Understudied and Underserved: Advancing Inclusive Mental Health Care for Individuals with Intellectual and Developmental Disabilities

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ABSTRACT

Individuals with intellectual and developmental disabilities (IDD) face profound inequities in accessing and receiving quality mental health care despite being at increased risk for psychological distress. This paper examines the historical and systemic barriers that perpetuate these disparities—including financial limitations, imbalances within the healthcare system, provider shortages, inadequate research funding, and persistent misconceptions about the therapeutic potential of individuals with IDD. The exclusion of individuals with IDD from research and psychotherapy further exacerbates these challenges, creating significant gaps in clinical knowledge and guidance. In addition, individuals with IDD face disproportionately severe mental health challenges, including heightened exposure to trauma, diagnostic overshadowing, and the impact of social stigma.

In response, inclusive strategies are proposed to improve care by addressing the unique cognitive, communicative, and emotional needs of this population. Central to these recommendations is a shift toward person-centered, dignity-affirming care that recognizes individuals with IDD as autonomous participants in their own treatment. To advance equity in mental health care, it is imperative to pursue transformative change through inclusive research, targeted provider training, and evidence-based therapeutic adaptations. By amplifying the voices of individuals with IDD and addressing the systemic factors that have long excluded them, it will be possible to move toward a more equitable and responsive mental health care system for this underserved community.

Keywords: intellectual and developmental disabilities (IDD), mental health disparities, diagnostic overshadowing, person-centered therapy, trauma-informed care, inclusive psychotherapy, disability advocacy

UNDERSTUDIED AND UNDERSERVED: ADVANCING INCLUSIVE MENTAL HEALTH CARE FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Individuals with intellectual and developmental disabilities (IDD) are multidimensional human beings with rich emotional lives and significant capabilities, yet they are often inadequately recognized as such. Despite growing awareness and advocacy efforts, outdated perceptions continue to shape societal attitudes, policies, and clinical practices. As a result, individuals with IDD frequently encounter barriers that limit their autonomy, access to care, and overall well-being.

IDD encompasses a broad range of conditions characterized by impairments in intellectual functioning and adaptive behavior that emerge during development and persist throughout a person’s lifetime (Eunice Kennedy Shriver National Institute of Child Health and Human Development [NICHD], n.d.). Per the NICHD (n.d.), these differences can impact multiple domains, including:

- Cognitive and learning abilities—reasoning, problem-solving, communication.
- Behavioral and social functioning—social skills, emotional regulation, self-care.
- Physical ability and motor skills—mobility, coordination.

IDD includes chromosomal conditions such as Down syndrome and fragile X syndrome, as well as neurodevelopmental conditions including autism spectrum disorder and fetal alcohol syndrome (NICHD, n.d.). Compared to the general population, individuals with IDD are more vulnerable to experiencing mental health challenges, including anxiety, depression, and PTSD—yet they remain far less likely to access appropriate resources and support (Lineberry et al., 2023).

Multiple factors contribute to the inequitable access to mental health care for individuals with IDD, including systemic barriers, research gaps, and long-standing misconceptions. Systemic challenges such as financial inequities, a shortage of trained providers, and a lack of accessible services create considerable obstacles to receiving appropriate care. Individuals with IDD also face a heightened risk of trauma and psychological distress, yet their mental health concerns are frequently overlooked due to diagnostic overshadowing and the impact of stigma.

These interconnected forces continue to perpetuate the disparities individuals with IDD experience in mental health care. Despite increased need, this population remains vastly underrepresented in psychological research, limiting the development of effective, evidence-based interventions. As a result, care often fails to reflect the diverse needs of the IDD community, leading to inadequate support and reinforcing an ongoing pattern of excluding them from active participation in their own care. This paper examines the systemic disadvantages that individuals with IDD experience in mental health care, highlights the intersecting barriers to equitable treatment, and proposes recommendations to foster greater inclusion and accessibility in therapeutic settings and beyond.

SYSTEMIC BARRIERS TO EQUITABLE MENTAL HEALTH CARE

Individuals with disabilities face systemic marginalization across various facets of their lives, limiting their access, opportunities, and inclusion. Deeply rooted historical discrimination and ongoing barriers have led to profound inequities—particularly in financial stability, access to mental and physical health care, and funding for research. These challenges significantly contribute to negative mental health outcomes.

HISTORICAL CONTEXT

Beginning in the 19th century and continuing well into the 20th century, the widespread institutionalization of people with disabilities led to their forced removal from society. Within these institutions, individuals were often subjected to dehumanizing conditions (Davis, 2015). This systemic othering contributed to the exclusionary view of individuals with disabilities as burdensome or even dangerous (Davis, 2015). These perceptions worsened as the eugenics movement gained traction between the 1900s and 1940s, when policymakers and medical professionals advocated for the forced sterilization of individuals with disabilities, further entrenching the belief that they were inherently flawed (O’Brien, 2023, chapter 3).

This deprivation of fundamental human rights had a detrimental impact on the mental health of individuals with IDD, though their psychological well-being was largely disregarded by institutions at the time (Burns, 2009). While the latter half of the 20th century saw monumental shifts away from this harrowing past with the rise of the Disability Rights Movement and landmark legal reforms, substantial barriers remain in addressing the injustices and ongoing challenges faced by individuals with IDD (Burns, 2009; Davis, 2015).

FINANCIAL INEQUITIES THAT LIMIT OPPORTUNITY

The consequences of this long history of discrimination manifest in various forms, including stark economic disparities that limit access to essential resources and opportunities. According to the National Disability Institute (2020), 26% of individuals with a disability live below the poverty line, compared to 11% of individuals without a disability. Structural barriers—including limited educational resources, discrimination in hiring, physically inaccessible workplaces, and inadequate social support—hinder financial stability (World Bank, 2023). This is further compounded by higher rates of unemployment, limited employment opportunities, and wage inequalities: Under Section 14(c) of the Fair Labor Standards Act, individuals with IDD can legally be paid subminimum wages, with median earnings as low as $3.50 per hour (Wage and Hour Division, 2024). These inequities make financial independence exceptionally difficult to attain. Additionally, individuals receiving Supplemental Security Income (SSI) face asset limits in which they risk losing crucial benefits, including Medicaid, if they save more than $2,000 (Musumeci & Orgera, 2021). This cycle of financial precarity impacts mental health, as financial instability contributes to chronic stress and limits access to resources—further deepening systemic disadvantages for individuals with disabilities (Houtrow et al., 2023).

LIMITATIONS IN HEALTHCARE

Healthcare access remains a major barrier for individuals with IDD, who often receive lower-quality medical and mental health care and face obstacles that impede comprehensive treatment (Krahn et al., 2015). An estimated 50% to 70% of individuals with IDD who require mental health services do not receive them, in part due to the lack of appropriate services covered by funded programs (Harris et al., 2018).

Medicaid, the primary funding source for IDD care, covers approximately 77% of essential services for individuals with IDD, including home- and community-based supports and general healthcare. However, it often provides only limited coverage for mental health services. These limitations include restrictions on specialized therapy, session frequency, and provider availability (Barth, 2021). Medicaid-funded programs tend to prioritize behavioral interventions over psychotherapy, reflecting outdated assumptions about the psychological needs of this population (Barth, 2021). While strictly behavioral interventions can be effective for managing specific concerns, neglecting emotional well-being leaves many individuals with IDD struggling with undiagnosed or untreated psychological issues (McNally et al., 2021).

Healthcare disparities extend beyond mental health to physical health. Individuals with IDD are more than twice as likely to experience chronic, preventable conditions—such as obesity, diabetes, heart disease, stroke, and other cardiovascular diseases—compared to those without disabilities (Dixon-Ibarra & Horner-Johnson, 2014). This elevated risk is often linked to systemic barriers, including inadequate access to routine and preventive care such as screenings, early interventions, and health education (Escudé, 2022; Gréaux et al., 2023). These structural shortcomings not only affect physical health but can also intensify mental health difficulties, creating a cycle in which one condition exacerbates the other (Division of Population Health, 2012).

LIMITED RESEARCH FUNDING

Beyond service access and coverage, another major challenge lies in the limited research infrastructure supporting IDD mental health care. Research on the mental health needs of individuals with IDD remains severely underfunded (Hassiotis et al., 2022). Government investment in this area is limited, partly due to systemic oversight and the minimization of IDD-related concerns within broader mental health policy agendas (Hassiotis et al., 2022). As a result, many initiatives depend on short-term grants from nonprofit organizations and private foundations (Hassiotis et al., 2022). Despite the substantial, well-documented needs of individuals with IDD, research specific to this population has historically received a disproportionately small fraction of overall mental health funding (National Institutes of Health, n.d.).

While nonprofit organizations play a vital role in supporting these efforts, their financial resources are far more limited than those of public institutions (Frumkin & Kim, 2001). This has made it difficult to initiate and sustain large-scale, long-term studies—limiting both the generalizability of findings and the ability to produce insights that are responsive to the varied needs within the IDD community (Frumkin & Kim, 2001). The scarcity of dedicated funding hinders scientific progress and restricts the development of effective, evidence-based interventions. These funding gaps contribute to the continued exclusion of individuals with IDD from both research and clinical care—reflecting and reinforcing broader patterns of systemic neglect.

LACK OF TRAINED PROVIDERS

Even when care is otherwise accessible, another major limitation is the shortage of trained professionals equipped to provide mental health treatment to individuals with IDD. Effective therapy for this population requires clinicians with specialized expertise in the psychological, biological, and sociocultural dimensions of IDD (American

Psychological Association [APA], 2022). However, many clinicians lack the necessary training and confidence to diagnose and treat mental health conditions in this community (Hinde & Mason, 2020). Although training opportunities are increasing, they remain insufficient to meet the growing demand (Lamar, 2020). Many states report a shortage of specialized providers, which causes long wait times: Some individuals face wait periods of three to six months before receiving mental health care (Lamar, 2020). These delays are particularly harmful to individuals with IDD who require timely support.

Existing clinicians often become overextended due to the shortage of trained professionals, the backlog of cases, and high caseloads. This overextension often dilutes the time and attention spent on each client. This, in turn, increases the likelihood of burnout and reduces the capacity to provide individualized care (Hinde & Mason, 2020). As a result, the quality of care suffers as clinicians struggle to meet the diverse needs of each client, which can contribute to worsening symptoms and diminished outcomes (Hinde & Mason, 2020). This issue highlights the critical need for both more specialized training and a greater number of qualified professionals to effectively address the unmet mental health needs of individuals with IDD.

The consequences of these systemic barriers are grave. Limited access to routine healthcare, higher prevalence of preventable physical conditions, elevated rates of mental health difficulties, and broader social determinants of health—such as economic instability and social exclusion—all culminate in an average 15- to 20-year reduction in life expectancy for individuals with IDD (White et al., 2023). A staggering 42% of deaths among individuals with IDD result from potentially preventable causes—nearly double the rate in the general population, 22% (Cooper et al., 2020). These disparities necessitate a multifaceted and systemic approach—one that addresses not only individual mental health needs but also the broader social, economic, and structural factors contributing to poorer health outcomes.

EXCLUSION FROM RESEARCH AND EVIDENCE-BASED PRACTICE

BARRIERS TO PARTICIPATION IN PSYCHOLOGICAL RESEARCH

Equitable care is not possible without a strong research foundation, yet the persistent exclusion of individuals with IDD from the research landscape has severely limited the understanding of their mental health needs and hindered the development of effective, evidence-based interventions (DeCormier Plosky et al., 2022). Individuals with IDD remain critically underrepresented in mental health research and clinical trials, resulting in a limited evidence base to guide psychological care (DeCormier Plosky et al., 2022; Friedman & Spassiani, 2024). Researchers have historically deemed controlled studies involving this population too difficult due to lingering misconceptions and various methodological challenges (Friedman & Spassiani, 2024). These challenges include participant recruitment, ethical concerns around ensuring informed consent, and the need for accessible accommodations, which can be costly (Friedman & Spassiani, 2024). Without appropriate infrastructure, researchers have often viewed such studies as too logistically challenging to pursue—inadvertently excluding this population even further.

However, recent efforts to rectify this historical exclusion have focused on increasing awareness of ethical research practices and actively addressing logistical barriers to participation. These efforts have led to the adoption of more inclusive methodologies, such as participatory research approaches (Sadler, 2023). These methods involve integrating individuals with IDD as active participants in the design and execution of studies, taking on collaborative roles such as co-researchers and advisors (Sadler, 2023). By showcasing the lived experiences of individuals with IDD, these approaches produce more accurate and contextually relevant findings, while helping counteract the historical exclusion of this community from research (Sadler, 2023).

DISPARITIES IN GLOBAL RESEARCH REPRESENTATION

While this progress is promising, there is a significant gap in research on how disability intersects with different racial, ethnic, and socioeconomic backgrounds, particularly in low- and middle-income countries (Magaña et al, 2022; Susanty et al., 2020). Cultural adaptations of psychosocial interventions are necessary to deliver effective support across diverse populations; however, such adaptations remain limited and underdeveloped (Susanty et al., 2020). Approximately 80% of people with disabilities globally live in developing countries, yet the vast majority of psychosocial interventions and research on IDD have been concentrated in high-income, Western countries, where the resources and frameworks for conducting such studies are more readily available (Susanty et al., 2020). This inequity places the vast majority of individuals with IDD at an even greater disadvantage, as most interventions designed in high-income countries fail to account for the cultural, socioeconomic, and contextual factors that shape their psychological needs.

Interventions must be designed to be both effective and accessible for individuals in resource-constrained settings, ultimately contributing to the reduction of global inequalities in disability care. True inclusivity cannot be achieved while much of the global IDD population remains especially overlooked. Only when these disparities—both between high- and low-income countries and across cultural groups—are addressed will meaningful equity in disability mental health care be within reach.

The exclusion of individuals with IDD from research is both a symptom and a driver of broader systemic inequities—rooted in inadequate funding, limited infrastructure, and ingrained biases within the research field. As a result, individuals with IDD continue to be left out of the very systems intended to support their well-being, perpetuating exclusion in both knowledge and care.

BARRIERS TO PSYCHOTHERAPY: MISCONCEPTIONS AND EMERGING PROGRESS

LEGACY OF EXCLUSION IN MENTAL HEALTH TREATMENT

Although participatory research approaches and more inclusive research have improved representation in mental health studies, misconceptions about the emotional experiences and therapeutic potential of individuals with IDD continue to limit their access to appropriate mental health care. Historically, disabilities were treated as illnesses requiring a cure rather than inherent parts of a person's experience (Linton, 1998). As psychology and Western psychotherapy emerged as formal disciplines in the late 19th and early 20th centuries, individuals with disabilities were systematically excluded due to prevailing discriminatory beliefs that viewed them as intellectually inferior (Linton, 1998). This "therapeutic disdain" (Bender, 1993) was rooted in assumptions that individuals with IDD lacked awareness of their mental health and were incapable of participating in their own psychological treatment.

These beliefs persisted into the 1990s and early 2000s, reinforcing the notion that psychotherapy was not a viable option for individuals with IDD. For decades prior, many professionals believed that individuals with IDD lacked the cognitive capacity to benefit from self-reflection or insight-based therapies (Bender, 1993). As a result, mental health treatment primarily followed the medical model, which focused on symptom management and modifying external factors, often without addressing deeper psychological needs (Olkin, 2022; Willner & Lindsay, 2016). Within this framework, concerns were predominantly addressed through pharmacological treatments, hospitalization, and strictly behavioral interventions (Olkin, 2022; Willner & Lindsay, 2016). These interventions were frequently administered by third parties—such as healthcare providers without mental health training or caregivers—often without the individual's consent (Willner & Lindsay, 2016).

Misconceptions about the cognitive capacity and self-efficacy of individuals with IDD led many professionals to assume they were incapable of making informed decisions about their own care (Bender, 1993). Consequently, treatment plans were often imposed rather than developed with their collaboration or consent, further stripping individuals of agency in their mental health treatment (Dunkley et al., 2018). Such methods distanced the individual from their own emotions and volition, reducing them to passive recipients of care and leaving mental health concerns inadequately addressed. When individuals with IDD are excluded from decisions about their care, it can lead to feelings of disempowerment and a reluctance to seek help in the future (Dunkley et al., 2018). This can contribute to medical trauma, worsen psychological distress, and deepen disparities in mental health support (Bradbury-Jones et al., 2020).

PROGRESS TOWARD INCLUSIVE AND EMPOWERING CARE

The long-standing belief that individuals with IDD cannot benefit from psychotherapy has begun to dissolve as research and advocacy efforts expand (Shepherd & Beail, 2017). In the late 1990s and early 2000s, emerging research began to demonstrate the effectiveness of adapted psychotherapeutic approaches, such as modified cognitive behavioral therapy—prompting a gradual shift in professional attitudes (Willner, 2005). Psychotherapy is now more widely recognized as an effective treatment for individuals with IDD (Porcelan et al., 2019; Shepherd & Beail, 2017). Informed mental health and disability professionals acknowledge that, with appropriate resources and support, individuals with IDD are wholly capable of growth, change, and recovery from mental illness through psychotherapy (Porcelan et al., 2019). This understanding has catalyzed positive change, prompting the integration of cognitive principles into behavioral therapy, creating a more comprehensive model that addresses potential behavioral challenges and the emotional experiences of individuals with IDD.

While many past misconceptions have been dispelled, remnants of these beliefs remain, and considerable progress is still needed to achieve truly equitable mental health care. Since psychotherapy for individuals with IDD is still a relatively new and evolving field, continued research is essential to refine and enhance treatment methods. Addressing research gaps and promoting integrated treatment approaches are key to strengthening the knowledge base needed to better support individuals with IDD. A crucial part of this effort involves amplifying the voices of individuals with IDD in both psychological research and clinical care, as inclusive mental health care cannot exist without their representation and participation.

MENTAL HEALTH EXPERIENCES AND TREATMENT

INCREASED RISK OF TRAUMA AND ADVERSE CHILDHOOD EXPERIENCES

The systemic inequities that limit access to inclusive care also contribute to the significantly higher rates of trauma, abuse, and mental health challenges experienced by individuals with IDD compared to the general population (Didden & Mevissen, 2022; Lunsky & Lake, 2019). Individuals with IDD are also more likely to experience multiple disabilities and comorbidities: Between 39% and 52% of people with IDD have a co-occurring psychiatric condition, such as anxiety or mood disorders (Healthy Minds Policy Initiative, 2024). Individuals with IDD are disproportionately exposed to adverse childhood experiences (ACES)—stressful or traumatic events experienced in childhood that can have lasting effects on an individual’s physical, emotional, and mental health. This further compounds their risk of psychological distress (Division of Violence Prevention, 2019; McNally et al., 2021).

Approximately 44% of people with IDD have experienced at least four ACEs, compared to just 13% of the general population (National Core Indicators, 2023). Some of the traumas individuals with IDD are more likely to experience include physical and emotional abuse and neglect at the hands of caregivers, as well as social challenges such as bullying, isolation, and exclusion (Didden & Mevissen, 2022; National Council on Disability, 2022). Individuals with IDD also experience higher rates of sexual abuse, coercion, and exploitation, as others may wrongly assume they lack decision-making capacity and exploit their trust, reliance on support, or limited access to resources (Beadle-Brown et al., 2010; Nixon et al., 2017). The cumulative impact of these experiences during crucial developmental years increases vulnerability to long-term mental health challenges, chronic health conditions, and persistent social isolation (National Core Indicators, 2023).

DIAGNOSTIC OVERSHADOWING

An additional barrier to effective mental health care for individuals with IDD is the tendency for providers to minimize or disregard their mental health challenges, or attribute them entirely to their disability. A pervasive issue known as diagnostic overshadowing occurs when symptoms are misattributed solely to a person's disability. This involves overemphasizing or focusing excessively on the disability while overlooking other important aspects of the individual's life, including life events, strengths and capabilities, and additional factors related to the client's presenting concerns (APA Task Force, 2022; Hallyburton, 2022). This bias results in individuals being perceived almost exclusively through the lens of their disability, often overshadowing their broader identity (APA Task Force, 2022).

While challenges associated with disabilities can contribute to mental distress, they are not the sole explanation for these individuals' difficulties. Disability may be an important and meaningful aspect of their identity, but it does not encompass the entirety of it. Unlike individuals without disabilities, who are typically viewed holistically by mental health professionals, individuals with IDD are frequently viewed through the restrictive framework of their condition (APA Task Force, 2022). Without proper training, many clinicians struggle to recognize how mental health conditions may present differently in individuals with IDD (Fletcher et al., 2016). Although clinicians generally mean well and are often motivated by a desire to help, the lack of sufficient training and awareness can unintentionally result in diagnostic overshadowing. The implications of this phenomenon are profound: Professionals often overlook or dismiss symptoms of anxiety, depression, PTSD, and other mental health disorders, leaving diagnosable and treatable mental health conditions unaddressed (Lunsky & Lake, 2019).

To effectively combat diagnostic overshadowing, treatment should aim to bridge the gap between the internal experiences and outward expressions of individuals with IDD. It is important for clinicians to have a foundational understanding that disabilities can profoundly affect mental health, while also recognizing that individuals often present with concerns unrelated to their disability. This awareness should inform the therapeutic process, wherein clinicians actively explore both disability-related and independent mental health challenges. This more nuanced perspective enhances diagnostic accuracy and fosters more compassionate, individualized care that addresses the full spectrum of challenges experienced by individuals with IDD.

IMPACT OF SOCIAL STIGMA

Social stigma and isolation may also harm the mental health of individuals with IDD. Although stigmatization has decreased in recent years due to growing awareness and advocacy efforts, residual stigma remains deeply ingrained in societal perceptions. Many individuals with disabilities unconsciously internalize these negative views, increasing their risk of psychological distress—particularly anxiety and depression—and contributing to social withdrawal and a decreased likelihood of seeking support (Dagnan & Waring, 2004).

In addition to stigma, factors such as low self-esteem, negative self-concept, unfavorable social comparisons, feelings of hopelessness, and limited social support have all been linked to heightened mental health difficulties among this population (Evans & Randle-Phillips, 2018). These psychosocial stressors, coupled with the ongoing lack of accessible mental health care, have been associated with increased suicide risk. Individuals with IDD are three times more likely to face suicide risks than the general population, and those on the autism spectrum are particularly vulnerable (Santomauro et al., 2024).

These disparities underscore the urgent need for accessible, trauma-informed mental health care that not only addresses the varied needs of individuals with IDD but also actively combats stigma and promotes psychological well-being. Without a nuanced understanding of how mental health conditions uniquely impact this population, clinical approaches risk overlooking the complex interplay between disability, trauma, stigma, and emotional well-being. To meaningfully improve care, it is vital to center the voices and lived experiences of individuals with IDD. Their perspectives offer invaluable insight into how mental health services can become more accessible, affirming, and responsive—ultimately contributing to a more inclusive and equitable mental health system.

RECOMMENDATIONS: THERAPEUTIC MODIFICATIONS FOR INCLUSIVE CARE

ADAPTING THERAPY FOR INDIVIDUALS WITH IDD

Traditional psychotherapeutic models often fail to address the unique cognitive, communicative, and social needs of individuals with IDD. Meaningful adaptations are integral to promoting engagement, enhancing comprehension, and creating a more empowering, supportive therapeutic experience. Therapy is most effective when tailored to the individual's developmental level, support needs, and cognitive and verbal abilities (Porcelan et al., 2019).

Clinicians should account for differences in how individuals with IDD communicate, express their emotions, process information, and use cognitive functions, such as emotional literacy, memory, and executive functioning (Porcelan et al., 2019). To support these differences, therapy can be modified in terms of time frame, session pace, and complexity of content. For example, therapists can adjust their speech, use visual aids to convey emotions or experiences, and alter the number of themes addressed in a single session to suit the individual's needs (Kneuer, 2024). Additionally, therapists should encourage multimodal communication as needed—using a variety of methods to accommodate different communication preferences and abilities—by incorporating assistive technology, gestures, or alternative methods (Communication Community, n.d.).

LANGUAGE CONSIDERATIONS

In addition to adapting therapeutic techniques, clinicians should also be intentional with their language and use terms that respect individual preferences to ensure inclusive therapy (Bui et al., 2018). Preferences for person-first language (PFL) and identity-first language (IFL) vary within the disability community (APA Task Force, 2022). Person-first language (e.g., "a person with IDD") prioritizes the individual and their personhood first, framing disability as one aspect of identity rather than a defining feature. Identity-first language (e.g., "an autistic person") places disability at the forefront, recognizing it as a core and inseparable aspect of identity. Many individuals with Down syndrome prefer PFL, whereas many autistic individuals advocate for IFL, though preferences are personal and not universal (National Down Syndrome Society, 2022; Taboas et al., 2022). Clinicians should ask clients about their language preferences to ensure that therapeutic conversations align with their sense of self. Sensitivity to language use fosters stronger relationships, validates identity, and challenges stigma (Bui et al., 2018).

While honoring personal preferences, clinicians should also be mindful of how broader language choices can unintentionally reinforce ableist assumptions. Using disability-friendly, inclusive language that is free from stereotypes and bias is necessary to promote equitable care. Language plays a powerful role in shaping public attitudes toward people with disabilities. Recognizing and working to counter implicit ableism is crucial to prevent harm to clients and avoid perpetuating societal stigma (Friedman, 2019). Terms like "heroic," "suffering from," or “wheelchair bound” reflect and reinforce limiting perceptions, while euphemisms such as “special needs” can diminish the reality of disability and contribute to discomfort and stigma (APA Task Force, 2022). It is imperative to focus on the whole person, and using respectful language—avoiding both overly idealized and stigmatizing terms—is an essential part of that commitment.

PROMOTING AUTONOMY AND DIGNITY IN THERAPEUTIC PRACTICE

Clinicians must also consider how their tone and behavior may affect a client’s therapeutic experience. One common concern in therapeutic settings is the risk of infantilizing clients with IDD. Infantilization occurs when adults with IDD are treated and spoken to as if they are younger than their actual age, often with an unintentionally patronizing tone (Robey et al., 2006). Assuming individuals with IDD lack agency and competency can undermine their autonomy and diminish their self-esteem (Schuengel et al., 2020).

Such assumptions can lead to learned helplessness—where an individual feels powerless to enact change, resulting in passivity and dependence (van der Molen et al., 2017). Infantilization may also contribute to internalized feelings of inferiority among clients with IDD (Robey et al., 2006). Clinicians should encourage independence, bolster self-confidence, and treat individuals as equals to eliminate harmful power dynamics and ensure dignity in therapeutic relationships. Clients have noted that the aspects of psychotherapy they most appreciate include feeling valued, validated, and treated like adults by their therapists (Pert et al., 2012). Feeling empowered and autonomous, along with engaging in meaningful conversations and observing changes taking place, significantly enhances their experience and outcomes (Pert et al., 2012).

IMPLEMENTING STRENGTHS-BASED CARE

Beyond avoiding infantilization and promoting autonomy, clinicians can support clients with IDD by employing a compassionate, strengths-based approach to therapy. Interventions that center personal strengths have been shown to promote positive mental health outcomes and help individuals with IDD experience a deeper sense of fulfillment and well-being (Flückiger et al., 2023). By recognizing and emphasizing clients’ strengths, clinicians can help bring about increased empowerment, resilience, and a sense of self-worth (Dunn & Dougherty, 2005). This approach encourages individuals with IDD to build on their existing capabilities, reinforcing their agency and capacity to navigate life’s complexities (APA Task Force, 2022).

Clinicians can strike a thoughtful balance—giving ample space to share and process difficult emotions while also highlighting clients’ inherent strengths. By remaining perceptive, offering validation, and allowing the client to guide the therapeutic process, clinicians can better attune to each person’s needs and provide life-enhancing care.

CENTERING THE CLIENT WHILE COLLABORATING WITH CAREGIVERS AND FAMILY

Effective therapy for individuals with IDD begins by centering the client as the primary participant, while involving caregivers as supportive partners when appropriate. Collaborating with family members and caregivers from residential or day programs can greatly enhance the therapeutic process, as their involvement helps individuals practice skills in natural, familiar settings (Rogers et al., 2024). In addition to reinforcing skills, family members often play a critical role in supporting emotional regulation and facilitating effective communication outside of sessions (Rogers et al., 2024). Strong, trusting relationships with caregivers and support systems promote emotional well-being and foster a greater sense of safety, consistency, and belonging (Hughes et al., 2023; Mestre et al., 2024).

While caregivers can be valuable supports, they should not become the primary focus of treatment. Less informed clinicians may engage almost exclusively with caregivers, unintentionally excluding the client (APA Task Force, 2022). However, therapy sessions should not just be about the client—they must actively involve and prioritize the client in their own treatment. For all clients, including nonspeaking individuals and those who use alternative communication methods, it is crucial that therapists directly address them and engage them in the conversation. Support members can assist as needed, but excluding clients from their treatment can be invalidating and disempowering (Pert et al., 2012). An especially vital adaptation in therapeutic practice with individuals with IDD is a deliberate shift toward actively involving them throughout the process—recognizing that they are the experts in their own experiences.

Collectively, these modifications help establish a therapeutic environment that honors dignity, promotes engagement, and empowers individuals with IDD as active participants in their care. When thoughtfully adapted to meet individual needs, psychotherapy can be a powerful and healing process (Porcelan et al., 2019). Although such practices are not yet standard in many therapeutic settings, implementing them consistently can help shift the field toward more responsive and person-centered models of care.

LOOKING AHEAD: FUTURE CONSIDERATIONS

To address the long-standing injustices faced by the IDD community, inclusion must be promoted at every level—with a strong focus on the mental health field. Individuals with IDD have experienced acute and enduring societal and institutional barriers that impact both access to and quality of care. Substantive progress requires increased research, education, advocacy, and awareness to promote a deeper understanding of their needs. Mental health professionals, social workers, and advocates must commit to ongoing learning and inclusive practices. At the heart of this work, advocacy efforts must center and elevate the voices of individuals with IDD—ensuring their needs and perspectives are heard and actively shape the future of care.

At the macro level, systemic change is fundamental. Policy reform must directly address the pervasive inequities in mental health care for individuals with IDD. This includes advocating for Medicaid coverage that prioritizes inclusive mental health services and expanding funding for clinician training programs. Advocacy efforts should highlight both the critical importance and the rewarding nature of IDD mental health care. Raising awareness of the urgent need—and the profound impact—of this work can inspire more providers to enter the field and help build a more prepared and responsive workforce.

Progress also requires increased investment in research to better understand the needs of individuals with IDD, close gaps in care, and enhance the quality of evidence-based interventions available to this population. Policies must mandate inclusive practices across healthcare settings, from ensuring equitable access to enforcing antidiscrimination standards. Additionally, addressing global disparities in mental health care for individuals with IDD should remain a key priority to advance equitable treatment for those who have been historically underserved.

At the micro level, meaningful change begins in clinical practice. Clinicians must adapt care to the individual and adopt a person-centered approach that honors agency and autonomy. Therapists and social workers should cultivate therapeutic environments characterized by empathy, dignity, and mutual respect, where individuals with IDD remain central to their own treatment. When professionals see and support the whole person, they contribute to better mental health outcomes and improved quality of life. These efforts help lay the groundwork for a society in which individuals with IDD are truly valued, included, and equipped with the resources they need to thrive.

Looking ahead, the goal is for individuals with IDD to be able to readily access therapy when needed and to be recognized as people with a wide breadth of life experiences—not reduced to individuals defined solely by their disabilities. Achieving this vision requires moving away from substandard practices toward an unwavering commitment to consistently exceptional, equitable care. While there is substantial work to be done, impactful progress is already underway. Through sustained effort, the barriers that have long restricted access to care can be dismantled—and in doing so, there is potential for a more genuinely inclusive future for the IDD community.

REFERENCES

American Psychological Association (APA) Task Force on Guidelines for Assessment and Intervention with Persons with Disabilities. (2022). *Guidelines for assessment and intervention with persons with disabilities*. APA. https://www.apa.org/about/policy/guidelines-assessment-intervention-disabilities.pdf

Barth, S., Lewis, S., & Simmons, T. (2020, October). *Medicaid services for people with intellectual or developmental disabilities—Evolution of addressing service needs and preferences. Report to the Medicaid and CHIP Payment and Access Commission*. Health Management Associates. https://www.macpac.gov/wp-content/uploads/2021/01/Medicaid-Services-for-People-with-Intellectual-or-Developmental-Disabilities-%E2%80%93-Evolution-of-Addressing-Service-Needs-and-Preferences.pdf

Beadle-Brown, J., Mansell, J., Cambridge, P., Milne, A., & Whelton, B. (2010). Adult protection of people with intellectual disabilities: Incidence, nature and responses. *Journal of Applied Research in Intellectual Disabilities*, 23(6), 573–584. https://doi.org/10.1111/j.1468-3148.2010.00559.x

Bender, M. (1993). The unoffered chair: The history of therapeutic disdain towards people with a learning disability. *Clinical Psychology Forum*, *54*, 7–12.

Bradbury-Jones, C., Rattray, J., Jones, M., MacGillivray, S., & Taylor, J. (2020). Promoting the health, safety and wellbeing of people with learning disabilities during the COVID-19 pandemic: A rapid realist review. *International Journal of Developmental Disabilities, 67*(2), 100–112. https://doi.org/10.1080/20473869.2020.1804387

Bui, K. V. T., Peplau, L. A., & Hill, C. E. (2018). Therapist–client language matching: Initial promise as a measure of therapist–client relationship quality. *The Counseling Psychologist*, 46(5), 615–642. https://doi.org/10.1177/0011000018777302

Burns, J. K. (2009). Mental health and inequity: A human rights approach to inequality, discrimination, and mental disability. *Health and Human Rights, 11*(2), 19–31. https://doi.org/10.2307/25653100

Communication Community. (2022). *What is multimodal communication?* https://www.communicationcommunity.com/what-is-multimodal-communication/

Cooper, S. A., Allan, L., Greenlaw, N., McSkimming, P., Jasilek, A., Henderson, A., McCowan, C., Kinnear, D., & Melville, C. (2020). Rates, causes, place and predictors of mortality in adults with intellectual disabilities with and without Down syndrome: Cohort study with record linkage. *BMJ Open, 10*(5), e036465. https://doi.org/10.1136/bmjopen-2019-036465

Dagnan, D., & Waring, M. (2004). Linking stigma to psychological distress: Testing a social–cognitive model of the experience of people with intellectual disabilities. *Clinical Psychology & Psychotherapy*, *11*(4), 247–254. https://doi.org/10.1002/cpp.413

Davis, L. J. (2015). *The disability studies reader* (4th ed.). Routledge.

DeCormier Plosky, W., Ne'eman, A., Silverman, B. C., Strauss, D. H., Francis, L. P., Stein, M. A., & Bierer, B. E. (2022). Excluding people with disabilities from clinical research: Eligibility criteria lack clarity and justification. *Health Affairs*, 41(10), 1423–1432. https://doi.org/10.1377/hlthaff.2022.00520

Didden, R., & Mevissen, L. (2022). Trauma in individuals with intellectual and developmental disabilities: Introduction to the special issue. *Research in Developmental Disabilities, 120*, 104122. https://doi.org/10.1016/j.ridd.2021.104122

Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion. (2012). *Mental health and chronic diseases*. Issue brief no. 2. Centers for Disease Control and Prevention (CDC). https://stacks.cdc.gov/view/cdc/105496

Division of Violence Prevention, National Center for Injury Preventyion and Control. (2019). *Adverse childhood experiences (ACEs) prevention resource for action: A compilation of the best available evidence.* Centers for Disease Control and Prevention. https://stacks.cdc.gov/view/cdc/158965

Dixon-Ibarra, A., & Horner-Johnson, W. (2014). Disability status as an antecedent to chronic conditions: National Health Interview Survey, 2006–2012. *Preventing Chronic Disease, 11:*130251. http://dx.doi.org/10.5888/pcd11.130251

Dunkley, S., Sales, R., & Watson, J. (2018). Exploring decision making in people with intellectual disabilities. *British Journal of Learning Disabilities,* 46(3), 149–156. https://doi.org/10.1111/bld.12227

Dunn, D. S., & Dougherty, S. B. (2005). Happiness, resilience, and positive growth following physical disability: Issues for understanding, research, and therapeutic intervention. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 651–664). Oxford University Press.

Escudé, C. (2022, October 20). Advancing health equity for people with intellectual and developmental disabilities. *HealthAffairs*. https://www.healthaffairs.org/content/forefront/advancing-health-equity-people-intellectual-and-developmental-disabilities

Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD). (n.d.). *Intellectual and developmental disabilities (IDDs)*. Retrieved March 2025, from https://www.nichd.nih.gov/health/topics/factsheets/idds

Evans, L., & Randle-Phillips, C. (2018). People with intellectual disabilities' experiences of psychological therapy: A systematic review and meta-ethnography. *Journal of Intellectual Disabilities, 24*(2), 233–252. https://doi.org/10.1177/1744629518784359

Fletcher, R. J., Barnhill, J., & Cooper, S.-A. (Eds.). (2016). *Diagnostic manual – intellectual disability (DM-ID-2): A textbook of diagnosis of mental disorders in persons with intellectual disability.* NADD Press.

Flückiger, C., Munder, T., Del Re, A. C., & Solomonov, N. (2023). Strength-based methods: A narrative review and comparative multilevel meta-analysis of positive interventions in clinical settings. *Psychotherapy Research*, 33(7), 856–872. https://doi.org/10.1080/10503307.2023.2181718

Friedman, C. (2019). *Mapping ableism: A two-dimensional model of explicit and implicit disability attitudes. Canadian Journal of Disability Studies, 8*(3), 95–120. https://doi.org/10.15353/cjds.v8i3.509

Friedman, C., & Spassiani, N. A. (2024). Making survey research accessible for people with intellectual and developmental disabilities. In G. Bennett & E. Goodall (Eds.), *The Palgrave encyclopedia of disability*. Palgrave Macmillan. https://doi.org/10.1007/978-3-031-40858-8_77-1

Frumkin, P., & Kim, M. T. (2001). *Making nonprofits work: A report on the tides of nonprofit management reform*. The Hauser Center for Nonprofit Organizations, Harvard University. https://ash.harvard.edu/wp-content/uploads/2024/02/effect_of_government_funding.pdf

Gréaux, M., Moro, M. F., Kamenov, K., Russell, A. M., Barrett, D., & Cieza, A. (2023). Health equity for persons with disabilities: A global scoping review on barriers and interventions in healthcare services. *International Journal for Equity in Health, 22*(1), 236. https://doi.org/10.1186/s12939-023-02035-w

Hallyburton, A. (2022). Diagnostic overshadowing: An evolutionary concept analysis on the misattribution of physical symptoms to pre-existing psychological illnesses. *International Journal of Mental Health Nursing, 31*(6), 1360–1372. https://doi.org/10.1111/inm.13034

Harris, M., Goodman, M., & Mackenzie, K. (2018). Access to healthcare for individuals with intellectual and developmental disabilities: A review of the literature. *Journal of Intellectual Disability Research, 62*(1), 14–23. https://doi.org/10.1352/1934-9556-62.1.14

Hassiotis, A., Ali, A., Strydom, A., Martin, G., & Holt, G. (2022). A call for better research funding for intellectual disability. *The British Journal of Psychiatry, 220*(3), 123–125. https://doi.org/10.1192/bjp.2021.141

Healthy Minds Policy Initiative. (2024, June 27). *Barriers to care for people with co-occurring mental health disorders and intellectual and developmental disabilities.* https://www.healthymindspolicy.org/research/barriers-to-care-for-people-with-co-occurring-mental-health-disorders-and-intellectual-and-developmental-disabilities

Hinde, K., & Mason, J. (2020). Health practitioner knowledge and confidence in diagnosis and treatment of mental health issues in people with intellectual disabilities. *Journal of Intellectual & Developmental Disability*, 45(3), 269–278. https://doi.org/10.3109/13668250.2020.1730075

Houtrow, A. J., Bates, D. W., Pruitt, Z., & Andrae, M. (2023). Health inequities among people with disabilities in the United States. *JAMA Health Forum*, 4(11), e234014. https://doi.org/10.1001/jamahealthforum.2023.4014

Hughes, K., Wathen, C. N., MacMillan, H. L., MacDonald, D. M., & Vaillancourt, T. (2023). *What interventions work to address trauma among people with intellectual disabilities?* Disability Evidence Portal. https://www.disabilityevidence.org/questions-evidence/what-interventions-work-address-trauma-among-people-intellectual-disabilities.

Kneuer, T. (2024). *Adapting therapy practices for clients with intellectual and developmental disabilities* (IDD4) [Slides]. EASA Community. https://easacommunity.org/wp-content/uploads/2024/07/IDD4_Adapting-Therapy-Practices.pdf

Krahn, G. L., Walker, D. K., & Correa-De-Araujo, R. (2015). Persons with disabilities as an unrecognized health disparity population. *American Journal of Public Health, 105*(S2), S198–S206. https://doi.org/10.2105/AJPH.2014.302182

Lamar, R. (2020). *National needs assessment: Mental health services for people with intellectual and developmental disabilities.* Mental Health and Developmental Disabilities National Training Center. https://www.mhddcenter.org/wp-content/uploads/2020/04/MHDD-National-Needs-Assessment-2020.pdf

Lineberry, S., Bogenschutz, M., Broda, M., Dinora, P., Prohn, S., & West, A. (2023). Co-occurring mental illness and behavioral support needs in adults with intellectual and developmental disabilities. *Community Mental Health Journal, 59*(6), 1119–1128. https://doi.org/10.1007/s10597-023-01091-4

Linton, S. (1998). *Claiming disability: Knowledge and identity.* New York University Press.

Lunsky, Y., & Lake, J. (2019). *Psychiatry in Primary Care.* Centre for Addiction and Mental Health.

Magaña, S., Heydarian, N., & Vanegas, S. (2022). Disparities in healthcare access and outcomes among racial and ethnic minoritized people with intellectual and developmental disabilities. *Oxford Research Encyclopedia of Global Public Health*. https://doi.org/10.1093/acrefore/9780190632366.013.288

McNally, P., Taggart, L., & Shevlin, M. (2021). Trauma experiences of people with an intellectual disability and their implications: A scoping review. *Journal of Applied Research in Intellectual Disabilities*, 34(4), 927–949. https://doi.org/10.1111/jar.12872

Mestre, T. D., Lopes, M. J., Mestre, D. M., Ferreira, R. F., Costa, A. P., & Caldeira, E. V. (2024). Impact of family-centered care in families with children with intellectual disability: A systematic review. *Heliyon, 10*(7), e28241. https://doi.org/10.1016/j.heliyon.2024.e28241

Musumeci, M., & Orgera, K. (2021, June 23). *Supplemental Security Income for people with disabilities: Implications for Medicaid.* KFF. https://www.kff.org/medicaid/issue-brief/supplemental-security-income-for-people-with-disabilities-implications-for-medicaid/

National Core Indicators. (2023). *Data highlights: Health outcomes and disparities for individuals with intellectual and developmental disabilities.* Retrieved March 2025, from https://idd.nationalcoreindicators.org

National Council on Disability. (2022). *The impact of adverse childhood experiences on people with intellectual and developmental disabilities.* https://ncd.gov/publications

National Disability Institute. (2020). *Race, ethnicity and disability: The financial impact of systemic inequality and intersectionality*. https://www.nationaldisabilityinstitute.org/wp-content/uploads/2020/08/race-ethnicity-and-disability-financial-impact.pdf

National Down Syndrome Society. (2022). *Preferred language guide*. https://ndss.org/sites/default/files/2022-07/Preferred%20Language%20Guide_Full_2022.pdf

National Institutes of Health. (n.d.). *Budget and spending.* Research Portfolio Online Reporting Tools. Retrieved March 2025, from https://report.nih.gov/funding/nih-budget-and-spending-data-past-fiscal-years/budget-and-spending

Nixon, M., Thomas, S. D. M., Daffern, M., & Ogloff, J. R. P. (2017). Estimating the risk of crime and victimisation in people with intellectual disability: A data-linkage study. *Social Psychiatry and Psychiatric Epidemiology*, 52, 617–626. https://doi.org/10.1007/s00127-016-1275-1

O'Brien, G. (2023). *Eugenics, genetics, and disability in historical and contemporary perspective: Implications for the social work profession*. Oxford University Press. https://doi.org/10.1093/oso/9780197611234.003.0004

Olkin, R. (2022, March 29). *Conceptualizing disability: Three models of disability.* American Psychological Association. https://www.apa.org/ed/precollege/psychology-teacher-network/introductory-psychology/disability-models

Pert, C., Jahoda, A., Stenfert Kroese, B., Trower, P., Dagnan, D., & Selkirk, M. (2012). Cognitive behavioural therapy from the perspective of clients with mild intellectual disabilities: A qualitative investigation of process issues. *Journal of Intellectual Disability Research*, 57(4), 359–369. https://doi.org/10.1111/j.1365-2788.2012.01546.x

Porcelan, J. A., Caujolle-Alls, K. E., & Gentile, J. P. (2019). Dismantling fears associated with intellectual disability psychotherapy: An evidence-based practice. *Innovations in Clinical Neuroscience,* 16(11–12), 14–18. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7006867/

Robey, K. L., Beckley, L., & Kirschner, M. (2006). Implicit infantilizing attitudes about disability. *Journal of Developmental and Physical Disabilities,* 18(4), 441–453. https://doi.org/10.1007/s10882-006-9027-3

Rogers, C., O'Brien, C., & Penner, A. (2024). Family-centered care for individuals with intellectual and developmental disabilities: A framework for collaborative practice. *Journal of Developmental and Behavioral Pediatrics, 45*(1), 12–23.

Sadler, T. (2023). *Inclusive methods for engaging people with intellectual and developmental disabilities in research practices.* Center on Knowledge Translation for Disability & Rehabilitation Research. https://ktdrr.org/products/info-briefs/KTDRR-EngagingPeopleWithIDD-508.pdf

Santomauro, D. F., Hedley, D., Sahin, E., Brugha, T. S., & Naghavi, M. (2024). The global burden of suicide mortality among people on the autism spectrum: A systematic review, meta-analysis, and extension of estimates from the Global Burden of Disease Study 2021. *Psychiatry Research*, 330, 115120. https://doi.org/10.1016/j.psychres.2024.115120

Schuengel, C., Jansen, R., Janssen, C. G. C., & Didden, R. (2020). Self-concept and self-esteem in people with intellectual disabilities: A meta-analysis. *Journal of Applied Research in Intellectual Disabilities, 33*(6), 1319–1329. https://doi.org/10.1111/jar.12738

Shepherd, C., & Beail, N. (2017). A systematic review of the effectiveness of psychoanalysis, psychoanalytic, and psychodynamic psychotherapy with adults with intellectual and developmental disabilities: Progress and challenges. *Psychoanalytic Psychotherapy, 31*(1), 94–117. https://doi.org/10.1080/02668734.2017.1286610

Susanty, D., Noel, P., Sabeh, M. S., & Jahoda, A. (2020). Benefits and cultural adaptations of psychosocial interventions for parents and their children with intellectual disabilities in low□ and middle□income countries: A systematic review. *Journal of Applied Research in Intellectual Disabilities, 34*(2), 421–445. https://doi.org/10.1111/jar.12820

Taboas, A., Doepke, K., & Zimmerman, C. (2022, October 13). Preferences for identity-first versus person-first language in a U.S. sample of autism stakeholders. *Autism, 27*(2), 565–570. https://doi.org/10.1177/13623613221130845

van der Molen, M. J., Henry, L. A., & van Luit, J. E. (2017). Working memory and susceptibility to learned helplessness in individuals with mild intellectual disabilities. *Journal of Intellectual Disability Research, 61*(5), 405–414. https://doi.org/10.1111/jir.12356

Wage and Hour Division. (2024). *Frequently asked questions: Proposed rule to end subminimum wage for workers with disabilities under section 14(c)*. U.S. Department of Labor. https://www.dol.gov/agencies/whd/workers-with-disabilities/nprm-employment-of-workers-with-disabilities-14c/faqs

White, A., Sheehan, R., Ding, J., Roberts, C., Magill, N., Keagan-Bull, R., Carter, B., Chauhan, U., Tuffrey-Wijne, I., & Strydom, A. (2023). *Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) report for 2022.* LeDeR Autism and Learning Disability Partnership, King's College London. https://www.kcl.ac.uk/research/leder

Willner, P. (2005). The effectiveness of psychotherapeutic interventions for people with learning disabilities: A critical overview. *Journal of Intellectual Disability Research, 49*(1), 73–85. https://doi.org/10.1111/j.1365-2788.2005.00633.x

Willner, P., & Lindsay, W. R. (2016). Cognitive behavioral therapy. In N. Singh (Ed.), *Handbook of evidence-based practices in intellectual and developmental disabilities* (pp. 197–218). Springer. https://doi.org/10.1007/978-3-319-26583-4_11

World Bank. (2023, April 3). *Disability inclusion*. https://www.worldbank.org/en/topic/disability