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ORIGINAL ARTICLE

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Adapting the protocol for narrative exposure therapy for adults with mild intellectual disabilities

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Abstract

Background: Narrative exposure therapy (NET) is a trauma-focused cognitive behavioural therapy, recommended by the National Institute for Health and Care Excellence in 2018, to treat posttraumatic stress disorder in adults. There is a lack of research exploring the effectiveness of NET with adults with intellectual disabilities. The aim of this study is to develop an adapted version of the NET protocol (IDNET) for use with adults with mild intellectual disability.

Methods: A qualitative research design was employed. Stage one involved systematically adapting the NET protocol for adults with mild intellectual disabilities in collaboration with a service user group comprising eight consultants. Stage two involved gaining professionals' views on the adapted protocol and on the use of NET in intellectual disability services. This comprised a focus group of eight clinical psychologists specialising in intellectual disabilities and an expert panel of three NET clinicians. The framework approach was conducted on the focus group data only following guidance from a previous study.

Findings: An adapted NET protocol and collection of 'easy read' therapy materials were developed (IDNET), which incorporated feedback from the three stakeholder groups. Key concepts of 'Optimism and motivation to adapt NET for people with mild intellectual disabilities' and 'Factors related to NET in practice' were developed to describe the views of clinical psychologists. A number of issues were raised by professionals regarding the delivery of IDNET.

Conclusions: Professionals were optimistic about IDNET; however, issues raised regarding the delivery of IDNET require exploration when IDNET is trialled in practice. Specific implications for clinical practice and future research are discussed.

KEYWORDS
intellectual disabilities, narrative exposure therapy, posttraumatic stress disorder

Accessible summary

- A traumatic experience is something that happens to us that is very scary. It is also scary when we think about it afterwards.

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- Narrative exposure therapy is a talking therapy. It helps people who have had more than one traumatic experience.
- We do not know if this therapy can help people with intellectual disabilities. Here, we talk to people with intellectual disabilities and those who work with them. We ask them how we can make this therapy suitable for people with mild intellectual disabilities.
- This is important because people with intellectual disabilities are more likely to have traumatic experiences than others.
- We hope that people will try using this therapy with people with mild intellectual disabilities. This will help us find out whether it is useful.

1 | BACKGROUND

Psychological trauma has been defined as 'the experience and psychological impact of events that are life-threatening or include a danger of injury so severe that the person is horrified, feels helpless, and experiences a psychophysiological alarm response during and shortly following the experience' (Schauer et al., 2011, p. 7). Although it is common to experience distressing symptoms following a traumatic event, for most people, symptoms resolve within the following weeks (Watkins et al., 2018). However, when symptoms persist and cause impairment in functioning, individuals may receive a diagnosis of posttraumatic stress disorder (PTSD).

The rise of trauma-informed care within health services in the United Kingdom has highlighted the need for patients to receive care that considers trauma and includes referral for trauma-focused treatment where appropriate (Sweeney et al., 2016). The (National Institute for Health and Care Excellence [NICE], 2018) recommends individual trauma-focused cognitive behavioural therapy (TFCBT) to treat PTSD in adults. Narrative exposure therapy (NET; Schauer et al., 2011) is a TFCBT recommended by NICE (2018).

In 2015, it was estimated that just under one million adults living in England had intellectual disabilities (Public Health England, 2016). Adults with intellectual disabilities experience a substantially higher prevalence of mental health conditions when compared to the general population (Hughes-McCormack et al., 2017). They are also at greater risk of experiencing adverse life events (Wigham & Emerson, 2015); surveys suggest that three-quarters have experienced at least one traumatic event, compared to one-third of individuals within the general population (Martorell et al., 2009; McManus et al., 2016). It is, therefore, unsurprising that adults with intellectual disabilities are more vulnerable to PTSD than the general population (Fletcher et al., 2016). A recent review reported the pooled prevalence rate of PTSD to be 10% among people with intellectual disabilities (Daveney et al., 2019); this is in comparison to 4.4% among the general population (McManus et al., 2016). It is likely traumatic stress in adults with intellectual disabilities is even higher than rates suggest due to factors, such as diagnostic overshadowing where symptoms are attributed to intellectual disabilities and communication difficulties that prevent a diagnosis from being identified (Byrne, 2020; Fletcher et al., 2016). Furthermore, in individuals with more severe intellectual disabilities, PTSD can often be misinterpreted as challenging behaviour or misdiagnosed as a feature of another psychiatric disorder (Bakken et al., 2014).

There are no specific NICE guidelines for the treatment of PTSD in adults with intellectual disabilities. NICE (2016) advises guidance relating to specific mental health problems should be referred to when treating adults with intellectual disabilities, in conjunction with recommendations regarding communication, tailoring interventions to individual needs, collaboration on decision-making and additional support. However, NICE (2018) does make additional recommendations regarding the care of people with PTSD and complex needs. Although this does not refer to adults with intellectual disabilities, it suggests allocating extra time to develop trust, considering the safety/stability of the individual's circumstances, managing barriers to engagement and planning ongoing support following treatment.

A systematic review found just eight case studies regarding TFCBT in adults with intellectual disabilities; the quality of these studies varied, as did adherence to NICE (2018) guidelines for TFCBT (Marlow et al., 2019). Therefore, although research suggests this population is at increased risk of developing PTSD, there is a lack of controlled research in this area (Byrne, 2020) and an absence of adapted TFCBT manuals. If treatments are in NICE guidance, they should be adapted so that they are available to all, and this includes all TFCBT specified by NICE (2018), including NET. Consequently, clinicians working in intellectual disability services rely on clinical judgement to adapt evidence-based treatments developed among the general population (Truesdale et al., 2019), rather than being able to refer to rigorous research regarding both useful and necessary adaptations for individuals with intellectual disabilities.

NET was developed for victims of multiple trauma and incorporates exposure therapy and testimonial therapy by exposing clients to traumatic events in chronological order and in the context of the rest of their life. NET follows three stages: psychoeducation; a lifeline session where the client physically creates an overview of their life using rope, stones and flowers; and narration sessions where the client is guided to narrate each event from the lifeline in detail. This starts with contextual information to facilitate autobiographical integration of trauma memories and

subsequently focuses on the sensory details of 'hot' memories to facilitate habituation to arousal. In the following session, the therapist re-narrates the event, having structured the account in the interim, and then moves on to the next symbol on the lifeline (Neuner et al., 2002; Robjant et al., 2017). A number of adaptations have allowed NET to be delivered to children/adolescents (KidNET; Schauer et al., 2011), veterans/violent offenders (FORNET; Hecker et al., 2015), survivors of a single traumatic event (NET-R; Zang et al., 2014) and gender diverse people (TA-NET; Lange, 2020). However, there is a lack of research literature exploring how NET can be adapted for adults with mild intellectual disabilities, in fact, having intellectual disabilities can exclude participants from research exploring the effectiveness of NET (e.g., Orang et al., 2018; Peltonen & Kangaslampi, 2019). This is despite the assumption that treatments recommended by NICE should be available for all, and evidence to suggest that adults with intellectual disabilities can access psychological therapies for traumatic stress with appropriate adjustments (Truesdale et al., 2019).

At face value, the directive and repetitive nature of NET appears suited to those with intellectual disabilities. However, it is acknowledged that in comparison to eye movement desensitisation and reprocessing (EMDR), which is also recommended by NICE (2018) to treat PTSD, a greater verbal ability is required within NET, which has caused some in the field to suggest EMDR may be considered more suitable for this population than TFCBT (Stenfert Kroese, 2021). As far as the authors are aware, there is only a single published article that reports the use of NET with a client with intellectual disabilities (Fazel et al., 2020); the authors state that the lower cognitive demands placed on individuals during NET may mean it is more accessible for this population (Fazel et al., 2020). Although this study relates to an adolescent, adaptations that could be generalised to adults with intellectual disabilities are outlined, such as the provision of written prompting questions. The literature base relating to KidNET can also be consulted for developmentally appropriate adaptations for use by those with intellectual disabilities.

In addition to the NICE (2016) guidelines, a number of other guidelines and recommendations exist to support the adaptation of psychological therapies for adults with intellectual disabilities. The British Psychological Society offers guidance on adapting CBT, which is relevant to NET as a TFCBT specified by NICE (Jahoda, 2016). This followed work by Lindsay et al. (2013), who outlined implications for therapy based on cognitive deficits and earlier work by Hurley et al. (1998), who described the major adaptations required for psychotherapy within this population. It is also essential to consider the guidance around accessible communication formats to inform the development of 'easy read' therapy materials, such as that provided by the Department for Work and Pensions (2018); the Department of Health (2010) and NHS England (2018). The above literature can, therefore, be drawn upon when exploring how NET can be adapted for adults with mild intellectual disabilities. Mild intellectual disability is defined in the current research as impairment falling two to three standard deviations below the population mean, based on standardised testing (World Health Organisation, 2020).

The aim of the study was to develop an adapted version of the NET protocol (IDNET) for use with adults with mild intellectual disability, which sought to answer the following research questions:

- How can NET be adapted for adults with mild intellectual disabilities to create a new protocol (IDNET) for further investigation in clinical practice?
- What are the views of service users on the IDNET therapy materials developed and how can they be incorporated?
- What are the views of professionals on using NET in intellectual disability services and on the adapted protocol (IDNET), and how can they be incorporated?

2 | METHODOLOGY

2.1 | Stage one: Developing IDNET

Both stages followed a qualitative research design and received ethical approval from the relevant committees. The NET manual (Schauer et al., 2011) provides a step-by-step description of the process of NET, which was worked through systematically by the lead researcher and speech and language therapist (SALT) over the course of nine virtual meetings. At each step, consideration was given to how the therapy could be adapted for adults with mild intellectual disabilities and what 'easy read' therapy materials would be required. This process was continuous and iterative and involved referring to the following:

- Adaptations to psychotherapy techniques for adults with intellectual disabilities (Hurley et al., 1998).
- Adapting CBT for people with intellectual disabilities and cognitive deficits (Jahoda, 2016; Lindsay et al., 2013).
- Guidance on developing accessible communication formats (Department for Work and Pensions, 2018; Department of Health, 2010; NHS England, 2018).
- Developmentally appropriate adaptations to NET are already documented in the literature (Fazel et al., 2020; Schauer et al., 2011).

Following this, the service user group provided written feedback on the accessibility of the 'easy read' materials. The group comprised eight consultants, including one group facilitator who did not have intellectual disabilities and who supported the group to give feedback. A virtual meeting was held subsequently between the lead researcher and the group to clarify written feedback where necessary, gain a majority decision on certain changes to the materials and gain verbal feedback from the group. The lead researcher met with the SALT subsequently to discuss this feedback and agree on changes to therapy materials.

2.2 | Stage two: Gaining the views of professional experts

A focus group comprising eight clinical psychologists working in intellectual disability services across the United Kingdom and the Republic of Ireland was conducted; this included four females and two males (two did not disclose gender identity). Participants' ages ranged from 35 to

54 years and all participants had at least eight years of experience working within intellectual disability services. Psychologists were recruited via an advert circulated by the Chair to all members of the British Psychological Society's Division of Clinical Psychology Faculty for People with intellectual disabilities. Psychologists were required to be registered with the Health and Care Professions Council and have at least two years of experience working within intellectual disability services.

An international expert panel comprising three NET clinicians was also consulted; participants were female with at least nine years of experience delivering NET and ages ranged from 45 to 64 years. Clinicians were recruited via a snowballing sample involving the lead researcher emailing clinicians prominent in the field. Clinicians were required to be English speaking and have an active interest as well as practical experience in delivering NET.

All correspondence with participants was conducted via email. Potential participants were asked to contact the lead researcher directly and were subsequently sent a Participant Information Sheet, which included information relating to ethical considerations. If willing to participate, participants subsequently completed a consent form and a demographics questionnaire. Psychologists were emailed IDNET and asked to provide written feedback on how the therapy materials and adapted protocol could be improved for use with adults with mild intellectual disabilities. Feedback was integrated anonymously by the lead researcher if it included minor changes to wording or was suggested by the majority of the participants and was sent back to psychologists to review before the focus group. The remaining feedback was taken to the focus group discussion. The virtual focus group was facilitated by the lead researcher; the first half involved participants reaching a majority agreement in relation to changes to IDNET suggested by the remaining feedback, the second half comprised a group discussion facilitated using a semistructured interview schedule exploring participants' views regarding the use of NET within intellectual disability services.

The focus group discussion with psychologists was transcribed by the lead researcher and a deductive framework approach (FA; Ritchie & Spencer, 1994) was employed, which was reviewed within the research team to uphold quality. Data were managed according to the following stages outlined by Ritchie and Spencer (1994): familiarisation; constructing an initial framework; indexing and sorting; reviewing data extracts and data summary and display. Interpretation then involved developing key concepts to discriminate the differences in the data. FA was chosen for the analysis as this approach is suited to "research that has specific questions, a limited time frame, a pre-designed sample (e.g., professional participants) and a priori issues" (Srivastava & Thomson, 2009; p. 73).

Following the focus group with psychologists, NET clinicians were emailed the amended IDNET to review before the virtual expert panel discussion. This was facilitated by the lead researcher using a semistructured interview exploring participants' views on delivering NET to adults with intellectual disabilities and the consistency of IDNET with the theory underpinning NET. Due to the smaller number of participants recruited to the expert panel comprising NET clinicians, a qualitative analysis was not appropriate. Instead, participants' comments were summarised, and a collaborative decision was made within the research team regarding whether comments: led to amendments to IDNET; were disregarded due to already existing within IDNET or because they were deemed inappropriate for those with intellectual disabilities; and/or were identified as future research questions to be explored when IDNET is trialled in practice.

3 | FIN

3.1 | Stage one: Developing IDNET

A protocol was developed, which comprised recommendations for how NET could be adapted for adults with mild intellectual disabilities, in addition to six information sheets and nine handouts in 'easy read' format that mapped onto the psychoeducational examples in the NET manual (see Figure 1, for an example of an information sheet). Table 1 shows examples of how IDNET was developed. Guidance relating to 'easy read' was referred to throughout the development of the therapy materials and therefore is not referred to specifically in Table 1. However, this includes the use of at least a 14-point font size and ensures that sentences are

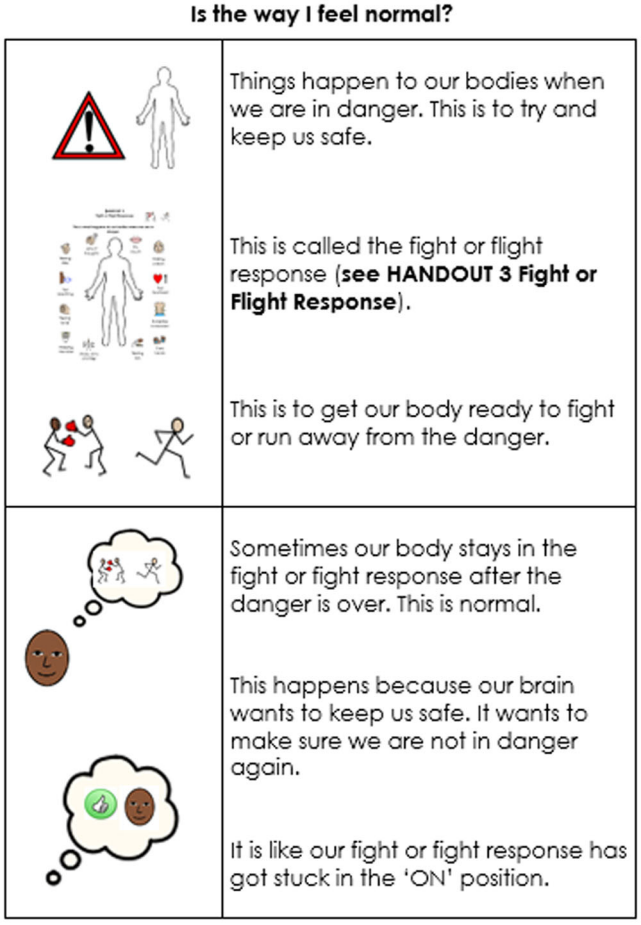

FIGURE 1 An example of an information sheet developed during stage one (first page only) [Color figure can be viewed at wileyonlinelibrary.com]

TABLE 1 Examples of how IDNET was developed.

What was developed?	How was relevant guidance followed?
Information sheet 'Is the way I feel normal?' (see Figure 1)	• Material is presented visually to support cognitive deficits (Beail, 2016; Fazel et al., 2020; Lindsay et al., 2013). • Material is simplified by breaking complex sentences (psychoeducation provided by the manual) into smaller chunks to support executive functioning (Hurley et al., 1998; Lindsay et al., 2013). • Language is adapted to reduce the level of vocabulary, for example, the substitution of words, such as 'perceive' and 'hypervigilant' (Hurley et al., 1998; Lindsay et al., 2013).
IDNET: The Lifeline exercise	• Repetition of the rationale for the lifeline exercise is recommended (Fazel et al., 2020; Lindsay et al., 2013). • Visual aids are recommended, such as emotional pictures to support the client's understanding of the meaning of the rope/stones/flowers (Fazel et al., 2020; Lindsay et al., 2013). • Directive questioning is recommended to keep the client focused on the lifeline as a whole once completed (Hurley et al., 1998). • Ways in which carers might support the client, if necessary and agreed by the client, are suggested (Beail, 2016; Hurley et al., 1998; Lindsay et al., 2013). • Completing the lifeline in one session is recommended if possible (as stated in the manual); however, it is acknowledged that it may need to be broken down (Beail, 2016; Hurley et al., 1998).
IDNET: Narration sessions	• Increased prompting and direction from the therapist are recommended to support the client's narration (Hurley et al., 1998). • Repetition of the rationale for narration, including psychoeducation about exposure, is recommended throughout sessions (Fazel et al., 2020; Lindsay et al., 2013). • Visual resources are recommended to support the client's expression. This includes the use of drawings, role play and visual prompts to guide the client in narrating different aspects of their experience, which also increases predictability for the client (Fazel et al., 2020; Hurley et al., 1998; Schauer et al., 2011).
IDNET: The duration and number of narration sessions.	• Additional time in sessions is recommended for clients to process information/emotions and return to baseline levels of arousal (Fazel et al., 2020). • Shortening of session duration is recommended as well as breaks if necessary, which may mean the number of sessions is increased from approximately 8 to 12, as suggested in the manual (Beail, 2016; Hurley et al., 1998; Lindsay et al., 2013).

Abbreviations: NET, narrative exposure therapy; IDNET, adapted version of NET.

short and include only one verb (Department for Work and Pensions, 2018).

The service user group provided 76 written comments on the 'easy read' materials. This included both positive comments, relating to where the group believed the materials were accessible for adults with mild intellectual disabilities, and suggestions for improvement. Suggestions included changes to the formatting of the materials and to the choice of certain words and symbols. Feedback was clarified with the service user group at the virtual meeting and the lead researcher and SALT agreed that all suggestions adhered to the guidance being followed and would therefore be incorporated.

3.2 | Stage two: Gaining the views of professional experts

Psychologists provided 341 written comments relating to IDNET and the 'easy read' materials. A large proportion of the comments were repeated across the feedback from the psychologists. Comments were condensed into the following categories.

'Easy read' materials:

- Positive comments relating to accessibility
- Suggestions for alternative formatting
- Suggestions for alternative wording
- Suggestions for additional information

The adapted protocol:

- Positive comments relating to the protocol
- Suggestions for preparing clients for NET
- Suggestions for how carers are involved
- Suggestions for how the safety and wellbeing of clients are considered
- Suggestions for supporting the content of sessions
- Suggestions for adapting the structure of NET

Of the 341 comments, 318 were implemented immediately as they met the conditions outlined in the methodology section. No concerns were raised by psychologists subsequently with regard to the suitability of these amendments. The remaining 23 comments were taken to the focus group to seek a majority consensus on whether they should be actioned or not (this consisted of seven psychologists as one female participant was unable to attend). For example, there was disagreement within the written feedback about the use of photos versus symbols to depict emotions and the use of different

TABLE 2 Key concepts developed from initial codes and themes.

Initial codes	Final themes	Core concepts
• The feasibility and potential usefulness of NET • NET working well in practice • The accessibility of NET compared to other trauma therapies • NET matching expectations about trauma therapy	Optimism about the suitability of NET for people with mild intellectual disabilities	Optimism and motivation to adapt NET for people with mild intellectual disabilities
• Recognising and understanding trauma in people with intellectual disabilities • The lack of treatment options for trauma in people with intellectual disabilities • The benefits of adapting evidence-based treatment	Motivation to adapt NET for people with mild intellectual disabilities	
• The complexities of working with people with intellectual disabilities • The potential challenges of trauma therapy generally • The potential challenges of delivering NET • The resistance from others to adapt therapies for people with intellectual disabilities	Challenges to overcome	Factors related to IDNET in practice
• Understanding and support required from the system around the client • The potential challenges related to the system around the client	The system around the client during therapy	
• Practical considerations when delivering IDNET • Decisions about who should deliver therapy • The similarities of NET to other therapies • Thinking about adaptations to NET and the need to learn more • Adapting approaches for people with intellectual disabilities generally	The practicalities of delivering and adapting NET	

Abbreviations: IDNET, adapted version of narrative exposure therapy; NET, narrative exposure therapy.

terminologies, such as 'trauma' as opposed to 'bad or difficult thing'. Following these majority decisions, the 'easy read' materials and adapted protocol were refined.

Table 2 shows the development of the two key concepts identified as a result of the FA applied to the focus group discussion.

Although the first key concept supports the rationale for the research, the focus will be on the second key concept due to its relevance to the study aim. The second key concept 'Factors related to IDNET in practice' comprised three themes, which are illustrated below with accompanying quotes.

3.2.1 | Challenges to overcome

Psychologists highlighted the diversity of clients with intellectual disabilities, who require treatment that is flexible and adapted to their needs. The specific challenges of delivering trauma-focused therapy within intellectual disability services were also discussed, such as the need for some level of stability for the client and being unable to fully adhere to manualised approaches. Furthermore, psychologists identified resistance from those trained in certain models to adapting therapies and experiences where access to training had been restricted/difficult due to being unable to fully adhere to the approach or because there was no evidence using that model within the population. However, one clinician did report an instance of perceiving a trainer as more open to adaptations.

> *The client group being so diverse and all of the adaptations and the flexibility that you have to do* (Sam)

> *When we're delivering trauma work it seems we're also trying to sort out their general lives as well and how that fits with a manualised therapy, I think it would very quickly, there'd be issues with the fidelity of the treatment* (Hugo)

> *We've had exactly the same battles, huge battles with EMDR people about, they call it model drift and sticking to the protocol* (Lisa)

3.2.2 | The system around the client during therapy

Psychologists highlighted the need for the system to have an understanding of NET, including how it might impact the client during therapy so that the client is supported accordingly. Discussions also highlighted potential challenges, such as the impact of carers' emotional responses on the client and the risk that others in

the system may attempt to continue NET sessions themselves without appropriate training.

> *There's the issue about support between sessions… it's important the people around the person are aware of perhaps the approach and some of the impacts it may have on the person as they're going through* (Marcus)

> *If someone you know feels worse before they get better, family members or carers can really panic, which you know can really unsettle the service user* (Mary)

3.2.3 | The practicalities of delivering and adapting NET

This included practical considerations, such as the time and cost implications of NET, as well as which professionals are able to deliver NET. Psychologists also reflected on aspects of NET that may be similar to other therapies, which already work in practice within this population. The need for NET to be adapted and trialled in practice was highlighted, to review and identify further adaptations and psychologists discussed the process of adapting approaches for people with intellectual disabilities more generally. It was highlighted that in practice this responsibility often falls to individual clinicians.

> *There are these things that are the kind of contextual factors that hold these therapies* (Hugo)

> *I suppose in a way we won't know until we try it a bit more and then we come back together and you review it and you adapt and you change it again* (Lisa)

> *To pick things up and implement them and adapt them and change them around it does require a broad range of understanding and experience and knowledge* (Mo)

Within the expert panel of NET clinicians, one participant reported instances of using NET in practice with adults with intellectual disabilities and all participants believed the delivery of NET may not differ drastically from other populations. With regard to feedback that led to amendments, the expert panel suggested if carers were present, as suggested in IDNET, therapy might continue outside of sessions and, therefore, the protocol was amended to emphasise that this should not occur. NET clinicians stated that clients do not need to be able to manage their own arousal, again as suggested in IDNET, as this is managed by the therapist. However, within intellectual disability services, if clients are unable to manage their own arousal, this could have potentially devastating consequences, such as a breakdown in their accommodation placement. Therefore, the protocol was amended to state that if the client is unable to manage their own arousal, the team around the client should understand that increases in distress are possible and have appropriate ways of managing this. In relation to feedback that was disregarded due to already existing or being deemed inappropriate, the expert panel advised against carers supporting in lifeline and narration sessions. However, NICE (2016) recommends that carers should be involved in the treatment of mental health difficulties within intellectual disability services, hence it was deemed inappropriate to exclude carers at this stage. Furthermore, IDNET outlines factors to consider when determining appropriate carers. Finally, with regard to feedback that was identified as a future research question when IDNET is trialled in practice, the impact of the presence of carers in all sessions of IDNET, and whether the client is required to have some ability to manage their own arousal before starting therapy, were identified as areas to be explored further. See the Supporting Information Appendix for further details on feedback from NET clinicians, how it was actioned by the research team and future research questions to be explored when IDNET is trialled in practice (highlighted in italics).

4 | DISCUSSION

As a first attempt to systematically adapt NET for adults with mild intellectual disabilities, in collaboration with a number of different expert groups and drawing on a range of published guidance, this study demonstrates an original contribution to the literature relating to trauma-focused therapies for this population. The study also adheres to recommendations regarding the involvement of people with intellectual disabilities in both the development of 'easy read' materials (Department for Work and Pensions, 2018; Department of Health, 2010) and research (Walmsley & Johnson, 2003). Studies such as this offer further avenues for clinicians working within intellectual disability services to explore when considering suitable treatments for PTSD, and a more rigorous process was followed when developing IDNET than the clinical judgement often used in practice when adapting evidence-based treatments for this population (Truesdale et al., 2019). However, the study is limited by the failure to recruit more than three participants to the expert panel, which may mean the views expressed here are only representative of a very small number of NET clinicians. Additionally, dominant voices existed among all stakeholder groups within the research, which may have silenced participants' who held opposing views (Kitzinger, 1995). Similarly, the order in which groups gave feedback on IDNET may have meant that the views of earlier groups were unintentionally overridden during subsequent stages.

The focus group highlighted a number of issues that warrant further consideration, such as the impact of the system around the client during therapy and the practicalities of adapting and delivering NET, which have important clinical implications. The challenges faced by clinicians when trying to adapt and deliver trauma-focused therapies were also highlighted, mirroring topics raised previously by professionals (Truesdale et al., 2019). Among these was resistance

to adapting evidence-based approaches, perhaps in an attempt by others to avoid what has been termed 'therapist drift' (Waller & Turner, 2016). However, there may be some confusion between 'therapist drift', where clinicians deviate from evidence-based practice when treatments are viable, and the need to adapt treatments to make them accessible for all. Challenges such as this highlight why people with intellectual disabilities are among those most disadvantaged in our society (Equality and Human Rights Commission, 2016), not only due to impairments in functioning but also as a result of the multiple barriers they face in their environment. Although, the concept of 'therapist drift' does point to further research implications regarding how adherence to IDNET can be measured in practice.

The expert panel also raised a number of contradictions to IDNET, which require further consideration, and which may lead to changes in the theory underpinning NET. For example, clinical psychologists thought that clients with intellectual disabilities should have some ability to manage their own arousal before completing IDNET; however, NET clinicians advised that this contradicts NET practice where emotion regulation is the sole responsibility of the clinician. Although the current evidence base may support certain ways of delivering NET, it is inevitable that when NET is trialled among people with mild intellectual disabilities, new ways of working are likely to emerge, as has been observed in KidNET, FORNET, NET-R and TA-NET. In relation to this, though a strength of the research design is the gaining of contributions from three major stakeholders in this area, it raised questions about which views are given preference when developing IDNET. NET is a manualised and structured approach to treating trauma, which was designed to be delivered individually (Schauer et al., 2011), whereas key adaptations to psychotherapy when working with people with intellectual disabilities are the need to use flexible methods and involve carers (Hurley et al., 1998). Therefore, this raises the question of what happens when these two different approaches to therapy come together. Although this has been explored initially in the current research, this question will not be answered fully until the adapted protocol is trialled in practice. Furthermore, decisions regarding the involvement of carers in IDNET should consider the views of those with intellectual disabilities, which were not explored in the current research.

The feasibility and effectiveness of IDNET will also need to be explored in practice, including the 'easy read' materials; current research may not support the effectiveness of 'easy read' in increasing the understanding of those with intellectual disabilities (Chinn & Homeyard, 2017; Hurtado et al., 2014). However, the focus group showed optimism for IDNET and both groups of professionals reported instances of the use of NET with people with intellectual disabilities already. The current research, therefore, indicates a number of implications for future research and calls for a piloting and feasibility stage, initially among those with mild intellectual disability for whom IDNET has been developed for. This may serve to

identify potential refinements to the intervention, address uncertainties around the feasibility of intervention trial methods, or test preliminary effects of the intervention (Pearson et al., 2020, p. 2)

The size of the piloting and feasibility study would depend on the research design chosen, for example, a single case study series of at least three participants would allow for cross-case comparisons. This would mark the next step in what should be the long-term aim of conducting a randomised controlled trial (RCT) into the use of IDNET. Although RCTs can be challenging within this population, they are possible with adaptations and are a moral necessity (Mulhall et al., 2018) to increase the evidence base with regard to trauma-focused therapies for adults with intellectual disabilities.

Finally, during the course of the current research, Mayer (2020) conducted an intervention study with adults with intellectual disabilities comparing a control group with a group receiving NET. This provided initial evidence of the positive impact of NET within this population and echoed recommendations arrived at during the current research, such as the need to shorten sessions and use more visual tools during therapy. The current research adds to this by systemically adapting the NET protocol and developing therapy materials with a number of stakeholders, including service users, who were not consulted by Mayer (2020). The two studies, therefore, offer hope that NET may benefit clients with mild intellectual disabilities, and initial guidance for clinicians on how delivering NET may differ within this population.

5 | CONCLUSIONS

The current research demonstrates the process of systematically adapting a NICE (2018) recommended trauma-focused therapy (NET) for adults with mild intellectual disabilities, in collaboration with several expert groups. Research like this creates a starting point when developing the evidence base for PTSD treatment in adults with intellectual disabilities. Future research should aim to explore the delivery of IDNET in practice to not only understand more about whether NET is feasible and effective in reducing symptoms of PTSD among adults with mild intellectual disabilities but also to answer further questions raised in relation to how IDNET is delivered.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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