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## PSYCHOTHERAPY WITH PEOPLE WITH INTELLECTUAL DISABILITIES: A HISTORICAL PERSPECTIVE

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**intellectual disability**  
**history**  
**history of psychotherapy**

### Summary

*The aim of this article is to reconstruct the history of psychotherapy for people with intellectual disabilities.*

*The article is a review of the literature on psychotherapy with people with intellectual disabilities. In chronological order, it presents selected content from the most important texts relating to this area of psychotherapeutic practice.*

*Leon Pierce Clark's writings from the early 1930s are considered a pioneer in the field of psychotherapy with people with intellectual disabilities, but already in 1928, Polish psychiatrist Gustaw Bychowski appealed for including those patients in psychotherapy. In the 1970s, the first attempts were made to use behavioral techniques in the therapy of people with intellectual disabilities. Concerning the psychotherapy of people with intellectual disabilities, original psychotherapeutic approaches were developed, such as Prouty's pre-therapy or Caton's symbolic interaction therapy. In the 1980s, progress in the development of the concept of psychotherapy for people with intellectual disabilities in psychoanalysis was made thanks to the work of the workshop group of the London Tavistock Clinic. Since the 1990s, Nigel Beail has been developing a methodology for researching the effectiveness of psychodynamic psychotherapy with people with intellectual disabilities. Nowadays, there are still new reports being published on the effectiveness of psychodynamic, cognitive-behavioral, and systemic psychotherapy, as well as literature reviews and meta-analyses.*

*Most works on the psychotherapy of people with intellectual disabilities refer to the poor literature on this subject and the ignorance of the psychotherapeutic mainstream. Despite an increasing number of theoretical studies and research on the effectiveness of psychotherapy for people with intellectual disabilities, it is still a topic marginalized by mainstream psychotherapeutic practice.*

### Introduction

The ICF classification (International Classification of Functioning, Disability and Health) defines disability as “an umbrella term for impairments, activity limitations or participation restrictions” [1, p. 3]. According to ICD-11, “disorders of intellectual devel-

opment”, divided into mild, moderate, severe, and profound, are included in the group of “neurodevelopmental disorders” and defined as “a group of etiologically diverse conditions originating during the developmental period characterized by significantly below average intellectual functioning and adaptive behavior that are approximately two or more standard deviations below the mean [...], based on appropriately normed, individually administered standardized tests” [2, <https://icd.who.int/browse/2024-01/mms/en#605267007>]. Stanisław Kowalik, emphasizing the complex system of psychosocial interactions between a person with a disability and his or her environment, defines disability as “resulting from damage to the organism [...] a relatively permanent human disposition that may become the source of many life problems” [3, pp. 91–92] specifying that “this disposition characterizes a person with a specific damage to the body in the same way as his other properties: gender, height, weight, education, marital status, etc. Therefore, it is not a pathological property, but rather a certain peculiarity that significantly directs human life”<sup>1</sup> [3, p. 92].

Mental disorders in the population of people with intellectual disabilities occur more often than in the general population [4]. According to Niemiec-Elanany [4, p. 192], “an IQ below 70 causes a 3-4 times greater risk of revealing and developing mental disorders compared to the general population”. Despite a large number of studies indicating that the most effective treatment for most mental disorders is a combination of pharmacotherapy and psychotherapy [5], in Poland the topic of psychotherapy for people with intellectual disabilities and co-occurring mental disorders is rarely discussed. Meanwhile, there is extensive literature on the use of psychotherapy in the population of people with intellectual disabilities and research on its effectiveness. The idea of using psychotherapy in this group of people in need dates back to the turn of the 1920s and 1930s.

This article aims to reconstruct the history of psychotherapy for people with intellectual disabilities (hereinafter referred to as ID).

## **Historical outline of the development of psychotherapy for people with intellectual disabilities**

### **First half of the 20th century**

When looking at the history of psychotherapy for people with ID, it is important to bear in mind that over the years, not only the practice of psychotherapeutic help for them has changed, but the very definitions of the concepts of disability [6] and psychotherapy [7]. Exploring the evolution of these concepts is beyond the scope of this study.

One of the few works on the history of psychotherapy for people with ID is by David O’Driscoll [8]. However, it focuses only on psychodynamic approaches. This article aims

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<sup>1</sup>) This and all further quotations from Polish literature are translated by the author of the article.

to complement O'Driscoll's work with other therapeutic approaches. This author traces the beginnings of interest in psychotherapeutic help to people, then called feeble-minded, in two works by the American psychiatrist and psychoanalyst Leon Pierce Clark from 1933: *The need for a better understanding of the emotional life of the feeble-minded* and *The nature and treatment of amentia: psychoanalysis and mental arrest in relation to the science of intelligence* [8, pp. 9-10]. Clark attempted psychoanalytic psychotherapy with mentally disabled people, despite the pessimism in the psychoanalytic community towards working with such patients. Clark's work, according to O'Driscoll, was particularly important for two reasons: "First, Clark suggested that each mentally defective patient had an active emotional life, which in itself was worth exploring [...]. Secondly, Clark's initiative was the first attempt by a psychoanalyst to create a dialogue with specialists in this area and as such can be seen as a forerunner of today's multidisciplinary practice" [8, p. 9].

Even before Clark's work, in 1928, Polish psychiatrist and psychoanalyst Gustaw Bychowski published an article titled "Psychotherapy of low-intelligence individuals" [*Psychoterapia osobników mało-inteligentnych*] [9]. Bychowski criticized the lack of interest in psychotherapeutic help for people who, according to Freud, were not eligible for psychoanalytic treatment. Bychowski emphasized the importance of this issue, which, in his opinion, aroused insufficient interest in medical circles, and drew attention to the problem of inappropriate psychotherapeutic methods to help this group of patients. The recommendations proposed by the Polish psychiatrist, based on suggestion and persuasion, which he called "non-psychoanalytic psychotherapy methods", may seem grotesque and strange today, but it should be borne in mind that Bychowski proposed them based on the principle that it is better to try to help people who are overlooked than not to try.

In 1934, Leona Chidester published an article in which she argued that mental retardation may, in some cases of disabled children, be a consequence of endocrine disorders, which in turn may be a symptom of neurosis [10]. Chidester's logic was as follows: if neurosis could be cured through psychoanalysis, the endocrine disorders would disappear, and therefore the symptoms of mental retardation should also disappear. Chidester's article is rich in considerations regarding emotional disorders in children with ID and childhood psychoses and their relationship to impairment and also contains references to the approaches of Melanie Klein and Anna Freud in child psychoanalysis. Two years later, Leona Chidester published, together with Karl Menninger, an article on the application of psychoanalytic methods to the study and therapy of mental retardation [11].

In 1948, Milton Cotzin published a report on group therapy of nine boys with IQs ranging from 50 to 79 [12]. According to him, the results were positive and encouraging to use psychotherapy in this group of patients.

### The second half of the 20th century

In 1953, Theodora Abel published a short article “Resistances and difficulties in psychotherapy of mental retardates”, in which she discussed common beliefs regarding undertaking psychotherapy with people with ID: firstly, that they are incapable of understanding the therapist’s interpretation, and, secondly, that working with them is too time-consuming and ineffective [13]. Abel gives the following recipe: “In working with disturbed mental deficiencies there first has to be a real conviction on the part of the counselor or therapist that the client is worthwhile [...]. Second, the goals of therapy should be simpler and more modest than the goals of working with more intelligent people” [13, p. 108].

In 1965, Albini and Dinitz conducted the first study on the effectiveness of psychotherapy with people with ID [14]. It was supportive, client-centered therapy. Seventy-three boys with emotional problems with ID were subjected to therapeutic interventions and compared with 37 “well-adjusted” boys. The study did not use a control group. Therapy was conducted individually or in small groups for a year, a single session lasting 30 minutes. There was no statistically significant improvement in functioning. Anne Hurley notes that the lack of a control group, a poorly defined therapy program, and the lack of established goals result in the limited usefulness of this study [15].

In the same year, Manny Sternlicht, discussing the dominant view that only people with a certain degree of development of verbal and intellectual abilities are eligible for psychotherapy, presented several techniques that allow psychotherapeutic work even in the face of impairment of these abilities [16]. Sternlicht included such techniques that allow establishing relationships and gaining insight into the difficulties of patients with ID as: projective techniques, painting/drawing, music therapy, dance therapy, relationship-based therapy, and supportive therapy, in which “it is hoped that the patient will unconsciously identify with the therapist and incorporate him as a new self-image” [16, p. 86], directive counseling consisting of education and suggesting solutions, social therapy, play therapy, psychodrama, group therapy, consultations with family members.

Also in 1965, a Lacanian psychoanalyst Maud Mannoni, working in Paris as a child psychologist, published the work “Challenge to mental retardation”. She was interested in the way intellectually disabled people establish relationships. Without denying the organic basis of disability, she believed that the psychological aspects of the functioning of people affected by it were insufficiently understood [8]. In 1972 she published the work “The backward child and his mother” [17].

In an article published in 1966, George Lott presented a balanced and quite critical approach to the possibilities of psychotherapy with people with ID: “As much as psychotherapy may be advocated, however, it should be pointed out that contraindications include anticipation that the defective might repeat severely difficult behavior previously shown. In fact, indirect treatment, special training, and educational methods may play a larger part than psychotherapy in smoothing the way to a share of happiness” [18, p. 232].

In 1973 Saribenne Stone and Phillip Caughlan analyzed the process of psychotherapy with people with ID in terms of four variables: controlling the topic in the therapist-client dyad, focusing on the problem in the therapist-client dyad, the therapist's expression and the client's affect [19]. Transcripts of sessions two through nine were assessed by independent judges. The results showed that between the second and ninth sessions, the intensity of behaviors unrelated to the problem increased, the therapist's expressiveness increased, and the client's affect decreased. The authors of the study interpreted these results as initial satisfaction with receiving the client's attention and subsequent resistance when starting to work on the actual problem.

In 1976 Garry Prouty published an article on a method of working with pre-expressive patients with a double diagnosis of psychosis and intellectual disability, which he called pre-therapy [20]. Prouty identified three areas that are customarily accepted as prerequisites for undertaking psychotherapy: "(1) There is some organized ego state, i.e., an ability to locate self as the locus of his experience; (2) The client can locate and feel his affect; and (3) The client can communicate" [20, p. 290]. Prouty noted that these are exactly the areas that people with ID and psychosis cannot cope with, so a psychotherapist should find a way to deal with these problems. As potential causes of psychoses associated with ID, Prouty identifies potential organic defects, but also psychosocial trauma or emotional neglect. To support contact with reality and patients's own self when working with these people, Prouty proposed two techniques: situational reflections and body reflections. Situational reflections are meant to strengthen the client's sense of reality by making ordinary observations about the physical surroundings, appearance, or behavior of the patient or therapist: "It's hot today", "the desk is between us", "the room is big", "we're both quiet today", "you're playing with the pencil" [20, p. 290]. Body reflections involve commenting on what is happening to the patient's body: "you're slumping in your chair", "you're standing straight", "you're leaning on your arms", "your feet are dangling", "you're waving your fingers in the air" [20, p. 291]. If the client does not respond to verbal messages, the therapist can reflect with his/her own body what the client embodies. The second problem area, i.e., locating and feeling affect, according to Prouty, can be developed by the therapist using two methods: reflection of facial expression or word-for-word reflections. The first involves linking the client's observed expression of emotion with the emotion that expression expresses – this allows for making sense of internal states and connecting them to bodily expressions. The second one concerns the attempt to establish verbal communication – one should catch and repeat aloud those words in an incomprehensible statement that are understandable or those words that, although incomprehensible, carry an affective charge.

As a guiding principle of psychotherapy with psychotic clients with ID, Prouty introduces the "reiterative principle", which states that one should patiently and slowly repeat sequences of bodily, situational, expressive, and verbal reflections [20, p. 293]. This applies

to those reflections that made an impression on the client. As Prouty summarizes: “This reiterative activity amounts to patiently, perhaps for weeks, repeating and re-sharing the same pre-expressive or expressive place” [20, p. 293].

In the 1970s, attempts began to help people with ID using various behavioral therapy techniques. In 1973, Michael Guralnick published a report on the therapy of a 21-year-old man with Down syndrome and acrophobia, to whom he used systematic desensitization, visualization, and behavioral shaping [21]. In 1977, Connie Peck published a report on the use of the systematic desensitization procedure in the treatment of anxiety in four people with ID. The study involved 20 participants with a phobia of rats or heights, which were divided into five groups (4 people were assigned to each): subjected to systematic desensitization based on modeling, subjected to vicarious desensitization using relaxation and video sequences, subjected to standard systematic desensitization; a control group subjected to stress training; a group not subjected to any influence [22]. There was a trend towards reduced anxiety symptoms in the modelling-based desensitization group, but due to the small sample size, the results are of limited value.

Richard Silvestri published a report on the effects of implosive therapy in a group of moderately intellectually disabled people [23]. Eight people were assigned to three groups: treated, pseudotherapy/placebo, and no therapy. Positive results were recorded in the group undergoing implosive therapy in all of the areas tested.

In 1980, at the London Tavistock Clinic, psychoanalyst Neville Symington established a workshop group to discuss the problems of psychotherapy for people with ID [24]. In 1981 he published his first article on this topic. The article is a summary of a two-year psychoanalytic psychotherapy process with a 33-year-old man whose IQ was estimated at 59 [25]. Symington noticed significant improvements in his patient Harry’s psychological and intellectual functioning after two years of psychotherapy. He concluded that, without denying the organic basis of most cases of intellectual disability, it is usually diminished as a result of the stereotypical attitude of caregivers, which does not take into account the possibility of improving intellectual functioning and leads to emotional neglect: “I have become more and more convinced that unwarranted despair on the part of those engaged in helping mental defectives is a far greater handicap to the patient than the organic defect. Neurological growth can be stimulated and it is certainly not static. What remains static are people’s expectations that change cannot occur” [25, p. 199].

He also identified such stereotypical attitudes towards people with mental disabilities among psychotherapists themselves. In his opinion, it is because “[...] we are retarded in some areas of our mental functioning [...]. When we treat a subnormal patient, we are reminded only too poignantly of our own mental retardation. It is only too understandable that we prefer not to be so reminded” [25, p. 199].

In 1980, a monograph edited by Szymanski and Tanguay was published, in which two chapters were devoted to psychotherapy with people with ID: Szymanski described

issues related to individual psychotherapy [26], and Szymanski and Rosefsky described issues related to group psychotherapy [27]. Szymanski identified three criteria for assessing the potential to benefit from psychotherapy for people with ID: the presence of mental disorders in which psychological factors play an etiological and/or worsening role, the potential to establish an appropriate relationship with the therapist and to some degree of communication; the chance that reducing symptoms will improve the patient's ability to use his cognitive potential [26].

In 1982, Johnny Matson published an article on behavioral therapies for depression in people with ID [28]. Four individuals with mild to moderate impairment received behavioral therapy based on identified problems in the following areas: number of words spoken, somatic complaints, irritability, grooming, negative self-statements, flat affect, eye contact, and speech latency. Impacts included: informing, providing feedback, and reinforcing desired behaviors. Matson saw significant improvement in all four people. Two years later, Matson addressed general issues regarding psychotherapy for people with ID [29]. He also published works on the treatment of phobias [30], obsessive-compulsive disorder [31], and psychosomatic disorders [32] in people with ID.

In 1983, Susan Godschalx, using Mark's case as an example, described the issue of formulating the goals of psychotherapy for people with ID and the psychotherapist's tasks in the early stages of therapy [33]. While the goals of therapy should be formulated concerning the patient's specific problems, Godschalx formulated the therapist's tasks in general. They include: building trust, balancing flexibility and directiveness, communicating empathy, and understanding countertransference.

In 1986, Chrissoula Stavrakaki and Jack Klein analyzed the existing literature on various psychotherapy modalities for people with ID, concluding that: "The need for psychotherapy with the mentally retarded is evident from the high prevalence of emotional disturbance in this group. Psychotherapy can be done following the same general principles as with nonretarded persons, with modifications for the level of cognitive and language skills" [34, p. 741].

In the same year, Anne Hurley and Frank Hurley presented guidelines for conducting an initial interview qualifying people with ID for psychotherapy. In their opinion, the purpose of the initial interview is to: make an appropriate introduction and presentation, identify problems, and assess the level of the client's cognitive functions and his/her education [35]. They also emphasized the importance of establishing a therapeutic alliance, which can be helped by the following techniques: setting a positive emotional tone, active listening, labeling feelings, and interpretation.

Also in 1986, Valerie Sinason published an article in which she presented the concept of secondary handicap and the relationship between mental retardation and trauma [36]. Sinason proposed a distinction between primary handicap and secondary handicap. Primary handicap includes all difficulties resulting from factors of an



organic nature. *S e c o n d a r y h a n d i c a p* is caused by various psychological factors that overlap with the primary impairment and exacerbate it. Sinason distinguished three categories of secondary impairment: *m i l d s e c o n d a r y h a n d i c a p*, describing people who exaggerate the difficulties resulting from their primary impairment to adapt to the requirements and beliefs about them of the outside world; *o p p o r t u n i s t h a n d i c a p*, describing people who, due to the impairment, develop personality dysfunctions related to the release of destructive drives; *h a n d i c a p a s a d e f e n s e a g a i n s t t r a u m a*, concerning people whose impairment serves to protect them from conscious confrontation with an unbearable memory of trauma.

In 1988, Julie Caton presented an original psychotherapeutic approach adapted to the needs of people with ID: symbolic interactional therapy (SIT) [37]. Her approach is based on establishing non-threatening, age-appropriate communication with people with ID using toy symbols and interaction through play. Caton considers the main goals of symbolic interactional therapy to be: to enable the client to explore internal conflicts, fantasies, or real-life situations without negative consequences, and to discover the client's perception of real or imagined interactions and his/her feelings towards them.

In 1989 Anne Hurley published a review of research on psychotherapy for people with ID, and her conclusion regarding the state of knowledge in this area was as follows: "There is a great need for research on psychotherapy with mentally retarded individuals so that there might be a stronger knowledge base to support the growing applications of clinical technique to this population" [38, p. 272]. The author noted the need for research both on the effectiveness of psychotherapy for people with ID and on the process.

In the 1980s, two important, comprehensive monographs on diagnosis, therapy, and institutional assistance for people with ID were published: in 1988 a work titled *Mental retardation and mental health: Classification, diagnosis, treatment, services* edited by Stark, Menolascino, Albarelli, and Gray [39] and in 1989 a work titled *Mental retardation and mental illness: Assessment, treatment, and service for the dually-diagnosed*, edited by Fletcher and Menolascino [40].

In 1992, a monograph edited by Alexis Waitman and Suzanne Conboy-Hill was published, presenting various psychotherapeutic approaches to working with people with ID [41]. In one of the chapters John Stokes and Valerie Sinason develop former Symington's observations and Sinason's concepts [24]. They begin by illuminating the developmental background of disability, consisting of the primary and largely unconscious reactions of caregivers to learning of their child's disability, in the form of feelings of guilt, loss, and mourning. Both caregivers and people with ID must deal with these feelings to be able to separate. A person with ID is often consumed by unconscious envy towards "normal" family members. If these feelings are not recognized and worked through, it leads to difficulties in separation. Additionally, cases of emotional neglect or sexual violence and abuse that frequently occur in the history of people with ID may intensify the symptoms of impair-



ment because they could be unconsciously used to defend against trauma. It is a kind of attack on the thinking mind, similar to psychosis in Wilfried Bion's theory. Stokes and Sinason also use an analogy to Bion's concept of the psychotic-non-psychotic part of the mind, talking about the impaired and non-impaired parts of the patient's mind.

Psychoanalytic psychotherapy for people with ID aims to understand and address the unconscious factors influencing the severity of the impairment [24]. In the rest of the monograph, Neville Symington explores countertransference reactions in psychotherapeutic work with people with ID [42]. In an honest confession, he writes about the experience of a workshop team at the Tavistock Clinic, in which it was recognized that each therapist had a deep unconscious contempt for patients with ID. In response to it, according to Symington, a feeling of guilt arises, which forces therapists to act overprotective and complicates the therapy process.

Rosalind Bates describes the psychotherapy process as consisting of the following steps: selection, setting goals, defining and describing the problem, overcoming resistance, raising awareness, overcoming language difficulties, weighing the costs of the problem and searching for solutions, using imagination [43]. In addition to working with imagination, Bates also advises using techniques such as directive suggestions or educating about feelings.

Joanna Beazley-Richards describes working with people with ID using Transactional Analysis [44]. Sheila Hollins presents the possibilities of conducting group analytic therapy with people with ID [45]. In the beginning, she addresses the stereotype that psychoanalytic psychotherapy assumes the necessary capacity for intellectual insight:

“There is a popular misconception that psychoanalytic psychotherapy is primarily an intellectual activity, whereas in reality it is an affective one. In other words it is a process which engages the therapist and the client emotionally. The first task of the therapist is to make an emotional bond which can then be used therapeutically. The main requirement of psychotherapy candidates is that they are capable of making an emotional relationship” [45, p. 139].

Hollins, emphasizing the social and institutional benefits of offering group psychotherapy to people with ID, notes at the same time that specialists working in this way must, firstly, take into account the developmental specificity of a specific person with ID and factors related to the family and social context, and, secondly, be diagnostically attentive in cases of dual diagnosis, distinguish between difficulties caused by intellectual disability and mental disorder and their interaction.

In 1994, Christine Nezu and Arthur Nezu published a literature review on psychodynamic, behavioral, and group psychotherapy with people with ID and associated psychopathology in outpatient settings [46]. Their conclusions are as follows:

“Despite the conclusion that individuals with mental retardation experience a full range of psychiatric disorders at higher rates than nonhandicapped individuals and are sorely in need of outpatient services, the treatment literature has not responded to their needs [...].

Behavioral approaches, especially those involving social-learning and cognitive-behavioral-based strategies, are clearly the forerunners in providing studies of documented efficacy [...]. Psychotherapy alternatives concerning psychodynamically-based interventions and group psychotherapy approaches, although offering theoretically sound rationales, suffer from a serious empirical void concerning their effectiveness. This is unfortunate, in that these treatments may represent powerful treatment alternatives for individuals with cognitive disabilities and should be seriously evaluated” [46, p. 38].

Psychodynamic and psychoanalytic psychotherapy in working with people with ID has been studied by British therapist Nigel Beail since the second half of the 1990s. In 1996, together with Sharon Warden, Beail presented the preliminary results of the use of psychodynamic psychotherapy in a group of 10 individuals with ID [47]. Psychodynamic psychotherapy is defined here as using the concepts of transference and countertransference to understand the patient’s inner world and using interpretation as the most common type of intervention. The initial intensity of clinical symptoms and their change as a result of psychotherapy were examined using the SCL-90R and General Severity Index questionnaires. The impact of psychotherapy on self-esteem was also examined using the Rosenberg Self-Esteem Scale. The authors noted a statistically significant reduction in symptoms and an increase in self-esteem [47].

In another study, Beail examined the impact of psychoanalytic psychotherapy, conducted one session a week, on problem behaviors in 25 men [48]. Problem behaviors identified in individual patients included: aggression towards people, aggression towards things, soiling and smearing, and persistent questioning. Twenty patients completed the program and the elimination of problem behaviors was observed, and the improvement was maintained for 6 months after therapy [48].

In 1998, Hurley, Tomasulo, and Pfadt published an article in which they proposed many adaptations of standard psychotherapy that should be carried out when working with people with ID [49]. The authors proposed the following adaptations [49, p. 368]:

1. Simplification: reducing the level of complexity of techniques, breaking the intervention into smaller fragments, shorter session duration.
2. Language: adjusting the language level, simplifying vocabulary, using short sentences and simple words.
3. Activities: enriching typical techniques with elements of activities such as *drawing* or homework.
4. Developmental level: taking into account the developmental level in the selection of techniques and presentation of material, using games, assessing the level of social development.
5. Directive methods: being more direct than usual, outlining therapy goals for the patient, assessing progress, giving additional visual cues.
6. Flexible methods: flexibility to adapt various techniques.

7. Involve care givers: using family and care workers to help, appointing family or care workers to help with homework.
8. Transference/countertransference: setting solid boundaries and frequent use of supervision, because attachment is established faster and stronger, and the therapist's reactions often resemble parental reactions.
9. Disability/rehabilitation approaches: directly addressing issues related to disability and supporting positive self-esteem.

Also in 1998, Biza Stenferd Kroese set three conditions for undertaking cognitive-behavioral psychotherapy with people with ID: "(1) the client is allowed and enabled to provide reliable and valid self-reports; (2) the client's knowledge and understanding of abstract concepts is assessed and the therapist is prepared to take on a didactic role if comprehension of concepts such as death are inaccurate or confused; and (3) self-regulation (and therefore generalization and maintenance of therapeutic gain) is encouraged by ensuring that the client lives in a world where human rights are respected and where self-determination is encouraged" [50, p. 320].

#### XXI century

New reports of psychodynamic [51–53] and cognitive-behavioral psychotherapy for people with ID [54–56] are constantly being published, as well as meta-analyses [57–59] and literature reviews [60, 61]. There are also articles on working with people with ID in therapeutic approaches other than psychodynamic and cognitive-behavioral ones, e.g., in systemic psychotherapy [62–64]. Most studies confirm the effectiveness of psychotherapy for people with ID, but critics note methodological shortcomings and a significant shortage of randomized controlled trials.

In 2002, Mark Linington asked the provocative question in the title of his article: "Whose handicap?" [65]. Linington believes that psychotherapy that closes itself to suffering is itself handicapped:

"But many people with learning disabilities are denied access to psychotherapy. They are often not seen as suitable for a treatment that relies on verbal representation and insight to provide its cure. But here it is psychotherapy that is handicapped. For this is a psychotherapy which is undermining its own ability to understand and respond to individual subjectivity. But perhaps psychotherapy now need not be thought of as such a limited process. Both psychotherapy and psychotherapists could be more fully accessible" [65, p. 413].

In an article written from the perspective of intersubjective psychoanalysis, Linington [65, p. 411] presents his understanding of what psychotherapy for people with ID is: "I think psychotherapy is about the mutual experience of handicap, the experience of a negated self with an other. People's handicaps, ingrained into them as the insecurity and trauma of their earliest relationships, find a safe place to emerge in the therapeutic relationship".

In Great Britain, steps have already been taken to include the issue of psychotherapy for people with ID in the institutional interest of organizations training psychotherapists. The Royal College of Psychiatrists, the main organization associating psychiatrists and responsible for their education in Great Britain, published a report on psychotherapy for people with ID in 2004, which recommends psychotherapy as a form of help and designates several institutional contexts for such services: voluntary sector, community intellectual disability team, services in a specialized psychotherapeutic facility, hospital psychiatric clinic for people with ID [66].

In 2009, the monograph “Intellectual Disability, Trauma and Psychotherapy” was published, edited by Tamsin Cottis, presenting many aspects of psychotherapy for people with ID, mostly from the point of view of psychoanalytic theory [67].

### Summary

According to David O’Driscoll “The history of the treatment of people with intellectual disabilities can, at best, be described as benign neglect” [8, p. 22]. Indeed, most works on this issue comment on the poor literature and ignorance of the psychotherapeutic mainstream. Some researchers, especially those of a psychoanalytic orientation, have tried to explain this fact with unconscious prejudice or even contempt towards people with ID.

The first works, in the first half of the 20th century, concerned the use of psychoanalysis in the therapy of people with ID and were based on case studies. Leon Pierce Clark and his writings from the early 1930s are considered pioneering in this field; however, already in 1928, Polish psychiatrist Gustaw Bychowski called for including patients with ID in the sphere of psychotherapy. In the 1970s, the first attempts were made to use behavioral techniques in the therapy of people with ID and to improve the methodology of testing the effectiveness of psychotherapy. Concerning the psychotherapy of people with ID, original psychotherapeutic approaches have been developed, such as Prouty’s pre-therapy or Caton’s symbolic interactional therapy. In the 1980s, progress in the development of the concept of psychotherapy for people with ID in the psychoanalytic mainstream was made thanks to the work of the workshop group of the London Tavistock Clinic and the writings of Neville Symington, Valerie Sinason and John Stokes. Since the 1990s, Nigel Beail has been developing the methodology for researching the effectiveness of psychodynamic and psychoanalytic psychotherapy with people with ID and publishing the results of his research. In the 21st century, there are still new reports on the effectiveness of psychodynamic, cognitive-behavioral, and systemic psychotherapy, as well as literature reviews and meta-analyses. However, it seems that this is still not enough to gain the attention of the psychotherapeutic mainstream.

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