Chapter 2

A Common Language For Understanding Intellectual Disability, Development, Emotions And Behaviour

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Introduction

A common language is the exchange of communication delivered without professional jargon, reliance on acronyms, or the assumption that the communication partner shares the same skill set and knowledge base to interpret the information given. Therefore, common language is the use of words, including terminology that is user-friendly and understood by all communication partners. When considering the individual with an intellectual disability and emotional/behavioural disorder as part of a system (i.e., family or service system) the issues to address become multi-faceted, with intervention often requiring a range of professional services. Working collaboratively and holistically requires a common understanding between agencies, clinicians, and professionals for any intervention to be successful.

Clinicians within multidisciplinary teams are required to work within a communal framework often made up of professionals from different disciplines and/or backgrounds. There is an expectation that professionals have an understanding or awareness of disciplines other than their own. This can lend itself to greater awareness, but also confusion and misinterpretation of roles, responsibilities, and the presenting problem. Difficulties in communication between professionals occur when supporting children in need (Salmon & Rapport, 2005). More specifically, Salmon and Rapport (2005) found that communication breakdown can occur ‘when professionals use the same words as each other, but apportion them with different meanings, in the belief that agreement has been reached in conversation, when in fact those conversing are at odds with one another’ (p. 430).

An interagency approach requires collaboration and effective exchange of information within clearly defined rules and processes. For example, the National

Health Service (NHS) in Scotland required a common usage of the word *integration* for its health services and attempted to derive a National Framework for Service Change (as cited in Scottish Executive, 2005). The concept of integration was a cornerstone of Scottish health policy and practice. Bell, Kinder, and Huby (2008) reviewed both the Scottish NHS policy and practices several years later and found that professionals habitually used the term integration in different ways. More specifically, for practitioners and managers engaged with service development and quality improvement, the rhetoric of integration failed to connect with practice. Bell et al. (2008) suggested that there was a need to develop a top-down approach to the change in service delivery, through policy and legislation, as well as a bottom-up approach from the service providers. This attempt to formulate a common usage of integration highlighted the complexities involved and acknowledged that language is dynamic and changeable over time in use and meaning (Bell et al., 2008). This holds true for language use in governments and agencies as well with professionals, clients and their families.

The Significance Of Language

Hebert, Brandt, Armstead, Adams, and Steck, (2009) suggested that the ability to communicate effectively across groups is through the willingness to treat individuals from other communities with respect and understanding. Additionally, Nicholson, Artz, Armitage, and Fagan (2000) found in their research on working relationships in multidisciplinary settings that, ‘working collaboratively’ was described as working together as ‘equals’, and valuing and utilising the perspectives and expertise of others. Working in a multi-disciplinary framework can also be considered as the coming together of differences. Sheehan (1996) described the differences as being a ‘clash of

cultures' (p. 76) characterised by differences in values, language, problem-solving strategies, and other elements of professional behaviour. According to Nicholson et al. (2000) different disciplines contribute separate and often competing philosophies, diagnoses of need and pathology, and models of the way the world works.

Specific terminology is necessary in different professions and professional bodies spend a great deal of time ensuring that the meaning is readily understood within their group. When the terminology is used outside the specific group for which it is intended, knowledge or understanding of this terminology is assumed. Clinically, it is known that this is not always the case. Language defines the clinicians' observations, their assessments and their diagnoses. Working in a multidisciplinary framework invites different skills, experiences and ultimately different perspectives to describe the same presenting problem. It is important to use language that conveys meaning to others outside professional bodies/organisations so that information is credible for working together in a holistic manner.

A Model For Working Together: Establishing A Common Language

To assist the collaborative process between professionals who work together, it is important that there is a shared terminology that is universal for those involved. To do so is a great challenge particularly given individual disciplines and professional bodies have their own models of practice, terminology, and rhetoric which have taken years of learning, research, and experience to arrive at a level of understanding. However, before information can be confidently transferred beyond the boundary of any one discipline, it is necessary that *within* a discipline, a common language is derived and adopted whole heartedly by its members. This may sound self-evident however Marks (2005) argued

that without a common language, confusion is likely. For example, Marks (2005) promoted the adoption of a common language among psychotherapy. He believed that the absence of a common language led different therapists to use different terms to describe the same procedure, and/or the same term to describe different procedures. Additionally, he insisted that using the same terms for common therapy procedures would enable the psychotherapists to better communicate what they do.

Despite recognising the value in better communication and the importance of individual disciplines speaking the same language, there is no assurance that understanding is possible for someone outside the discipline who does not have appropriate training to interpret the meaning and the language accurately. Therefore, professionals who work with children and young persons with disabilities and emotional disturbances need to have information and knowledge that transcends the boundaries of their disciplines. The real challenge then lies in seeking a common language for both the disability and mental health sectors, but more importantly a language that families of clients find meaningful, interpretative and informative in their dealings with all professionals.

A Common Language For Working With Children, Young People And Their Families

Professionals working with children and young people with intellectual disabilities use different and multiple conceptual models or ‘lenses’ to ascribe meaning to emotional and behavioural difficulties that are seen as challenging. A comment such as ‘this child has bizarre language’ can be interpreted in many valid ways depending upon the professional’s knowledge, attitude, and skills (Beukelman & Mirenda, 2005).

Understanding a child's emotional and behavioural disturbances along with their developmental disability reflects understanding and experience in both the mental health and disability fields, and requires familiarity of language used in both sectors. Furthermore, depending upon clinicians' professional training, where they work and even where they live, not to mention their own cultural and social values, there are subtle influences in the language that is adopted and used when working with clients. Language is used to define and label, as well as interpret and represent the child or young person's presenting issue or problem. In practice, this may involve summarising the presenting problems in the language that the child or family has used as well as describing it in professional terminology.

When considering abnormal child development, there is an assumption or understanding of what this is, how it is measured, an idea of what the child will be like, and how they will present. The child is often given a diagnosis by a qualified professional who develops a hypothesis and formulates an intervention for the presenting problem. However, not all professionals or family members will observe the same thing or even use the same common language to describe what they see. At times, even the child/young person and the clinician can experience difficulties in sharing the same view. This is demonstrated in the case study below.

A Case Study

The young child could be seen struggling to find words to answer the question posed by the clinician who was pointing at the middle sized circle. On the table in front of the child were three circles, a larger circle, a medium circle and a smaller circle. The clinician waited, with an expectant look on her face, knowing that a child with

intellectual disability may need additional time to process the verbal command. It had taken many weeks to get to this point. This young child was reluctant to attempt new activities, had repeatedly moved away from exciting and enticing novel items and was now showing signs of increased anxiety. The previous reports had stated that this child was not able to sit still at a table and therefore could not be formally assessed. With gentle coaxing and much encouragement, the young child and clinician had begun the process of assessment tasks. After what seemed to be a long time, the child triumphantly yelled, 'Its Maurice!' and started to laugh.

Interestingly this scenario could have been interpreted in many ways. Whilst the child understood the concept of middle, evidently the child's answer was incorrect and could not be scored as the target answer of 'medium', 'middle-sized', 'middle' for the assessment item as this was not achieved. Rather, the child used a different viewpoint or generalisation of knowledge that he had gained in another context to apply to this situation. Fortunately the clinician was experienced in working with children in early intervention and was familiar with the not-so-regular characters from the Australian Broadcasting Corporation's (ABC) television program and books, *Playschool* (see Playschool, 2006). In Playschool, *Maurice* was the *other* bear, not 'Little Ted' and not 'Big Ted'. The clinician was familiar with the language used by the child, and did not misinterpret the child's response.

Conceptualising A Common Language: Examining Language Variation Over Time

Shared knowledge of the use of language can change over time. Tracking the way words are used allows us to map changes in the way people think and see the world.

Tracking these changes also provides an understanding as to how individuals with mental health issues or intellectual disability have been perceived and supported over time. Riding, Swann, and Swann (2005) suggested that 'The way in which we perceive the needs and relative value of vulnerable people has an important influence on the way in which we legislate and provide for them' (p. 7). According to Riding et al. (2005), the decision to exclude people with an intellectual disability from the *Mental Health Act 1983* reflected changing social perceptions and an increased awareness of those with special needs, in particular the needs of people with intellectual disability.

Terminology changes within a profession as time elapses so that what was once common usage may now be seen as inappropriate. As further information is gathered and more accurate terminology is sought, particular philosophies or frameworks are newly applied, legislation or governmental policies adopt specific terms (or acronyms), State, National or International groups form, and a consensus on terminology is gained. An example of this is the desire for evidence-based research to inform clinical practice and the creation of web-based databases devoted to 'best practice' interventions and treatment efficacy, such as SpeechBITE and PsycBITE.

Reliance on information technology for exchange of communication and documentation, unlike ever before, has instilled an expectation that professionals across disciplines share a mutual definition or understanding of the information delivered. By examining the current use of language, many different terms (e.g., interdisciplinary, multidisciplinary, transdisciplinary, interprofessional) are used in the literature without an (unanimous) understanding of their meaning (Nicholson, et al., 2000). Furthermore, Graham et al. (2006), did a '*Google'* search of known terms to describe the application of knowledge to practice, such as, *knowledge translation, knowledge transfer,*

knowledge exchange, research utilization, implementation, dissemination, and diffusion. After reviewing the first dozen pages for each term, the researchers had difficulty in finding consistent and meaningful definitions for each of the terms. They also acknowledged that these terms were often interchangeable, sometimes used as a *noun* to reflect the entire process of gaining knowledge, or as a *verb* to reflect specific strategies. This example demonstrated that language that is thought to be common, is in fact not so. Language that is open to interpretation and processes that are not streamlined makes effective clinical practice difficult. The use of discipline specific assessments, ensures sharing of meaning of a child/young person's presenting issues, but limits the application and deliverance of information to only knowledgeable recipients. Whilst these assessments may assist to provide clinical insight within a discipline, they fall short of achieving a common language across disciplines.

Deriving A Common Language For Clinical Practice

When considering this issue on a more global level, there are several universal tools that can be used from which to derive a clinical framework. The text revision of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR, APA, 2000) lists all known mental disorders, and assumes a common understanding of interpretation and diagnosis, as does the tenth revision of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10, WHO, 2007). A point of difference is that the ICD-10 works in tandem with the *International Classification of Functioning, Disability and Health* (ICF, WHO, 2002). The ICD-10 and the ICF are classification tools that assist to derive a common language for professionals working across disciplines and professional bodies. The ICD-10 is 'used to classify disease at the

level of the health condition in the ICF model' (Imms, 2006, p.65) and aims to provide a common interdisciplinary language for communication and understanding of health, health-related outcomes, and health determinants. Simeonsson et al. (2003) reported that due to the disproportionate prevalence of disability in developing countries, with children constituting the largest percentage of those with functional and developmental limitations, there was a need for universal measures that are brief and effective for use in surveillance and screening.

The ICF, at its core, addresses this broad need for a common language and classification of functioning and disability (Simeonsson et al., 2003). Additionally, Jette (2006) stated that, 'If widely adopted, the ICF framework could provide the rehabilitation field with a common, international language with the potential to facilitate communication and scholarly discourse across disciplines and national boundaries, to stimulate interdisciplinary research, to improve clinical care, and ultimately to better inform health policy and management' (p. 726). Although the ICF may assist in providing a universal language across health and disability services, the classification system is still complex and questions remain about its practicability (Allet, Burge, & Monnin, 2008). It would appear that from reviewing clinical practices and professional disciplines that there are varying degrees in which the ICF and the ICD-10 are used to shape the clinical direction of service delivery. Therefore, it may be necessary to utilise alternate approaches to establishing a common language that could include clinical frameworks that are not discipline specific but focus on the client and identifying, and addressing their needs.

Clinical Frameworks That Assist With Establishing A Common Language

Ecological Systems Theory

It is important for clinicians to examine a child/young person's presenting disability and emotional/behavioural issues from a holistic point of view. Brofenbrenner (1979) developed Ecological Systems Theory in order to looks holistically at a child's development within the context of his/her environment. Brofenbrenner's theory defined complex layers of the child's environment that each had an effect on his/her development. Brofenbrenner (1979) argued that the interaction between factors in the child's maturing biology, his/her immediate family/community environment, and the societal landscape directed development. He also argued that changes or conflict in any one layer would ripple throughout other layers and may have an adverse impact on the child's developmental trajectory. Therefore, in determining the impact of having a disability on the child's development, the child and his/her immediate environment needs to be examined followed by an exploration of the child's interaction with the larger environment.

Bio-Psycho-Social Model

The bio-psycho-social model is used within the mental health and disability fields and provides a framework for considering the child's emotional, behavioural, and developmental wellbeing. Stokes, Matthews, and Shafik-Eid (2006) noted that the ICF used the bio-psycho-social model to help conceptualise and measure health and health-related issues. Therefore, by linking the ICF to child mental health and disability services using the bio-psycho-social model, clinicians can establish a common language for considering the predisposing, precipitating, perpetuating, and protective factors in

understanding the complexity of a child/young person's presenting problems (Havighurst & Downey, 2009).

Dossetor, Santhanam, Rhodes, Holland, and Nunn, (2005) took this idea a step further to explore the influence of the psychiatry of intellectual disability on child psychiatry, and conversely, the influence of child psychiatry on the understanding of the mental health needs of those with intellectual disability. Dossetor et al. (2005) argued that child psychiatry needed to expand its understanding of the bio-psycho-social approach in the management of young people with intellectual disability. Furthermore, they proposed that a more dynamic and broader conceptual framework of developmental neuropsychiatry was one that encompassed a bio-*developmental*-psycho-social-*cultural* model. This enhanced model could then assist in establishing a common understanding of the mental health needs of all children, including the implications for assessment, diagnosis and treatment.

Summary: Achieving A Common Language

Establishing a *common language* in child mental health and disability fields is important and continues to evolve. The challenge has been to achieve a definition and a common understanding of its impact on clinical practice. There is strong agreement that a common language is needed across disciplines and agencies yet there are varied models and frameworks as to how this can be established. This chapter has highlighted that the need for a common language is evident at all levels of government, within and across agencies, disciplines and fields, and for families and clients. An awareness of clinical tools and clinical frameworks is also necessary so that communication and collaboration is meaningful for all clinicians across both the child mental health and disability sectors.

A common language is central to meeting complex developmental, emotional and behavioural needs of children and young people with intellectual disability (see Figure 2.1).

[Insert Figure 2.1 here]

Laming (as cited in Salmon & Rapport, 2005) suggested that a common language must be established 'For use across all agencies to help those agencies to identify who they are most concerned about, why they are concerned, who is best placed to respond to those concerns and what outcome is being sought from any planned response' (p. 373). Although, there are differences in how a common language is derived. Professionals, agencies, and governments may use the universal clinical tools such as the DSM-IV-TR (APA, 2000), ICD-10 (WHO, 2007) or ICF (WHO, 2002) to inform clinical practice. Or, they may use the clinical frameworks such as *Ecological Systems Theory (*Brofenbrenner, 1979) or the *bio-developmental-psycho-social-cultural model* (Dossetor et al., 2005). At the end of the day there is no easy answer as to how to derive a common language. However, it is evident that there is a need for professionals to collaborate, exchange information, have a willingness to work across disciplines, form partnerships, and share knowledge.

Nicholson et al. (2000) outlined that for professionals to achieve a common language, it is necessary to have a multidisciplinary, collaborative approach and to practice asking lots questions for clarification. A commitment to effective communication and the time it requires, acceptance of individual differences, flexibility, reflection in practice and valuing the input and participation of others (clients and co-

workers). Thus whenever possible, professionals should adopt a language that is current and easily understood, that is respectful of clients and families whilst being mindful of the significance and connotation of certain words. Professionals should also actively learn new terminology to help with interdisciplinary and interagency communication, use an evidence-based approach, and importantly, keep an open mind. Finally, professionals should be aware that ‘The lack of a common language across agencies has been identified as one of the critical factors in the success or failure of multi-agency collaborations’ (Salmon & Rapport, p. 430).

Figure 2.1

Common Language: The Central Focus Of Effective Clinical Practice