing and graduation session. The process of group counseling and the treatment program was modified. These modifications were made to meet the needs of a population with a mild intellectual disability. The curriculum-based treatment program is designed to be delivered using group counseling strategies (Reilly et al., 2002).

Methods

Participants

The Institutional Research Committee approved the study and subsequent publication of the results. Group members resided at a large facility in the central Midwest for people diagnosed with an intellectual or developmental disability. The 10 male participants ranged in age from 16 to 24 years old. They were diagnosed with a mild intellectual disability with an I.Q. range between 65-72. All group members were currently attending or graduated from public high school. They were capable of expressing their basic needs and wants. Additionally, group participants were able to verbally express why they wanted to participate in an anger management group and how that experience would be a benefit. All but one participant had recent behavior data indicating the presence of verbal aggression, aggression, and property destruction in the six weeks prior to the start of the group. One participant had verbal aggression and aggression, but no recent incidents of property destruction. The rationale for his referral to the group was the reported severity of his aggressive episodes, which had been noted to result in frequent staff injuries. The participants were all taking psychotropic medications for the management of their aggressive behaviors. During the timeframe of the group, and 12 weeks after the conclusion of the group, there was only one adjustment in any group member's medication treatment. This one group member had a reduction in the dose of their antipsychotic medication. Additionally, no intervention or procedural changes were made to the group member's Behavior Support Plan (BSP) during or for the 4-week period of time after the conclusion of the group experience.

Notification of the purpose, participant criteria, and the recruitment process for the anger management group was sent to treatment team supervisors. Members were selected by treatment teams based on criteria including having a BSP that included verbal aggression, physical aggression, and property destruction behaviors as target behaviors. Group members were also required to be verbal and able to express their general wants and needs. Group members were screened for selection by the group facilitators and were administered a pre-assessment. The brief pre-assessment was a self-report survey that questioned the type of coping strategies they

were currently utilizing, success of those strategies, and capacity to engage in discussions regarding anger management issues. All members were required to be able to explain and give consent to participate in the group and agree to voluntarily attend each weekly session. The pre-assessment ended by informing participants that they would not be provided with a reward for participation. The pre-assessment gave the counselors the opportunity to verify verbal and social skills. Each member was required to be able to communicate verbally and engage in a back-and-forth conversation. Counselors also assessed each potential member's willingness to participate in the group process. Potential members were required to verify their own desire to join the group. The counselors wanted to eliminate any potential pressure from direct care staff or the treatment team, pressuring the potential member to join the anger management group.

Treatment Program Modifications

The group followed the modified anger management curriculum, which was altered to teach anger management and coping skills to adolescent and young adults with ID. The group curriculum, therefore, included activities aimed at building group cohesion, a didactic portion of information sharing, and a period of discussion, geared toward developing adaptive social skills. The use of a social skills component served two purposes. First, it provided the group members with a model of appropriate interpersonal behavior and allowed them an opportunity to practice new social patterns (Yalom & Leszcz, 2020). Second, the social skills component provided an opportunity for participants to display the full range of behavioral patterns, maladaptive or appropriate, in the safety of a controlled environment. Therefore, the group provided a measure of safety and allowed the group leaders to process current behavioral opportunities and foster client learning (Yalom & Leszcz, 2020). Each group session was divided into four sequential components. The first component was the introduction and check-in phase. During this time, members were reminded of the group rules they had developed during the initial group session. Next, members shared their visual anger meter results for the prior week. Then, members were asked to share something positive that they had experienced during the previous week. This positive reflection was intended to redirect any negative thoughts from the revealing of their anger meter. The check-in process lasted about 5-10 minutes each week. The second component of each session was a social skill-building element, which focused on engaging the members in pro-social activities. This component lasted between 5-10 minutes. These social activities included playing putt-putt golf, tossing a soft ball, or creating origami. The addition of a social skills component was twofold. It was believed that members would be more likely to participate in sessions if there was an enjoyable activity (MacMahon et al., 2015). Additionally, the social activity led into providing the members with a social opportunity whereby they would exhibit their natural behavioral patterns. The social activity led to an understanding that modifying behavioral patterns would lead to a more productive outcome. An example of this was having the members toss a soft sponge like football across the room to each other. After each member had tossed and received the ball several times, the pattern was modified so that each member would toss the ball to the person on their right. During such exercises if members became upset, they were encouraged to reflect on any cues or triggers and implement their anger control plan if necessary. The third component was the application of the anger management treatment, which lasted between 40-45 minutes. Group members discussed the group as outlined in the modified treatment manual. The final component involved members providing a reflection regarding some learned group component that they found helpful that week. This reflection stage lasted about 5 minutes and served as a reminder of learned content and skills. In addition

to the format modifications of the group experience, group counseling principles were highlighted each week.

The first group session tasks included defining the purpose of anger management group counseling, reviewing group rules, defining anger, discussing myths associated with anger, reviewing how anger can become a habitual response and the process for breaking that cycle, group member introductions, and introducing the anger meter. Modifications to the group outline for week one required members to create their own group rules. While members created rules similar to the program rules, it was felt that creating rules would increase member's felt ownership of the group process. The resulting difference between the program's rules and the rules members created was dividing rules into more basic concepts. Group members separated verbal aggression, physical aggression, and keeping your hands to yourself into three rules, whereas the program provided rules covering those under group safety. The only other rule that deviated from the program's rules was the requirement that any direct care staff in attendance must participate in the group process. Having direct care staff attend sessions was an important addition to group members. The other change made to the program was modifying the 1-10 numeric anger meter. It was felt the numeric anger meter would confuse some of the group members, so a visual anger meter was created (see figure 1). Group members were instructed to use the modified visual anger meter once for the morning and once in the evening. It was suggested that the staff change at these times would be a good reminder for the group members to complete their visual anger meter.

Figure 1. Visual Anger Meter

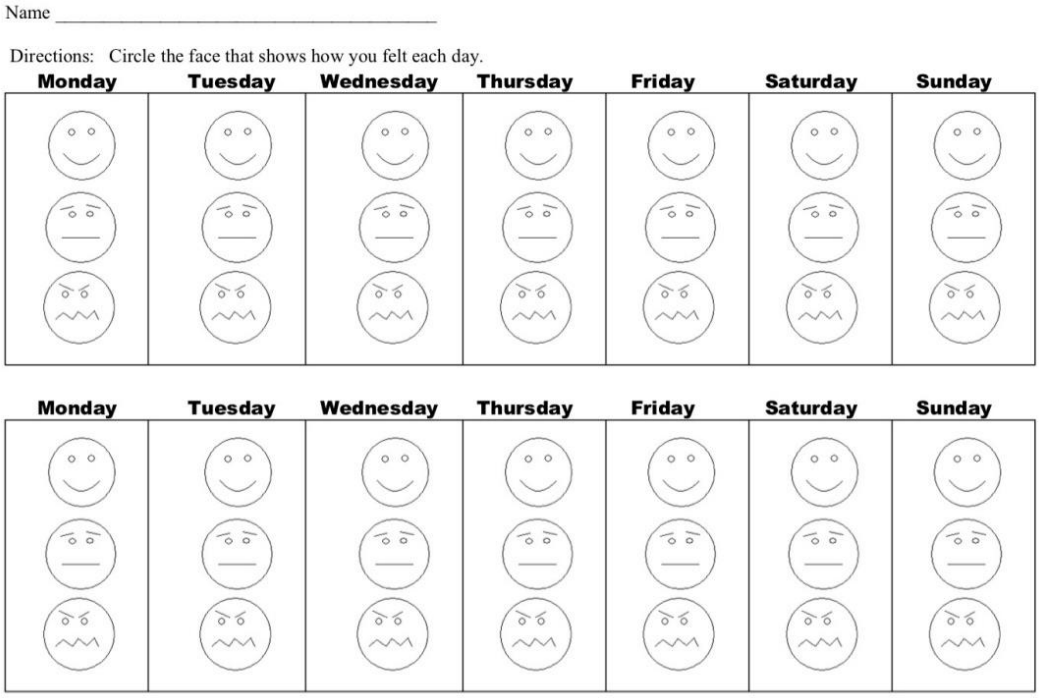

Figure 1. A visual representation of the anger meter.

The second group session focused on anger triggers and cues as well as explaining the check-in process. The examples of events that trigger anger were adapted to a treatment facility

environment to make them more realistic for group members. Additionally, each member was required to provide an example of an event that triggered an anger event in their recent past. It was felt that discussing abstract events only would not provide members with an understanding of how triggers applied to their situation. Last, the cues to anger examples provided were expanded to include additional examples of physical, behavioral, emotional, and cognitive cues.

The third group session focused on creating an anger control plan and learning a relaxation breathing exercise. While each of the group members had a BSP that outlined strategies for staff to intervene and preventative procedures to prevent target behaviors, it was felt that the group members should be able to develop their own interventions without consideration of their BSP. Additionally, some of the terms used in the program's anger control plans was altered due to the negative nature of the terms. One such change was eliminating the word timeout, which was understood as being placed in a timeout room rather than taking a break. Last, the breathing exercise was replaced with a diaphragmic breathing exercise. The use of the diaphragmic breathing exercise was made because it was an intervention not previously used by any group member's BSP.

The fourth session taught group members about the aggression cycle and they learned a progressive muscle relaxation exercise. The visual representation of the aggression cycle was replaced with a visual aggression cycle (see figure 2). The same symbols used in the visual anger meter were also used in the visual aggression cycle to promote consistency. Some of the group members had a limited ability to read. It was determined that modifying the aggression cycle would allow all members to use the same model, thus no one member was exposed for their limited reading capacity.

Figure 2: Visual Aggression Cycle

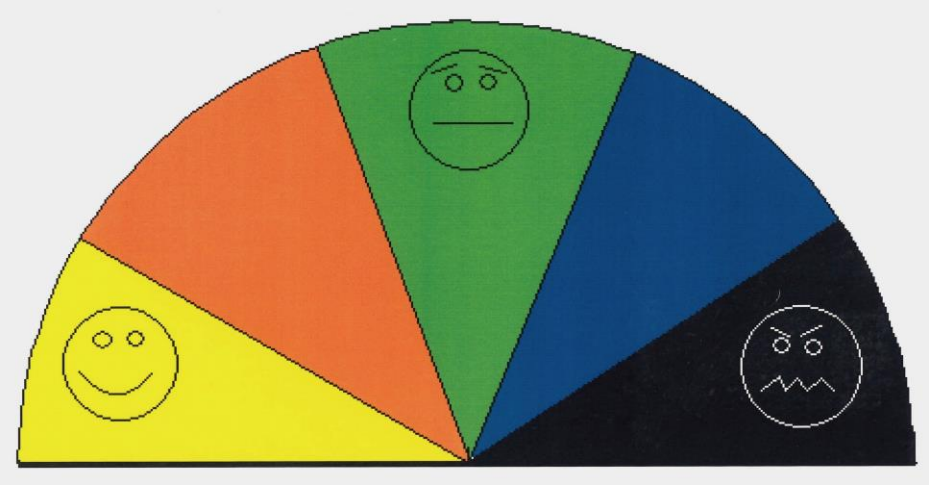

Figure 2. A visual representation of the aggression cycle, which included narrative explanations for each phase of the cycle.

The fifth session explained Ellis' A-B-C-D model and thought stopping. The A-B-C-D model presented as a challenge due to the group member's experience with behavioral therapy's presentation of Antecedent Behavior Consequence (A-B-C). Several role plays were used to explain the A-B-C-D concept using the main theme that an aggression cue may have multiple

interpretations, which changes how the cue is viewed. One example of this was a client noting that they saw someone holding a special pillow their mother gave them. The client noted they typically would hit the person and take the pillow back. The dispute, or alternate interpretation, was that their roommate may have found their pillow in the common room and wanted to protect it because they knew the pillow's special meaning. Rather than getting mad and hitting the person with the pillow, with the new information, it was agreed they should thank the thoughtful roommate. Additionally, rather than adopt thought stopping as a concept, the group members were familiar with redirecting, which was an intervention in all group member's BSPs. Therefore, it was felt that the similar nature of the concepts made reinforcing redirecting appealing rather than adding a new concept or label.

The sixth session functioned as a review week. Members reviewed the learned concepts and clarified any misunderstandings about anger management or the group process in general. There were no changes to this session other than continued use of the aforementioned program modifications.

The seventh and eighth sessions covered assertiveness training and a conflict resolution model. Assertiveness was summed up as the right to say that someone else hurt you. It was felt that some of the subjective nature of assertiveness may be a challenge for some members to grasp. Additionally, there was concern that some of the members would feel the group was promoting aggression. Therefore, the group leaders made sure to emphasize that assertiveness is not the same as retaliation. The conflict resolution model was replaced with a script that group members practiced. The script was as follows: When you ____, I feel _____, it makes me _____, and I would like _____. An example of one member's script was: When you take my pillow, I feel mad, it makes me want to hit you, and I would like you to apologize and give me my pillow back. The script was practiced several times by each member using interactions they described as behavioral cues.

In the original treatment program, session nine and ten were combined to discuss anger in the family unit. It was felt that increasing the number of review sessions would be more productive, thus session nine functioned as an additional review week. Members reviewed the learned concepts and clarified any misunderstandings about anger management or the group process in general.

The tenth session focused on how anger and emotions were displayed by parents and families. Some of the group members had no recollection of their families, therefore the group focused on families, staff, roommates, and any other important people in member's lives where they noted past experiences with anger behaviors or emotions.

Session eleven functioned as another review week. Members reviewed learned concepts and discussed gains made using their anger control plan. There were no major changes to this session other than the use of role play for practicing problematic behavior situations.

The twelfth session functioned primarily as a review session and graduation ceremony. In addition to reviewing major learned concepts, members were able to make any additional comments desired regarding the program or their success in controlling their anger expressions.

Data Collection Method

Daily behavior, reinforcement, and replacement training program data was collected for each participant. Behavior data collection methods varied between two methods based on each participant's BSP; however, the method of data collection and the type of data collected for each group member remained constant during the group experience and for a 4-week period after the group concluded. One of the types of behavior data collected was interval data. For interval data each 30-minute interval of the day staff noted the presence or absence of the observed behaviors for each client. Staff would circle a letter that represented each targeted behavior or the absence of targeted behaviors each 30-minutes. The second type of data collected was frequency data. For frequency data, staff noted each observed occurrence of the target behaviors along with the antecedent and consequence of that behavior. Staff were required to describe the behavior in detail, a time intensive process. Interval data was more frequently used for tracking a well-documented behavior, one that the function of the behavior was understood, and that behavior was low frequency. Due to the variance in data collection method for group members, data were represented in percentage of change due to the use of two different data collection methods.

The data collection process included reliability checks and staff quizzes to ensure staff were collecting accurate data. Reliability checks were performed monthly by professional staff, including the psychology assistant, psychologist, and treatment program manager assigned to each client. Reliability checks were performed by having the professional staff, preferably without the knowledge of the staff, observe the client from afar for a 30-minute interval and record any instances of the observed behaviors. The reliability check data was compared with the data sheet completed by the staff and any discrepancies were noted, which resulted in additional staff training. In addition to reliability checks, staff were quizzed monthly over BSP knowledge, which included target behaviors, replacement behavior programs, and reinforcement procedures. Staff that did not pass the quiz were required to receive additional training on that program. Because the reliability checks involved staffing, including employment discipline, the results of these checks were not reviewed for this study.

Treatment Fidelity

The group facilitators were Licensed Professional Counselors trained in individual and group counseling methods. Both counselors had two-years' experience providing individual and group counseling for people with an intellectual and developmental disability. These counselors were not members of the group participant's treatment teams and did not have input into the development or implementation of group member's BSPs.

To ensure treatment protocols were followed, the group facilitators met prior to and after each session to review the manual and discuss the session. The pre group review was designed to review the manual and any planned alterations and ensure that both group facilitators understood the planned interventions. The post group review session focused on the completed session and compared the session against the manual to ensure each aspect of treatment was followed. The post group session also included a brief review and documentation of each member's progress and level of participation.

Hypothesis

H1: Participation in an anger management group would reduce instances of target behaviors such as verbal aggression, aggression, and property destruction during the group experience as indicated by behavior data.

H2: Participation in an anger management group would reduce instances of target behaviors such as verbal aggression, aggression, and property destruction for four weeks after participating in a group experience as indicated by behavior data.

H3: Participation in an anger management group would reduce instances of target behaviors such as verbal aggression, aggression, and property destruction for six months after participating in a group experience as indicated by behavior data.

Results

To statistically analyze the target behavior data of the anger management group participants, a Wilcoxon Signed-Rank test was utilized to conduct the data analysis. This non-parametric test is appropriate for small sample sizes where each participant serves as his or her own control (Wilcoxon, 1945). To determine the level of target behavior reduction, data were compared to the 4-week period prior to the start of the group process. The data for this 4-week period was combined to gain a measure of each target behavior.

Research question one addressed if there would be a reduction in target behaviors during the group experience as measured by target behavior data. Results for each individual target behavior and the combined target behaviors were significant at $p < .05$. Thus, participants of the anger management group demonstrated a significant reduction in measured target behaviors while participating in an anger management group experience. Research question two addressed if there would be a maintained reduction in target behaviors for a four-week period after the conclusion of the group experience. Results for the combined target behaviors was not significant at $p = .096$. Results for verbal aggression and aggression were not significant; however, results for property destruction were significant at the $p = 0.05$ level. Thus, participants of the anger management group demonstrated a significant reduction in property destruction, but not verbal aggression or aggression. Research question three addressed if instances of target behaviors would maintain a reduced level for a six-month period after the conclusion of the group experience. Results for the individual and combined target behaviors was not significant. Results suggest that participants were not able to maintain a reduced level of target behaviors for a period of six months after participating in an anger management group experience. Effect size is used to understand the size of difference between measured data. Effect size was calculated for the treatment group data during the group experience compared to the four-week period prior to the start of the anger management group experience, which indicated a medium effect of Cohen's $d = 0.5$.

Discussion and Implications for Practice

Results support the position that people with a mild ID can benefit from participation in a modified anger management group to reduce instances of verbal aggression, aggression, and property destruction. Furthermore, a treatment widely used in the community to help people with anger management issues, with minimal adaptions, can be used to help individuals with

intellectual and developmental disabilities. Therefore, rather than creating a new treatment specifically for people with intellectual and developmental disabilities, current and readily available anger management strategies should be considered. Additionally, the group focus was primarily anger management strategies that empowered members to accept responsibility for their own behaviors. A significant difference between the group members prior methods to deal with their aggressive behaviors and the current group treatment is that the group members developed their own anger plans to address times when they struggled with aggressive behaviors. Each group member's behavior support plan was developed by professionals based on an analysis of their behaviors. Plans created by group members were not altered and group members received no requirements for adjusting their plans. Therefore, each group member accepted responsibility for their positive behavior change through the development and modification of their anger plan. An overarching premise of this group was empowering group members to understand and accept responsibility for their behaviors and then to address their aggressive behaviors rather than the usual approach of simply applying a therapy to a client. The last aspect of this anger management group was to meet the requirements of the implementation phase of a settlement agreement that required traditional counseling approaches be utilized with people residing at the facility (The United States of America v. The State of Iowa, 2004). With modifications, to account for learning disabilities, the anger management group was successful in adapting an anger management group strategy commonly utilized with non-ID populations.

A major drawback of the treatment was that the learned skills and group participant developed interventions were not generalized into the group member's BSPs to continue positive behavior gains. People with ID often struggle generalizing learned skills in one environment to a different setting (Gargiulo & Bouck, 2018). Therefore, group members returned to the prior intervention methods as outlined in each group member's BSP. These interaction procedures were prescribed to maintain safety and comply with policy and did not necessarily reflect each individual's perspective on managing their own behaviors. Thus, the concepts discussed through the group were not reflective of typical treatment received by the group members through their BSP.

One additional aspect to consider is that of shared experiences. Each member participated in these weekly sessions and through these group interactions actively discussed numerous aspects of their anger. This experience was unique in that anger was usually avoided and not addressed because of related behavioral concerns. This variation to treatment as usual also highlighted two principles of the group experience, universality, and socializing techniques (Yalom & Leszcz, 2020). Members of the group knew that they all had struggles controlling their anger and were able to share in their struggles and successes. The group process offered members the opportunity to express their internal dialogue, which offers relief from the sense of unique isolation (Yalom & Leszcz, 2020). While group members knew other members had anger management issues, they had not heard the internal thoughts and feelings associated with these behavioral expressions. Members were provided with their peer's rationalization for using aggressive behaviors. While the rationalization was not expressed as justification, peer members understood how their own interactions served as cues for this person's behaviors. This different understanding of the event led to an increased expressed level of empathy for other group members. Additionally, group members discussed and practiced learned skills. Sharing the application of those skills helped some members further understand how each skill applied to an

actual situation. Members participated in discussion surrounding anger management, which also increased their ability to express thoughts, feelings, and behaviors in an acceptable public forum. Yalom and Leszcz described the skill-based socialization process as naturally occurring within the confines of group treatment (2020). The evidence of therapeutic factors within the group process provided additional support for the use of group counseling as a treatment option for people with an ID.

One last factor to consider is the self-designed interventions versus standard interventions prescribed to members through their BSP. Interventions prescribed through the BSP were general and designed to intervene after an aggressive incident. These interventions were universal for everyone who resided at the facility with minimal variation. Therefore, the interventions were not based on any unique client need. While the BSP interventions were universal and reactive in nature, the self-designed interventions were unique and based on each person's perspective of how to address their own behaviors. It should be noted that the self-designed interventions were not based on the function of a behavior and may not have had long term efficacy had they been adopted into each group member's BSP.

This study provides an example for the application of modified group counseling as a useful treatment modality for clients with mild ID. Using an adapted anger management group process that includes a social component with a here-and-now approach is an effective change facilitator for people who are diagnosed with a mild ID and have anger management needs. The key factor in the provision of the group counseling approach is that the person be able to process maladaptive behavioral patterns and create their own plan for addressing their behavior in the group. This process requires the member to have the capacity for a basic comprehension of course material and a willingness to participate.

Limitations and Future Research

Some limitations of this study may be that it was conducted in an institutional setting in the central Midwest and the level of functioning among the members was mild ID. Thus, the application of group counseling with people who function at a more severe range of ID was not discussed. Additionally, all members of the group have a behavior support plan and take psychotropic medications, which also contributes to positive behavioral change. Furthermore, the members of this group were primarily adolescent and future studies should focus on a broader range of ages.

Group counseling can benefit members of populations that require both anger management treatment and socialization due to being limited or isolated from peers for various reasons. The authors suggest future research to first replicate the findings of this study. With additional support, and demonstrated efficacy, group therapies should be included in BSPs to generalize learned skills. Another alteration to consider would be to train staff on group counseling anger management principles and techniques prior to running the anger management groups. Once direct care staff better understand the group counseling and anger management principles, they would be more able to help adjust treatment to each person's unique needs. To build on this study, the authors suggest counselors adapt other group therapies in an effort to reach other such isolated populations. Two specific recommendations would be to explore the use of counseling social skills groups and of friendship skills groups. Last, the authors suggest researchers consider the potential for changes in administrative policy, as people with ID largely

experience treatment from the behavioral perspective. Running counseling groups for people with ID, that include direct care staff in the treatment process, would be a significant shift from typical treatment.

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