The provision of psychological therapy to people with intellectual disabilities: an investigation into some of the relevant factors

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Abstract

Background Five factors are proposed as important in influencing the provision of psychological therapy to people with intellectual disabilities (IDs): the perceived effectiveness of psychological therapy, individual clinician competence, service resources (number of trained clinicians), the level of the client’s disability and the diagnostic overshadowing bias.

Method A prospective questionnaire design was used. A survey style questionnaire was sent out to clinical psychologists (n = 412) and psychiatrists (n = 274) working in ID services in the UK. Responses were received from 133 psychologists and 90 psychiatrists.

Results Perceived competence, the level of the client’s disability and the diagnostic overshadowing bias all appeared to be important factors. The perceived effectiveness of psychological therapy with this client group and service resources appeared less important than hypothesized.

Conclusion Whereas the debates in research publications tend to focus on broad issues of effectiveness, clinicians themselves appear more concerned with their personal skill levels. The issue of the appropriateness of psychological therapies for people with more severe levels of disability remains largely un researched.

Keywords intellectual disability, psychological therapy

Introduction

This study examines five factors that are proposed to be important in the provision of psychological therapy to people with intellectual disabilities (IDs): (1) the perceived effectiveness of psychological therapy with this client group; (2) the perceived competence of individual clinicians in delivering psychological therapy to this client group; (3) the number of trained clinicians in the service; (4) the level of the client’s ID; and (5) the influence of the diagnostic overshadowing bias.

The importance of demonstrating the effectiveness of psychological therapy is increasingly emphasized in the modern National Health Service. Although the number of research studies demonstrating the effectiveness of a variety of styles of psychological therapy with people with IDs is slowly growing (e.g., Beail & Warden 1996; Lindsay et al. 1997; Beail et al. 2005; Rose et al. 2005; Taylor et al. 2005), they are generally based on small numbers of participants and are low in number. In turn, the relatively specialist nature of providing established models of psychological ther-
apy to this client group raises obvious questions of how competent clinicians feel in delivering them, especially when one considers the applicability of current models of psychological therapy to people with severe and profound disabilities (see Sinason 1992; Beal 1995). A number of authors have also commented on the low number of clinicians (psychologists and psychiatrists) choosing a career in this field (e.g. Lavender & Thompson 2000; Rose et al. 2001). These findings are largely echoed by the Royal College of Psychiatrists. In discussing the general barriers to providing psychological therapy to people with IDs, the Royal College of Psychiatrists (2004) note that clinicians report concerns regarding the appropriateness of psychological therapy with this client group, the availability of training and competing priorities as some of the most significant issues.

In addition to the importance of treatment effectiveness, individual levels of competence and service resources, two further factors were hypothesized to be important. The diagnostic overshadowing bias, whereby the symptoms of mental health problems are disregarded as being ‘part of having an intellectual disability’, has been demonstrated in a number of research studies (e.g. Reiss et al. 1982; Spengler et al. 1990; Mason & Scior 2004), and was considered to be a possible mechanism by which psychological problems in this client group can be overlooked. Finally, the level of ID (mild, moderate, severe or profound) presented by the client was hypothesized to be important in directing clinician’s decision about the appropriateness of psychological therapy. Although little direct research exists to support this view, it is arguably implicit in much of the research in this area, which is aimed at people with mild and borderline levels of intellectual functioning. Furthermore, position papers, such as Rush & Frances’s (2001) ‘expert consensus’ on the treatment of mental health problems in this population and Willner’s (2005) critical review of the literature, emphasize the lack of applicability of current models of psychological treatment to people with more severe disabilities.

Method

Participants

Participants were identified in a variety of ways. Psychiatrists working in ID services were identified from a central register, compiled by the Royal College of Psychiatrists. All those of Specialist Registrar level and Consultant level were contacted by post, and asked whether they would like to take part in the research (n = 274). Qualified clinical psychologists were contacted via British Psychological Society Special Interest Groups and via universities (n = 412). A total of 133 psychologists (33%) and 90 psychiatrists (31%) returned completed questionnaires.

Design

Items for the questionnaire were developed independently by the first author with reference to previous literature, and then discussed and modified with the help of a focus group containing five academic psychologists working in the field of IDs. The questionnaire asked participants to indicate how effective they considered a range of different psychological therapies to be and to indicate how competent they felt in administering them on a 5-point Likert-type scale. Twelve questions were presented, asking respondents to indicate their agreement with statements relating to the role of psychological therapy with people with mild, moderate and severe IDs.

Following Reiss et al. (1982), two different case vignettes (one describing a person with an ID) were provided, in order to assess the importance of the diagnostic overshadowing bias in the provision of psychological therapy to people with IDs and mental health problems. Data were also gathered on the number of trained clinicians working in their service and the amount of psychological therapy provided to their clients.

Cronbach’s alpha (internal consistency) for the questionnaire was 0.7, which was considered to be moderately good.

Procedure

Two versions of the questionnaire were sent out by post. Participants were randomly allocated to one of two conditions. Half of the participants received a questionnaire containing the attitude survey and a case vignette of a person with an IQ falling within the normal range. The other half of the participants received a questionnaire containing the same attitude survey, but with a vignette of a person whose IQ fell within the ID range (i.e. below 70). Apart from the
differences between the vignettes, all questionnaires were identical.

**Results**

Table 1 summarizes the influence of: (1) number of trained clinicians; (2) perceived effectiveness of therapy; and (3) perceived competence in administering therapy on the provision of three types of psychological therapy using a series of multiple regression analysis. The standardized beta weights and their associated significance levels are reported for each variable for the sake of completeness. Finally, squared semipartial correlations (SSPC) are reported as a way of interpreting the relative significance of each of the variables (i.e. importance) of each variable to the overall regression.

As well as showing each regression to be significant, Table 1 also clearly demonstrates the consistent importance of ‘perceived competence’ in administering psychological therapy to people with IDs. This is most clearly shown by the relatively high SSPC values associated with ‘perceived competence’ for each type of psychological therapy. Again, using SSPC as a guide, ‘perceived effectiveness’ only appears to be an important issue in the case of deciding whether or not to undertake psychodynamic-oriented work, whereas the importance of having trained clinicians only appears to be an issue on the case of systemic-oriented therapy.

A significant main effect was also noted for the effectiveness of psychological therapy on the level of disability ($F_{2,218} = 262.69, P \leq 0.0001$). Analysis using pairwise comparisons revealed that respondents felt that psychological therapy became less effective as the level of disability increased ($P \leq 0.05$).

Omnibus $F$-tests showed statistically significant overall effects for diagnostic overshadowing ($F_{9,209} = 10.26, P \leq 0.0001$). A follow-up analysis of the means using pairwise comparisons analysis showed that the character portrayed in the ID vignette was more likely to be thought of as having schizophrenia ($P \leq 0.05$). The character was also less likely to be considered for an admission to a psychiatric hospital ($P \leq 0.05$), for a mental health act assessment and as suitable for medication ($P \leq 0.05$).

**Discussion**

Perceived individual competence, the level of the client’s disability and the diagnostic overshadowing bias all appeared to be important factors. The number of trained clinicians and the perceived effectiveness of psychological therapy appeared less important (see Table 1), despite both of these issues receiving recent attention in the literature (e.g. Beail et al. 2005; Taible 1 Summary of regression models for effect of competence, effectiveness and number of trained clinicians on the provision of CBT, psychodynamic and systemic therapy

<table>
<thead>
<tr>
<th></th>
<th>Standardized beta</th>
<th>T</th>
<th>Significant</th>
<th>SSPC</th>
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<td><strong>CBT ($R^2 = 0.22, F_{1,217} = 19.84, P \leq 0.0001$)</strong></td>
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<tr>
<td>Effectiveness</td>
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<td>0.90</td>
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<td>0.46</td>
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<td>0.19</td>
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<td>-0.89</td>
<td>0.371</td>
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<td><strong>Psychodynamic ($R^2 = 0.39, F_{1,219} = 45.33, P \leq 0.0001$)</strong></td>
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<td>Effectiveness</td>
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<td>Competence</td>
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<td>8.36</td>
<td>0.0001</td>
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<td>&lt;0.01</td>
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<td><strong>Systemic ($R^2 = 0.30, F_{1,217} = 31.2, P \leq 0.0001$)</strong></td>
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<td>Effectiveness</td>
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CBT, cognitive behavioural therapy; SSPC, squared semipartial correlations

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Recently, Sturmey (2005, 2006) has argued that much of the effective psychological therapy that is carried out with this client group is most correctly classified as being ‘behavioural’ in nature. Sturmey notes, for example, that reviews of the effectiveness of psychological therapy with this client group, such as Prout & Norwak-Drabik’s (2003) meta-analysis, are in fact largely comprised of studies of behavioural interventions (e.g. assertiveness and relaxation training), and so do not contain evidence for the effectiveness of interventions such as cognitive behavioural therapy. It is, according to Sturmey, difficult to argue for the effectiveness of any psychological intervention other than behavioural ones in people with IDs, because the evidence does not permit it. In this sense, then, clinicians could hardly be criticized for attributing relatively little importance to issues of ‘effectiveness’ when selecting any psychological intervention other than a behavioural one, as there is some argument as to whether such evidence actually exists. It is possible that, as ideas from the scientific literature percolate down to other professionals, these issues will gradually assume a more prominent role within the decision-making process of clinicians working in the field. Despite Beail’s (2003) lamentation of the ‘serious lack of progress’ (p. 471) in research with people with IDs over the past decade, the recent increase in published research, coupled with a swell of opinion that psychological therapy can be helpful with this population, may indicate a slow but marked turning of the tide (e.g. Willner & Hatton 2006).

The lack of importance attributed to the availability of trained clinicians (see Table 1) also requires explanation. This was included as a crude measure of service resources, which were hypothesized to be an important variable in the decision-making process of how clinicians decide which psychological therapies to utilize. Although resources for people with IDs and mental health problems are known to be inadequate (Day 1988; Rose et al. 2001), the data collected in this study did not support the hypothesis that this would in turn affect service provision. This is surprising, given that one might reasonably expect service resources, particularly staff numbers, to strongly influence whether or not people with IDs are offered direct psychological therapies (which tend to be relatively staff-intensive). There are a number of possible reasons for this finding. First, it is possible that the way in which service resources were measured (essentially, a calculation of available clinicians) does not reflect the true nature of the aspects of a service that make it ‘well resourced’. For example, it may be that access to libraries with current journals relevant to treating mental health problems in people with IDs is an important factor, as may be links with local clinical psychology training courses and other professionals working in the field. In addition, there may also be important aspects of the structure as opposed to the size of services that render them more or less able to provide psychological therapy. For example, there may be strict boundaries concerning who provides therapy in the service. Whereas some services may take the approach that, with appropriate supervision, assistant psychologists, psychiatrists, occupational therapists, educational staff and other multidisciplinary team (MDT) members can provide certain types of psychological intervention, others may take the approach that psychological therapy is only appropriately carried out by clinical psychologists.

As well as structure playing an important part in the allocation of resources, service ethos also may play an important role. The apparent lack of staff resources as a key factor in deciding whether people with IDs are offered direct psychological therapies suggests that there may be a far less straightforward relationship between resources and provision of a range and choice of services for people with IDs. Services for people with IDs are known to vary widely across the UK (e.g. Bouras et al. 1994; Mason 1998; Department of Health 2001), and Bouras et al. (1994) note that staff characteristics and organizational practices are two of the most important factors in determining the manner in which a service is structured. It is conceivable therefore that some services, due to staff and management considerations, structure their services in such a way as to affect the provision of psychological therapy, perhaps by influencing who carries out different therapeutic activities and in what setting (e.g. in clients’ homes or workplaces, as opposed to a more traditional therapy model where clients are seen in dedicated service settings).

This research also suggests that, in a climate where increasing importance is being placed upon working
with people with IDs in generic health services (Department of Health 2001), it will be particularly important to consider ways of enhancing the level of competence that clinicians feel they have in delivering psychological therapy to this client group, especially to those with more severe and profound disabilities (see also Baum & Webb 2002). This research has shown that clinicians feel psychological therapy to become decreasingly effective as the level of ID increases, and while this is perhaps unsurprising, it raises important issues about the contribution of training and continuing professional development to the development of a skilled and ‘competent’ workforce. The importance of ‘feeling competent’ in persisting with a task has been emphasized in Connell & Wellbourn’s (1991) model of self-efficacy, and one might expect that, if those working in specialized service settings for people with IDs are identifying the need to feel competent as a key process variable, those with less experience and expertise may feel this need even more keenly.

It also will be important to support clinicians to develop reliable ways of identifying those who require their help. Currently, this may be influenced by a diagnostic overshadowing effect, causing clinicians to ‘misread’ the signs of psychological distress as simply being part of being ‘intellectually disabled’. Although the recent advances in diagnostic and assessment tools suitable for this population are likely to represent an important step forward in combating this (e.g. Bouras & Holt 1997; Moss et al. 1997; Mindham & Espie 2003; Ebensen et al. 2005), it seems likely that one of the challenges that continues to face clinicians working in this field is that of finding ways not just of treating people with IDs who have mental health problems, but also of identifying them in the first place.

As with most research, there are a number of limitations to this study. For example, taking ‘number of trained clinicians’ to indicate the level of resources at the disposal of a service to offer psychological therapy was, in all likelihood, an oversimplification. The ability of a service to offer psychological therapy seems to be more complex than simply being derived from the number of available clinicians (perhaps including training budgets, available space, etc.). The way in which diagnostic overshadowing was measured, though in line with the majority of research in this area, is also problematic in that it is really a measure of what clinicians may do, not what they actually do. Finally, although some authors have successfully experimented with using existing models of psychological therapy with people with more severe disabilities (e.g. Sinason 1992; Beail 1995, 1998), their relevance to this client group clearly needs wider exploration, as do alternative methods of psychological intervention. Authors such as Willner (2005) Sturmey (2005) and Rush & Frances (2001) seem more pessimistic about this possibility, noting that the application of non-behavioural methods with those with severe disabilities is questionable, and unlikely to afford greater benefits than behavioural techniques.

References


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