DUBLIN BUSINESS SCHOOL

AN EXPLORATION INTO THE USE OF PSYCHOTHERAPY WITH INTELLECTUALLY DISABLED CLIENTS

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Abstract

Intellectual disability has a history of exclusion from traditional talk therapies and research. This paper reviews the growing body of research in the use of psychotherapy with this unique client group. Research has shown that people with an intellectual disability have an increased risk of mental health difficulties and emotional distress which is often mistaken for a symptom of the intellectual disability. The first part of this paper explores the number of difficulties faced by these clients in their development and how they are often denied the necessary milestones needed to develop a full sense of self. This paper further explores the process of psychotherapy with intellectually disabled clients, looking at communication issues that can arise and the importance of flexibility on the therapists part and use of alternative communication. Working with this client group evokes strong transferencial responses as therapists face their own issues with ability, illness and loss. There is a need for reflective practice on the therapist part and good supervision. This paper concludes that given the wide range of difficulties that these clients face, often from the moment of birth, there is a need of psychotherapy with this group however more research is needed in order to understand the specific issues that arise when working with this client group.

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Introduction

'Intellectual disability is always profound because it enlarges, disrupts, pauses, questions and clarifies what it means to be human' (Goodley & Runswick- Cole, 2014 p 1).

Freud stated that a "certain measure of natural intelligence" was essential for people starting psychoanalysis (Freud, 1904 p 254) and for a great deal of time it was the case that people with intellectual disabilities (ID) were excluded from psychoanalysis and psychotherapy. In 1993, Bender wrote an article describing a history of exclusion in therapy for adults with intellectual disabilities and used the metaphor of an 'unoffered chair' to describe the reluctance from therapists to include this type of client. This thinking has shifted and disability psychotherapy is shaping into a field on its own. The body of research and literature about this unique client group is growing. Inspired by the pioneering work occurring in the Tavistock Clinic under Neville Symington, Valerie Sinason (1992) began writing a number of articles around emotional intelligence and engaging with psychodynamic psychotherapy. Her work, which is discussed later in this paper, has been hugely influential and continues to inform practice of therapists in this field today.

Freud (1905) believed that natural intelligence was required however; there are other forms of intelligence recognized rather than just cognitive intelligence. Stokes (1987) introduced the idea of emotional intelligence, which clients could use to partake in the therapeutic encounter. Although there has been debates over the years about whether people with ID should be included in talk therapies, some research has shown that people in this demographic prefer a person centered

approach of listening, respect and attempting to help, over other forms of mental health services that they had experienced (O' Brien & Rose 2010).

Through research we know that people with an ID are at an increased risk for mental health difficulties and experiencing psychological distress (Lewis, Lewis & Davies. 2014, Royal College of Psychiatrists, 2004). Further research has outlined that someone with ID is more vulnerable to facing abuse, exclusion, isolation or neglect (Dodd & McGinnity, 2003). It appears that people are becoming more aware of the need for psychotherapy with this group. A survey in 2004 by the Royal College of Psychiatrists showed that 83% of respondents believed there was a moderate to high demand for psychotherapy for people with ID. Despite all this, research suggests that there is still inadequate treatment available for people with ID when it comes to emotional distress and mental health problems (Hatton, 2002; Hollins & Sinason, 2000; Weber, 2003). Some theorists believe that they are still excluded from literature and research due to old assumptions that they could not use or benefit talk therapies (Attavar & Bhogal, 2019).

Similarly, to the exclusion of this group from the use of therapy they have been typically excluded from mainstream research (Lewis, Lewis & Davies, 2014). Many people with ID are capable of participating in research studies and excluding them from research is an important opportunity that should no longer be missed (Brown, Duff, Karatzias & Horsburgh, 2011). According to Sinason (1992) the lack of clarity in the literature around with this group comes from the ambiguous nature of their impairments and the lack of consistency in how we even refer to them. Intellectual disability is the most widely used term now but there has been a number of different terms such as handicapped or special needs, which were used in the past. There is clear ambiguity in the research and literature with this client group. Additionally, there can be complex issues around consent that arise while working with people who have ID which could be contributing to their exclusion from

large scale research studies, which are needed in order to improve their access and experience of talk therapies (Brown et al., 2011). If we do not use research to fully understand the complex and varied needs of this cohort there is a danger that they will continue to be marginalized (Brown et al., 2011). Despite the research being limited, there is literature that supports the idea that overall, psychotherapy is effective for people with ID and there can be a reduction in symptoms (Beail & Warden, 1996, Shepherd & Beail 2017, & Thompson, Prout & Browning, 2011).

Having established that there is a need for psychotherapy with this cohort, this paper seeks to explore the use of psychotherapy for clients with ID. The first chapter gives an outline of some of the various issues that people with ID face throughout their development, in relation to their development of self, emotional regulation and attachment. Following on from this, chapter two explores some of the processes of therapy with these clients. This chapter highlights the various communication difficulties that can arise in the therapy and stresses the importance of flexibility on the therapist's behalf (Weber, 2003). Following on from Benders (1993) idea of the 'unoffered chair', chapter three explores transference, specific to ID. Finally, this paper discusses areas of further research required.

Chapter 1: Intellectual disability and development.

Emotional development is an important task of childhood (McClure, Halpern, Wolper, & Donahue, 2009) and children with ID are not an exception to this. Clients with ID will have faced multiple challenges throughout their childhood (Attavar & Bhogal, 2019) and their development is impacted in various ways (Dodd & McGinnity 2003). This chapter explores these challenges and look at the various ways in which development can be affected. Looking at development and attachment in intellectually disabled clients is unique because many of them can live in a state of suspended childhood as their bodies outgrow their minds, they can be stuck in a place between infancy and maturity (Corbett 2014). It is useful when working with clients who have a disability to be aware of some of the particular disruptions they may have faced in their development; however, it is important to note that despite these disruptions the majority of people with disabilities achieve emotional maturity (Wilson, 2003, p. 25).

The impact of the disability is something that is observable from the moment of birth; research has shown that the birth of a disabled child can bring a sense of loss and mourning for the parents (Bartram, 2013). Even without a physical death, the parents can still mourn for the healthy child they were expecting to have. Corbett (2014) talks about the narcissistic wound that is inflicted on parents by the birth of a disabled child and the loss of the hoped for child. Along with a sense of loss, parents can also feel embarrassment; experience low self-esteem and experience overall psychological distress (Kandel & Merrick, 2003). Not only do people with ID face this feeling of loss in the parents at birth but it can be rekindled at various stages in their life, when previous

expectations for them are not met (Dodd & McGinnity, 2003). This can leave clients in a permanent cycle of loss and disappointment in the family.

A child who is born disabled can have additional needs, spend increased time in hospitals or require specific care and we must consider the impact of this on the parent-child relationship, the development of the ego, object relations, attachment and many other important aspects of development. People with a disability are often denied necessary developmental milestones that are needed to form a full sense of self (Corbett, 2014, p. 10). One such milestone is in relation to attachment.

Attachment theory originates from the work of John Bowlby (1998) and has become an important part of therapy in the last decade. Attachment theory while appearing complex is quite simple and based on the premise that relationships in our earliest years shape us profoundly and remain central throughout life to our social and emotional functions (Schore, 2001). Attachment is essential for children's sense of safety (Hollins & Sinason, 2000) and plays a vital role in the regulation of affect and emotional development (Schore, 2001). Working with clients who have ID there are likely to be issues around attachment and their attachment is more likely to be insecure (Hollins & Sinason, 2000) or disorganized (Hamadi & Fletcher 2019). Disorganized attachment is believed to come from alarming and unpredictable behaviour from a carer which leads the child to seek but also fear contact (Hamadi & Fletcher, 2019). As we have seen the stress that a parent can be under with a disabled child it is clear to see how that could result in an insecure or disorganized attachment. The implications for this in therapy will be discussed in chapter two.

According to Bowlby (1988) it is essential that children have a secure base. It was his belief that a child with a strong base and attachment to a caregiver can develop and separate from that caregiver, later discovering attachment in other healthy relationships with friends etc. A child with ID may

have faced considerable disruptions to their attachment system and to their secure base, they may also physically faced issues exploring from this secure base. Increased stays in hospitals, time with therapists, stays in respite and the many other interventions aimed at improving the quality of life for the caregivers and the disabled child can have potentially negative effects on their attachment (Frankish, 2016). Bowlby (2005) believed this process becomes internalized and sets someone up for future relationships. One way in which Bowlby's theory is applied today is the idea of the therapeutic relationship acting as the secure base for the client.

Margaret Mahler's (1973) work on the stages of development and individuation is often cited in the literature on disability. Importantly, Mahler outlined a number of different stages, which begin with the child and the mother as one. The child eventually reaches the individuation stage whereby they realize they are separate from the mother and go into the world as an individual. The separation/individuation process between the mother and an infant is complicated by a disability as their need for help and support can be much greater than that of a healthy child. Winnicott (1957) describes how through the process of mirroring from the mother, the baby gains a sense of self. From the research, we know that a child with a disability can evoke anxiety and feelings of grief in a parent, which can be reflected back to the child, in the mirroring process as outlined by Winnicott. Children rely on adults to regulate their emotions through their responses, when a child becomes distressed and they are comforted by an adult, their emotional state can return to baseline (McClure et al 2009).

One of Winnicott's most profound contributions to psychotherapy is in relation to the mother infant relationship. Winnicott (1975) believed that due to the dependence on the mother for

survival the baby did not exist independently, only as part of the mother-baby unit. As discussed previously the birth of a disabled child can have a negative impact on the mother and therefore the mother-child dyad. Sinason and Osborne (1993) describe the process of the birth of a disabled child and how it can be considered a trauma for the parents. This trauma can also include mourning the loss of the healthy child. There are no rituals through which mourning is facilitated for the death of the healthy, imagined child (Corbett, 2014) and parents may find it difficult or may feel guilty about speaking of such things and in turn miss support that they might need. Following on from that some parents may over identify and see their child as an extension of themselves and therefore have difficulty accepting the impairment to the child's body as they could see it as an impairment to their own body, which is difficult to accept (Wilson, 2003). We can see this in other parts of the world where disabled children are still kept separate to the family or even abandoned. Winnicott (1965) refers to the 'true self' and the 'false self' and believed that children develop their 'true self' when there has been adaptations to their needs. In the instance of disability, the impairment could potentially make it impossible for the mother or care giver to adequately adapt. The needs of an ID child can be more complex and as parents may be processing this shock, trauma and loss.

We have shown some of the ways in which people with ID face deprivation, in either their attachment or their development of self. This could be considered the first deprivation and is something that the child cannot control. The double deprivation outlined by Henry (1974) refers to the defenses that the child develops that can prevent them from use of support, which is applicable to those with ID. We will discuss these defenses in chapter two. Louise Emanuel introduces a concept of triple deprivation where the defenses against the anxiety that the child has developed gets reflected back by the system (Emanuel, 2002). Much of this work is in relation to

neglected children and children in the foster care system, we can however look at this concept of triple deprivation in relation to people with ID. We have established that there is an initial deprivation through the aspects of their development which they are so often denied. There is a clear defense system which can be understood as the second deprivation, as exemplified by the handicapped smile (Vinason, 1992) which will be explored in the following chapter. Considering a triple deprivation in relation to ID evidence can also be found in the history of exclusion from psychotherapy (Bender, 1993) and through their continued exclusion from large-scale psychological research (Lewis, Lewis & Davies, 2014). Furthermore, deprivation can be experienced in the therapeutic disdain (Bender, 1993) that can be reflected back to them, which we will explore further, in chapter three. Looking at the various road blocks that people with ID have faced in their childhood in relation to their development of self and their attachment, chapter two will go on to look at how this is played out in the therapy.

Chapter 2: Intellectual disability and therapy.

As with other clients, the therapeutic relationship is the key factor for promoting healing (King, 2005). Literature about ID and psychotherapy is still growing, therefore literature outlining the process of therapy with clients who have ID is lacking (Jackson & Beail, 2013).

One area that there is a growing body of research emerging in, is the communication difficulties faced by clients with ID. It can take time to establish effective communication in any therapeutic relationship, and even more so in those with ID who are vulnerable to being misunderstood or even excluded due to complex communication issues (Brown, et al, 2011). Clients with ID can have difficulty expressing themselves and feeling heard (Robinson, Escopri, Stenfert-Kroese, Rose, 2016) his could be due to a lack of traditional communication skills, a difficulty in processing information or they may be non-verbal. People with ID can face an array of communication issues and therapists will need to be able to adapt and understand the communication needs of their client (Attavar & Bhogal, 2019). A flexible approach is essential to the effectiveness of therapy with ID clients (Weber, 2003).

The process of interpreting meaning behind the client's behaviour may be particularly relevant for clients who have ID as they may be hindered in communicating verbally complex ideas by some intellectual or communicative impairments (Jackson & Beail, 2013). For many people with ID the use of creative and visual aids can make the therapy more accessible (Lewis, Lewis & Davies, 2014). Not only can clients face communication issues due to their communication ability but they can also have little to no experience with the kind of personal conversation that takes place in therapy (Weber, 2003).

A unique element to therapy with someone who has ID, and something that has the potential to impact the therapy, is the involvement of an outside third party (Jackson & Beail, 2013). This third party could be a carer or an institution. Lewis, Lewis and Davies (2014) in their interviewing of people with ID and their experience of therapy found that many respondents were concerned over the issue of confidentiality and sharing within the system. This is something that will need to be managed by the therapist.

Dependency and separation can be issues facing disabled clients (King, 2005). Not only can it be more difficult for people with IDs to break away from their parents and have some sort of independence it can also be difficult for parents to let go and facilitate independence (Hollins & Sinason, 2000). Therapists must hold the clients transference without marginalizing them, hold their own reactions without transferring them onto the individual, all while trying to facilitate personal growth in the client. This must all be done while encountering the defense systems from themselves and the client. Ryle (1991) proposes working within the clients Zone of Proximal Development (Vygotsky, 1978) and (Weber, 2003) highlights the importance of techniques aligning with the mental age as well as the chronological age of the client. There are nonverbal ways of working within the clients ZPD such as forms of creative therapies and the use of color (King, 2005). When making inquiries or explaining to the client it is important to use examples that are accessible and easy to understand (Weber, 2003). Therapy with individuals who are non-verbal or need alternative methods of communication requires strong clinical supervision on the therapist's part (Brown, et al, 2011) and may involve a longer commitment time frame (Weber, 2003). People with ID can have difficulty with goal setting and follow through, and this may result

in them forgetting the reason why they are attending therapy (Weber, 2003) and therapists may use a more direct approach than with other clients.

Clients with ID express emotional distress differently to others and often through their behaviour (Hollins & Sinason, 2000). Reiss, Levitan and Szyszko (1982) coined the term diagnostic overshadowing, which is how the ID can overshadow any potential mental illness or emotional distress, as symptoms are all attributed to the ID. Traumatic symptoms are also significantly under-recognized in people with ID (Hollins & Sinason, 2000) and could even be misinterpreted as a behaviour of the ID. Similar to traumatic symptoms there can be a tendency to confuse emotional and behavioral difficulties to the ID rather than emotional needs or pain (Hollins & Sinason, 2000).

McClure and colleagues (2009, p. 39) describe emotional dysregulation as an inability to understand and recognize emotions, an inability to modulate the intensity of negative emotions and emotional responses and a difficulty engaging in goal directed behaviour while experiencing negative emotions. Research although limited has shown that individuals with ID can typically distinguish between negative and positive emotions but face difficulties in identifying specific emotions (McClure et al 2009). Although the research and literature on emotional dysregulation is growing, people with ID seem to be left behind and many unanswered questions remain (McClure et al 2009). This highlights the necessity for large scale, contemporary research.

Chapter one outlined how clients with ID can are more likely to have an insecure or disorganised attachment. Some argue that this can have an impact on the therapeutic relationship as insecurely attached clients can avoid forming a bond with the therapist,

which negatively impacts the therapeutic alliance (Smith, Msetfi & Golding, 2010). Schauenburg (2010) found that insecurely attached clients can be linked to poorer therapeutic outcomes however the research on this is ongoing. Bucci, Seymour-Hyde, Harris, & Berry (2015) concluded from their study that there was no direct link between attachment style and the working therapeutic alliance. It is clear that future research is needed and particularly future research with ID clients. Insecure attachment patterns are not unique to ID clients and there has been much research done on modifying attachment styles through the therapeutic relationship (Bowlby, 1988). Expanding on this Wei, Heppner and Mallinchrodt (2003) propose modifying clients coping strategies in therapy as an easier alternative to changing their attachment style, yet still yielding a positive reduction in symptoms. Although there is research on modifying attachment styles and managing insecure attachment in the therapeutic relationship, there is little focusing on clients who have ID. This is an area for further research.

Chapter 3: Intellectual disability and transference/countertransference.

Freud (1904) who first elaborated on the subject of transference went on to define it as an essential part of the therapeutic process, which is still in line with current views of transference, as most modalities view it as an important part of the process and something that can provide great insight. The transferencial process results from the complex interplay of the conscious and unconscious mind of the therapist and client (La Planche & Pontalis, 1988). There are a number of ways in which working with this client group can affect the transference.

People with ID can experience chronic trauma, which may be enacted or played out in the transference process (Hollins and Grimmer, 1988). The 'disability transference' stems from the idea that disability is a trauma and not something natural and this has the ability to 'disable the therapist' in an unconscious way (Corbett, 2014). How we relate to disability is very personal and is influenced by our own values, upbringings and relationships (Wilson, 2003). Transference issues can arise from feelings of intense compassion (Sinason, 1992) or feelings of contempt (Symington, 1992). According to Corbett (2014) we all exist on a spectrum of disability and being around people with ID forces us to look at our own psyche and concepts that resonate such as loss and ability. Faced with difficulties that come with ID we may become aware of our own unconscious psychological pain and it may be easier to project this onto those with ID rather than look at our own emotional wounds (Cotter, Holloway & Carr, 2017). Therapists who work with what they perceive as human suffering can develop some distance defense mechanisms, which will affect the therapy (Wilson, 2003). Isobel Menzies- Lyth (1959) work on organizational anxieties is relevant here. Although originally written about nurses looking after ill patients it is applicable to ID. Menzies (1959) believed that when working in the face of human suffering, primitive anxieties

emerge and to protect ourselves from these anxieties we deploy a number of different defenses such as detachment or projection. Her work is hugely insightful for institutions and given that, people with ID often spend time in an institution this is something that they might be experiencing in many areas of their life. If therapists have not dealt with their own anxieties around loss, death, and ability then it would appear according to Menzies (1959) that they are at risk of detaching which would question the quality of the therapeutic relationship that is key to the therapy (King, 2005).

Corbett (2014) discusses how therapists can feel disabled themselves dealing with a client who has ID and one way in which their defensive structures could manifest is to put words in the client's mouth to shield from the not knowing. This is something that therapists working with this client base need to be aware of. Therapists must overcome their own countertransferential responses with disability (King, 2005).

Countertransference is the responses triggered in the therapist by the client, such as bias, values, unresolved personal issues, anything that can affect the therapist's ability to provide safe and appropriate therapy (Wilson, 2003). Working with intellectually disabled clients may evoke strong countertransferential responses (Alvarez & Reid, 1999; Weber, 2003). People can project feelings of inadequacy and insecurity onto people with ID (Hodges, 2003) and therapists must be aware of this to prevent it from affecting the therapeutic relationship. Mannoni (1973) states that a maternal countertransference with a client from this cohort is not comfortable for the therapist because of negative feelings that are present in the original mother-child dyad with a disabled child, even if these feelings are disguised. Further, Mannoni (1973) elaborates that the lack of cognitive ability from the client could result in boredom and lack of satisfaction for the therapist. With this in mind,

it is important when providing therapy to clients with ID to be aware of our own limitations and defenses (Attavar & Bhogal, 2019).

Ryle and Kerr (2002) describe two different forms of countertransference – 'personal and elicited'.

Personal being what is brought by the therapist and elicited being what is invoked or coerced in the therapist from the client. A pathological countertransference occurs when the therapist fails to understand when the client resembles aspects of the therapist themselves and they are not aware of these blind spots (Corbett, 2014). Heimann (1950) believed the emotional responses from the therapist is an important tool for exploring the clients unconscious.

An important contribution by Winnicott in psychoanalysis is recognizing the role of hatred in the countertransference (Winnicott, 1975) which refers to how the mother or the therapist can sometimes hate their client or child and how we must not repress these feelings of hate, but rather accept them. When faced with clients who can bring about our own worries about becoming disabled, therapists must learn to work with the hatred in the trauma that the client embodies (Corbett, 2014). Parents with a disabled child can overcompensate for their feelings of objective hate and diminish the child's capacity for objective love (Wilson, 2003). Distorted attitudes toward ID can bring undesirable effects during therapy (Weber, 2003).There are many forms in which distorted views about disability can manifest and they may not all be negative distortions, but they could still effect the therapeutic relationship. The therapist could have a distortion in that they feel overprotective of the client, or even patronizing (Weber, 2003).

Corbett (2014) elucidates on the unconscious fears that can arise, such as the fear that the disability is somehow contagious. Discussing the potential impact, he says "in working with intellectual

disabilities countertransference is affected not just by un-analyzed parts of the therapist's neurosis but also by the therapist's relationship to his own disabilities' (Corbett, 2014, p. 79). He expands on this and states that the countertransference is one of the most powerful tools and the ability of these clients to make the therapist feel disabled gives insight as to what it might be like in a mind that does not work like everyone else (Corbett, 2014, p. 87). Disabled clients can trigger the therapists own vulnerability and death anxiety and only if therapists are able to bear the discomfort of these feelings can they be fully open to their client (Wilson, 2003).

It is clear from the literature that therapy with this type of client is vulnerable to strong transferences, which have the potential to interfere with the work. The need for therapist supervision is apparent. The importance of the therapists own personal work in the form of psychotherapy in their training is also clear as we have shown how working with this group will be influenced by the therapist's own experiences and thinking (Corbett, 2014; Wilson, 2003).

Conclusion

The premise of this dissertation was to explore the use of psychotherapy in clients who have an ID. On reviewing the literature, it is clear that there has been a reluctance to include people with ID in talk therapies (Attavar & Bhogal, 2019; Bender, 1993). Although the thinking around this does seem to be shifting, there are still issues with this group accessing psychotherapy and being included in large-scale research (Brown et al., 2011). As therapists, we need to look at why we might have reluctance to work with this client group. As Corbett (2014) outlined it could be due to how ID forces us to look at our own disability and brings about unconscious fears about loss and ability. The need for therapist's own personal work, reflective practice and supervision is apparent.

Chapter one explored some of the difficulties that these clients can face in their development. What is evident from this research is that client's with ID are often denied opportunities that allow them to hit developmental milestones that they need to form a full sense of self (Corbett, 2014). Not only can they face difficulty in forming a full sense of self, but they are also more likely to have an insecure or disorganized attachment style (Hollins & Sinason, 2000). Facing such challenges as these one could conclude that they are more likely to need psychotherapy however there is still a reluctance from therapists.

Chapter two explored some of the issues that arise in working with these clients. This client group faces a number of communication issues and flexibility is essential to its effectiveness (Weber, 2003). Common to a majority of the literature reviewed in this area was the importance of using creative and visual aids to therapy (Lewis, Lewis & Davies, 2014, King, 2005, Weber, 2003). This

eludes to a need for specialized training. The term ‘diagnostic overshadowing’ (Reiss, Levitan & Szyszko 1982) was an importance concept that emerged from this literature review. It calls on therapist’s to be aware that not all symptoms are related to the ID and can be a symptom of emotional or psychological distress.

Finally, chapter three explored transference in relation to ID. One clear outcome from this literature is that working with this client group evokes strong transferential responses in the therapist. Corbett (2014) highlights how ‘the disability transference’ has the ability to ‘disable the therapist’ and that it might be easier to project onto the client rather than face our own inability. Wilson (2003) outlines how therapists working with this level of perceived human suffering can develop defense systems that will affect the therapy. Overall, the need for the supervision and reflective practice is apparent.

There are additional considerations when working with this client group and specific issues that may arise however, the research has shown that clients with ID can benefit from talk therapies and do value it (O' Brien & Rose 2010). Even though the research is mostly on a small scale it has been shown to reduce psychological distress and reduce symptoms (Dodd & McGinnity, 2003). More research is needed in order to avoid this vulnerable client group being further marginalized (Brown, Duff, Karatzias & Horsburgh, 2011).

Further research

On review of the literature for this dissertation topic, it is clear that large gaps in the research remain. While the research on development and the transference with this group is growing, there is little research on the process of psychotherapy with this client group. A lot of the research while valuable is dated and there are a number of different angles that could be explored, for example Bender (1993) and the concept of the unopened chair. While this concept appears in the majority of studies and it is widely accepted that there still is a reluctance there, there is no large-scale study with therapists exploring why there remains a resistance. Another area that needs further research is the experience of ID clients and therapy. There are small studies, which highlight that these clients can participate in research and give valuable feedback about their experiences however, issues around consent and adapting the studies to their varied levels could be preventing people from undertaking these studies. No study was found looking at the experience of Irish therapists with ID clients, which may be a worthwhile focus of a future research project.

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