Perspectives

Responses to Sturmey (2005) on Psychotherapy

Evidence Base for Behavioral Interventions: Critical Commentary

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In his commentary “against therapy,” Sturmey (2005) concluded that “given the hundreds of studies documenting the effectiveness and efficiency of behavioral interventions, behavioral approaches must remain the preferred treatment option for people with mental retardation” (p. 56). The evidence on which he makes this conclusion are the nine controlled studies in Prout and Nowak-Drabik’s (2003) meta-analysis, Carr et al.’s (1999) narrative review, two meta-analytic reviews of single-case experimental design studies (Didden, Duker, & Korzilius, 1997; Scotti, Evans, Meyer, & Walker, 1991), clinical practice guidelines (New York Department of Health, 1999a, 1999b, 1999c), and a meta-analysis of choice-making interventions (Shoegren, Faggalla-Luby, Bae, & Wehmeyer, 2004). Sturmey pointed out that these authors documented a very large number of empirical studies of behavior interventions, including those for mental health problems, and an absence of well-conducted empirical studies for nonbehavioral interventions. However, Sturmey did not provide any critical analysis or commentary on the evidence base for behavioral interventions. In this commentary I draw attention to a number of significant aspects of this evidence base that practitioners need to be aware of when formulating behavioral interventions.

Sturmey (2005) is right in his assertion that there is a lack of evidence for nonbehavioral interventions. This was the conclusion of two recent reviewers of cognitive–behavioral and psychodynamic interventions (Beail, 2003; Willner, 2005). However, the research reviewed in Beail (2003) and Willner (2005) reflected a process of development from descriptive case reports to empirically evaluated case series and, more recently, attempts at controlled designs, a progression known as the hourglass model (Roth & Fonagy, 1996). This differs markedly to the evidence base for behavioral interventions, which largely consists of hundreds of reports of single-case experimental designs in which the participants act as their own control. Carr, Innis, Blakeley-Smith, and Vasdev (2004) described the ethical, practical, and conceptual reasons why group designs are so uncommon. However, because participants in behavioral intervention research are “not randomly assigned to treatments, the validity of our conclusions may be jeopardized” (Didden et al., 1997, p. 397).

Didden et al.’s (1997) meta-analysis is an extension of Scotti et al.’s (1991). Thus, they cover the same and additional studies. Didden et al. expanded the number of journals included and extended the time period. This present commentary is focused on these analyses due to their extensive coverage and the existence of an audit trail provided by the detailed tables in their reports.

For Whom Are Behavioral Interventions Effective?

Examinations of characteristics of the participants in the studies reviewed suggest some significant limits on the generalizability and transferability of the evidence base.

Age. The majority of the participants in the hundreds of studies were children. Scotti et al. (1991) reported that 76% of the participants were children. Didden et al. (1997) did not report age ranges but did note that the average age of participants was 16 years. Further, the New York Department of Health (1999a, 1999b, 1999c) publications, quoted by Sturmey (2005), only cover children up to 3 years of age. Thus, adults with mental retardation are underrepresented.
Level of functioning. The majority of the participants had severe or profound mental retardation (Didden, 1997: 74.8%; Scotti et al., 1991: 74%), with only 10.5% having mild mental retardation (Didden et al., 1997).

Presenting problem. Didden et al. (1997) found 34 presenting problems, but over half of the participants presented with self-injurious behavior or stereotypy. When grouped for the meta-analysis with other internally maladaptive behaviors, the percentage of such behaviors rose to 69.6. This is perhaps not surprising because the majority of the participants also had severe or profound levels of mental retardation; for this population internally maladaptive behaviors are a major reason for clinical intervention. Also, in most cases the behavior being measured occurred at a high frequency.

Of Didden et al.’s (1997) 34 topographies, only 3 could be classified as a mental health as opposed to a behavior problem. Taken together, these 3 topographies accounted for 1.25% of the data in the analysis. Neither Scotti et al. (1991) nor Didden et al. included mental health presentations as a variable in their analyses.

Didden et al. (1997) and Scotti et al. (1991) did include externally destructive behaviors as a category in their analyses. In the psychotherapy literature reviewed by Beail (2003), anger featured as a major outcome variable. In the cognitive-behavioral approach, anger is treated as a mediating variable for aggression. Thus, the goal of therapy is a reduction in self-reported feelings of anger. Anger was not one of Didden et al.’s (1997) topographies, but aggression was represented (9.3%). However, Scotti et al. and Didden et al. concluded that such behaviors tend to be less successfully treated than are internally maladaptive behaviors.

Range of Interventions

In their more extensive review, Didden et al. (1997) found 64 primary treatment procedures. They grouped these into four categories, one of which was pharmacology. However, this was the smallest category, accounting for only 6.78% of the interventions. Thus, the results of the meta-analysis are based on three broad groupings of behavioral interventions. More detailed analyses of treatment procedures were not possible due to missing data for many cells. Another feature of the data on which the meta-analysis was conducted was the number of aversive interventions. Scotti et al. (1991) noted an increase use in these methods over time, but Didden et al. did not comment on this. Aversive techniques accounted for 25% of the behavioral interventions. In addition, further interventions were listed that are based on physical restraint or punishment. Such interventions have been subjected to increasing criticism and have become associated with inhumane treatment and as being out of step with current service values and philosophies. A meta-analysis carried out today would most likely show a significant decline in published reports of aversive- and punishment-based interventions.

Intervention Location and Standards of Practice

Scotti et al. (1991) reported that 95% of the interventions were implemented and evaluated in nonintegrated settings. Similarly, Carr et al. (1999) and Didden et al. (1997) noted the lack of community-based interventions. Scotti et al. concluded that “Overall, the standards of practice revealed by the published literature can only be described as highly disillusioning” (p. 254). Didden et al. confirmed Scotti and colleagues’ finding of a positive relation between functional analysis and treatment outcome. However, Carr et al., Didden et al., and Scotti et al. all identified a lack of functional analyses being carried out (almost 80%). Scotti et al. found all levels of treatment intrusiveness being applied to all levels of behavior severity. Only 22% of the researchers showed any evidence of trying to employ a hierarchy of least intrusive alternative treatments. Also, they noted that women were more likely to be subjected to aversive interventions. They were also concerned about the lack of procedural documentation, especially where intrusive interventions were concerned.

Methodological Weaknesses

Didden et al. (1997) and Scotti et al. (1991) also commented on methodological weaknesses in the studies they reviewed. Scotti et al. noted that only 30% of the investigators reported any attempt at generalization, and Carr et al. commented that reports concerning generalization were largely anecdotal. Scotti et al. also criticized the researchers for their lack of follow-up data. Over half did not report any, and of those that did, it was for 6 months or less. Didden et al. critiqued the meta-analytic measure, percentage of nonoverlapping data, that were used. They pointed out that by em-
ploying this measure, investigators failed to consider magnitude of change. Thus, similar percentages of nonoverlapping data scores represent different magnitudes of change. Also, because authors of many single-case reports did not include phase mean and standard deviations or raw data, the issue of magnitude of change could not be included in their analysis.

Conclusions

In this commentary I have tried to draw attention to some of the limitations of the evidence base for behavioral interventions. The evidence base has a number of features that clinicians need to consider when formulating interventions and for future research. The majority of the participants were children with severe and profound levels of mental retardation presenting with high frequency internally maladaptive behaviors. Thus, the evidence base for this client group is good. However, such claims have to be tempered by the fact that over 25% of the behavioral interventions were aversive- or punishment-based. Further, aversive interventions were not more effective, so there is an evidence base as well as an ethical and humanistic base for not using them.

The evidence base has limited applicability to treatments for adults with mild mental retardation and those who present with externally destructive behaviors. This client group seems to be receiving greater attention in the cognitive–behavioral and psychodynamic literature (Beail, 2003; Willner, 2005). Further, contrary to Sturmey’s (2005) claim, there is very little evidence for the effectiveness of behavioral treatments for mental health problems.

The majority of the interventions in the evidence base were implemented in segregated settings, with very few community-based interventions. The evidence base may not generalize or transfer to community-based settings. Whittaker (1993) has argued that we may need to develop new approaches regarding aggression, but this would seem to be the case for the treatment of many other challenging behaviors in community settings. Whittaker also drew attention to the fact that behaviors treated in the extant behavioral literature tended to be high frequency, whereas in the community they tended to be low frequency but high impact. Also, Carr et al. (2004) noted that as we enter a new era emphasizing community-based approaches for dealing with challenging behavior, much flexibility and innovation will be required for both research design and measurement strategies.

In this commentary, I have suggested that there is no room for complacency with regard to the evidence base for behavioral interventions. The evidence base has a number of positive aspects but also limitations regarding transferability and generalizability. These limitations make it difficult to accept Sturmey’s (2005) generalization that behavioral approaches remain the preferred treatment option for all people with mental retardation. Clinicians should use the evidence base more critically and with greater specificity when formulating interventions. However, we also need to continue to be creative and explore the use of interventions that have been researched as effective with the general population. The lack of evidence does not mean that nonbehavioral interventions are ineffective. Further, people with mental retardation have a right to a similar range of therapies that are used in the general population. We also need to adapt and develop behavioral interventions that have potential application in community-based settings and continue to research our endeavours to develop the evidence base.

References


Psychotherapy is an Essential Tool in the Treatment of Psychiatric Disorders for People With Mental Retardation

Anne D. Hurley

Sturmey (2005) recently published a piece in this journal in response to Lynch (2004), which was also published in Mental Retardation. Sturmey aimed to rebut the “claims” of efficacy of psychotherapy with individuals who have mental retardation proposed by Lynch. Sturmey specifically criticized the work of Prout and Nowak-Drabik (2003), a meta-analysis of 92 studies cited by Lynch, and critiqued it from a variety of methodological and statistical perspectives. Indeed, meta-analysis of a large number of studies on any topic can be criticized from a variety of perspectives, yet we hope to learn about general trends. However, Sturmey’s aim to rebut the article was not successful and his conclusions are erroneous.

Sturmey (2005) presented an exceedingly narrow conclusion without research evidence. In his concluding paragraph, he summarized his rebuttal as follows. First, there is an absence of well-conducted research on the effectiveness of psychotherapy. Second, there are many studies showing that behavioral interventions are effective. He then, however, concluded that behavioral interventions must be recommended because they are the only methods with research evidence of efficacy; thus, psychotherapy cannot be recommended. By his own scientific standards, his conclusions are not supported. In other words, if there are no long-term, well-controlled studies on the various forms of psychotherapy with this population, how can one con-
clude that psychotherapy is ineffective and not recommend it? If there are no rigorous studies on any particular form of psychotherapy showing that it is as good as, better than, or worse than behavioral techniques, how can we draw a conclusion? There are no rigorous studies directly comparing psychotherapy against a "behavioral intervention." There are no rigorous studies with specific recommendations for what problems and for what subpopulation of people with mental retardation is Sturmey making his sweeping generalized recommendations that "behavioral approaches must remain the preferred treatment option for people with mental retardation" (p. 56)? His logic is flawed.

In his response Sturmey's (2005) used definitions of psychotherapy and behavioral intervention that are not accurate. Psychotherapy is a mental health treatment rendered in the forms of individual, group, and family settings. It is a treatment that is mental rather than physical and includes the use of relationship, suggestions, persuasion, reeducation, reassurance, and support as well as specific techniques, such as hypnosis, psychoanalysis, role play, cognitive restructuring, and instruction. Common psychotherapeutic approaches in the United States include: psychoanalytic, psychodynamic, interpersonal, psychodrama, cognitive–behavioral, behavioral therapy, and rational emotive behavioral psychotherapy. Sturmey referred to “traditional” psychotherapy, which does not actually exist.

Sturmey (2005, p. 55) criticized Lynch (2004), stating that Lynch was not correct for including the following methods as psychotherapy: assertiveness training, relaxation training, social skills training, and problem-solving training. Lynch was, however, correct because those techniques are very commonly used by mental health counselors, psychologists, and social workers, particularly those trained in cognitive–behavioral psychotherapy. They are not pure behavioral interventions. Cognitive–behavioral group treatment is often used to address social skills, assertiveness, and stress-management techniques, such as relaxation. These methods are employed for individual treatment or are used in a group format. The techniques are not behavioral interventions but are cognitive (mental) and behavioral (directive voluntary activities initiated by the patient). For example, when using relaxation techniques, psychotherapists spend sessions giving verbal instruction on relaxation, work with the patients by providing feedback as to how he or she is applying the method, and assigns "homework" (self-therapy) of practicing the technique. Then, the patient is helped to use relaxation in response to specific or generalized stressors and to apply it to generalized anxiety. Thus, this is not a behavioral intervention; it is a cognitive–behavioral form of psychotherapy. Further, the fact that these treatments have documented success provides evidence that people with mild mental retardation can benefit from other forms of psychotherapy because they can use the interpersonal relationship format, follow advice, accept feedback, and learn new ways of thinking and behaving as a result of this treatment.

Sturmey (2005) insisted that rigorous scientific evidence is required to recommend psychotherapy. By doing so, he chose to ignore other reviews and evidence for the effectiveness of many forms of psychotherapy used with people who have mental retardation (Butz, Bowling, & Bliss, 2000; Hurley, Pfadt, Tomasulo, & Gardner, 1996; Hurley, Tomasulo, & Pfadt, 1998; Nezu, Nezu, & Gil-Weiss, 1994). Further, he ignored the numerous clinical case reports, papers, and books on using individual, group, and family psychotherapy for people with mental retardation. In 2000, Fletcher, Hurley, and Bellordre published a bibliography on psychotherapy for this population within a book on psychotherapy. They cited over 300 publications. Since that time, there have been many more reports and books on psychotherapy for this population. For example, I recently reported on the use of a cognitive–behavioral approach for agoraphobia and panic disorder in a man with Down syndrome (Hurley, 2004). This is the preferred choice of treatment for all patients with this disorder, regardless of intelligence level, and it worked well with little modification for my patient. Razza and Tomasulo (2005) recently published a book on group psychodrama psychotherapy for people with mental retardation who have posttraumatic stress disorder and a trauma history. In their classic volume, Szymanski and Tanguay (1980) forcefully supported psychotherapy, and this book is as fresh today in this area as the day it was published. The American Academy of Child and Adolescent Psychiatry developed the Practice Parameters for the Assessment and Treatment of Children, Adolescents, and Adults with Mental Retardation and Comorbid Mental Disorders, and work group members recommended psychotherapy (Szymanski, King, & the Work Group on Quality Issues, et al., 1999).

By beginning the title of his rebuttal with “Against,” Sturmey (2005) chose the strongest pos-
Perspectives: Responses to Sturmey (2005) on psychotherapy

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sible negative position on psychotherapy as a form of treatment for people with mental retardation. His paper may be used by agencies as “proof” that psychotherapy is ineffective and, thereby, cause further limits in access to mental health treatment for people with mental retardation. For example, it is possible that the Center for Medical Services in the federal government will revise the Medicare regulations to prevent all people with mental retardation from receiving these services. State governments may find that psychotherapy is not medically proven and prevent Medicaid reimbursement of psychotherapy services. Private insurance companies could then prevent psychotherapy services for people with mental retardation because these treatments would be considered “experimental” and not a valid form of care.

I currently use psychotherapy to treat a large number of people with mild mental retardation and have done so for more than 30 years. I am an expert in this field and a cognitive–behavioral psychotherapist as well. I find that many patients with mild mental retardation respond very well to psychotherapy and that it is responsible for improvement as well as mental stability. How would Sturmey suggest I use “behavior interventions” to treat the following problems in my patients.

- A woman married for 10 years whose husband has lost sexual interest in her?
- A woman whose child was taken away by social services and is suffering grief and guilt?
- A woman who experiences anxiety and panic attacks at work when asked to do new tasks because she feels inadequate?
- A man whose parents died suddenly in a car accident, leaving him to live alone?
- A married couple with increasing conflict in their relationship due to financial hardship?

Finally, Sturmey (2005) did not advocate a need for research on all forms of psychotherapy. In 1989, I published such a paper calling for research on psychotherapy. I agree with Sturmey that funding of such research has not occurred and will probably not be forthcoming. Despite this lack of scientific research, it is imperative that clinicians continue to treat people with mental retardation using psychotherapy when it is appropriately indicated.

I disagree with Sturmey’s (2005) rebuttal to Lynch’s (2004) paper in that, in my opinion, Lynch was very measured and careful in his presentation of the evidence and in his conclusions. Lynch wrote:

Within the past 20 years, however, significant development has occurred. The literature base has grown substantially and a greater sense of cohesiveness has been obtained through conferences, trainings and the efforts of professional organizations. . . . However, there are some current concerns that the field will need to address . . . fiscal constraints . . . and demonstrating the effectiveness of psychotherapy for individuals with mental retardation through empirically rigorous research. (p. 402)

Further, Lynch (2004) himself, while citing the Prout and Nowak-Drabik (2003) study, stated that the authors themselves “acknowledged that many of the studies were poor in terms of methodological rigor or design” (p. 402). What, then, did Sturmey (2005) need to rebut so vigorously?

Finally, Sturmey’s (2005) title is certainly very unfortunate. He might have instead titled his rebuttal “A Call for Rigorous Research on Psychotherapy With People Who Have Mental Retardation: A Response to Lynch.”

References


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**Proceeding With Compassion While Awaiting the Evidence: Psychotherapy and Individuals With Mental Retardation**

Robert King

Do you really believe that the sciences would ever have originated and grown if the way had not been prepared by magicians, alchemists, astrologers, and witches whose promises and pretensions first had to create a thirst, a hunger, a taste for hidden and forbidden powers? Indeed, infinitely more had to be promised than could ever be fulfilled in the realm of knowledge. (Nietzsche as cited in Paradi, 2002, p. 240)

The purpose of this response is to rebut with intense nonscientific vigor, the assertion by Sturmey (2005) that the acknowledged absence of methodologically adequate studies of “traditional psychotherapy” for individuals with mental retardation (Lynch, 2004; Prout & Nowak-Drabik, 2003) justifies the conclusion that behavioral supports “must remain the preferred treatment option for people with mental retardation” (Sturmey, 2005, p. 56). I also object to Sturmey’s implication that it is in the best interest of individuals with mental retardation and emotional distress (arising from mental illness or a myriad of other life sources as comprehensively detailed by Lynch, 2004), to label social skills training, problem-solving training, relaxation exercises, and assertiveness training as “behavioral methods,” distinct from traditional psychotherapy.

Integrated biopsychosocial models are based on the premise that behavioral and emotional challenges faced by individuals with mental retardation represent the dynamic influence of biomedical (including psychiatric and neuropsychiatric), psychological, and social factors. Best practice features of these models incorporate the role and magnitude of effects of biomedical and psychosocial vulnerability, instigating and maintaining variables in understanding emotional distress. These models highlight the need to identify skills and related emotional/motivational supports required by individuals to cope effectively. They encourage an enhancement of competency, build on strengths, and acknowledge the need for environmental change to accommo-
date need and accommodation in a proactive manner. They encourage us to translate the multiple modalities of influence on an individual’s life into a paradigm that may assist us in understanding, stressing that our understanding of the distress of others will evolve over time. These models encourage the development and implementation of multimodal support plans, with the recognition that mental health consists of both the presence of personal contentment and the relative absence of psychological distress (Griffiths, Stavrakaki, & Summers, 2002).

As allies and providers of support to individuals with mental retardation and emotional distress, we do not know what works best from a psychotherapeutic perspective. We barely have an inklng of understanding of the efficacy of psychotherapy from a scientific perspective for individuals without mental retardation (Wolpe, 1993). I have had the privilege, however, of working with many therapists and clinicians committed to supporting individuals with mental retardation and emotional distress. My colleagues and, more importantly, the individuals whom I have supported have taught me numerous things. (a) Many individuals with mental retardation are, at times, in grave need of emotional support. (b) All sectors of professional support are underfunded and staff members are grossly undertrained. This reality challenges individuals who are providing support to modify the format of their respective theoretical modalities in order to optimally meet the needs of individuals with mental retardation (Lynch, 2004). (c) I have learned that a systemic lack of training negatively affects treatment outcomes and should be considered an obstacle to accurately measuring the benefits of specific treatment modalities offered to individuals with mental retardation (Beasley, 2004). (d) Advice and training is available to assist willing participants to learn to modify their support approaches. (e) “The absence of evidence for efficacy is not evidence of ineffectiveness” (Beail, 2003, p. 471). Rather, inadequate outcome measures and a lack of effort to even attempt to measure outcomes due to the stigmatization and discrimination experienced by all individuals with mental retardation are more likely explanations for our current lack of knowledge in this area. Practice-based evidence, versus evidence-based practice, exists and should and does inform the clinical efforts of many committed therapists (Beail, 2003). (f) I have learned that self-advocates with mental retardation and autism spectrum disorders are available (although they are proceeding with self-preserving caution) to assist professionals to improve on our efforts to reduce the intensity of emotional distress experienced by individuals with mental retardation during their lifetimes (Shore, 2004).

Support should be dictated by need. The value of available support is difficult to measure with scientific outcome variables. Practice-based evidence does suggest that psychoterapeutic support, if offered with respect and compassion to individuals with mental retardation, can be life-enhancing. Learning to love yourself after being repeatedly raped by a family member and/or careprovider; seeking peace after experiencing repeated failures of attachment, personal, social, and cultural dislocation; moving from community to institution and, hopefully, back to community; grieving the loss of your biological family; and adjusting to opportunities for new roles and responsibilities after a lifetime of being punished for attempting to be yourself will not be helped by behavioral methods or traditional psychotherapy. As people privileged to walk alongside individuals with mental retardation during their life paths and as professionals in the field, we have no right to perpetuate turf wars or “await the evidence.” We need to proceed, with caution and hope, but proceed and find our way as the evidence follows (or not).

During her journey with her autistic son, Valerie Paradi (2002) asked, “How will I hear my son’s voice if it’s entangled in such a legacy of wartime fear, cultural misogyny, and ideological posturing?” (p. 70).

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In Support of Psychotherapy for People Who Have Mental Retardation

John L Taylor

In his paper, Sturmey (2005) stated that his purpose was to rebut the claims of efficacy of psychotherapy with individuals who have mental retardation made by Lynch (2004). It is not clear, however, that this is the main purpose because Sturmey concluded, based on the evidence supporting their effectiveness and efficacy, that behavioral interventions must remain the treatment of choice for people with mental retardation. The evidence he cited to support his arguments concerning the superiority of behavioral interventions over psychotherapy for people with mental retardation raises a number of issues that are explored below.

Efficacy and Effectiveness

The evidence to support the efficacy of psychotherapy for people with mental retardation is indeed limited. This is the conclusion reached in a number of recent reviews, critiques, and commentaries (e.g., Beail, 2003; Hatton, 2002; Prout & Nowak-Drabik, 2003; Willner, 2005). Unfortunately, Lynch (2004) appears to have conflated efficacy with effectiveness in relation to the evidence for psychotherapy for people with mental retardation cited by Prout and Nowak-Drabik (2003) and others. Efficacy research demands internal validity in order to evaluate how effective particular interventions are for specific, usually homogeneous, study samples; whereas effectiveness studies require external validity to demonstrate how generalizable treatment effects might be under routine care conditions in the wider population from which the sample has been drawn (Wells, 1999). Lynch (2004) and Prout and Nowak-Drabik (2003) are concerned with the effectiveness of psychotherapy for people with mental retardation for which there is a wealth of evidence, particularly cognitive–behavioral approaches (Willner, 2005). On the other hand, evaluations of behavioral interventions are almost exclusively conducted in highly controlled environments, with high staff ratios; therefore, the generalizability of these findings to nonsegregated settings is questionable (Scottri, Evans, Meyer, & Walker, 1991).
bik (2003) included studies that, among other characteristics, involved direct face-to-face contact between the therapist and clients; aimed to assist clients in modifying their feelings, values, attitudes, and behaviors; and did not involve behavior modification. In Sturmey’s (2005) critique of Prout and Nowak-Drabik’s meta-analysis, he re-labeled a range of psychotherapeutic approaches as behavioral interventions. Consequently, in Sturmey’s view, studies showing good outcomes for assertiveness, social skills, and problem-solving training become evidence for the efficacy of behavioral interventions. The cognitive and meta-cognitive skills training involved in the self-management and self-instructional techniques (e.g., self-monitoring, self-evaluation, self-reinforcement) underpinning the interventions in these studies were not acknowledged by Sturmey (2005).

What Works for Whom and for What?

The evidence set out by Sturmey (2005) to support his argument for superiority of behavioral interventions seems impressive. It is not clear, however, for what kinds of problems (behavioral, emotional, mental health), experienced by what type of clients (adult, child, with mild or severe mental retardation), and in what contexts (institutional, community) investigators have suggested these approaches are effective for. Studies providing evidence for the effectiveness of behavioral interventions have generally concerned high frequency challenging behaviors, such as self-injury and stereotypy (Didden, Duker, & Korzilius, 1997), involving people with severe and profound mental retardation (Scotti et al., 1991), and conducted in segregated settings (Carr et al., 2000). It has been proposed elsewhere that for mental health and emotional problems (e.g., anger dyscontrol) experienced by adults with mild mental retardation, cognitive–behavioral treatment is a more beneficial approach (Taylor, 2002). The potential advantage of these interventions is that they are self-actualizing in nature (i.e., they aim to help clients develop self-control over their emotional and behavioral problems). Promoting portable internalized control in order to facilitate transfer across situations is helpful when the target problem is low frequency, but high impact—as is often the case for aggressive behavior presented by people with mild mental retardation (Taylor & Novaco, 2005). There is emerging evidence that these approaches can be beneficial for a range of mental health and emotional problems experienced by people with mild mental retardation across a number of settings (Willner, 2005).

Example of Anger Dyscontrol

Anger dyscontrol, which is closely associated with aggression among people with mental retardation (Taylor & Novaco, 2005), is a good example to look at in more detail due to its prevalence and consequences for clients and people and systems supporting them. The evidence to support behavioral interventions for aggression in people with mental retardation is extensive (e.g., Carr et al., 2000; Lennox, Miltenberger, Spengler, & Efranian, 1988; Scotti et al., 1991; Whitaker, 1993). However, most studies showing the effectiveness of these approaches have involved contingency management techniques applied to people with moderate, severe, and profound mental retardation who exhibit high frequency aggression in segregated environments with high staff ratios (Whitaker, 1993). Thus, these approaches have been shown to be effective when applied to a small proportion of the mental retardation population in specific settings. Approximately 85% of people with mental retardation have mild mental retardation (American Psychiatric Association, 1994). In a narrative review, Taylor and Novaco (2005) reported that post-1985, there have been 19 published studies showing the effectiveness of cognitive–behavioral anger treatment involving people with mild mental retardation in a range of institutional and community settings. The majority of these studies are case and case-series reports, but 6 studies included control group comparisons that yielded significant between-group differences and moderate to large treatment effects (Lindsay et al., 2004; Rose, West, & Clifford, 2000; Taylor, Novaco, Gillmer, Robertson, & Thorne, in press; Taylor, Novaco, Gillmer, & Thorne, 2002; Taylor, Novaco, Guinan, & Street, 2004; Willner, Jones, Tams, & Green, 2002).

The above analysis indicates that at least for anger dyscontrol, the apparent weight of evidence supporting behavioral interventions is less impressive when applied to adults with mild mental retardation across a range of settings. For this majority constituency of people with mental retardation, cognitive psychotherapy would seem to be effective
and, possibly, more beneficial in terms of psychological well-being.

Conclusions

Behavioral interventions have been shown, largely through single case experimental design studies, to be effective for a range of challenging behaviors exhibited by people with more severe levels of mental retardation in nonintegrated settings. The superiority of behavioral interventions over psychotherapeutic approaches for these types of problems among this relatively small proportion of the mental retardation population is unquestionable. However, behavioral interventions are less effective when applied to lower frequency, more complex behavioral problems (e.g., sexually aggressive behavior) characteristic of higher functioning individuals (Willner, 2005).

People with mental retardation are more likely to experience mental health and emotional problems than are individuals in the general population (Deb, Thomas, & Bright, 2001; Prosser, 1999). Very few studies of behavioral interventions have targeted the mental health needs of these clients (Didden et al., 1997), and behavioral approaches would appear to be of limited benefit to the majority of people with mild mental retardation who are vulnerable to a range of emotional problems (Stenfert Kroese, 1998). People with mental retardation have the same rights as others to access to psychological therapies that can help to relieve the distress experienced as a result of such problems. There is limited but growing evidence, including controlled trials, that cognitive–behavioral psychotherapy can be effective and of benefit to people with mental retardation experiencing emotional problems. In this regard it is probably both premature and unhelpful to promote the superiority of behavioral approaches at the expense of psychotherapy for these clients.

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Perspectives: Responses to Sturmey (2005) on psychotherapy

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