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Adapting Individual Psychotherapy for Adults with Intellectual Disabilities: A Comparative Review of the Cognitive–Behavioural and Psychodynamic Literature

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Background Historically, adults with intellectual disabilities have had little access to individual psychotherapy. Over the last 20 years an increasing body of literature has described psychotherapy with this client group and reported methods for adapting traditional psychotherapeutic techniques.

Method The current review identified the frequency of adaptations suggested by Hurley *et al.* (1998) [*Journal of Developmental and Physical Disabilities*, vol. 10, pp. 365–386] within cognitive behavioural and psychodynamic studies with adults with intellectual disabilities. Twenty-five studies were reviewed, 10 cognitive–behavioural and 15 psychodynamic.

Results A total of 94 adaptations were identified. Within cognitive behavioural therapy (CBT) studies, flexibility in method was the most frequently considered adaptation whilst transference and countertransference issues were most frequently considered within psychodynamic studies. Across the two approaches, disability and rehabilitation issues were given the least consideration.

Conclusions Implications for practitioners and services are highlighted along with recommendations for future research.

Keywords: cognitive–behavioural therapy, intellectual disabilities, psychodynamic therapy, psychotherapy

Introduction

The emotional lives and mental health of adults with intellectual disabilities

The emotional lives of adults with intellectual disabilities is an area that has traditionally been paid little attention, and is described by Arthur (2003) as one that has been neglected, largely because of institutionalization, where adults with intellectual disabilities were, 'out of sight and out of mind' (p. 26). It is now accepted that adults with intellectual disabilities experience full emotional lives (Jones *et al.* 1997) and suffer from the same mental health difficulties as the general population and that prevalence is, if anything, slightly higher (Dosen & Day 2001).

Individual therapy with adults with intellectual disabilities

The slightly higher prevalence of mental health problems combined with evidence suggesting that some adults with intellectual disabilities have the ability to self-report on their emotional states (Lindsay *et al.* 1994; Stenfert Kroese *et al.* 1998) suggests that individual therapeutic interventions should be widely available to the general population. Historically, however, adults with intellectual disabilities have had little access to individual therapeutic interventions for psychological problems (Stavrakaki & Klein 1986; Hurley 1989; Butz *et al.* 2000; Dodd & McGinnity 2003; Johnson *et al.* 2003; Lynch 2004). Bender (1993) describes the 'therapeutic disdain' of mental health professionals towards psychotherapy

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with this client group and, like Stenfert Kroese (1998) and Hurley *et al.* (1998), highlights the over-reliance on behaviour modification and use of medications. Stenfert Kroese (1998) stresses that these methods neglect the psychological well-being of the client and Waitman & Reynolds (1992) suggest that interventions such as these are often designed to meet the needs of the service provider rather than those who are experiencing difficulties.

In more recent times, barriers to individual psychotherapy for adults with intellectual disabilities have become less restrictive. Studies have reported the use of psychotherapy with this client group for a range of difficulties including anxiety (Lindsay *et al.* 1997), depression (Lindsay *et al.* 1993), psychosis (Leggett 1997), anger (Taylor *et al.* 2002), sexual abuse and trauma (Hollins & Sinason 2000; Cooke 2003), offending behaviour (Beail 2001), challenging behaviour (Berry 2003) and understanding of intellectual disabilities (Johnson *et al.* 2003). In comparison with the amount of literature on psychotherapeutic approaches in general adult mental health, however, the number of studies remains small.

Effectiveness of psychotherapy with adults with intellectual disabilities

A number of reviews have attempted to address the issue of efficacy of psychotherapy with adults with intellectual disabilities (Hurley 1989; Nezu & Nezu 1994; Butz *et al.* 2000; Beail 2003; Prout & Nowak-Drabik 2003; Sturmey 2004; Willner 2005). Prout & Nowak-Drabik (2003) adopted an 'expert consensus' model to review 92 studies that used psychotherapy with this client group and also conducted a small meta-analysis of nine studies that included control groups. They reviewed a wide range of psychotherapeutic variables including type of experimental design, age, level of intellectual disability, type of treatment and theoretical orientation. They concluded that psychotherapy with this client group resulted in moderate change and was moderately effective or beneficial. They also conducted exploratory analyses of the data and found that individual, clinic-based interventions were more effective than other treatment options such as group interventions and treatments that took place in client's home.

This review has recently been criticized by Sturmey (2005) who questioned the broad definition of psychotherapy and also highlights that only one study in the meta-analysis included traditional psychotherapy. A number of other methodological issues are raised such as the 'expert ratings' and the interpretation of the effect sizes. Recent reviews by Beail (2003) and Willner (2005) also claim that the difficulties with the existing literature make it hard to reliably comment on the effectiveness of psychotherapeutic approaches with this client group. Willner (2005) proposes that cognitive, cognitive behavioural and psychodynamic approaches can be an effective intervention with this client group but highlights a lack of randomized control trials and lack of evidence regarding which specific components of interventions are effective. Beail (2003) makes similar criticisms of the literature but suggests that the evidence base of cognitive behavioural approaches has progressed further than psychodynamic approaches.

Two papers reviewing the effectiveness of psychotherapy with this client group (Prout *et al.* 2000; Prout & Nowak-Drabik 2003) have criticized studies for unclear descriptions of the therapeutic procedures used. This may highlight a further reason as to why access to individual therapy has been difficult for adults with intellectual disabilities, as clinicians may be unsure about how to adapt traditional approaches with this client group.

Adapting psychotherapy for adults with intellectual disabilities

Sternlicht (1965) wrote a review paper on psychotherapeutic techniques that were useful with the 'mentally retarded' that emphasized the importance of the relationship between therapist and client in individual therapy stating, 'it seems not unlikely that the success of any therapeutic or rehabilitative endeavour may be mainly the result of the sense of importance that a patient feels when an intact stranger is sufficiently concerned with him to spend time and effort for the patient's benefit' (p. 86).

Stavrakaki & Klein (1986) outlined a number of principles that they believed should be considered when undertaking psychotherapy with adults with intellectual disabilities. This included an assessment of the client's receptive and expressive language to guide the therapist in the use of verbal and non-verbal techniques during therapy whilst also using the therapeutic relationship as a secure relationship and a new experience in social learning for the client. They highlighted the need for the therapist to be aware of negative countertransference feelings due to the client's sensitivity to non-verbal communications, which may arise as a consequence of verbal language difficulties. They suggested that directive techniques of suggestion, persuasion and reassurance should be used rather than non-directive methods. They

stressed that it was important for therapy to be flexible in terms of length of sessions, have realistic, simple goals and for external support to be available from caregivers to reinforce progress in therapy.

Similar to the propositions of Stavrakaki & Klein (1986), Hurley *et al.* (1998) stress that psychotherapists adapt the way that they work with each individual client, therefore altering their approach to a person with intellectual disabilities should not be problematic, especially if they have at their disposal some basic principles for adapting therapy for this client group. They draw attention to a number of alterations that they have found within the literature and emphasize that therapists must pay particular attention to the developmental level, dependence needs, and verbal and cognitive abilities of the client that they are planning to work with. Within this paper, they provide descriptions of nine ways in which psychotherapy can be adapted for adults with intellectual disabilities. A summary of these adaptations is reproduced below as Table 1.

Hurley *et al.* (1998) acknowledge that some adaptations may be thought of as somewhat specific to particular theoretical models of psychotherapy and propose that rather than working from one particular theoretical framework, such as cognitive–behavioural or psychodynamic, success in working with adults with intellectual disabilities is increased if a flexible, innovative approach is adopted.

The need for adaptation to traditional models of psychotherapy has recently received support in a report on *Psychotherapy and Learning Disability* published by the Royal College of Psychiatrists (2004). They state, 'for psychotherapies to be effectively delivered to this group, established models of therapy can be modified to accommodate differences in intellectual ability……rigid adherence to established models of psychotherapy and its delivery can effectively exclude people with learning disabilities from receiving appropriate treatment' (p. 7).

Two of the most common types of psychotherapy available to the general population are cognitive–behavioural therapy (CBT) and psychodynamic psychotherapy, both of which have been applied to people with intellectual disabilities.

CBT for adults with intellectual disabilities

There has been an increasing amount of interest in the use of CBT for adults with intellectual disabilities culminating in the book, *Cognitive Behaviour Therapy for People with Learning Disabilities* by Stenfert Kroese *et al.* (1998). Stenfert Kroese (1998) argues that the cognitive *content* of adults with intellectual disabilities (what a person thinks) has been overlooked in favour of the

Table 1 Adaptations of psychotherapy techniques (Hurley *et al.* 1998)

Adaptation	*Definition/Example*
Simplification (S)	Reduce usual technique in complexity; breakdown interventions into smaller chunks, shorter length of sessions
Language (L)	Reduce level of vocabulary, sentence structure and length of thought. Use short sentences; use simple words
Activities (A)	Augment typical techniques with activities to deepen change and learning. Add drawings, homework assignments
Developmental level (DL)	Integrate developmental level into presentation of techniques and material. Use games; assess development into relevant social issues
Directive methods (DM)	Because of cognitive limitations, must be more direct. Outline treatment goals, progress, give extra 'visual' guides
Flexible methods (F)	Adjust usual techniques to suit cognitive level and lack of progress. Draw from other modalities
Involve caregivers (IC)	Use family, support staff to help with change. Assign homework or rehearsals at home with the help of staff or family
Transference/countertransference (TC)	Attachments are stronger, quicker; therapist reactions similar to parental view. Therapists urged to be stronger in boundaries and to ensure peer supervision
Disability/rehabilitation approaches (DR)	Issue of disability must be addressed within treatment; therapist must raise issues and support positive self-view

cognitive *process* (how a person thinks). This paper draws upon existing literature to argue that CBT, which addresses the cognitive content of adults with intellectual disabilities, can be utilized if adaptations to traditional methods are made. These include facilitating valid self-reports, assessing and adapting to the client's comprehension and expression of abstract concepts, and promoting self-regulation by assessing the impact of current environmental factors.

Dagnan & Chadwick (1997) and later Dagnan *et al.* (2000) importantly discuss issues surrounding the assessment of suitability of adults with intellectual disabilities for cognitive therapy. They outline pre-therapy assessment procedures that investigate a client's ability to link antecedents, beliefs and consequences. They report that adults with intellectual disabilities can have the skills to use this type of therapy although they acknowledge that some adults will need introductory training to help them grasp the concepts, and others will not be able to benefit from CBT methods even with introductory training.

Lindsay (1999) provides a summary of his work using CBT with over 50 adults with intellectual disabilities and describes how the essential aspects of Beck *et al.* (1979) cognitive therapy (e.g. agenda setting, testing cognitions and setting homework, etc.) can be retained whilst modifying and simplifying techniques for this client group.

Psychodynamic psychotherapy for adults with intellectual disabilities

In comparison with the amount of literature on the use of CBT with adults with intellectual disabilities there is a larger body of literature that has considered the use of psychodynamic and psychoanalytical principles (e.g. Balbernie 1987; Howard *et al.* 1989; Frankish 1992; Stokes & Sinason 1992; Symington 1992; O'Hara 1993; Gaedt 1995; Hassiotis 1999; Hollins & Sinason 2000; Linington 2002). Beail (1989a,b, 1995, 1998, 2001, 2003) and has been one of the main contributers to the literature in this area and dates the application of psychoanalytical ideas to adults with intellectual disabilities back to the 1930s (although acknowledges that the first case report of individual therapy using this approach was not published until Symington 1981). Sinason's (1992) book, *Mental Handicap and the Human Condition* outlines the work that she and her colleagues have undertaken at the Tavistock Clinic. One of the central tenets of this book is the concept of secondary handicap and she describes how organic deficits, or primary handicap, can be worsened by, 'defensive exaggerations' (p. 2). Sinason (1992) views intelligence, as measured by IQ scores, as something that is a result of both primary organic damage and secondary ways of coping with these deficits.

Aims of the current review

This article aims to report the frequency in which studies using cognitive–behavioural and psychodynamic psychotherapeutic approaches with adults with intellectual disabilities have considered and reported the adaptations suggested by Hurley *et al.* (1998). The focus of this review is therefore on the process of therapy rather than the outcome.

Method

The studies were identified by a number of methods. An automated search was conducted using Psychinfo, Medline and Web of Science using and combining the following terms 'learning disabil*', 'intellectual disabil*', 'developmental disabil*', 'mental handicap', 'mental retardation' 'psychotherapy', 'cognitive behaviour therapy', 'CBT', 'psychodynamic', 'psychoanalysis' 'counselling', 'psychological therap*'. It was not possible to use the term 'therapy' alone in the search as this vastly expanded the search. The search was augmented by citations from other journal articles and books along with an extensive search undertaken by the British Institute of Learning Disabilities (BILD).

The results were initially screened to identify those of relevance to the current review. Papers were selected if they provided information that described the process of individual cognitive behavioural or psychodynamic approaches. Those relating to indirect approaches and working with groups or children were excluded. Papers were also excluded if they were purely theoretically based and did not provide information on treatment process.

Using the method described above, 25 references were identified. Once selected, the first author reviewed the studies to identify if the adaptations proposed by Hurley *et al.* (1998) had been considered. This process was then repeated to ensure that adaptations were not missed. In order to obtain inter-rater reliability data, the second author also carried out this process.

Results

Tables 2 and 3 present the adaptations identified in the studies reviewed. Because of the considerable variation

Table 2 Adaptations evident in CBT studies

				Consideration of adaptations evident		
Research Design	*Reference*	*n*	*Presenting problem(s)*	*Rater 1*	*Rater 2*	*Percentage agreement*
Comparison designs	Taylor *et al.* (2002)	9	Anger	(4) A, DM, F, IC	(4) A, DM, F, IC,	100
Case series experimental designs (AB)	Lindsay *et al.* (1993)	2	Depression	(4) S, A, DM, F	(4) S, A, DM, F	100
	Lindsay *et al.* (1997)	2	Anxiety	(6) S, L, A, DL, DM, F	(6) S, L, A, DL, DM, F	100
	Haddock *et al.* (2004)	5	Psychosis	(8) S, L, A, DL, DM, F, IC, DR	(8) S, L, A, DL, DM, F, IC, DR	100
Single-case experimental designs	Clare *et al.* (1992)	1	Fire setting	(3) S, F, IC	(3) S, F, IC	100
	Lindsay *et al.* (1998a)	1	Stalking	(3) S, F, DL	(3) S, F, DL	100
Case reports	Golden & Consorte (1982)	4	Anger	(2) S, A	(3) S, A, F	67
	Creswell (2001)	1	Relationships/aggression	(3) A, DL, F,	(3) A, DL, F	100
	Johnson *et al.* (2003)	1	Disability issues	(4) DM, F, TC, DR	(4) DM, F, TC, DR	100
	Willner (2004)	1	Nightmares and post-traumatic ruminations	(5) S, L, DM, F, IC	(5) S, L, DM, F, IC	100

with regard to the reporting of the number of sessions and duration of treatment, this information was excluded from the tables.

It is beyond the scope of this article to describe all the adaptations in each of the studies reviewed. The study that considered the highest number of adaptations and provided the most detail of adaptations from both CBT and psychodynamic perspectives will be described more fully. Across both CBT and psychodynamic studies, all adaptations were considered and examples of these will be briefly presented.

Simplification

Golden & Consorte (1982) reported using a simplified version of Ellis's (1962) Rational Emotive Therapy and Hernadez-Halton *et al.* (2000) reported simplifying the verbal communication used to discuss patient's thoughts and feelings.

Language

Lindsay *et al.* (1997) described using a few simple words whilst setting an agenda in sessions to assist the client's understanding and Beail (1998, 2001) stated that all interpretations that were given to his participants were done so at a level that they would understand.

Activities

Taylor *et al.* (2002) set homework tasks as part of their treatment of anger amongst offenders and Summers & Witts (2003) used drawings to assist their understanding of their patients.

Developmental level

Whilst not specifically undertaking an assessment of developmental level, Creswell (2001) used material from soap operas to help the client understand complex relationships and identify the consequences of their behaviour and Sinason (1992) outlines some of the non-verbal materials that she uses with this client group, including musical clocks, dolls and plasticine.

Directive methods

This adaptation was not evident in any psychodynamic paper, however, Lindsay *et al.* (1997) reported using a flipchart to record agenda items and highlight important points that arose during the sessions.

Table 3 Adaptations evident in psychodynamic/analytic studies

				Consideration of adaptations evident		
Research design	*Reference*	*n*	*Presenting problem(s)*	*Rater 1*	*Rater 2*	*Percentage agreement*
Comparison designs	Beail (2001)	13[1]	Offending behaviour	(3) L, F, TC	(2) L, TC	67
Case series experimental designs (AB)	Beail & Warden (1996)	10	Various difficulties	(1) TC	(2) TC, F	50
	Beail (1998)	20	Behaviour problems/ offending	(3) L, F, TC	(3) L, F, TC,	100
Case reports	Symington (1981)	1	Violent tantrums	(3) IC, TC, DR	(4) F, IC, TC, DR	75
	Beail (1989a,b)	1	Disruptive behaviour	(1) F	(1) F	100
	Beail (1989b)	2	Disruptive behaviour/ cross dressing	(3) F, IC, TC	(3) F, IC, TC	100
	Frankish (1989)	1	Aggressive behaviour	(5) A, DL, F, IC, TC	(5) A, DL, F, IC, TC	100
	Applegate & Barol (1989)	1	Disruptive behaviour	(4) A, F, IC, TC	(4) A, F, IC, TC	100
	Sinason (1992)	2	Self-harm/sexual abuse	(6) A, DL, F, IC, TC, DR	(6) A, DL, F, IC, TC, DR	100
	Carlyle (1997)	1	Challenging behaviour	(4) DL, F, IC, TC,	(3) F, IC, TC	75
	Berry (1999)	1	Depressive behaviour	(3) DL, IC, TC	(3) DL, IC, TC,	100
	Kilchenstein (1999)	1	Intellectual disabilities	(6) L, DL, F, IC, TC, DR	(6) L, DL, F, IC, TC, DR	100
	Hernadez-Halton *et al.* (2000)	1	Concerns over safety	(4) S, L, DL, TC	(5) S, L, A, DL, TC	80
	Berry (2003)	4	Challenging behaviour	(3) DL, F, IC	(4) A, DL, F, IC,	75
	Summers & Witts (2003)	1	Bereavement	(4) A, DL, IC, TC	(4) A, DL, IC, TC	100

[1]versus 5 refused treatment.

Flexible methods

Clare *et al.* (1992) accompanied their client to a fire station and facilitated a meeting with fire officers as part of their treatment for fire setting and Berry (2003) took his patient, who was unable to tolerate the therapeutic context, for rides in his car.

Involving caregivers

Taylor *et al.* (2002) involved client's caregivers at the end of sessions to discuss progress and homework and Sinason (1992) involved caregivers that accompanied her patient to elicit information regarding progress between sessions.

Transference/counter transference

Johnson *et al.* (2003) discussed boundaries at the beginning of therapy and clarified the relationship between the client and the therapist and Hernadez-Halton *et al.* (2000) report being careful when giving transference interpretations to a sensitive client.

Disability/rehabilitation

Johnson *et al.* (2003) describe how their intervention focussed on issues relating to having an intellectual disability and Symington (1981) describes tackling the secondary gain of his patient's disability, which he interpreted as being maintained in order to secure his mother's love.

Cognitive–behavioural treatment studies

Table 2 presents the 10 published studies that adopted a cognitive–behavioural approach. These have applied CBT treatments to a variety of presenting problems ranging from mental health difficulties such as depression to offending behaviours such as stalking. Four of these are case reports, two adopt a single-case design and three apply single-case designs to a case series. Only one of these adopted a comparison design between a waiting list and a treatment group.

Across these studies, consideration of the highest number of adaptations was evident in the study by Haddock *et al.* (2004). They report that their modifications

were informed by clinical experience and the literature on CBT for people with intellectual disabilities. They provide evidence of eight adaptations that were proposed by Hurley *et al.* (1998). They describe how they simplified their methods (shortened sessions); considered the language abilities of their clients (used pictures and audiotapes); used activities (diary sheets) and considered the developmental level of the client (a preparatory and engagement phase to assess ability to understand a CBT approach and the use of supplementary materials to describe the approach). They also showed evidence of using directive methods (summary materials); flexibility (length and structure of sessions); involving caregivers (developing strategies to liase and feedback to caregivers) and consideration of disability issues (stigma associated with having an intellectual disability).

Psychodynamic/psychoanalytical treatment studies

Table 3 outlines the 15 psychodynamic and analytical studies with adults with intellectual disabilities. The majority of the treatment studies are case studies, with only one (Beail 2001) including a control group.

Kilchenstein (1999) describes the psychoanalytical treatment of a 25-year-old man who presented with a range of difficulties including repetitive behaviours, hallucinations and delusions. The language used in therapy was considered (by attempting to 'stay close to the language of the patient', p. 741) and developmental level (by using language that was slightly ahead of his patient's developmental level). The author involved caregivers (by maintaining weekly telephone contact with his patient's parents) and considered transference/countertransference issues (he used countertransference to, 'catch the major internal events of the session', p. 744). As regards disability/rehabilitation approaches, Kilchenstein (1999) reports that treatment resulted in improvements in the ability to self-reflect and capacity for more mature object relations.

Summary of Results

Table 4 summarizes the frequency by which the adaptations to traditional therapeutic techniques proposed by Hurley *et al.* (1998) were considered in the CBT and psychodynamic studies. Across the two treatment approaches, rater 1 identified 94 adaptations and rater 2, 99. Within the CBT studies, flexibility in method was the adaptation most frequently considered whilst for the psychodynamic studies, consideration of transference and countertransference issues was evident in the highest number of studies. When the two treatment approaches are combined, flexible methods was the most frequently considered adaptation.

Disability and rehabilitation issues and the use of more directive methods were given the least consideration across the two treatment approaches with only two CBT study and three psychodynamic studies incorporating disability issues into therapy. Whilst six CBT studies reported the use of directive methods with this client group this was not apparent in any of the psychodynamic

Table 4 Summary of results

	Number of studies in which adaptations were evident						
		CBT (n = 10)			*Psychodynamic/analytic (n = 15)*		
Adaptation	*Total (n = 25)*	*Rater 1*	*Rater 2*	*Rater agreement (%)*	*Rater 1*	*Rater 2*	*Rater agreement (%)*
Simplification	8	7	7	100	1	1	100
Language	7	3	3	100	4	4	100
Activities	10–12	6	6	100	4	6	67
Developmental level	11–12	4	4	100	8	7	88
Directive methods	6	6	6	100	0	0	100
Flexible methods	19–21	9	10	90	10	11	91
Involve caregivers	14	4	4	100	10	10	100
Transference/countertransference	14	1	1	100	13	13	100
Disability/rehabilitation approaches	5	2	2	100	3	3	100
Total	94–99	42	43	–	52	55	–

treatment studies. Only one CBT study considered issues relating to transference and countertransference and only one psychodynamic study reported simplifying the therapeutic process. Table 4 also illustrates that only seven of the 25 studies showed evidence of adapting the language used in therapy for adults with intellectual disabilities.

Discussion

The current review has highlighted ways in which traditional psychotherapy can be adapted to accommodate the needs of adults with intellectual disabilities. The number of treatment studies remains small however. Only 25 studies were included in the current review as they provided some description of methods and procedure.

It could be argued that some of the adaptations appear to be fairly specific to the particular approach that was adopted. Discovering that psychodynamic studies were more likely to consider transference and countertransference issues during treatment than CBT studies or that CBT studies were more likely to use directive methods than psychodynamic studies is not surprising as these form part of the therapeutic process in these approaches and therefore may not actually represent a major deviation from customary practice. What is encouraging, however, is that the majority of studies showed evidence of flexibility in approach in order to accommodate the needs of adults with intellectual disabilities.

Overall, issues relating to disability and rehabilitation were given the least consideration within the literature reviewed. This is surprising as emotional difficulties experienced by adults with intellectual disabilities can be associated with having a disability and their perception of being 'different' to other adults (Johnson *et al.* 2003). Undertaking individual psychotherapy with someone with intellectual disabilities allows issues surrounding social stigmatisation and social rejection to be addressed if they are pertinent to the person in therapy. It affords clinicians an opportunity to promote a positive approach to disability and value the person as a worthy human being (Hurley *et al.* 1998).

The current review utilized a robust methodology for assessing the adaptations in studies using psychotherapy in people with intellectual disabilities. Generally there were high levels of agreement between the two raters (Tables 2–4). There was 100% agreement in nine of 10 CBT and nine of 15 psychodynamic studies. As regards the specific adaptations identified, there was 100% agreement in eight of the nine within-CBT and six of the nine within-psychodynamic studies. It is possible that these discrepancies were due to the lack of clearly defined adaptations within the studies and also to overlap between the adaptations proposed by Hurley *et al.* (1998). As a consequence, the identification of adaptations includes a subjective element although the current methodology attempted to reduce this. Moreover, many of these studies only showed a consideration of the adaptation as opposed to fully following the guidelines suggested by Hurley *et al.* (1998). An example of this is developmental level. Many studies reported that they adapted their procedures to the developmental level of their client, although none undertook any formal assessment.

Similar to the criticism by Prout *et al.* (2000) and Prout & Nowak-Drabik (2003), many of the studies did not clearly describe adaptations to the therapeutic process, or comment on how far these constituted departures from the underlying model. A major drawback of this is that it makes replication or development of therapeutic approaches by other clinicians difficult. Furthermore, there was considerable variation in the reporting of length of treatment either by number of sessions or timescale.

Recommendations for Future Research

There is a need for much more published research into psychotherapy with adults with intellectual disabilities including randomized controlled trials (RCTs) (Nezu & Nezu 1994; Sturmey 2004; Willner 2005) and larger scale outcome studies (Lindsay *et al.* 1998a). Difficulties undertaking RCTs with this client group have been acknowledged, such as the access to small sample sizes, which lead to problems with statistical power and generalization (Oliver *et al.* 2002; Willner 2005). Willner (2005), however, cites two recent RCTs of anger management interventions with this client group (Taylor *et al.* 2002; Willner *et al.* 2002).

Further research on the effectiveness of psychotherapy with this client group needs to focus on the effectiveness of the specific components of therapy interventions (Willner 2005) and include detailed analysis of therapeutic process and engagement aspects of work with people with intellectual disabilities. The current review highlights a need for clinicians and researchers to accurately and consistently detail adaptations to traditional therapeutic approaches. The authors also recommend that future studies detail adaptations using the categorization described by Hurley *et al.* (1998). It is hoped that this

will facilitate consideration of the impact of specific adaptations upon engagement and outcome, an aspect that is currently not known. In addition, greater consistency is needed in reporting duration of treatment to enable more thorough analysis of both process and outcome data.

Increasing the volume and quality of literature on individual psychotherapy for adults with intellectual disabilities that clearly describes procedures, methods and outcome data will have implications for intellectual disabilities services, as they will have to develop expertise in order to meet the therapeutic needs of their clients (Dodd & McGinnity 2003), and mental health services, which will need training in intellectual disabilities issues (Prout & Nowak-Drabik 2003). The need for specialist skills and training is an issue that has recently been raised by Beasley (2004) and is also highlighted in the report on *psychotherapy and learning disability* by the Royal College of Psychiatry (2004). The report describes a survey of 424 psychiatrists, psychologists and psychotherapists working within learning disability services. The survey suggested that people did have access to psychotherapy but it depended on the skills of practitioners and that a major barrier to receiving psychotherapy was the lack of appropriately trained clinicians.

If treatment studies are not published and traditional methods are not adapted, adults with intellectual disabilities will continue to have little access to individual treatment methods. Adults with intellectual disabilities will be denied access to a service which research suggests can be effective in treating psychological problems (Prout & Nowak-Drabik 2003). If adults with intellectual disabilities continue to have little access to individual treatment methods, Linington (2002) argues that, '…it is psychotherapy that is handicapped. For this is a psychotherapy which is undermining its own ability to understand and respond to individual subjectivity' (p. 413).

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