

Group Psychotherapy for People With Intellectual Disabilities: The Interactive-Behavioral Model

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ABSTRACT. The authors describe a model of psychotherapy designed to treat people who have intellectual disabilities in addition to psychiatric disorders. The model, termed interactive-behavioral therapy, represents a modification of standard techniques from group psychotherapy and psychodrama. The authors briefly review the historical context in which the treatment model evolved and establish the need for effective therapeutic intervention for this population of dually diagnosed individuals. They also present preliminary efficacy research on the model.

Key words: group psychotherapy, interactive-behavioral model for psychotherapy, psychotherapy for people with intellectual disabilities

PROFESSIONALS WORKING WITH PEOPLE with intellectual disabilities generally recognize that the mental health needs of people with mental retardation have traditionally been neglected (Charlot, Doucette, & Mezzacappa, 1993; Hurley, Pfadt, Tomasulo, & Gardner, 1996; Reiss, Levitan, & McNally, 1982). This neglect is an apparent correlate of a wide-ranging neglect for the overall health care of people with mental retardation. In his report, former U.S. Surgeon General David Satcher (Monday Morning, 2002) declared that health care in general, across the entire spectrum of medical needs, is still sorely lacking for people with mental retardation. Satcher concluded that the U.S. health care system has “failed to respond to changes in the lives of people with mental retardation,” noting that “[e]ven a quick glimpse at the health status of persons with mental retardation, both children and adults, reveals glaring deficiencies that must be addressed” (p. 3).

The mental health needs of people with intellectual disabilities have received increasing concern over the past two decades. An evolution in our thinking about people with intellectual disabilities has led to a surge in treatment efforts and research studies on therapeutic advances with this population (Fletcher & Dosen, 1993; see also Hurley, 1989; Hurley et al., 1996; Nezu & Nezu, 1994; Pfadt, 1991; Prout & Strohmer, 1995; Schneider, 1986; Tomasulo, 1999). Although experts concur that treatment availability is still widely lacking (Hurley et al.; Mansell & Sobsey, 2001) academic interest and treatment innovation has been substantial in recent years. For example, 1999 marked the establishment of the first peer-reviewed journal devoted entirely to the mental health issues of people with intellectual disabilities. The journal, *Mental Health Aspects of Developmental Disabilities*, had outgrown its former status as a newsletter, the result of increasing academic contributions to this field.

Moreover, the journal *Professional Psychology: Research and Practice* published an extensive review of the literature on psychotherapy with people who have intellectual disabilities (Butz, Bowling, & Bliss, 2000). The authors concluded that there is a need for well-defined diagnostic distinctions so that subtle signs of psychological disorders are not missed simply because a person meets the criteria for mental retardation. Butz and colleagues stressed that psychologists in general need to be better informed about the possibility of conducting psychotherapy with people who have intellectual disabilities. They concluded that, although not widely known, there is a growing body of research on psychotherapy for this group. They described the existing literature as limited in that it tends to be “qualitative and descriptive” (Butz et al., p. 46), but acknowledged that this limitation is common to the literature in many other areas of psychotherapy not just to that pertaining to people with intellectual disabilities.

Mental Health Needs of People With Intellectual Disabilities

Epidemiological researchers have demonstrated that the prevalence of psychiatric disorders is higher in the intellectually disabled population than it is in the general population. Following an extensive review of the literature, Nezu, Nezu, and Gill-Weiss (1992) reported that children and adults with intellectual disabilities may have a rate of psychiatric illness from three to four times greater than that of unimpaired people. In a literature review, Caine and Hatton (1998) reported that for people with intellectual disabilities, researchers find prevalence rates of 25% to 40% for concurrent psychiatric disorders. They noted further that in studies in which psychiatric disorders are more broadly defined to include the range of behavioral disturbances commonly seen in people with intellectual disabilities, researchers reported prevalence rates to be as high as 80%.

In their review, Nezu et al. (1992) concluded that a broad array of factors contribute to the higher-than-average rates of psychiatric disorders experienced by people with intellectual disabilities. Those factors had been previously established to be contributory to depression and other psychiatric disorders for people in the general population. Sadly, the factors are even more prevalent among people with intellectual disabilities. As reported in Nezu et al., these factors are as follows:

1. low levels of social support;
2. poorly developed social skills;
3. a sense of learned helplessness (and correspondingly low sense of self-efficacy);
4. low socioeconomic level;
5. increased presence of physical disabilities (especially epilepsy);
6. heightened family stress;
7. heightened maternal stress;
8. increased likelihood of central nervous system damage;
9. increased presence of reading and language dysfunction;
10. decreased opportunity to learn adaptive coping styles;
11. increased likelihood of chromosomal abnormalities, metabolic diseases, and infections; and
12. decreased inhibition in responding to stressful events.

To this already lengthy list, we add higher-than-average rates of exposure to sexual abuse, a factor that is known to be involved in the development of a wide range of psychiatric disorders in the general population. This increased rate of sexual abuse among men, women, and children with intellectual disabilities is another area of developing research (Furey, 1994; Mansell & Sobsey, 2001; Mansell, Sobsey, & Calder, 1992; Mansell, Sobsey, & Moskal, 1998; Perlman & Ericson, 1992), with some studies indicating that women with intellectual disabilities are at great risk. For example, the Wisconsin Council on Developmental Disabilities (1991) has estimated that 83% of the female population with intellectual disabilities experience sexual abuse at some point in their lives.

The Interactive-Behavioral Model of Group Psychotherapy

Interactive-behavioral therapy (IBT) grew from the need to provide an effective therapeutic modality for people with cognitive impairments. We drew the model's theoretical underpinnings, as well as many of its techniques, directly from psychodrama, as originated by Moreno (Blatner & Blatner, 1988). We briefly describe the IBT model here, noting specifically what distinguishes it from traditional psychodrama. We refer interested readers to

Razza and Tomasulo (2004) and Tomasulo (1998, 1999) for a comprehensive discussion of the model and related treatment issues for people with intellectual disabilities.

Moreno's conceptualization of psychotherapy is particularly well suited to the types of people whose limitations are in the cognitive realm. Moreno emphasized engaging the patient as fully as possible and not limiting patient-therapist interaction to the cognitive tasks of thinking and talking (Blatner & Blatner, 1988; Kipper, 1986). By involving the individual through behavioral and emotional means, in addition to the usual verbal modality, the individual's opportunity to do meaningful work is significantly enhanced.

A typical psychodrama session has three stages: (a) the warm-up, (b) the enactment, and (c) the sharing. We modified this format for patients with intellectual disabilities to the following four stages: (a) the orientation, (b) the warm-up and sharing, (c) the encounter, and (d) the affirmation. We added a new first stage, which we call the *orientation*, to help people with cognitive impairments develop skills needed for successful group participation. Many people with intellectual disabilities are unfortunately accustomed to people not listening to them and will continue to talk whether others are listening or not. Many are not in the habit of listening when others talk, particularly when the other is a peer. People with cognitive disabilities have learned to devalue their peers (and themselves) and tend to talk over each other, clamoring for the facilitator's attention. The orientation stage is designed to alter that pattern.

When one member is speaking, the facilitator interrupts and asks him or her to indicate who is listening. The facilitator then asks the member to choose another member to check whether the other member heard his or her statement. If the listener heard the communication, the facilitator then has an opportunity to reinforce the listener verbally for attending to the peer and to reinforce the sender for communicating clearly and being aware of who was listening. If the listener did not hear the communication, the sender is to choose another member. If that member also failed to receive the communication, the sender repeats his or her statement and tries the checking process again. In this way, members are taught to speak so that others understand them and to listen attentively to what others say. The facilitator's attention is typically a powerful reinforcer, and through judicious use of praise and acknowledgement, the facilitator can shape the group members' behavior toward adaptive interpersonal behavior. Once the facilitator has these norms well established, as in long-term, ongoing groups, the facilitator's direction in this regard can be attenuated.

In groups with only mildly impaired members, the orientation is often considerably less demanding than it is in groups whose members have more severe limitations. However, through our many years of experience with IBT groups, we have learned that through this process even more limited group

members become able to increase their focus on, and genuine interest in, their peers. We strongly recommend that IBT groups be organized on an ongoing basis, rather than in a time-limited, serial fashion. Once the therapist establishes norms for prosocial group behavior, it is relatively easy to bring a new member's behavior into line. Long-term members who are ready to terminate can "graduate" on an individual basis.

The second and third stages of IBT are essentially the same as the warm-up and enactment stages in traditional psychodrama. We move from the orientation into our stage two, *the warm-up and sharing stage*, in which members deepen their level of disclosure and choose a protagonist. We collapsed the warm-up and sharing stages from traditional psychodrama into this second stage because we found that the typical types of sharing in nonintellectually able adults were not possible with this population. Instead, the second stage, warm-up and sharing, allows for a shift from horizontal self-disclosure (typically person to person, but with little emotional content) to vertical self-disclosure (a more personal divulgence with more emotionally laden material). This is also the point in the therapy when the content of the group comes to light from a particular curriculum (e.g., anger management issues, sexual education, etc.) or, if it is a psychotherapy group, the agenda for each member is revealed. We then move into the third stage, the *enactment*, in which traditional psychodramatic techniques increase emotional engagement of the members (Hurley et al., 1996).

The fourth and final stage, like the first, reflects a deviation from standard psychodramatic practice. We call this stage the *affirmation*. Following an enactment, we ask the members to say what was good about what the protagonist just did or what they liked about it. We seek this affirmation for the protagonists because of the vulnerability they experience in exposing themselves through enactments, and also because it is an opportunity to reinforce in protagonists such therapeutic factors as self-disclosure, self-reflection, increased self-awareness, behavior change through trying out a new role, and so on. We then make a point of reinforcing each member for any efforts that represent growth, and verbally acknowledge each one individually. This helps the session end with all members feeling good about themselves and their efforts, and with all members consciously taking in a new cognition to challenge damaged self-beliefs.

We move into the affirmation stage rather than the more traditional sharing stage because we have learned that many members with intellectual disabilities have difficulty with abstract thinking and cannot always relate analogous experiences from their own lives. Some members, however, can and do acknowledge life experiences or emotional dilemmas similar to the one presented by the protagonist. We encourage those members who are moved to share a related concern for their own lives to do so, and they are then affirmed

as well. As sessions progress and members become attuned to the group process, the facilitators encourage members to provide affirmations to each other as well. This further encourages members to attend to each other and increases each member's value in the eyes of his or her peers. Members take increasing interest in each other as a result and are more given to offer spontaneous support and to experience a healing sense of universality.

We earlier cited the rationale for conducting ongoing rather than time-limited groups. We add that, for persons who have intellectual disabilities, membership in an ongoing group has the further advantage of allowing them the unique opportunity to be genuinely helpful to others. In much the same way that veteran AA members with many years sobriety continue to gain through their work in supporting newcomers, veteran group members with intellectual disabilities gain a valuable sense of self-efficacy through their ability to help new members. As facilitators, we encourage their support and feedback to new members. We especially encourage them to share their own experiences of self-growth. We frequently defer to the long-term members in working with new members, acknowledging them for their ability to understand and share with the new members in ways that we cannot. People with intellectual disabilities have almost no opportunity to feel competent, helpful, or valuable to others; ongoing groups offer them a unique and powerful dose of this therapeutic factor.

Initial Research on the IBT Model

In recent studies, researchers investigated the IBT model with some promising results. Blaine (1993) tested the efficacy of an IBT group treating intellectually disabled and non-intellectually disabled participants over 17 sessions. Using a number of measures, she concluded that both types of patients showed significant positive change from the therapy and that those patients with intellectual disabilities demonstrated higher frequencies of most therapeutic factors. In addition, each patient set goals and then evaluated himself or herself with regard to the amount of success achieved. The final evaluations suggested that patients' achievements of their interpersonal goals exceeded their expectations.

Keller (1993) studied the emergence of therapeutic factors in a 12-week IBT group with participants diagnosed with intellectual and psychiatric disorders. Keller had professional therapists review videotapes of group sessions and asked them to rate the tapes for the presence of various therapeutic factors. The therapists were blind to the nature of the study and to whether they were watching early or late-stage groups. The reviewers documented the emergence of seven of eight targeted therapeutic factors, suggesting that the therapeutic process does indeed evolve with participants who have intellectual disabilities.

Other therapists found the IBT model to be effective with another chronic population: people with chronic mental illness. Daniels (1998) tested the IBT model with a group of chronically mentally ill adults who carried diagnoses of schizophrenia or schizoaffective disorder. Multiple clinical rating scales were administered to measure changes in social functioning and negative symptomatology. She tested three hypotheses and each supported the ensuing data. She specifically found that for this population (a) IBT increases overall social competence, (b) IBT improves the negative symptoms often associated with poor treatment outcome, and (c) IBT facilitates the emergence of those therapeutic factors found to enhance social competence.

Carlin (1998) studied the IBT model and explored its value in helping individuals with intellectual disabilities cope with bereavement. She found that all group members showed evidence of being able to engage in the bereavement process through three therapeutic factors specific to the grieving process: acknowledging the reality of death, recalling special characteristics about the deceased, and verbalizing feelings related to the loss.

Implications

After our experience in treating patients with intellectual disabilities and from our study of the research that is beginning to accumulate, we suggest that not only is this subgroup of the population in great need of therapeutic service, but also that such service can be truly beneficial. We found that the use of psychodramatic techniques greatly enhances treatment efficacy with individuals who have cognitive impairments and have modified the IBT model, drawing from the theoretical underpinnings of psychodrama, to suit the needs of people with cognitive impairments. Although still in its infancy, our research and clinical experiences point to the need for further scientific investigation in the area of therapeutic efficacy for people with intellectual disabilities and to the establishment of effective clinical services for this long-neglected group.

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