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# Psychoanalytic psychotherapy with men with intellectual disabilities: A preliminary outcome study

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Psychotherapy has been demonstrated to be an effective form of treatment for people with psychological problems. However, there is considerable resistance to attempts to generalize these findings to people with intellectual disabilities. Such therapeutic disdain has a long history without any empirical foundation. Recently it has been argued on philosophical grounds that people with intellectual disabilities should have access to the same services as everyone else. Furthermore, that people with intellectual disabilities should be actively targeted as they are more likely to have psychological difficulties than non-handicapped people.

The therapeutic literature concerning people with intellectual disabilities is overwhelmingly behavioural. More recently various psychotherapeutic approaches have been explored as alternatives to behavioural interventions. Publication of several case studies in the late 1980s and early 1990s has provided some evidence for the benefit of various psychotherapeutic approaches with people with intellectual disabilities. However, there are no outcome studies.

This paper reports an outcome study of individual psychoanalytic psychotherapy provided in normal clinical practice for 25 men with intellectual disabilities who were referred for behaviour problems. Of the 25 participants in the study, 20 completed treatment. In most cases the problem behaviour was eliminated and this was maintained at six months follow-up.

Psychotherapy has been demonstrated to be an effective form of treatment for people with psychological problems (see, for example Bergin & Garfield, 1994). However, there is considerable resistance to attempts to generalize these findings to people with intellectual disabilities. Bender (1993) has charted the history of therapeutic disdain towards people with intellectual disabilities. This dates back to the early days of psychoanalysis (Freud, 1904). Subsequent schools of thought have either excluded people with intellectual disabilities from their therapies through the development of exclusion criteria or have simply ignored them altogether. Bender (1993) points out that the arrival of normalization (Wolfensberger, 1972) had little effect. In terms of health-care delivery the principle of normalization implies that people with intellectual disabilities are entitled to the same services as everyone else. But access to psychotherapy services was not taken up as a target. However, there are good reasons why this group should be actively targeted.

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They are more likely to have psychological and emotional difficulties than non-handicapped people (Reiss, Leviton & McNally, 1982; Rutter, Tizard & Whitmore, 1970). Recent studies have shown that they are vulnerable to sexual abuse (Beail & Warden, 1995; Turk & Brown, 1993). People with intellectual disabilities also engage in a range of behaviours which challenge services (Qureshi, 1994). However, reviews of treatment approaches show that these have been limited to behavioural interventions or medication (Holland & Murphy, 1990; Scotti, Evans, Meyer & Walker, 1991).

The first published report of weekly psychoanalytical treatment of a person with intellectual disabilities was by Symington (1981). Prior to this psychoanalytic contributions to the field of intellectual disability amount to a few 'moments of curiosity' (Sinason, 1992). Prior to 1981 published case reports which claimed to have applied psychoanalytic ideas to people with intellectual disabilities—as Sinason (1992) points out—concerned individuals who were either handicapped by emotional difficulties or were of low-average intellectual ability.

Since the publication of Symington's (1981) paper several more case studies reporting psychoanalytic treatment with people with intellectual disabilities have been published. Sinason has published several accounts of once weekly psychoanalytic psychotherapy. These are all reported in her book (Sinason, 1992). Balbernie (1985), Beail (1989) and Frankish (1989*a*) have reported one or two cases each and J. Symington, (1988) published the first account of five times a week psychoanalysis of an intellectually disabled young man. These accounts focus more on the process of therapy rather than outcome. Indeed, outcome data are very hard to come by (see Beail, 1995 for a review). Not all of the case studies concerned completed treatments and those that did did not employ any systematic outcome measures. Where information on outcome is provided it is anecdotal and not necessarily positive. For example, of the seven cases reported by Sinason (1992) three did not complete treatment due to transport problems, one refused treatment after nine months, one died, one 'could not really use it' and in one case no outcome information is reported. However, lack of outcome data or the fact that treatment ended for other reasons does not mean that the clients did not benefit from therapy. Sinason's accounts show that treatment had numerous positive aspects for the clients.

Only one published report of psychoanalytic psychotherapy focuses on treatment outcome. Frankish (1989*b*) reported the outcome of therapy for seven intellectually disabled children and adults. She provided descriptions of the participants' presenting behaviour before and after or later in therapy. In every case the presenting problem behaviour was reduced, but in only one case was it eliminated. No follow-up data were reported.

The dearth of psychoanalytic psychotherapy outcome research contrasts with the large outcome literature concerning the treatment of behavioural problems in people with intellectual disabilities by behavioural methods. A meta-analysis of intervention research with problem behaviour in people with intellectual disabilities was carried out by Scotti *et al.* (1991). Their review covered published studies in 18 journals over a 12-year period. Altogether, 318 papers were included reporting 403 studies (all single case) of which 398 concerned behaviourally orientated treatments. For the five exceptions medication was the mode of treatment. Whitaker (1993) reviewed the literature on psychological treatments for aggression in people with intellectual disabilities. He reported 78 studies all concerning behavioural treatments. Both reviews show that most of these studies were

carried out in institutional or non-integrated settings with people who present with high frequency problem behaviour.

With regard to outcome Scotti *et al.* (1991) found only 44 of the 398 behavioural studies to be highly effective and medication was found to be highly ineffective. Whitaker (1993) concluded that the methods that have been found to be most effective are behavioural in nature! However, this is not surprising as he did not have any other studies with which to compare. The proportion of the studies reviewed by Whitaker which were effective was not reported.

Thus, people with intellectual disabilities have had a limited range of therapeutic services made available to them, which is in sharp contrast to the rest of the population. Behavioural treatment research mainly concerns its application in institutional settings and as Whitaker (1993) points out these approaches may not transfer to non-institutional settings. In contrast the few applications of psychoanalytic psychotherapy have been in community-based clinics. With regard to aggression Whitaker (1993) argues that if this is to be reduced in community settings there may be a need to develop and evaluate new approaches. He offers some direction of the development of behavioural interventions but does not consider other therapeutic approaches. It would seem both morally and ethically that clinicians should explore a range of therapeutic approaches to help this client group. The application of psychoanalytically informed therapy is now being explored as are other approaches (Brandon, 1989; Lindsay, Howells & Pitcaithly, 1993; Waitman & Conboy-Hill 1992), but outcome data are distinctly lacking.

This paper reports an outcome study of individual psychoanalytic psychotherapy for men with intellectual disabilities who were referred for aggression, offending or other behaviour problems.

## Method

### *Participants*

The participants were a consecutive series of 25 men with intellectual disabilities who had been routinely referred over a three-year period by medical practitioners, social workers and community nurses to a district clinical psychology service because they presented behaviour problems or had offended. The sample only included men as the referral rate is four men to each woman. Of the women referred few presented with behaviour problems and most were seen by a female therapist not involved with the study. Therefore, the few women seen by the author were excluded.

Of the 25 participants, five did not complete treatment, one died, one moved into a long-stay hospital and one moved out of the area. Two participants did not attend after one session in one case and five sessions in the other. Thus 20 participants completed treatment of whom 12 were referred for aggression and other behaviour problems and eight were referred because they had committed an offence.

During the course of treatment further issues emerged which were not known at the time of referral. For example, at some stage during treatment 10 participants disclosed sexual abuse (see Beail & Warden, 1995 for a full report), four revealed that they were engaging in fetishistic behaviour, and six had additional mental health problems.

The participants ranged in age from 16 to 42 years ($M = 22.95$ years, $SD = 6.99$). Sixteen lived with their parents, two lived in a local authority hostel and two lived in a small hospital for people with intellectual disabilities. Eleven had attended a school for children with moderate intellectual disabilities and nine attended a school for children with severe intellectual disabilities.

Recent psychotherapy research studies in the field of adult mental health (see, for example, Shapiro & Firth, 1987, and Shapiro, Barkham, Rees, Hardy, Reynolds & Startup, 1994) have dispensed with no-treatment controls in view of the ethical difficulties and the overall evidence of the efficacy of psychotherapies. In view of the resistance to generalize the findings concerning efficacy from adult mental health to

the field of intellectual disability some consideration needs to be given to including controls. To some extent these are outweighed by ethical difficulties as including controls would involve withholding or delaying treatment for no other reason than the research design. It could be argued that other factors account for change such as maturation or that behavioural difficulties fluctuate over time. However, longitudinal studies have found considerable stability in the presence of behavioural difficulties in people with intellectual disabilities (Eyman, Borthwick & Miller, 1981; Raynes & Sumpton, 1985). In fact, Eyman *et al.* (1981) were concerned that the persistence of behaviour problems reflected a lack of effective treatment or programming. Therefore treatment controls were not included in the design but those that did not complete treatment were followed up.

### *The therapist*

The therapist was the author who trained as a clinical psychologist and received supervision in the area of adult mental health from a psychoanalytic psychotherapist and psychoanalyst. When the author began working psychoanalytically exclusively with people with intellectual disabilities, supervision from other psychoanalytic psychotherapists and psychoanalysts was impossible to obtain. Some claimed inexperience with the client group as a reason for refusal but others expressed therapeutic disdain. At that time other clinical psychologists were exploring the application of psychoanalytic therapies with people with intellectual disabilities and formed a group to provide supervision. Links were also forged with the Mental Handicap Workshop at the Tavistock Clinic. When this study began the author had been working psychoanalytically with people with intellectual disabilities for three years. Supervision was received from the group throughout the course of the study.

### *Treatment*

The literature on the use of psychoanalytic psychotherapy with adults with intellectual disabilities is extremely sparse and no texts, guides or manuals are available. The application of this approach in this study was, therefore, exploratory.

All participants received once weekly sessions lasting for one hour. Prior to treatment the participants were offered sessions with the author to see if they could be given some help to overcome their problems. The frequency, time and place of the sessions was held constant (except for participant and therapist's holidays) and no time limit was set on the length of treatment. The treatment room contained a couch and comfortable chairs. Most participants chose the chairs, some chose the couch and some used both.

As the study was exploratory the treatment was not problem focused. Participants were encouraged to free associate. The therapist maintained a neutral stance, listened to the participants' free associations, asked for clarification and monitored counter-transference feelings. The client's discourse was recontexualized (Smith, 1987) within the alternative contexts of transference, developmental theory (mainly Kleinian) and dynamics. Interpretations were formulated using mainly Malan's triangles of conflict and the person (Malan, 1979). The therapist also acted as a container by collecting, tolerating and integrating projected parts of the participant's self. Through understanding and giving meaning to the projected parts, the clients begin to see that they do not damage or destroy the therapist, which allows them to become transformed into a more tolerable form and be re-introjected.

All interpretations were made in clear language at a level the participant could understand. As some interpretations can be lengthy and complex and this client group has memory problems, they were delivered in parts and built up as the client showed understanding of the content.

Opinions vary as to whether interpretations should be given when the transference is negative. Freudian approaches only give interpretations when the client is in a state of positive transference. Kleinians depart from this approach and see the act of interpretation as dealing first and foremost with the negative transference. Klein (1932) found that the maximum point of anxiety was reached during negative transference and interpretation shifted the feelings for the analyst in a positive direction. This has now become a key feature of Kleinian technique.

Prior clinical work using free association with people with intellectual disabilities found that many clients' material came in the form of experienced urges and impulses encapsulated in fantasy, which were sexual, aggressive and sado–masochistic in content (Beail, 1989). Klein's approach to interpretation was adopted and

found to be successful and so this approach continued to be adopted during the course of this study. Other considerations also supported the use of this approach. Firstly, it avoids the risk of the client forgetting some features of the content due to memory problems. Secondly, case studies (Beail, 1989, Sinason, 1992) suggest that people with intellectual disabilities defend themselves against anxiety through splitting and disowning parts of themselves and their experience. Thus deferring interpretation runs the risk of material being lost or disowned if only temporarily. Termination of treatment was as far as possible by mutual agreement.

### *Treatment length*

For the 12 participants referred for a behaviour problem the length of treatment is shown in Table 1. Treatment varied in length from three months to 38 months ($M = 11.83$, $SD = 10.63$) with half the participants receiving treatment for six months or less. For the eight participants who were referred because they had committed an offence the length of treatment is shown in Table 2. Treatment varied in length from three months to 43 months ($M = 19.38$, $SD = 15.27$). Only three of the offender group were in treatment for six months or less.

### *Intake and outcome measures*

Previous outcome studies concerning behavioural problems of people with intellectual disabilities have concerned single-case behavioural interventions for high frequency behaviours occurring in institutional settings (Scotti *et al.*, 1991; Whitaker, 1993). In these studies intake and outcome measures were frequency counts of the target behaviour over various time periods and measurement was by direct observation in the institution. Such an approach does not transfer to community out-patient clinic-based research. A reliable and valid method of obtaining a measure of target behaviour frequency was required which could be used in an out-patient setting with individuals living in the community presenting with behaviour problems. The use of diaries was piloted with carers. This was successful with those who lived in staffed accommodation but less so with those who lived with relatives. So information on frequency had to be obtained from relatives at assessment sessions by interview. The method developed by Rutter & Brown (1966) seemed appropriate. They devised an interview approach for the measurement of aspects of family life and relationships in families containing a child who had been referred to the psychiatric services. Several of their measures concern the frequency of events and activities. The approach involves insisting on reports of actual happenings, not generalizations, during a defined, recent and usually short period of time. With most measures they question about the week preceding the interview and then go on to find out about the frequency over a longer period such as one to three months. The measures are, therefore, based on frequencies rather than general ratings and the method has been shown to be reliable and valid (Brown & Rutter, 1966; Rutter & Brown, 1966). This approach was therefore adapted for this study.

### *Frequency of behaviour problems*

For behaviour problems a frequency score was derived by interviewing each participant with his carer. The problem behaviour was clarified first, then reports of actual happenings during the last week were obtained. This was then extended to cover the preceding month (the minimum period between referral and assessment). The frequency of incidents ranged from once per week to several times per day. A rating of frequency was therefore made on a scale of one to seven representing the number of days per week the behaviour had occurred over the last month.

### *Offending behaviour*

The same measure could not be used with those referred for offending behaviour. Incidents of offending in some instances were very infrequent and most had not offended in the month prior to assessment. Therefore for this group the intake measure was the index offence and the outcome measure was any incidents in the last three months of treatment.

*Follow-up*

Outcome measures were made again six months after treatment was completed.

## Results

Of the 12 participants referred for a behaviour problem the frequency at intake, outcome and follow-up are shown in Table 1. In 11 cases the behaviour was eliminated when therapy was completed. However, as reduction in frequency has a major influence on the decision to terminate, the outcome at six-months follow-up better reflects the impact of treatment. At follow-up the problem behaviour had not reemerged in all 11 cases. In one case the frequency of the behaviour was reduced considerably from occurring every day to one incident per week. This was maintained at follow-up. One client continued to receive supportive psychotherapy at his own request after treatment was completed. He continued to attend the clinic on a monthly basis at six-month follow-up.

Table 1. Frequency of behaviour problems at intake, outcome and at six-month follow-up

| Participant No. | Presenting behaviour | Length of treatment (months) | Frequency: Number of days per week incidents occurred taken over the previous four weeks | | |
|---|---|---|---|---|---|
| | | | Intake | Outcome | Six-month follow-up |
| 1 | Aggression towards people | 6 | 3 | 0 | 0 |
| 2 | Aggression towards people | 10 | 3 | 0 | 0 |
| 3 | Aggression towards people | 22 | 5 | 0 | 0(sp)[a] |
| 4 | Aggression towards people | 3 | 3 | 0 | 0 |
| 5 | Aggression towards people | 3 | 1 | 0 | 0 |
| 6 | Aggression towards property | 8 | 7 | 0 | 0 |
| 7 | Aggression towards property | 3 | 1 | 0 | 0 |
| 8 | Aggression towards property | 6 | 3 | 0 | 0 |
| 9 | Aggression towards property and theft | 5 | 3 | 0 | 0 |
| 10 | Aggression towards property and theft | 26 | 1 | 0 | 0 |
| 11 | Soiling and smearing | 38 | 1 | 0 | 0 |
| 12 | Persistent questioning | 12 | 7 | 1 | 1 |

[a] sp = continuing supportive psychotherapy.

The index offence, outcome and follow-up for the eight clients referred for offending behaviour is shown in Table 2. For all eight participants in the offenders group there were no further incidents during the three-month period prior to termination and there had been no further incidents at follow-up. In fact none of the participants had reoffended during therapy or during the follow-up period. One client (no. 16) has two entries as he dropped out of therapy after two months. He reoffended six weeks later and rereferred himself with the support of the probation service. He successfully completed therapy but requested continued contact after termination. Another client also

made the same request. They continued to receive supportive psychotherapy at six-months follow-up.

**Table 2.** Frequency of offending behaviour at outcome and at six-month follow-up

| Participant No. | Presenting behaviour | Length of treatment (months) | Incidents over three-month period | |
|---|---|---|---|---|
| | | | Outcome | Six-month follow-up |
| 13 | Arson | 36 | 0 | 0 |
| 14 | Indecent assault | 3 | 0 | 0 |
| 15 | Indecent assault | 43 | 0 | 0(sp)[a] |
| 16a | Indecent exposure | 2 | dropped out, reoffended and re-referred | |
| 16b | Indecent assault and exposure | 36 | 0 | 0(sp)[a] |
| 17 | Indecent exposure | 15 | 0 | 0 |
| 18 | Indecent exposure | 12 | 0 | 0 |
| 19 | Indecent exposure | 6 | 0 | 0 |
| 20 | Indecent exposure | 4 | 0 | 0 |

[a] sp = continuing supportive psychotherapy.

*Follow-up of participants who did not complete treatment*

As there was no control group an attempt was made to follow-up the four men who did not complete treatment. The two participants who 'did not attend' were in fact referred during the course of the study. Their presenting problems had not changed and they did not take up offers of further appointments. The participant who was admitted to hospital was discharged to a community placement. The participant did not present any problem behaviour whilst in hospital but a few months after discharge the same behaviour presented again causing the breakdown of his community placement. The participant who moved out of the area was traced and was found to have received no further treatment and was still presenting the same problem behaviour.

## Discussion

It has long been assumed that existing psychotherapeutic techniques are not appropriate with people with intellectual disabilities. The results of this study challenge that assumption. Psychoanalytic psychotherapy provided on a once-weekly basis is shown to be an effective form of treatment for aggression, offending and other behaviour problems. Of the 25 participants in the study, 20 completed treatment. In most cases the problem behaviour was eliminated and this was maintained at six months after termination.

It may be that the follow-up period for those who commit offences may need to be longer. Bailey & MacCulloch (1992) have shown that mentally ill offenders who need conditions of maximum security may need follow-up periods of four years or longer. However, Bailey & MacCulloch's population is very different to the participants in this

study, of whom only one was considered to need conditions of maximum security when convicted. For adults with intellectual disabilities who offend the issue of outcome in the long term needs further research.

This study was concerned with the reduction of behaviour problems and offending behaviour and the outcome variable was limited. During the course of treatment other variables became prominent such as other mental health problems, fetishism and sexual abuse. Future studies will need to include broader measures of mental health and interpersonal problems such as those used in psychotherapy outcome research (see Lambert & Hill, 1994, for a review). However, most of these measures are in a self-report format requiring at least average reading ability. But some single trait measures have been modified for people with intellectual disabilities and are administered in an interview format (see Sturmy, Reed & Corbett, 1991 for a review). Also, in a current study, Beail & Warden (1996) are using a multi-trait measure—SCL90-R (Derogatis, 1983)—in an interview format. The interview method used in this study was limited to recording reductions in the presenting problem behaviours, but this approach could be extended to record increases in prosocial behaviours.

This study did not include process measures and therefore only anecdotal information can be provided on the processes which account for the success of treatment. At a minimum, someone sat down with the participants each week and gave them individual attention, listened to them and focused on their feelings as well as their behaviour. It seemed that through therapy, clients assimilated their problematic experience into a schema or model of understanding (Stiles *et al.*, 1990) and experienced past traumas, events and relationships in a less damaging way or felt contained and not rejected. Process research has only recently been extended to work with intellectually disabled populations (Beail & Warden, 1996; Newman, 1996).

The sample was small, limited to men and there was no control group other than the four participants who did not complete treatment. These participants were found to present the same problems when followed up as they did at intake. As there were no female participants these finding cannot be generalized to women, but the treatment effect justifies the decision to dispense with no treatment controls. However, the ethical considerations are considerable especially when treatment can last up to 43 months with a six-month follow-up period. Length of treatment was determined by need not by design. However, the criticism that psychoanalytic psychotherapy is too time consuming is not borne out as nearly half the sample completed therapy in six months or less. It is interesting to note that in this study outcome showed no difference between treatments of different lengths. The method fails to reflect the rate at which behaviour problems reduced over the course of treatment or follow-up. But of the eight offenders none reoffended during the course of treatment or during the six-month follow-up period. Decisions regarding termination were heavily influenced by the nature of the participants' fantasies about offending during treatment. Future studies could employ more intensive single-case methodologies or process method to explore these issues further. When a better understanding of the process of therapy with people with intellectual disabilities has been reached, treatment length could become a research variable.

A further criticism of this study is that no attempt was made to address patient satisfaction with the treatment provided. Approaches to measuring the satisfaction

of clients with intellectual disabilities with psychological interventions have been developed (Chapman & Oakes, 1995) and should be incorporated into future studies.

As with all psychotherapy outcome studies in community settings little or no control can be exercised over other factors which may influence treatment outcome. This is not generally considered an issue in psychotherapy outcome research but it is in the field of intellectual disability. Reasons for this include the popularity of environmental/ behavioural interventions and the high level of control clinical researches have been able to exercise in institutional settings. In this study the majority of the participants lived at home with their parents and attended various centres during the day. It could be argued that parents and staff were also attempting to reduce the problem behaviour by various means. In this study no advice or guidance was given to parents or staff on how to treat or manage the behaviour problems. However, clients clearly had an impact on and learned to bring about changes in their environment during the course of therapy.

The vast majority of people with intellectual disabilities live and always have lived in the community. The focus of attention on the closure of long-stay hospitals and the development of care in the community policies has focused attention on the minority who live in institutions. The few psychiatrists and psychologists who have worked in the field have been located in these institutions and most research has been carried out there too. Recent epidemiological research (Harris, 1993), however, has shown that a large proportion of people with intellectual disabilities who live in the community engage in a range of behaviours which challenge services and the majority, like the participants in this study, engage in these behaviours less frequently than once a day. This is in addition to other studies which show higher levels of psychological problems in this group and increased vulnerability to physical, emotional and sexual abuse. This preliminary outcome study shows that in the population studied, and taking into consideration the methodological limitations of the design, psychoanalytic psychotherapy showed a striking decrease in aggression, offending and other behaviour problems in men with intellectual disabilities at termination and at six-months follow-up. The findings provide a more positive picture than that given so far in published case studies (Beail, 1995) and confirm the findings of Frankish (1989*a*,*b*). However, in view of the methodological limitations of this study, further research is needed on the outcome and process of psychoanalytic and other psychological therapies with people with intellectual disabilities.

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