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# Naturalistic Evaluation of the Effectiveness of Psychodynamic Psychotherapy with Adults with Intellectual Disabilities

Nigel Beail<sup>\*†</sup>, Sharon Warden<sup>‡</sup>, Kim Morsley<sup>‡</sup> and David Newman<sup>\*</sup>

<sup>\*</sup>Barnsley Learning Disability Service, The Keresforth Centre, Barnsley, UK; <sup>†</sup>The University of Sheffield, Sheffield UK;

<sup>‡</sup>Psychological Health Sheffield, Sheffield, UK

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*Background* Despite repeated calls for research on the efficacy and effectiveness of psychotherapy with people with intellectual disabilities there has been little progress in this area. This paper reports a naturalistic study of the effectiveness of individual psychodynamic psychotherapy provided in routine clinical practice.

*Method* The study was an open trial design with a 3-month follow-up period. Widely available and used psychotherapy outcome measures were adopted, but administered in an assisted completion format at intake, outcome and follow-up. Data were analyzed using repeated measures ANOVA. Effect sizes were also computed.

*Results* The results show statistically significant reductions in recipients' levels of psychological distress and

interpersonal problems and an increase in self-esteem. Effect sizes were modest to large.

*Conclusions* The study shows that adults with intellectual disabilities can benefit from individual psychotherapy provided in routine clinical practice. The method has obvious limitations because of its uncontrolled, open trial design. However, the study had a recipient group that represents the client population and thus has greater generalisability to clinical practice. This study also provides some suggestions for routine audit and evaluation exercises and more rigorous designs.

*Keywords:* effectiveness, intellectual disabilities, outcome, psychodynamic, psychotherapy

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Despite the growth of interest in and provision of psychodynamic psychotherapy for people with intellectual disabilities, there has been little progress regarding the evaluation of its efficacy and effectiveness. Gunzberg's (1974) review found only case studies. These concerned individuals who appeared to be handicapped by emotional difficulties or were of low average ability rather than having a diagnosis of intellectual disability (mental retardation) (Sinason 1992). Reviews published two decades later, similarly only reported that there were a few case studies (Nezu & Nezu 1994; Hurley *et al.* 1996). Almost a decade later Prout & Nowak-Drabik (2003) have conducted a systematic review of psychotherapy effectiveness with people with intellectual disabilities. They found across all treatment modalities that almost one-third of the published reports were case studies with observable behavior being the most frequently employed outcome measure. They also reported that group interventions were the most

frequently evaluated and few studies could be viewed as rigorous from a methodological perspective. Almost half of the studies in the review concerned behavioral or cognitive behavioral interventions, and over a third could not be classified in terms of theoretical orientation. Reports of psychodynamic psychotherapy were few and largely consisted of case reports. However, there were two research reports of preliminary outcome studies (Frankish 1989; Beail 1998). Both studies involved a solitary clinician engaged in normal clinical practice. Both studies reported significant reductions in problem behaviour at outcome.

Prout & Nowak-Drabik (2003) carried out an expert consensus evaluation of the effectiveness of all psychotherapies with people with intellectual disabilities. They concluded that psychotherapy brings about a modest amount of change and is moderately effective and beneficial across theoretical approaches. In a later review, Beail (2003) reported on two further studies of

psychodynamic psychotherapy. One examined recidivism rates following psychodynamic psychotherapy amongst male offenders with intellectual disabilities. These were better for those who accepted a course of treatment. The other was a preliminary report on the study to be reported here.

The use of psychodynamic psychotherapy with people with intellectual disabilities calls for formal evaluation of its efficacy (the results the treatment achieves in the setting of a research trial) and its clinical effectiveness (the outcome of the treatment in routine clinical practice). This latter approach is now referred to as practice-based evidence. Progress to date seems to reflect what has been described in the hourglass model (Salkovskis 1995). In this process what usually happens first is the reporting of case studies concerning theory and practice. This is followed by exploratory studies such as single case designs or studies of a series of recipients in which technical standards of design and implementation are relatively relaxed. This kind of exploratory analysis then allows a narrowed focus on key effects. Here there is a requirement for research that conforms to the most rigorous standards of enquiry – equivalent to the pinch in the hourglass. This involves a fuller range of control groups, more stringent measures and statistical techniques and careful specification of recipients to ensure replicability. Paradoxically the designs of these studies can limit the clinical applicability of the research as internal validity takes priority. However, issues concerning generalisability can be answered in a subsequent phase of practice-based research. The reviews of outcome research with people with intellectual disabilities shows that psychodynamic psychotherapy is in the 'very early' stages of the hourglass model. Further practice-based exploratory studies are needed to evaluate effectiveness and facilitate decisions that need to be made in the development of more rigorous research. However, there may be philosophical problems, which may impede progress for psychodynamic psychotherapy research.

Enquiry in the psychodynamic field has been dominated by theoretical discussion and illustrative case reports. This tradition can be clearly identified in the emerging literature on psychodynamic psychotherapy with people with intellectual disabilities (Beail 1995, 2004). Psychodynamic psychotherapists have also argued that the effects of treatment are not measurable or that the process of measurement would damage the therapeutic relationship and the treatment's effect. For example, Denman (1995) states there is a widespread criticism that the investigations that research requires (completing questionnaires, tapes of sessions, reports

from patients during therapy) contaminate therapy and may adversely alter its course. On the other hand, Denman points out that if claims as to cure or outcome are desired then this cannot be insulated from calls for validation or refutation. Despite objections, short-term psychodynamic psychotherapies have been the subject of extensive evaluation in the field of adult mental health (Bergin & Garfield 1994; Roth & Fonagy 1996).

In this paper, we report a naturalistic exploratory practice-based study of the effectiveness of individual psychodynamic psychotherapy provided for people with intellectual disabilities. This is an open trial or case series employing commonly used psychotherapy outcome measures as opposed to measures of behaviour. On the basis of the limited work in this area to date it was hypothesized that psychodynamic psychotherapy would produce significant reductions in recipients' psychological distress and improve their interpersonal functioning and self esteem.

## **Method**

### **Participants**

The study was carried out in normal clinical practice without additional resources. Thus, aims with regard to sample size had to be modest and our aim was for 20 completed treatments. To be involved in the study, in addition to consenting to treatment, participants also consented to participating in the research. A total of 35 people were approached to take part in the study. Five of these could not consent to being a research participant. The remainder did consent but 10 dropped out of treatment. Therefore, data were collected on the completed treatment and follow-up for 20 people. There were 17 men and three women with a mean age of 29.3 years (range: 17–48 years). Of which 13 lived with their parents, five lived in supported housing, one in a community hospital and one in their own home with support. The reasons given by referring agents for referral to the service were aggressive behaviour for nine participants, sexually inappropriate behaviour for three, psychotic/bizarre behavior for three and relationship difficulties, self injury, depression, bulimia and obsessive compulsive disorder for one each.

### **Procedure**

People referred to the service were invited to an assessment interview with a therapist. The therapists assessed their problem, circumstances and treatment needs. They

also obtained their consent to the intervention. The treatment was described in simple terms. For example, 'This treatment involves coming to see me each week to talk about any difficulties you are having in private. Together we will try and understand your difficulties and overcome them.' The therapist informed the client about the positives and negatives of the treatment. This includes telling them that the treatment may help reduce their symptoms and improve their quality of life with reference to their difficulties and possible outcomes. The negative aspects of therapy include it being a difficult process involving talking about painful or upsetting things. The therapist checks that the client has retained and understood this and weighed the positive and negatives and made a choice. After consent to treatment is obtained the therapist invited the client to take part in the research. It was explained that this would involve completing some questionnaires with another psychologist before, during and at the end of treatment. That they had a right to say no and that refusal to take part would not effect their treatment in any way.

Those who consented to treatment were introduced to the graduate psychologist who then conducted the pre-treatment assessment. Treatment then commenced the following week. As this was an exploratory study, no time limit was set for the length of treatment, but all recipients received once weekly sessions lasting for 50 min. The number of session ranged from five to 48 with a mean of 13.2. with nine participants receiving up to eight sessions, four up to 16 sessions, two up to 24, three up to 32 and two 48 sessions.

A graduate psychologist independently administered all the measures following the assisted completion procedure described in Kellett *et al.* (1999). Assessments were made at intake, outcome and at 3-month follow-up. Therapists were kept blind to the outcomes of the assessments until after follow-up.

#### Intake and outcome measures

This study was concerned with outcome in normal clinical practice and therefore measures were needed that encompassed a range of symptoms rather than a single trait. Psychotherapy studies have also been criticized for being primarily symptom orientated and thus insensitive to changes in interpersonal functioning and the self. This study therefore explored the use of measures evaluating symptom, interpersonal and self-change, used in general psychotherapy outcome research that could be administered in an assisted completion format. These were the Symptom Checklist 90-Revised (SCL-90-R;

Derogatis 1983), the Inventory of Interpersonal Problems-32 (IIP-32; Barkham *et al.* 1996) and the Rosenberg Self Esteem Scale (Rosenberg 1965).

#### The SCL-90-R

The SCL-90-R provides scores in nine symptom areas as well as general indexes of distress. The SCL-90-R can be administered in an assisted completion format and this has been found to have good reliability and discriminative validity with people with intellectual disabilities (Kellett *et al.* 1999).

#### The IIP-32

The original IIP (Horowitz *et al.* 1988) has 127 items, some of which involve language and concepts too difficult for people with intellectual disabilities. The shorter version (Barkham *et al.* 1996) has only 32 items and was administered in an assisted completion format. However, this was exploratory, as no reliability data are available on this measure when used with people with intellectual disabilities. Also, only 14 of the 20 participants could complete this measure.

#### Rosenberg Self-Esteem Scale

The Rosenberg Self-Esteem Scale is brief, widely used and only requires minor modifications to wording to be used with people with intellectual disabilities. However, there are no reliability data on its use with people with intellectual disabilities.

#### The service

Psychodynamic psychotherapy is provided by the authors as part of a comprehensive range of psychological services to adults with intellectual disabilities living in an area with a population of 227 000. Clients are referred by a wide range of professionals and carers and by themselves. The service is provided on an outpatient basis in the same setting as services for non-disabled people. The therapists were clinical psychologists who work with people with intellectual disabilities with a special interest and had further training in psychodynamic psychotherapy.

#### The treatment

In psychodynamic psychotherapy the therapist is concerned with the patient's mental representation of

themselves within the world and seeks to identify the origin, meaning and resolution of difficult feelings and inappropriate behaviours. The work entails making links between early life experiences and how these experiences influence unconscious and conscious expectations of relationships in the present day.

Psychodynamic sessions begin with the therapist providing the client with space to free associate. This involves inviting the client to say whatever is in their mind and whatever comes to mind. The psychotherapist will be interested in anything that the client says, including information on their current problem, circumstances, current and past relationships, dreams, fantasies and so on. The therapist resists giving the client information about themselves. The therapist presents him or her self as a type of screen on to which the client can project their imagined perceptions of the therapist.

The therapist uses a number of methods to enable the client to tell their story and then formulates interpretations aimed at accessing and making sense of unconscious content. Thus, the therapist may give *information giving responses* about their treatment, reason for referral, and about matters such as time left in the session and so on. However, advice and instruction are not usually within the remit of the psychodynamic model. The therapist will be carefully *listening to and observing* the client's verbal communications. The therapist attends to what the person says in terms of the factual content, the words used and also what is not said. The therapist also observes the client's mood, as communicated through what they say, the way they say it and how they behave. The client may talk about a range of things and the therapist does not interrupt. Whilst listening to the client the therapist monitors their own feelings, fantasies and reactions in response to the client's material. These are accepted as meaningful elements in the communication between client and therapist. This is referred to as the *counter-transference*.

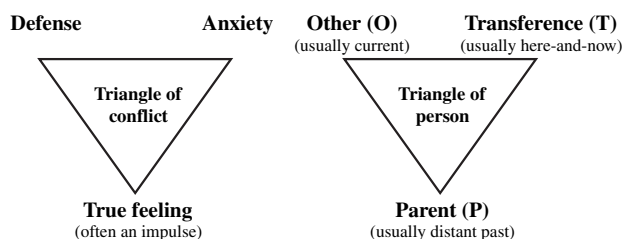
At various times when the client is telling their story the therapist may *reflect back*, paraphrase or *précis* what the client has been telling them or acting out. Also, *exploratory and information seeking responses* attempt to draw out more information from the client. These are generated from hypotheses about what the client may not be saying in words but may be hinting at through behaviour or tone of voice. Information seeking responses are aimed at clarification, which helps sort out what is happening by questioning and rephrasing. Psychodynamic psychotherapists also make *linking responses*. Here, words and/or actions are linked

together as a tentative interpretation to try and understand the nature of the client's anxiety in the session. These responses differ from the others in that they aim to elucidate unconscious feelings and ideas.

Psychodynamic therapists seek to understand with the client the latent or unconscious meaning of the client's communications. In order to do this they recontextualize the manifest content of the communications as *transference* (Smith 1987). Freud (1912) described transference as occurring when psychological experiences are revived and instead of being located in the past are applied to dealings with a person in the present. In psychodynamic psychotherapy the establishment, modalities, interpretation and resolution of the transference are in fact what define the cure (Laplanche & Pontalis 1988). Transference within therapy allows the therapist to identify interpersonal issues and deal with them as empirical data in the here-and-now. This process allows early traumatic experiences and empathic failures on the part of parents and other caregivers to be relived and corrected.

Psychodynamic psychotherapy also seeks to understand unconscious communications through models of the internal world. Most significantly, we all have an ego, which is the location of the anxiety caused by unconscious material. It is the ego that employs a range of defences to ward off anxiety. There is also a range of psychodynamic theories of development, which the therapist may also employ to understand the origins or development of difficulties and conflicts, as well as coping styles. Clarkson (1993) highlights the reparative/developmentally needed relationship and defines this as the intentional provision by the therapist of a corrective/reparative or replenishing parental relationship (or action) where the original parenting was deficient, abusive or over-protective. Such a relationship modality is a further facet of the therapist's intervention and style.

Malan (1979), depicts the aim of psychotherapy in the form of the 'Two Triangles' (see Fig. 1). The two



**Figure 1** Malan's triangles of conflict and the person.

triangles describe the process of psychodynamic psychotherapy. Each triangle stands on its apex. The aim of the therapeutic endeavour is to reach beneath the defence and anxiety to the true feeling. At this point, the true feeling can be traced back from the present transference location – the therapy room – to its origin in the past – usually to the relationship with parents or significant carers. Malan (1979) states that ‘The importance of these two triangles is that between them they can be used to represent almost every intervention that a therapist makes; and that much of the therapist’s skill consists of knowing which parts of which triangle to include in his interpretation at any given moment’ (p. 91). For an illustration of this process see Beail & Newman (2004).

## Results

Table 1 shows repeated measures ANOVA and effect sizes (Cohen’s *d*) (Cohen 1988) comparing intake, outcome and follow-up scores on the highest symptom score and general severity index of the SCL-90-R and the total score on the IIP-32 and Rosenberg Self-esteem Scale.

Some normative data for people with intellectual disabilities on the SCL-90-R has been reported (Kellett *et al.* 1999). The results of this study show that participants mean GSI score are approaching the scores found in community samples of people with intellectual disabilities. This gives an indication of the clinical as well as the statistical significance of the results.

*Post hoc t*-tests found that change in scores on the IIP only reached statistical significance from intake to follow-up.

For Cohen (1988), a *d* of 0.2 is a small effect size, 0.5 a medium effect size and 0.8 or over, a large effect size. Table 1 shows all effect sizes to be modest to large.

Correlational analyses were conducted to see if participant age or length of treatment accounted for any variations in outcomes. Spearman’s Rho correlations between improvement scores for the four outcome variables and age and treatment length were all non-significant except for age with the IIP (Rho =  $-0.65$ ,  $P < 0.05$ ).

## Discussion

The results presented here suggest that psychodynamic psychotherapy, provided in routine clinical practice, can produce significant reductions in psychological distress, improve interpersonal functioning and increase self esteem in adults with intellectual disabilities. However, this was a naturalistic study and, therefore, beset with associated limitations. However, researchers cannot justify conducting controlled studies without a period of developmental work in line with the hourglass model. This study indicates that people with intellectual disabilities may benefit from psychodynamic psychotherapy and, therefore, the treatment warrants the level of investment that further investigation would entail. This study can inform future research in the area of design and methodology.

The study provides some indications on significant decisions that researchers need to make. Readily available psychotherapy outcome measures were used. This was achieved by employing the assisted completion format as suggested in the SCL-90-R manual and developed by Kellett *et al.* (1999) to be suitable for people with intellectual disabilities. The results show that change could be detected on these measures, but further work on their reliability and validity is needed. Some clients could not complete the IIP sufficiently for inclusion and so the language on this scale needs to be reviewed to increase inclusion.

**Table 1** Results: Means, standard deviations, repeated measure ANOVA and effect sizes comparing intake, outcome and follow-up

	Intake	Outcome	3-Month follow-up	F	Effect sizes	
					Intake–Outcome	Intake–Follow-up
Mean highest symptom score on SCL-90-R	1.76 (0.87)	1.15 (0.88)	1.10 (0.79)	(2/38) = 6.6; $P < 0.01$	0.71	0.76
General Severity Index on SCL-90-R	0.95 (0.64)	0.59 (0.64)	0.44 (0.41)	(2/38) = 8.64; $P < 0.001$	0.55	0.78
IIP-32	1.23 (0.60)	0.97 (0.89)	0.61 (0.53)	(2/28) = 6.55; $P < 0.005$	0.46	1.02
Rosenberg	2.95 (1.19)	4.00 (1.37)	4.00 (1.12)	(2/38) = 7.77; $P < 0.002$	0.88	0.88

SCR-90-R, Symptom Checklist 90-Revised; IIP-32, Inventory of Interpersonal Problems-32; Rosenberg, Rosenberg Self Esteem Scale.

A major design question is how long should treatment be in an efficacy or effectiveness study. This has been difficult to determine because of lack of exploratory studies or series of case reports. This study did not set a limit on treatment length. The results show that the average number of sessions provided was 13.2 with 65% of recipients completing treatment in 16 sessions. This is similar to the findings of Beail (1998) in which nearly half of the recipients completed psychodynamic treatment in 6 months or less. However, length of treatment was not related to outcome for three of the four outcome scores. Thus, a more controlled study could explore the outcome of shorter psychodynamic interventions. However, this and previous studies (Beail 1995, 1998, 2001) suggest that there are also clients that may need long-term treatment. This is no different to the findings of psychotherapy researchers generally (Roth & Fonagy 1996).

The researcher needs to set entry criteria to improve internal validity of treatment trials. This study had fairly wide entry criteria and therapists were kept blind regarding the assessment results. Thus, the recipients were a heterogeneous group. However, nine of the participants were referred for aggression. Thus, if a homogeneous sample were to be recruited then the chances of recruiting sufficient numbers would be increased by selecting people referred for aggression. This would also seem to be reflected in the few published research studies on cognitive-behavioural psychotherapy with people with intellectual disabilities (Whittaker 2001; Beail 2003).

In planning research on outcomes, some estimate needs to be made of the rates of attrition. In this study 10 people who agreed to participate dropped out of treatment and therefore the study. This figure compares favourably with studies in non-disabled populations where several times the desired sample size is often recruited (Bergin & Garfield 1994). A further difficulty when conducting any form of research with people with intellectual disabilities is capacity to consent. Five potential participants were unable to give consent in this study. They were provided with treatment, which had the impact of increasing the length of the study. This was a fairly simple study in terms of design features. Researchers need to make plans to accommodate this within their designs and anticipate further difficulties with more complex designs involving randomization.

This study originally included session by session process measures, which were also completed in an interview format. The therapists were also kept blind to this procedure. Unfortunately, funding available for graduate psychologists fluctuated throughout the project and so data collection at this level could not be sustained

and insufficient data were collected. However, a project evaluating the process of assimilation of problematic experience in psychotherapy with people with intellectual disabilities has been reported (Newman & Beail 2002). The report illustrates the degree of investment needed to include a process element to such studies.

In summary, this study shows that people with intellectual disabilities can benefit from psychodynamic psychotherapy, provided in routine clinical practice. The study has obvious limitations because of its uncontrolled, open trial design. However, the study had a participant group that represents the client population and thus has greater generalisability to clinical practice. The methods can also be realistically adopted in more routine audit and evaluation exercises (Newman *et al.* 2003). This study also provides some suggestions regarding length of treatment and participant characteristics, which may inform how more rigorous designs could be conducted.

## Correspondence

Any correspondence should be directed to Prof. Nigel Beail, Barnsley Learning Disability Service, The Keresforth Centre, Off Broadway, Barnsley S70 6RS, UK. (e-mail: nigel.beail@barnsleypct.nhs.uk)

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