The Journal of Psychodrama, Sociometry, and Group Psychotherapy, Vol. 60, No. 1

Empirically Validated Treatment: Evidence-Based Application of Psychodrama in Interactive-Behavioral Therapy

Daniel J. Tomasulo[1] and Nancy J. Razza[2]

Interactive-Behavioral Therapy has emerged over the past 25 years as the only empirically validated form of group therapy specifically designed to meet the needs of people with intellectual and chronic psychiatricdisabilities. In 2005 it was the subject of the American Psychological Association's first book on psychotherapy for those affected by these conditions and enjoys wide international usage for both psychotherapy and training uses. At the core of IBT are action methods adopted from psychodramatic practice. The following is a review of the research validating the IBT process in a variety of settings.

KEYWORDS: Intellectual disabilities; group therapy; mental retardation; psychodrama; psychiatric disabilities; dual diagnosis.

The interactive-behavioral therapy (IBT) model of group psychotherapy has evolved over the past 25 years through work with individuals who are diagnosed with both intellectual disabilities (IDs) and psychological disorders. The model's theoretical underpinnings, and many of its techniques, are drawn directly from psychodrama as originated by J. L. Moreno (Blatner and Blatner, 1988; Marineau, 1989; Razza and Tomasulo, 2005a; Tomasulo, 1998, 2006). Certain adaptations to the model have been made to enhance its efficacy with the intellectually disabled population and have been described elsewhere (Razza and Tomasulo, 2005b; Tomasulo and Razza, 2007). These modifications, as well as process and outcome research on IBT, are discussed in this article.

It is generally recognized in the field of developmental disabilities that the mental health needs of people with developmental disabilities have traditionally

1 Associate Professor, New Jersey City University, 130 Maple Ave., Bldg. 8, Suite 9, Red Bank, NJ 08750.

2 Psychologist, The Elizabeth M. Boggs Center on Developmental Disabilities, UMDNJ–Robert Wood Johnson Medical School, P.O. Box 2688, New Brunswick, NJ 08903.

ISSN 0731-1273

been neglected (Charlot, Doucette, and Mezzacappa, 1993; Hurley, Pfadt, Tomasulo, and Gardner, 1996; Razza, 2008; Reiss, Levitan, and McNally, 1982). In fact, this neglect is an apparent correlate of a wide-ranging neglect for the health care of people with intellectual disabilities. A report by former U.S. Surgeon General David Satcher (*Monday Morning*, 2002) declares that health care generally, across the entire spectrum of medical needs, is still sorely lacking for people with intellectual disability. Satcher concludes that the U.S. health care system has "failed to respond to changes in the lives of people with mental retardation," noting, "Even a quick glimpse at the health status of persons with mental retardation, both children and adults, reveals glaring deficiencies that must be addressed" (p. 3).

Fortunately, however, the mental health needs of people with developmental disabilities have been drawing concern over the past two decades. An evolution in our thinking about people with developmental disabilities has led to a growth in treatment efforts and research studies on therapeutic advances with this population (Hurley, 1989; Hurley, Tomasulo, and Pfadt, 1998; Nezu and Nezu, 1994; Prout and Strohmer, 1995).

In 1992 Nezu, Nezu, and Gill-Weiss put forth an ambitious volume on the subject of psychopathology in people with developmental disabilities, including a broad literature review of the existing data on prevalence rates along an extensive spectrum of psychiatric disorders. These authors noted the recent growth in studies on the mental health problems of this underserved population, and they suggested that an important change was under way. A 1998 article by Hurley, Tomasulo, and Pfadt described early literature that reported successful use of psychotherapeutic techniques with people with developmental disabilities, countering the prevailing assumption that such efforts would fail. The authors described modifications of standard therapeutic techniques found to be successful with people with developmental disabilities. More recently, Butz, Bowling, and Bliss (2000) conducted an extensive review of the literature on psychotherapy with people who have developmental disabilities. They concluded that there is a need for well-defined diagnostic distinctions so that subtle signs of psychological disorders are not missed simply because a person meets the criteria for intellectual disability. The authors stressed that psychologists in general need to be better informed about the possibility of conducting psychotherapy with people who have developmental disabilities. Finally, they concluded that, although not widely known, there is a growing body of research on conducting psychotherapy with people who have developmental disabilities. The authors described the existing literature as limited in that it tends to be "qualitative and descriptive" (p. 46), but they acknowledged that this limitation is common to the literature on many other aspects of psychotherapy, not just to that pertaining to people with developmental disabilities.

An effort to address the need for mental health treatment for people with developmental disabilities was put forth by Prout and Strohmer (1994) in an

edited volume that provides descriptions of various therapeutic approaches for this population. The book contains a chapter presenting an overview of psychopathology in people with developmental disabilities that is particularly useful. A team of British psychologists (Emerson, Hatton, Bromley, and Caine) published an edited volume in 1998 that attempts to address many of the issues related to the provision of psychological care to people with developmental disabilities. Noting the absence of a comprehensive and practical text, these authors, together with other contributors, created a resource that provides information on the epidemiology and causes of intellectual disability and on the treatment of a number of clinical problems, including sexual abuse, mental health problems, parents with developmental disabilities, and a range of challenging behaviors. It provides specific information on British legal, human service, and health care systems. Another group of British clinicians (Kroese, 1997) contributed an edited volume in 1997 devoted entirely to cognitive–behavioral treatment approaches for people with developmental disabilities and various psychological disorders. The importance of accurate diagnosis and treatment of psychiatric disorders in adults with developmental disabilities is the subject of a chapter by Moss (2001). A 2003 book by Hodges, also published in England, is devoted to the topic of counseling for people with developmental disabilities (referred to as learning disabilities, the British government–recommended term). The author provides suggestions for helping people with developmental disabilities to explore their internal worlds and suggestions for working with the many social, governmental, and family systems that support the individual's functioning.

Recent epidemiological research has demonstrated that the prevalence of psychiatric disorders (e.g., schizophrenia, major depressive disorder, posttraumatic stress disorder) is higher in the developmentally disabled population than in the general population. The extensive literature review in the volume by Nezu et al. (1992) suggests that adults and children with developmental disabilities may have up to four times the rate of psychiatric illness of nondisabled people. Similarly, a review by Nugent (1997) concludes that at least one in five, and perhaps as many as one in three, people with developmental disabilities also have psychiatric disorders. In a review of the literature on prevalence rates of psychiatric disorders, Caine and Hatton (1998) report that for people with developmental disabilities, studies tend to find prevalence rates of 25% to 40%. However, they note that in studies in which psychiatric disorders are more broadly defined to include the range of "behavioral disturbance" commonly seen in people with developmental disabilities, prevalence rates have been reported to be as high as 80%.

The variance in these prevalence rates is in no small way related to the complexities of discerning and defining psychiatric disorders in people who have developmental disabilities (Day, 2001). Exactly what constitutes a psychiatric

disorder in a person with intellectual disability is a subject of ongoing study (Day, 2001; Nezu et al., 1992). As early as 1982, Reiss, Levitan, and Szyszko reported that symptoms of psychiatric disorders often go undetected in people with intellectual disability because professionals tend to attribute their symptoms to the retardation itself. In other words, genuine, clinically significant psychological symptoms have been misunderstood as mere behavioral components of cognitive deficits. Reiss and his colleagues coined the term *diagnostic overshadowing* to describe this phenomenon. Even such severe symptoms as suicide attempts have been misconstrued as merely self-abusive behavior (Kaminer, Feinstein, and Barrett, 1987). Our sensitivity to the accurate assessment of the mental health of people with developmental disabilities has benefited greatly from continuing research, yet even the recent literature review by Butz et al. suggests that diagnostic overshadowing still muddies clinical understanding in general practice.

Of equal importance is our understanding of the nature of the psychiatric disorders experienced by people with developmental disabilities. Despite early misunderstandings and the unfounded assumptions of many mental health professionals, people with developmental disabilities experience the same types of psychiatric illness as their nondisabled counterparts (Charlot, 1998; Nezu et al., 1992; Nugent, 1997). Charlot's research provides descriptions of symptoms that may differ from those more commonly seen in the nondisabled population; for example, people with developmental disabilities suffering from depression often talk to themselves out loud rather than ruminate silently. This literature suggests that there may be variations in the typical symptom picture of a given disorder, but the experience of the nature of the disorder (e.g., depression, anxiety, even psychosis) is inherently the same.

INFLUENCE OF SEXUAL ABUSE

A broad array of factors have been found to contribute to the higher-than-average rates of psychiatric disorders experienced by people with developmental disabilities. It is important to note that each of these factors has been previously established to contribute to depression and other psychiatric disorders in the general population. Sadly, these factors are even more prevalent among people with developmental disabilities. These factors, as reported in Nezu et al. (1992), include the following:

- low levels of social support
- poorly developed social skills
- a sense of learned helplessness (and correspondingly low sense of self-efficacy)
- low socioeconomic level
- increased presence of physical disabilities (especially epilepsy)
- heightened family stress

- heightened maternal stress
- increased likelihood of central nervous system damage
- increased presence of reading and language dysfunctions
- decreased opportunities to learn adaptive coping styles
- increased likelihood of chromosomal abnormalities, metabolic diseases, and infections
- decreased inhibition in responding to stressful events

Finally, to this already lengthy list we may add higher-than-average rates of exposure to sexual abuse, known to be involved in the development of a wide range of psychiatric disorders in the general population.

It is against this backdrop of evolving awareness that our treatment of psychopathology and trauma in people with developmental disabilities is set. As we began working with larger numbers of dually diagnosed individuals (i.e., people with developmental disabilities and psychiatric disorders), we found that many of them had been victims of sexual abuse. This was particularly true for the female patients. We also began to receive a large number of referrals for males who had committed some type of sexually offensive behavior.

Research suggests that the high rates of sexual abuse we found in the people with psychiatric and developmental disabilities at our facility are not unusual. In general, people with psychological disorders are much more likely than nondisordered people to have experienced some form of sexual abuse (van der Kolk, 1996). In fact, the experience of trauma of any kind (e.g., sexual abuse, battering, the witnessing of domestic violence) has been implicated in the development of a broad range of psychological disorders (Herman, 1992b; van der Kolk, 1996). Van der Kolk (1996) and Herman (1992a, 1992b, 1995), both renowned for their expertise in the area of psychological trauma, note that it has been consistently found that the majority of psychiatric inpatients have histories of severe trauma, often from within their own families.

Given the higher-than-average rates of both sexual abuse and sexual offense behavior in people with developmental disabilities, there is a clear need for therapeutic intervention with this population. In an effort to address this need, we will review the specific workings of the interactive-behavioral model of group psychotherapy (Tomasulo, 1998) and its utility in addressing sexual abuse and related mental health problems in people with developmental disabilities.

PSYCHODRAMA AND THE TREATMENT OF PEOPLE WITH INTELLECTUAL DISABILITIES

The theoretical formulations of psychodrama have much to offer the treatment of people with intellectual disabilities. Moreno, like Freud, believed that a person's early experiences were responsible for his or her psychological development.

However, he differed from Freud in his ideas regarding the most effective ways to help people get better. Moreno believed that therapy ought to engage the person as completely as possible; interactions between therapist and patient should not be limited to simply thinking and talking. Thinking and talking are cognitive activities; the person is engaged cognitively. Moreover, in the case of people with ID, the therapeutic process remains dependent on the patient's least-developed skills. However, if you add action, if the person is invited to get up and demonstrate the problem, he or she is being engaged behaviorally and, ultimately, emotionally as well. In this manner, more of the sensory modalities are stimulated, and memory for therapeutic change is enhanced (Hurley et al., 1998; Razza and Tomasulo, 2005b; Tomasulo, 1998).

NECESSARY MODIFICATIONS IN PSYCHODRAMA FOR THE IBT MODEL

A typical psychodrama session has three stages: (1) warmup, (2) enactment, and (3) sharing (Tomasulo, 1998; Razza and Tomasulo, 2005b). The three stages allow group members to prepare for interactive role-playing, take part in an enactment of the issue being explored, and then reflect on the process just experienced. Because of the cognitive limitations of people with intellectual disabilities, we found the traditional stages unworkable, and we experimented using various readiness techniques and action methods at different times during the group process. What made them unworkable was the fact that people with ID did not have the depth of cognitive ability necessary to fully benefit from a reflection on taking part in, or witnessing, a psychodrama. What emerged was a four-stage format specifically modified for patients with intellectual and psychiatric disabilities. The four stages are (1) orientation, (2) warmup and sharing, (3) encounter, and (4) affirmation (Tomasulo, 2000). The IBT model's primary function is to produce peer support. Each of the stages builds on the process of the facilitator(s) fostering interaction between the members while keeping facilitator–member interactions to a minimum.

Orientation Stage

We added a new first stage, which we call the orientation, to help people with cognitive impairment develop skills needed for successful group participation. Many people with intellectual disabilities are accustomed to people not listening to them and will continue to talk whether others are listening or not. They often struggle with secondary audiological and visual disabilities.

As a result, many are not in the habit of listening when others talk, particularly when the other is a peer. People with cognitive disabilities have learned to devalue their peers (and themselves) and tend to talk over each other, clamoring for the facilitator's attention.

The orientation stage is designed to change that pattern. When one member is speaking, the facilitator interrupts and asks him or her to indicate who is listening. The facilitator then asks the member to choose another member to check whether the other member heard his or her statement. We call this process cognitive networking.

If the listener heard the communication, the facilitator then has an opportunity to reinforce the listener verbally for attending to the peer and to reinforce the sender for communicating clearly and being aware of who was listening. If the listener did not hear the communication, the sender is to choose another member. If that member also failed to receive the communication, the sender repeats his or her statement and tries the checking process again. In this way, members are taught to speak so that others understand them and to listen attentively to what others say. The facilitator's attention is typically a powerful reinforcer, and through judicious use of praise and acknowledgment the facilitator can shape the group members' behavior toward adaptive interpersonal behavior. Once the facilitator has these norms well established, as in long-term, ongoing groups, the facilitator's direction in this regard can be attenuated. The first step in activating therapeutic effect is to be sure the members of the group are ready to interact with each other; the orientation stage facilitates this process

Warmup and Sharing Stage

We move from the orientation into the second stage, the warmup and sharing stage, in which members deepen their level of disclosure and choose a protagonist. We collapsed the warmup and sharing stages from traditional psychodrama into this second stage because we found that the typical types of sharing in non–intellectually disabled adults were not possible with this population. Instead, the second stage, warmup and sharing, allows a shift from horizontal self-disclosure (typically person to person but with little emotional content) to vertical self-disclosure (a more personal divulgence with more emotionally laden material). This is also the point in therapy when the content of the group comes to light from a particular curriculum (e.g., anger management issues, sexual education). But whether it is a psychoeducational group or a psychotherapy group, each member sets his or her own agenda in turn, verbalizing the concern he or she would like to address in the day's session.

Enactment

We then move into the third stage, the enactment, in which traditional psychodramatic techniques increase emotional engagement of the members (Hurley et al., 1996). It is during this stage that role-playing and deep action methods are used as primary means through which therapeutic factors are likely to be

activated. This stage is the central feature of the IBT model, and the techniques used are modifications derived from psychodrama (reflecting issues unique to an individual's life) and sociodrama (issues that reflect a collective concern). Before the development of the IBT, the primary use of role-playing was for role training. More specifically, these techniques were used almost exclusively for social skill training rather than for the purpose of facilitating therapeutic interactions. The teachers in these groups fostered interaction between themselves and the participants rather than between the participants. Because the emphasis was on teaching a skill, the attention had to be focused on the teacher or trainer. In the interactive-behavioral format, the emphasis is on interaction between the participants for the purpose of creating a therapeutic environment. As part of the IBT process, a protagonist, the person whose issue is reflected and can be supported by the group membership, emerges. Thus, there is a major shift from a teaching or training model to a peer support and interaction model in which behaviors having therapeutic value are reinforced as a way of strengthening viable group processes. It is during the enactment stage that techniques such as the double are used.

Supportive Interactive Techniques

Space limitations for this article do not allow for an in-depth discussion of the application of techniques such as the double, empty chair, role reversal, and representational drama. A complete elaboration of these techniques and their use within the IBT can be found in the work of Razza and Tomasulo (2005b). Therefore, only a brief overview is included here.

The primary vehicle for the protagonist's evolution in the group is support. Toward this end, the action technique of the double is particularly well suited. Typically, the person playing the double is positioned behind the protagonist and slightly to one side. This arrangement allows the emotional expression, emotion support, or reorganizing of perceptions to emerge more naturally. If the double can be used to reflect the inner voice of the protagonist (what can be called an isomorphic condition matching his or her emotional state), the opportunity for change is greatly enhanced (Tomasulo, 1999a). As facilitator, the therapist can arrange for the protagonist to be seated (most often in the center of the group if it is agreeable to the protagonist, and seated because many of the members have difficulty with balance and mobility) and for the double to stand behind the chair. When the double stands behind the protagonist, he or she is taking a nonconfrontational and more supportive position. This position is contraindicated when it increases anxiety, as it usually does with people who are paranoid or when the protagonist's resistance or shame is too great. As an alternative, the double can sit or stand alongside the protagonist. This allows the protagonist to watch and hear rather than be activated by the double being

behind him or her. The choice of who will be the double can happen in one of several ways:

- The facilitator can choose the double.
- The protagonist can choose the double from the group.
- A group member can volunteer.
- The facilitator can do the doubling.
- The protagonist can double himself or herself.

A protagonist too frightened to seat himself or herself in the middle of a group could still benefit from a multiple double with the use of an empty chair in place of the protagonist in a representation setting. We have found that people who have been sexually abused often do not want attention from the group, but they needed the group's support. For them, being chosen was a double-edged sword. They were chosen *and* abused. The act of being chosen by the group and having attention put on them may actually recapitulate their trauma. In this situation, an empty chair is used in the center of the group to represent the protagonist, while the protagonist remains in her chair within the group. First, the facilitator supports the protagonist's decision not to go into the center of the group as an act of assertiveness rather than resistance. Then, with permission from the protagonist, the facilitator places an empty chair in the middle of the group to represent the protagonist. The doubling techniques described earlier can then continue, with the protagonist having experienced a sense of control over his or her limitation while still gaining support from the group.

Affirmation Stage

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

In the event of critical comments, questions for the protagonist, or egocentric references unrelated to the protagonist's work, the members are redirected

to identify what was good about what the protagonist did and then asked to choose the next person to give feedback to the protagonist. This redirection is typically very successful when combined with a statement back to the member that outlines the redirection. An example might be, "Phyllis, we want to hear more about what is happening for you, but for right now can you say what (the protagonist) just did that was good? Then choose the next person to give (the protagonist) feedback. If there is time left afterwards, before the group ends, we will come back to you."

If the member hesitates or can't say something supportive, he or she is asked to choose the next person to go while he or she is thinking of what to say. This almost always allows the process to continue.

We move into the affirmation stage rather than the more traditional sharing stage because we have learned that many members with intellectual disabilities have difficulty with abstract thinking and cannot always relate analogous experiences from their own lives. However, some members can and do acknowledge life experiences or emotional dilemmas similar to the one presented by the protagonist. We encourage members who are moved to share a related concern for their own lives to do so, and they are then affirmed as well. Initially facilitators do all the affirmations, but as sessions progress and members become attuned to the group process, the facilitators encourage members to provide affirmations to each other as well. This further encourages members to attend to each other and increases each member's value in the eyes of his or her peers. Members take increasing interest in each other as a result, and are more likely to offer spontaneous support and to experience a healing sense of universality.

For people who have intellectual disabilities, membership in an ongoing group has the further advantage of allowing them to be genuinely helpful to others. Just as veteran Alcoholics Anonymous members with many years of sobriety continue to gain through their work in supporting newcomers, veteran group members with intellectual disabilities gain a valuable sense of self-efficacy through their ability to help new members. (This is particularly important in light of the effectiveness of Alcoholics Anonymous membership found in the *Consumer Reports* study [Seligman, 1995] and its relevance to a recent IBT study identified later.) As facilitators, we encourage their support and feedback to new members. We especially encourage them to share their own experiences of self-growth. We frequently defer to the long-term members in working with new members, acknowledging them for their ability to understand and share with the new members in ways that we cannot. People with intellectual disabilities have almost no opportunity to feel competent, helpful, or valuable to others; ongoing groups offer them a unique and powerful dose of this therapeutic factor.

APPLICATION OF THE TECHNIQUE

Over the past 20 years the IBT model has been investigated in studies with some promising results. Blaine (1993) tested the efficacy of an IBT group treating both intellectually disabled and nondisabled participants over 17 sessions. Using a number of measures, she concluded that both types of patients showed significant positive change from the therapy, and interestingly, the subjects with intellectual disabilities demonstrated higher frequencies of most therapeutic factors (as identified by Razza and Tomasulo, 2005b; Tomasulo, 1998; Yalom, 1995; Yalom and Leszcz, 2005). In addition, patients set goals for themselves and then evaluated themselves with regard to how successful they felt they had been. The final evaluations suggested that patients' achievements of their interpersonal goals in therapy exceeded their expectations.

Keller (1995) studied the emergence of therapeutic factors in a 12-week IBT group with participants diagnosed with both intellectual and psychiatric disorders. The emergence of therapeutic factors is frequently studied because it is considered a robust measure of the therapeutic value of a group. Keller had professional therapists review videotapes of group sessions and asked them to rate the tapes for the presence of various therapeutic factors. The therapists were blind to the nature of the study and to whether they were watching early- or late-stage groups. The emergence of seven out of eight targeted therapeutic factors was reliably documented by the observers, suggesting that the therapeutic process does indeed evolve with participants who have intellectual disabilities.

IBT AND CHRONIC MENTAL ILLNESS

The IBT model has also been found to be effective with chronic mental illness. Daniels (1998) tested the IBT model with a group of chronically mentally ill adults who carried diagnoses of schizophrenia or schizoaffective disorder. Multiple clinical rating scales were administered to measure changes in social functioning and negative symptoms. Three hypotheses were tested, and each was supported by the ensuing data. Specifically, it was found that IBT increases the overall social competence of people with chronic schizophrenia or schizoaffective disorders; IBT improves the negative symptoms that are often associated with poor treatment outcomes for people diagnosed with schizophrenia or schizoaffective disorders; and IBT facilitates the emergence of the therapeutic factors found to enhance social competence in people with chronic schizophrenia and schizoaffective disorders. Note that both Blaine (1993) and Daniels did not limit their research to people with intellectual disabilities. Daniels's study suggests that the IBT model may provide a viable forum for people with chronic mental illness, whose treatment programs often include group psychotherapy.

The IBT model was also studied by Carlin (1998), who explored its value in helping people with intellectual disabilities cope with bereavement. She found that all group members showed evidence of being able to engage in the bereavement process through three therapeutic factors specific to the grieving process: acknowledging the reality of death, recalling special characteristics about the deceased, and verbalizing feelings related to the loss. Additionally, a study by Oliver-Brannon (2000) compared IBT with behavior modification techniques in treating subjects with dual diagnoses of intellectual disability and psychiatric disorders. The study suffers from small sample size and nonrandom assignment, but data collection revealed that subjects in the IBT group, compared with the behavior modification controls, evidenced greater reduction in target behaviors, increased problem-solving skills, and earlier return to the community.

In a recent doctoral dissertation, Lundrigan (2007) designed a questionnaire based on Seligman's (1995) *Consumer Reports* survey of client satisfaction with mental health services. She administered the survey to 40 IBT clients, all of whom were dually diagnosed. Clients reported feeling helped by their participation in IBT groups, as evidenced by their responses to the questionnaires and in the in-depth clinical interviews in which a percentage of the subjects participated. Of the 40 clients who were surveyed, 34 (85%) felt they had been helped by therapy. It is of note that this figure corresponds closely to the 87% satisfaction rate found in Seligman's *Consumer Reports* study. Additionally, 21 (52.5%) of IBT participants felt they had been helped a great deal by therapy. The high degree of satisfaction reported in the questionnaire lends support to the presence of the therapeutic factors in IBT groups identified by Blaine (1993), Daniels (1998), Keller (1995), and Razza and Tomasulo (2005a). These therapeutic factors are considered a robust measure of the therapeutic value of a group.

Although research interest in the area of mental health and intellectual disabilities has grown in recent years, a historical distinction between research and practice in mental health, and research and practice in developmental disabilities, has resulted in a dearth of clinical understanding of people who have both psychiatric disorders and developmental disabilities (Fletcher, Loschen, Stavrakaki, and First, 2007). Studies indicate a great variability in estimates of psychiatric disorders among the developmentally disabled (Caine and Hatton, 1998; Cooper, Smiley, Morrison, Williamson, and Allan, 2007). Estimates of psychiatric disorders range from 25% to 40%, with some as high as 80% for this population (Caine and Hatton, 1998). A recent population-based study of more than 1,000 people (Cooper et al., 2007), designed to overcome some of the sampling biases and limitations of earlier studies, found that more than one third of people with ID met *Diagnostic and Statistical Manual of Mental Disorders* criteria for additional clinical diagnosis.

People with ID have long been subjected to what Reiss called diagnostic overshadowing (Reiss et al., 1982), "the tendency on the part of professionals

to attribute symptomatology to the retardation itself. In other words, clinically significant symptoms have been misunderstood as mere behavioral components of cognitive deficits" (Razza and Tomasulo, 2005b, p. 31).

Tomasulo and Razza have conducted studies on the therapeutic factors identified by Yalom in the IBT groups (Razza and Tomasulo, 2005b). Yalom's (1995) extensive studies on group therapy identified 11 therapeutic factors. Tomasulo and Razza examined the presence of these factors, along with three additional therapeutic factors, at work in the IBT groups: acceptance and cohesion, universality, altruism, installation of hope, guidance, catharsis, modeling, self-understanding, learning from interpersonal action, self-disclosure, corrective recapitulation of the primary family, existential factors, imparting of information, and development of social skills.

The IBT model has been written about extensively in *Habilitative Mental Healthcare Newsletter* (Razza and Tomasulo, 1996a, 1996b, 1996c; Tomasulo, 1994, 1997, 1998; Tomasulo, Keller, and Pfadt, 1995) and in edited volumes on intellectual disabilities (Fletcher, 2000; Jacobson and Mulick, 1996; Wiener, 1999). It is the subject of *Action Methods in Group Psychotherapy* (Tomasulo, 1998) and was the focus of the American Psychological Association's first book on psychotherapy for people with intellectual disabilities (Razza and Tomasulo 2005b). It has been taught to thousands of human service and mental health personnel via direct training and videotaped instruction (Tomasulo, 1992). It has been recommended as a valuable means of treating adults with intellectual disabilities who are at risk for suicide (Kirchner and Mueth, 2000).

CONCLUSION

There is a slowly growing awareness among mainstream clinicians of the need for psychological services for people with intellectual disabilities. This has been evidenced by the publication of the *Diagnostic Manual—Intellectual Disabilities (DM-ID)* and the accompanying clinical guide (Fletcher et al., 2007). This two-volume set is published by the National Association for the Dually Diagnosed in conjunction with the American Psychiatric Association in an effort to help clinicians reach an accurate diagnosis within the *Diagnostic and Statistical Manual of Mental Disorders*. The section on posttraumatic stress disorder (Tomasulo and Razza, 2007) was informed by our work with IBT groups, which grounded clinical understanding of how trauma may manifest in people with intellectual disabilities. We hope that more clinicians will take up the challenge of treating people with intellectual disabilities, as they remain one of the largest yet most underserved populations (*Monday Morning*, 2002).

REFERENCES

Blaine, C. (1993). *Interpersonal learning in short-term integrated group psychotherapy.* Unpublished master's thesis, University of Alberta, Canada.

Blatner, A., & Blatner, A. (1988). *Foundations of psychodrama history: Theory and practice.* New York: Springer.

Butz, M., Bowling, J., & Bliss, C. (2000). Psychotherapy with the mentally retarded: A review of the literature and the implications. *Professional Psychology: Research and Practice, 31,* 42–47. doi:10.1037/0735-7028.31.1.42

Caine, A., & Hatton, C. (1998). Working with people with mental health problems. In E. Emerson, C. Hatton, J. Bromley, & A. Caine (Eds.), *Clinical psychology and people with intellectual disabilities* (pp. 210–230). Chichester, England: Wiley.

Carlin, M. (1998). *Death, bereavement, and grieving: A group intervention for bereaved individuals with cerebral palsy.* Unpublished doctoral dissertation, Long Island University, C. W. Post campus.

Charlot, L. (1998). Developmental effects on mental health disorders in persons with developmental disabilities. *Mental Health Aspects of Developmental Disabilities, 1*(2), 29–38.

Charlot, L., Doucette, A., & Mezzacappa, E. (1993). Affective symptoms of institutionalized adults with mental retardation. *American Journal on Mental Retardation, 98,* 408–416.

Cooper, S. A., Smiley, E., Morrison, J., Williamson, A., & Allan, J. (2007). Mental ill-health in adults with intellectual disabilities: Prevalence and associated factors. *British Journal of Psychiatry, 190,* 27–35.

Daniels, L. (1998). A group cognitive–behavioral and process-oriented approach to treating the social impairment and negative symptoms associated with chronic mental illness. *Journal of Psychotherapy Research and Practice, 7,* 167–176.

Day, K. (2001). Treatment: An integrative approach. In A. Dosen & K. Day (Eds.), *Treating mental illness and behavior disorders in children and adults with mental retardation* (pp. 519–529). Washington, DC: American Psychiatric Publishing.

Emerson, E., Hatton, C., Bromley, J., & Caine, A. (Eds.). (1998). *Clinical psychology and people with intellectual disabilities.* Chichester, England: Wiley.

Fletcher, R. J. (Ed.). (2000). *Therapy approaches for persons with mental retardation.* Kingston, NY: NADD Press.

Fletcher, R., Loschen, E., Stavrakaki, C., & First, M. (Eds.). (2007). *Diagnostic manual–intellectual disability (DM-ID): A clinical guide for diagnosis of mental disorders in persons with intellectual disability.* Kingston, NY: NADD Press.

Herman, J. (1992a). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5*(3), 377–391.

Herman, J. (1992b). *Trauma and recovery.* New York: Basic Books.

Herman, J. (1995). Crime and memory. *Bulletin of the American Academy of Psychiatry and the Law, 23*(1), 5–17.

Hodges, S. (2003). *Counselling adults with learning disabilities*. Basingstoke, England: Palgrave.

Hurley, A. D. (1989). Individual psychotherapy with mentally retarded individuals: A review and call for research. *Research in Developmental Disabilities, 10*(3), 261–275.

Hurley, A. D., Pfadt, A., Tomasulo, D., & Gardner, W. (1996). Counseling and psychotherapy. In J. Jacobson & J. Mulick (Eds.), *Manual of diagnosis and professional practice in mental retardation* (pp. 371–378). Washington, DC: American Psychological Association.

Hurley, A. D., Tomasulo, D., & Pfadt, A. (1998). Individual and group psychotherapy approaches for persons with mental retardation and developmental disabilities. *Journal of Developmental and Physical Disabilities, 10*(4), 119–123.

Jacobson, J., & Mulick, J. (Eds.). (1996). *Manual of diagnosis and professional practice in mental retardation*. Washington, DC: American Psychological Association.

Kaminer, Y., Feinstein, C., & Barrett, R. P. (1987). Suicidal behavior in mentally retarded adolescents: An overlooked problem. *Child Psychiatry and Human Development, 18*, 90–94.

Keller, E. (1995). *Process and outcomes in interactive-behavioral groups with adults who have both mental illness and mental retardation*. Unpublished doctoral dissertation, Long Island University, C. W. Post campus.

Kirchner, L., & Mueth, M. (2000). Suicide in individuals with developmental disabilities. In R. Fletcher (Ed.), *Therapy approaches for persons with mental retardation* (pp. 127–150). Kingston, NY: NADD Press.

Kroese, B. S. (1997). Cognitive–behaviour therapy for people with learning disabilities. In B. S. Kroese, D. Dagnan, & K. Loumidis (Eds.), *Cognitive–behaviour therapy for people with learning disabilities*. London: Routledge.

Lundrigan, M. (2007). *Interactive behavioral therapy with intellectually disabled persons with psychiatric disorders: A pragmatic case study*. Unpublished doctoral dissertation, Rutgers University, New Brunswick, NJ.

Marineau, R. F. (1989). *Jacob Levy Moreno, 1889–1974*. London: Routledge.

Monday Morning: A newsletter of the New Jersey Developmental Disabilities Council. (2002). Surgeon general releases report on health disparities and mental retardation. *Copy Editor, 8*(6), 1.

Moss, S. (2001). Psychiatric disorders in adults with mental retardation. In L. M. Glidden (Ed.), *International review of research in mental retardation*. San Diego, CA: Academic Press.

Nezu, C. M., & Nezu, A. M. (1994). Outpatient psychotherapy for adults with mental retardation and concomitant psychopathology: Research and clinical imperatives. *Journal of Consulting & Clinical Psychology, 62*(1), 34–42.

Nezu, C. M., Nezu, A. M., & Gill-Weiss, M. J. (1992). *Psychopathology in persons with mental retardation: Clinical guidelines for assessment and treatment*. Champaign, IL: Research Press.

Nugent, J. (1997). *Handbook on dual diagnosis: Supporting people with a developmental disability and a mental health problem.* Evergreen, CO: Mariah Management.

Oliver-Brannon, G. (2000). Counseling and psychotherapy in group treatment with the dually diagnosed (mental retardation and mental illness—MR/MI) (Doctoral dissertation, The Union Institute, 2000). *Dissertation Abstracts International, 60*(10-B), 5230.

Prout, H. T., & Strohmer, D. C. (1994). Issues in counseling and psychotherapy. In D. C. Strohmer & H. T. Prout (Eds.), *Counseling and psychotherapy with persons with mental retardation and borderline intelligence.* Brandon, VT: Clinical Psychology Publishing.

Prout, H. T., & Strohmer, D. C. (1995). Counseling with persons with mental retardation. *Journal of Applied Rehabilitation Counseling, 26*(3), 49–54.

Razza, N. (2008, Fall). Meeting the needs of people with intellectual disabilities. *New Jersey Psychologist,* pp. 36–38.

Razza, N., & Tomasulo, D. (1996a). The sexual abuse continuum: Therapeutic interventions with individuals with mental retardation. *Habilitative Mental Healthcare Newsletter, 15,* 84–86.

Razza, N., & Tomasulo, D. (1996b). The sexual abuse continuum: Part 2. Therapeutic interventions with individuals with mental retardation. *Habilitative Mental Healthcare Newsletter, 15,* 84–86.

Razza, N., & Tomasulo, D. (1996c). The sexual abuse continuum: Part 3. Therapeutic interventions with individuals with mental retardation. *Habilitative Mental Healthcare Newsletter, 15,* 116–119.

Razza, N., & Tomasulo, D. (2005a). Group dynamics in the treatment of people with intellectual disabilities: Optimizing therapeutic gain. *Mental Health Aspects of Developmental Disabilities, 8*(1), 22–28.

Razza, N., & Tomasulo, D. (2005b). *Healing trauma: The power of group treatment for people with intellectual disabilities.* Washington, DC: American Psychological Association.

Reiss, S., Levitan, G., & McNally, R. (1982). Emotionally disturbed mentally retarded people: An underserved population. *American Psychologist, 37,* 361–367.

Reiss, S., Levitan, G., & Szyszko, J. (1982). Emotional disturbance and mental retardation: Diagnostic overshadowing. *American Journal of Mental Deficiency, 86,* 567–574.

Seligman, M. (1995, December). The effectiveness of psychotherapy: The *Consumer Reports* study. *American Psychologist, 50*(12), 965–974.

Tomasulo, D. (1992). *Group counseling for people with mild to moderate mental retardation and developmental disabilities: An interactive-behavioral model* [Video]. New York: Young Adult Institute.

Tomasulo, D. (1994). Action techniques in group counseling: The double. *Habilitative Mental Healthcare Newsletter, 13,* 41–45.

Tomasulo, D. (1998). *Action methods in group psychotherapy: Practical aspects.* Philadelphia: Taylor and Francis.

Tomasulo, D. (1999a). Getting to hope: Role-playing in the treatment of denial, resistance and shame. *Mental Health Aspects of Developmental Disabilities, 2*(4), 1–9.

Tomasulo, D. (1999b). Group therapy for people with mental retardation: The interactive

behavioral therapy model. In D. Wiener (Ed.), *Beyond talk therapy: Using movement and expressive techniques in clinical practice.* Washington, DC: American Psychological Association.

Tomasulo, D. (2000). Group psychotherapy for people with mental retardation. In R. Fletcher (Ed.), *Therapy approaches for persons with mental retardation* (pp. 65–85). Kingston, NY: NADD Press.

Tomasulo, D. (2006). Group psychotherapy for people with intellectual disabilities: The interactive-behavioral model. *Journal of Group Psychotherapy, Psychodrama, and Sociometry, 59*(2), 85–93.

Tomasulo, D., Keller, E., & Pfadt, A. (1995). The healing crowd. *Habilitative Mental Healthcare Newsletter, 14*, 43–50.

Tomasulo, D. J., & Razza, N. J. (2007). Posttraumatic stress disorder. In R. Fletcher, E. Loschen, C. Stavrakaki, & M. First (Eds.), *Diagnostic manual—Intellectual disability (DM-ID): A textbook of diagnosis of mental disorders in persons with intellectual disability* (pp. 365–378). Kingston, NY: NADD Press.

van der Kolk, B. A. (1996). The complexity of adaptation to trauma: Self-regulation, stimulus discrimination, and characterological development. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 182–213). New York: Guilford.

Wiener, D. J. (1999). *Beyond talk therapy: Using movement and expressive techniques in clinical practice.* Washington, DC: American Psychological Association.

Yalom, I. (1995). *Group psychotherapy* (4th ed.). New York: Basic Books.

Yalom, I., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.

The authors would like to thank Tom Treadwell of the University of Pennsylvania for his encouragement in publishing information on the interactive-behavioral therapy model. Two earlier newsletter articles in the *Group Psychologist*, the APA division 49 Society of Group Psychology and Group Psychotherapy publication, provided the inspiration and direction for this article.