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A systematic review of the effectiveness of psychoanalysis, psychoanalytic and psychodynamic psychotherapy with adults with intellectual and developmental disabilities: progress and challenges

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Objectives: This systematic review aimed to critically appraise the literature on the efficacy and effectiveness of psychoanalysis, psychoanalytic and psychodynamic psychotherapy in adults with intellectual and developmental disabilities (IDD). *Method*: A systematic search of electronic databases was carried out. The methodological quality of the studies was assessed using a quality assessment tool and comparisons were made with a review of the quality of research on the effectiveness of cognitive behavioural therapy (CBT) for people with IDD. *Results*: The search yielded 13 papers which provided evidence for the effectiveness but not efficacy of psychoanalytic and psychodynamic psychotherapy; but none were found for psychoanalysis. The quality of the research was generally poor compared to the current research on the effectiveness of CBT. *Conclusions*: Positive outcomes have been indicated for psychoanalytic and psychodynamic psychotherapy with people with IDD. Larger scale, more controlled research is necessary to advance the evidence base.

Keywords: psychoanalysis; psychodynamic psychotherapy; psychoanalytic psychotherapy; intellectual disability; effectiveness

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There is a growing body of evidence concerning the effectiveness of various types of psychological therapy for people with intellectual and developmental disabilities (IDD) (Beail, 2016). Effectiveness concerns the outcomes of therapy delivered in routine practice, whereas efficacy refers to the results achieved in a research trial (Roth & Fonagy, 2005). The largest and most developed research literature concerns cognitive behavioural therapy (CBT) with people who have IDD. This has been the subject of three meta-analyses largely concerning the effectiveness of the approach in the treatment of anger. These have shown positive outcomes (Hamelin, Travis, & Sturmey, 2013; Nicoll, Beail, & Saxon, 2013; Vereenooghe & Langdon, 2013) from studies with a good level of methodological rigour but a need for improved reporting standards and larger samples (Nicoll et al., 2013). This paper seeks to examine the literature on the efficacy and effectiveness of

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psychoanalysis, psychoanalytic and psychodynamic psychotherapy with people who have IDD.

Interest in providing psychoanalysis, psychoanalytic and psychodynamic psychotherapy for people who have IDD took off from about 1980 and a literature has gradually grown since then. However, earlier efforts were made (O'Driscoll, 2009), but failed to gain momentum. By the 1990s, concern was being raised about the history of therapeutic disdain towards people who have IDD (Bender, 1993) but by then some momentum had been gained. What has become available in the literature has tended to focus on the specific issues, difficulties and unique considerations of providing psychotherapy (Sinason, 1992), described case accounts of work (Jackson & Beail, 2013; Sinason, 1992) or reported outcome studies on the effectiveness of the work (Beail, 2016; James & Stacey, 2014). Other literature has offered psychodynamic perspectives on having an intellectual disability (DeGroef & Heineman, 1999) and the history of the psychodynamic movement with this group (Bender, 1993; Frankish, 2016; Sinason, 1992). Fletcher (2011) has argued that we are now in an era of growing acceptance, albeit limited, with respect to the provision of psychotherapy for people who have IDD. However, descriptions of the practice and process of psychodynamic psychotherapy with people who have IDD are noticeably scarce.

In their review of the practice of psychodynamic psychotherapy with people who have IDD, Jackson and Beail (2013) concluded that the available literature suggests that a general account is partially emerging. They did not contrast the practice of psychodynamic therapy with people with intellectual disabilities with that of practice with the general population. However, the literature they review suggests that the general underlying model is highly similar to that offered to the general population, but with some adaptations to accommodate the differing needs of clients who have IDD. Most accounts of treatment concern weekly appointments whether described as psychodynamic or psychoanalytic, whereas in the general population psychoanalytic psychotherapy is distinguished as being more frequent. Jackson and Beail (2013) found that therapists were reporting a similar range of therapeutic actions but there was an absence of clear accounts of the process of formulation on which interpretations and other actions are based.

The concept of 'hierarchy of evidence' provides a framework to evaluate health care interventions such as psychoanalysis, psychoanalytic and psychodynamic psychotherapy. It is conceptualised as a pyramid, in which studies most susceptible to threats to internal validity reside at the bottom, and those least prone reside at the top (Ho, Peterson, & Masoudi, 2008). In this framework, efficacy studies using randomised controlled trials (RCT) are considered the gold standard, as they minimise the risk of confounding factors, thus providing the most reliable evidence on effectiveness (Akobeng, 2005). The reviews of CBT for people with IDD all included studies using a controlled methodology, but RCTs were notably absent, suggesting that CBT research with this client group is progressing up the hierarchy. Research into other forms of psychotherapy with individuals with IDD has seemingly struggled to achieve this degree of progression. This is likely due to a number of factors, for instance many professionals consider individuals with IDD unsuitable for psychotherapy, and IDD is routinely used as a criterion

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to exclude individuals from research (Fletcher, 1993). Studies with people with IDD tend to make adaptations to accommodate differences and the impact of the individual's disability on the process of therapy. Thus, manuals of psychotherapy for people with IDD needed for RCTs have been slow to develop. Practical issues, such as achieving large enough homogenous groups to ensure statistical power so that outcomes can be attributed to the intervention, also hinder the implementation of controlled studies (Beail, 2010).

A lack of progression up the hierarchy of evidence is particularly evident from the psychodynamic and psychoanalytic psychotherapy sphere. Flynn (2012) argues 'psychodynamic therapies remain the least well investigated of the psychological therapies in intellectual disabilities' (p. 344). One of the most recent reviews in this field found case study papers and very few research reports (Jackson & Beail, 2013). Their review explores the process and practice of psychoanalysis, psychoanalytic and psychodynamic psychotherapy. It does not address outcome or effectiveness.

The disparity between research into the CBT and psychoanalytic schools of therapy with individuals with IDD can be viewed in relation to the Salkovskis (1995) hourglass model. Salkovskis (1995) explains the process of development in clinical practice, in terms of an hourglass, conceptualising three phases required to build a sound evidence base. The initial phase is exploratory and focuses on in-depth investigation of few participants using case studies, case series and/or uncontrolled trials. As research continues to develop, it moves to a phase using controlled designs before progressing to studies that are at the pinch of the hourglass, mainly taking the form of RCTs. Finally, studies investigate the applicability of research to the real world using practice-based designs (Salkovskis, 1995). The Medical Research Council in the UK (Campbell et al., 2007) and Thornicroft, Lempp, and Tansella (2011) propose a schema to explain the process of development, evaluation and implementation of interventions. There are five phases, the first being 'basic discovery' in which research aims to generate and appraise theories and hypotheses. During the second phase, research identifies key components of the intervention and the third phase finalises the components and considers alternatives through well-controlled efficacy studies. In the next phase, confirmatory clinical trials are carried out in order to identify factors that may hinder the uptake of the evidence-based practice found in the previous phase. Thereafter, wider implementation follows. Thornicroft et al. (2011) place equal importance on all phases. These are considered essential stepping-stones in the research process to establish efficacy and effectiveness of an intervention.

Previous reviews have shown that research on psychodynamic psychotherapy in people with IDD is yet to progress to the pinch of the hourglass in Salkovkis' (1995) model (Beail, 2003; Prout and Nowak-Drabik, 2003; Willner, 2005). In contrast, research on psychodynamic psychotherapy in the general population has been subject to rigorous evaluations. Shedler (2010) has reviewed 8 meta-analytic studies, of which 6 concerned 50 controlled trials which showed positive gains which endure and also increase with time. He reports that RCTs support the efficacy for psychodynamic psychotherapy for a range of psychological problems,

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including depression, anxiety, eating disorders, personality disorders, somatic problems and substance misuse.

Progress in the development of an evidence base in the general population and with those who have IDD has been hampered by objections by some psychoanalytic and psychodynamic psychotherapists to outcome research. One concern has been that the research places an evaluative frame around the therapy and that this interferes with the process of transference and consequently the effectiveness of the work. In the field of IDD, the provision of psychodynamic psychotherapy has been a late development, largely emerging with the closure of long-stay hospitals. Most treatment provided to people with IDD before this was based on behavioural approaches. It is likely that the same objections to research with the general population were held by practitioners working in the field of IDD due to them undertaking similar training.

Nezu and Nezu (1994) argue that RCT's should have participants that are homogeneous with regard to (a) level of IDD, (b) psychiatric diagnosis and (c) age. Additional factors not mentioned by them, but are requirements of RCT's, include samples of sufficient size for the statistical methods employed, no co-morbidity, valid outcome measures, and control over length of treatment, manualisation of treatment, control of therapist experience and monitoring of therapist adherence to treatment. This poses problems for recruitment as people with IDD only comprise about two percent of the population and at any one time only about 15% present with mental health problems of which a small proportion have a single presenting problem. This is before all the other issues can be addressed. However, it is important to note that the controlled studies of psychodynamic psychotherapy with the general population have included participants with a range of presenting problems. In contrast, studies of CBT have had more homogeneous groups (largely anxiety and depression), which is also the case with people who have IDD where the main presenting problem has been anger (Nicoll et al., 2013).

James and Stacey (2014) were the first to focus solely on the effectiveness of psychodynamic psychotherapy in IDD. They reviewed 13 studies, including approaches with a psychodynamic component, such as cognitive analytic therapy (CAT). The review provided some support for the use of psychodynamic psychotherapy and CAT with clients with IDD, across a range of presenting problems. Whilst James and Stacey (2014) offer some general critiques of the research, no criteria were applied to critically evaluate the studies methodologies. So there remains a need to critically appraise this literature. The aim of this systematic review was to assess the quality of the research into the effectiveness of psychoanalysis, psychoanalytic and psychodynamic psychotherapy with individuals with IDD.

Method

Search strategy

The initial strategy involved searching four major electronic databases (Web of Science, MEDLINE, PsychInfo and CINHAL). Beail (1995) conducted the first

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review on the outcome of psychoanalysis, psychoanalytic and psychodynamic psychotherapy with people with IDD, therefore the period searched in this study was from 1995 to 2015. Applied search terms in the topic field were combinations of: '*psychodynamic* OR *psychoanalytic* OR *psychoanalysis* OR *psychotherapy* AND *learning disabilit** OR *intellectual disabilit** OR *mental retardation* OR *developmental disabilit**'. This returned 1452 references from the combined databases.

Screening

The screening process is shown in Figure 1. Duplicate papers were removed and the remaining studies were screened for relevance based on title and abstract. Included papers were published in English in peer-reviewed journals, examined psychoanalysis, psychoanalytic or psychodynamic psychotherapy with adults with IDD, and outcomes were measured. This yielded 16 relevant papers, however, 3 papers' data were concatenated in other papers and so those with the least data or concerned secondary analyses were removed. The final 13 studies are listed in Table 1. No papers were found evaluating the outcome of psychoanalysis. Twelve of the studies were carried out in the UK; the exception was carried out in Sweden.

Quality assessment

Poor study design, misconduct in data collection and analysis, and poor quality reporting of methods and results can all result in under or overestimation of the true effect of an intervention (Centre for Reviews & Dissemination, 2009). When reviewing studies, it is therefore necessary to assess the quality of research in these areas. Quality assessment instruments consider the risk of bias and the standard by which the study has been conducted; therefore quality assessment tools should be used to assess each study in a systematic review (Higgins & Altman, 2008).

A number of tools are recognised for quality assessment. The Critical Appraisal Skills Programme tools (CASP, 2006) were considered for this review; however they produce separate scores depending on study design, which would not allow for comparison across studies. The Downs and Black checklist (1998) is a highly regarded and widely implemented tool for systematic reviews (Wells & Littell, 2009). It evaluates both quality and internal validity, and purports to appraise randomised and non-randomised research. However, Cahill, Barkham, and Stiles (2010) found it to be ill matched and unresponsive to the design features of practice-based research. Cahill et al. (2010) adapted Downs and Black (1998) to allow for the assessment of a wider range of methodological designs. Some features in Downs and Black, such as a heterogeneous population, are seen only as deficits, yet these features enable practice-based evidence to reflect practice (Cahill, 2014). As previous reviews have shown, much of the current research in this area is based

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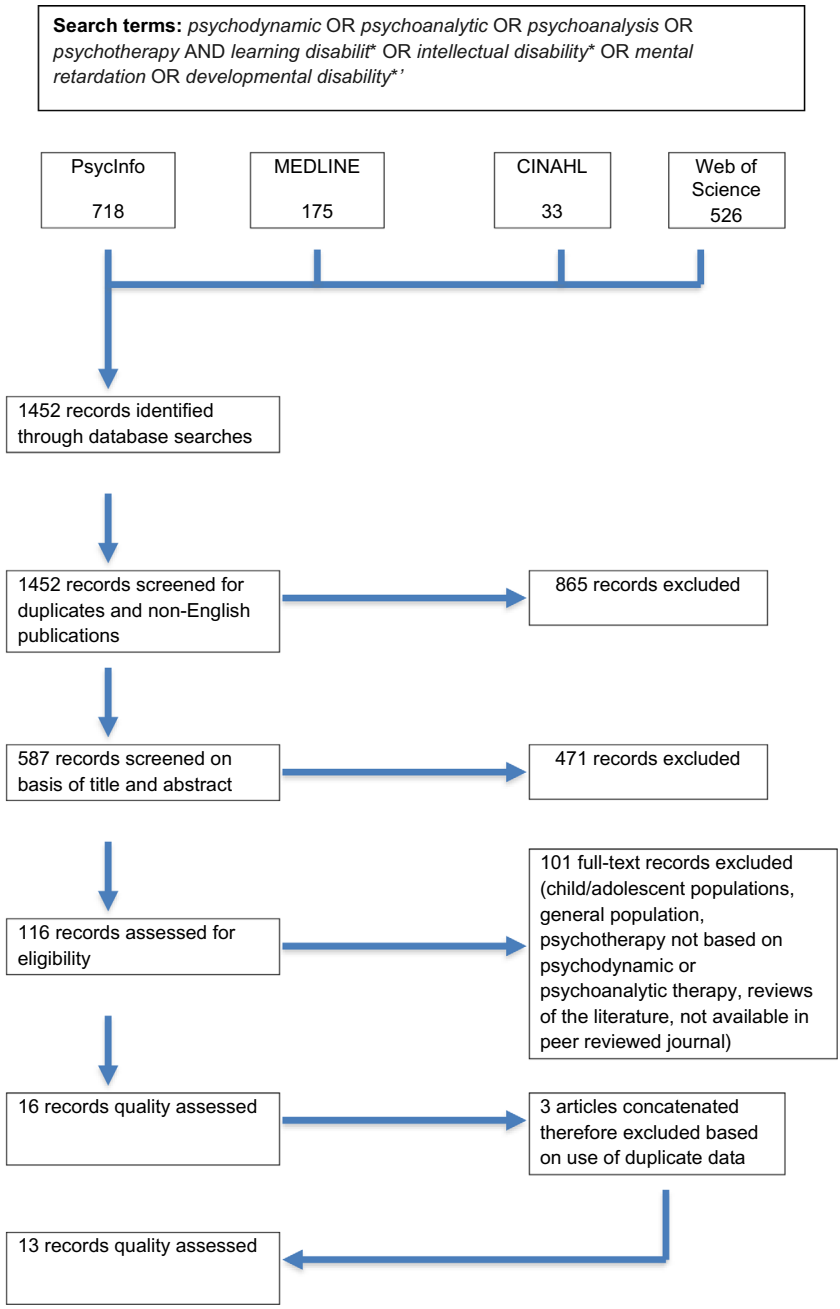


Figure 1. PRISMA flow diagram.
Note: This figure illustrates screening process for inclusion of studies.

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within clinical practice and Cahill et al.'s checklist (2010) enables more aspects of this practice-based research to be captured. Furthermore, Cahill et al.'s checklist (2010) was used to assess quality of research in Nicoll et al.'s (2013) review of CBT, the only review of psychotherapy with people with IDD to use a quality assessment tool. Use of the same checklist allows for the quality of research into CBT to be compared to that for psychoanalytic and psychodynamic psychotherapies. The checklist assesses overall quality as well as four separate subscales:

(i) *Reporting:* assesses the extent to which the reader is able to make unbiased assessment of the findings.
(ii) *External Validity*: assesses whether the findings can be generalised.
(iii) *Internal Reliability*: addresses the rigour of the measurement of the intervention.
(iv) *Internal Reliability Sampling:* addresses confounding factors and selection bias.

To check inter-rater reliability, the first author and an independent rater (Doctoral student) rated the quality of the full text of a random subsample of four papers. Pairwise agreement for these ratings was $K = .80$ which falls into the 'substantial' range of agreement (Landis & Koch, 1977).

Table 2 shows the combined scores and percentages of the overall quality and subscales for the studies, using Cahill et al.'s (2010) checklist. Overall, the studies addressed 38.5% of the quality appraisal criteria. A Spearman's Rank correlation was calculated to explore whether there had been improvement in the quality of the studies over time. No relationship was found, ($r^s = -.27(11)$, $p > .5$). Studies were split based on design (case series/group designs, single case experimental design, case study and qualitative studies). The overall quality criteria addressed were 45.1, 43.8, 23.4 and 31.3%, respectively. Within the subscales, *Reporting* scores were generally highest (45.5%) with the lowest levels observed in *Internal Reliability Sampling* scores (10%). The final column of Table 1 shows the studies' individual quality ratings; the mean quality rating score for all studies was 12.2 (SD = 4).

The percentage of overall quality rating addressed by the studies did not exceed 50% for any subscale. Thus, they could not be considered to be of high quality. These were all lower than those reported by Nicoll et al. (2013) for CBT; where all studies achieved scores of 70% or more. The papers were reviewed in terms of the subscales and their quality relative to each other.

Reporting

The studies reviewed were relatively strong in this area, meeting 45.5% of the quality rating criteria in this subscale. This suggests that the studies provided some information for the reader to make an unbiased decision about the findings

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Table 1. Summary of studies included in review. Studies are ordered by design from most controlled to least controlled, then chronologically within each section.

Author and year	Design	Sample/degree ID/co-morbid issues	Group/ Indiv'l	Duration	Outcome measurement	Outcome	Follow-up	Quality rating (Max 32)
Case series								
Bichard et al. (1996)	Case series/ Contrast group	11 adults/IQs <30–69 /stealing, self-injury, depression, social isolation	Indiv'l	1–3 years	A cognitive test e.g. WAIS-R, Draw-a-Person (DAP)	Therapy group showed improved DAP scores, only one contrast group showed improvement Therapy did not have an impact on IQ	None	16
Beail (1998)	Case series	25 Men/ IQ not stated/ aggression, behavioural problems, offending	Indiv'l	3–43 months	Frequency of behaviour at end of therapy and follow-up or re-offending	In 11 cases behaviour was eliminated and had not re-emerged at follow-up In one case behaviour reduced and reduction was maintained at follow-up None re-offended during therapy or at follow-up	6 months	13
Carlsson (2000)	Case series	4 Women, 3 Men/IQ 35–58/ Psychosis, MPD, depression, ASD, behavioural disorders	Indiv'l	18 months	WAIS-R Defense Mechanism Test (DMT) Perceptgenetic Objection Relations Test (PORT) Secondary Handicap	WAIS-R no change DMT & PORT – increased integration, better ego functioning, decreased defense mechanisms Secondary handicap diminished	None	10

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Beail (2001)	Case series	13 Men/IQ not stated/sexual offences, theft, arson	Indiv'l	4–43 months (mean = 16.15)	Recidivism rates	None re-offended during treatment 11 had not re-offended at follow-up	4 years	16
Beail et al. (2005)[2]	Case series/open trial	17 Men, 3 Women/IQ not stated/aggression, sexually inappropriate behaviour, psychotic, relationship difficulties, OCD, self-harm, bulimia	Indiv'l	5–48 session (mean = 13.2)	Symptom Checklist Revised (SCL-90R) Inventory of Interpersonal problems (IIP) Rosenberg Self-Esteem inventory	SCL-90R scores fell to below caseness Significant change in IIP scores from intake to follow-up Self-esteem inventory score rose significantly at outcome and follow-up Effect sizes modest to large	3 months	21
Newman and Beail (2005)[2]	Case series	2 Women, 6 Men/IQ 45–65/anxiety, behavioural, sexual offending	Indiv'l	8 sessions (1, 4, & 8 recorded)	APES level	APES level higher at end of session. Significant increase between 1 and 8	None	12
Newman and Beail (2010)	Case series	2 Women, 6 Men/IQ 45–65/anxiety, behavioural, sexual offending	Indiv'l	8 sessions (1, 4, & 8 recorded)	Defense mechanism rating scale (DMRS)	No change in defense functioning	None	12

(*Continued*)

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Table 1. (*Continued*).

Author and year	Design	Sample/degree ID/co-morbid issues	Group/ Indiv'l	Duration	Outcome measurement	Outcome	Follow-up	Quality rating (Max 32)
Single case								
Kellett et al. (2009)	Single case	1 Man, 1 Women/ IQ 55, other not stated/hypochondriasis, ambulophobia	Indiv'l	1 = 13 sessions 2 = 8 sessions	Idiographic data	1 = significant change 2 = non-significant clinical change	1 = 1 month continuous post treatment 2 = 3 months	14
Case studies								
Salvadori and Jackson (2009)	Case study	1 Man/not stated/epilepsy	Indiv'l	10 session (short-term psychodynamic)	Subjective reports APES level	Appeared meaningful, more assertive APES increased 0 to 4	None	7
Alim (2010)	Case study	1 Man/mild/ aggression	Indiv'l	18 sessions	Malan's model; Novaco Anger Scale; Behaviour incidents records BSI; Rosenberg Self-Esteem Scale; & IIP	Reached highest level (9) of Malan at session 9 but this fell to 6 by end of therapy Reduction on all scales except IIP which showed an increase	None	8

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Service user satisfaction								
Mac-Donald et al. (2003)	Qualitative interview, IPA	5 Women, 4 Me/not stated, men sexual offenders	Group	Attending group between 2 months and over a year	Semi-structured interview	Valued therapy and talking about painful emotions but group emotionally painful, no positive change identified	None	7
Merriman and Beail (2009)	Qualitative, IPA	6 Men, mild-moderate/ not stated	Indiv'l	2+ years	Qu-aires generated by team	Positive about therapists & therapy, positive changes in behaviour & emotions. Difficult changing therapists and criticising service	None	10
Khan and Beail (2013)	Qu'aire	8 Female, 12 Men, mild-moderate ID/ bereavement, sexually inappropriate behaviour, anger, offending, low mood	Indiv'l	10–31 sessions (mean 14.1) (15 had psychodynamic, 2 integrated counselling, 3 CBT)	Experience of Service Qu'aire (ESQ) Satisfaction with therapy & therapist scale (STTS-R)	Improvement in ESQ & STTS-R scores High level of satisfaction with therapy	None	13

Notes: MPD, Multiple Personality Disorder; ASD, Autism Spectrum Disorder; IQ, Intelligence Quotient; WAIS-R, Wechsler Adult Intelligence Scale-Revised; APES, Assimilation of Problematic Experiences Scale (Stiles et al., 1990); OCD, Obsessive Compulsive Disorder; BSI, Brief Symptom Inventory, (Derogatis & Spencer, 1993); ² denotes studies that are concatenated with one other study.

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Table 2. Scores and corresponding percentages of checklist criteria address by the studies.

	Reporting subscale		External Validity subscale		Internal Reliability subscale		Internal Reliability Sampling subscale		Overall Quality Rating	
Studies	Score	% score[a]	Score	% score	Score	% score	Score	% score	Score	% score
Case series (n = 6)	38	49.4	36	46.7	20	57.1	7	20	101	45.1
Single case (n = 1)	6	54.5	5	45.5	3	60	0	0	14	43.8
Case study (n = 1)	7	31.8	6	27.3	2	20	0	0	15	23.4
Service user satisfaction (n = 3)	14	42.4	12	36.4	4	26.6	0	0	30	31.3
All studies (*N* = 11)	65	45.5	59	41.3	29	44.6	7	10.8	160	38.5

[a]% score is the quality criteria score achieved by the study (score), divided by the total possible score for the subscale. A 100% score would indicate that all quality criteria had been met by the study.

of the research. The majority of the studies stated their aim and presented the findings clearly. Only Beail, Warden, Morsley, and Newman (2005) stated a specific, directional hypothesis: 'psychodynamic psychotherapy would produce significant reductions in recipients' psychological distress and improve interpersonal functioning' (p. 246).

Overall, characteristics of clients were well reported. There were a higher proportion of male (n = 95) than female participants (n = 25) across the studies. Bichard, Sinason, and Usiskin (1996) did not state the gender of their participants. Participants were aged between 17 and 64 with the most common age range across the studies being 20–40. Ten studies described the intervention as 'psychodynamic' (Alim, 2010; Beail, 2001; Beail et al., 2005; Kellett, Beail, Bush, Dyson, & Wilbram, 2009; Khan & Beail, 2013; MacDonald, Sinason, & Hollins, 2003; Merriman & Beail, 2009; Newman & Beail, 2005, 2010; Salvadori & Jackson, 2009) and three as psychoanalytic (Beail, 1998; Bichard et al., 1996; Carlsson, 2000). The detail of the intervention was generally poorly described across the studies. The two case studies (Alim, 2010; Salvadori & Jackson, 2009) provided the most comprehensive description of the process of their intervention. Beail's (1998) description of psychoanalytic psychotherapy is almost identical to his description of psychodynamic psychotherapy (Beail, 2001), suggesting the terms are used interchangeably. Ten of the 11 studies assessed weekly individual psychotherapy. Only MacDonald et al. (2003) evaluated weekly group psychotherapy, however, no descriptive details of the content of the groups were provided.

There was large variability in the length of therapy provided; five sessions was the lowest, but this study also reported the largest range in number of sessions from 5 to 48; M = 13.2 (Beail et al., 2005). Therapy lasted for two or more years in five of the studies (Beail, 1998, 2001; Bichard et al., 1996; Carlsson, 2000; Merriman & Beail, 2009). Three of the case series studies and the single case study provided follow-up data (Beail, 1998, 2001; Beail et al., 2005; Kellett et al., 2009), which ranged from one month to four years. Whilst *Reporting* scores were a relative strength, only three studies scored above half (Beail, 2001; Beail et al., 2005; Kellett et al., 2009).

Internal Reliability

This subscale considers the rigour of measurement used to assess the outcome of the intervention. The overall quality rating addressed from all the studies on this scale was 44.6%. Three studies used measures developed for the general population and used in psychodynamic outcome studies (Roth & Fonagy, 2005) which have also been validated for people with IDD. Beail et al. (2005) used the Symptom Checklist Revised (SCL-90; Derogatis, Lipman, & Covi, 2007). This has been found to have good reliability and discriminative validity in an assisted completion format with individuals with IDD (Kellett, Beail, Newman, & Mosley,

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1999). Alim (2010), Beail et al. (2005), and Kellett et al. (2009) used the Inventory of Interpersonal Problems (IIP-32; Barkham, Hardy, & Startup, 1996) and the Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965). The IIP-32 has been found to have sufficient stability and sensitivity with individuals with mild IDD. Four of the eight subscales and the IIP-32 were replicated in people with IDD; however, caution is advised if considering the other four subscales independently (Kellett, Beail, & Newman, 2005). Kellett et al. (2009) found no change in IIP-32 scores at therapy completion or follow-up, whilst Alim (2010) found IIP-32 scores worsened. In contrast, Beail et al. (2005) found a statistically significant change in scores on the IIP-32 from intake to follow-up. However, only 14 of the 20 participants were able to complete the measure due to the complexity of language, suggesting adaptation is required.

Kellett et al. (2009) found no significant change in RSES scores but Alim (2010) and Beail et al. (2005) found a significant change post treatment, which was maintained at follow-up. The change in RSES scores showed the largest effect size in Beail et al.'s study. Unlike the IIP-32, the RSES has been found to have moderate reliability and poor validity with clients with IDD (Davis, Kellett, & Beail, 2009), which questions its suitability in this area of research and Alim (2010) and Beail et al.'s (2005) findings should be interpreted with caution. Alim (2010) and Kellett et al. (2009) also used the Brief Symptom Inventory (BSI; Derogatis & Spencer, 1993), and found improvements in BSI scores following therapy, providing some evidence for the effectiveness in reducing symptom severity. The BSI has been found to be a reliable and valid measure when used with people with IDD (Kellett, Beail, & Newman, 2004; Kellett, Beail, Newman, & Frankish, 2003). The merits of employing measures previously used in research with the general population will enable comparison of outcomes between these groups. It also shows that outcomes are being evaluated in the same way. Most outcome research has focused on symptom reduction (Shedler, 2010) but some psychodynamic researchers have argued for a focus on interpersonal issues hence the use of the IIP (Barkham et al., 1996).

Two studies used projective tests to measure specific psychoanalytic concepts. Carlsson (2000) used the Defence Mechanism Test (DMT; Kragh, 1969) and the Percept-genetic Object-Relation Test (PORT; Nilsson, 1995) and found a decrease in primitive defensive functioning. Bichard et al. (1996) used the 'Draw-A-Person' (DAP) part of the 'House-Tree-Person' test (Buck, 1948). Bichard et al. (1996) compared the DAP scores of participants who received weekly psychoanalytic psychotherapy to participants in a contrast group seen annually. Clients in the therapy group showed improved DAP scores, while only one participant in the contrast group showed improved scores. However, these projective measures are questionable in their standardisation and objectivity and are not validated measures of change.

The Assimilation of Problematic Experiences Scale (APES; Stiles et al., 1990) was used to assess change in two studies (Newman & Beail, 2005; Salvadori &

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Jackson, 2009). The APES proposes that individuals progress through stages during psychotherapy gaining more understanding with decreasing negative affect. Both studies found an increase in APES levels across therapy, suggesting a positive impact of psychodynamic psychotherapy. Newman and Beail (2005) also used the Defence Mechanisms Rating Scale (Perry, 1990) to measure changes in defence functioning as an indication of positive outcome of psychotherapy, but found no significant change. Recidivism rates were used as an outcome measure in two studies where some or all of the participants were offenders (Beail, 1998, 2001). Of the 21 male participants across the studies, none re-offended during therapy (range 4–43 months) and only two had re-offended at four year follow-up.

Three studies measured service user satisfaction with therapy as an outcome (Khan & Beail, 2013; MacDonald et al., 2003; Merriman & Beail, 2009). MacDonald et al. (2003) and Merriman and Beail (2009) used qualitative, semi-structured interviews analysed using Interpretative Phenomenological Analysis (IPA). MacDonald et al. (2003) interviewed four men who attended a group for sexual offending and five women who attended a women's group. Themes emerging from the interviews were defined as both positive and negative. Positive themes included 'ability to communicate with others about difficult experiences' and 'feeling valued within the group' (p. 346). There was also an overarching theme of positive feelings towards the therapist. The negative themes that emerged were participants' desire to 'avoid the emotional pain', 'finding the characteristics of other group members difficult' and 'feeling that the group had not had an impact' (p. 347). Merriman and Beail (2009) interviewed six male clients receiving long-term individual psychodynamic psychotherapy and found similar positive feelings towards therapy and therapists. Unlike MacDonald et al. (2003), the authors found that clients did identify positive changes in behaviour and emotion as a result of psychotherapy. Whilst the use of qualitative methods from service user perspective provided in-depth information, no objective measure of outcome was included. These studies did not score highly on the *Internal Reliability* subscale.

Khan and Beail (2013) used adapted versions of the Experience of Service Questionnaire (ESQ; Commission for Health Improvement, 2002) and the Satisfaction with Therapy and Therapist scale (STTS-R; Oei & Green, 2008) for service user views during routine clinical practice. Qualitative data from 20 participants showed similar results to MacDonald et al. (2003) and Merriman and Beail (2009). Positive feelings towards both therapy and therapist were expressed, however if appropriate adaptations to the therapy had not been made, participants expressed dissatisfaction. Quantitative data from the ESQ and STTS-R showed high levels of satisfaction with therapy and therapist. However, there is a risk that people who have IDD may be more acquiescent when asked about their satisfaction with services. Unfortunately the measures employed did not control for this effect.

Overall, the studies indicate positive change following psychotherapy with clients with IDD. However, over a decade on from Prout and Nowak-Drabik's

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(2003) review there is still insufficient data to carry out any form of meta-analysis. A variety of outcome measurements were used in the studies showing change across a wide range of difficulties. However, of the measurements used, a number had been adapted from the original versions and only a small proportion had been validated for individuals with IDD. This limits the confidence with which findings from these studies can be interpreted and highlights the need for reliable and valid outcome measurements for this client group.

External Validity

The *External Validity* subscale addresses whether the findings of the studies included in the review can be generalised. The overall quality rating addressed in this subscale was 41.3%. An influential factor in this subscale was the study participants' level of intellectual ability. There was generally poor reporting of level of intellectual ability. Carlsson (2000) and Newman and Beail (2005) reported IQ score ranges of 35–58 and 45–65, respectively. Kellett et al. (2009) reported an IQ of 55 for one of their single case participants but no score was reported for the other participant. Of the remaining studies, two described participants as having a mild to moderate IDD (Khan & Beail, 2013; Merriman & Beail, 2009), whilst the remaining five studies simply described participants as having an IDD. The impact of different levels of intellectual functioning on the adaptations needed to the therapy was also not discussed in these papers.

A second variable of interest in this subscale is the presenting problem for which participants were referred to therapy. Participants were referred for a range of psychological and behavioural issues including: sexually inappropriate behaviour (Beail, 1998; Beail et al., 2005; Newman & Beail, 2005, 2010); offending (Beail, 1998, 2001); psychotic symptoms (Beail et al., 2005; Carlsson, 2000); self-harm (Beail et al., 2005; Bichard et al., 1996); anger or aggression (Alim, 2010; Beail, 1998; Beail et al., 2005); and hypochondriasis and ambulophobia (Kellett et al., 2009). There were differences in presentation both between and within study participants.

Whilst the range of level of intellectual ability and presenting problem is more representative of clinical practice, it creates heterogeneous groups, which limits the generalisation of findings. Impacts of the intervention, both positive and negative, may also be diluted within such heterogeneous groups. This might lead to unclear or incorrect conclusions being drawn from the results.

Internal Reliability Sampling

This subscale assesses the handling of confounding variables within the research. Only 10.8% of the quality rating was achieved by the studies reviewed, making it the weakest area for study quality. This score reflects the poor designs and methods employed by the studies. The only studies to contribute to this score were

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those with a case series/group design. However, they still only addressed 20% of the quality rating. This was due to the fact that no control group was used in any of these studies; therefore there was no protection against confounding variables and sampling bias.

Bichard et al. (1996) received the highest score on this subscale due to the inclusion of a contrast group of individuals referred to the service but who were unable to begin therapy, as there were no therapeutic vacancies. Within the contrast group there was no attempt to match or randomise the groups. Although Beail (1998, 2001) did not use a control group, four and five participants respectively who refused treatment were referred again because their problematic behaviour had remained unchanged.

In contrast, there have now been numerous methodologically robust published studies concerning the effectiveness and efficacy of psychodynamic psychotherapy with the general population (Shedler, 2010). However, these largely concern short-term psychodynamic psychotherapy. The lack of controlled studies also compares unfavourably with studies of CBT with people who have IDD. However, there are a larger number of practitioners providing CBT and also it is largely delivered in group formats.

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Discussion

The aim of this review was to systematically evaluate the quality of available literature pertaining to the efficacy and effectiveness of psychoanalysis, psychoanalytic and psychodynamic psychotherapy for individuals with IDD. No papers that were found from the systematic searches evaluated psychoanalysis, therefore the review focused on 13 studies reporting outcomes for psychoanalytic and psychodynamic psychotherapy. All of these studies were conducted in routine practice and therefore concern effectiveness. Overall, the studies suggest that psychoanalytic and psychodynamic psychotherapy can be effective, but with many reservations. Improvements in self-esteem, interpersonal problems and level of assimilation were reported. Symptomatic behaviour and offending were found to decrease and clients' satisfaction with therapy was high. However, there was variability in the findings across the studies.

The quality of the research was assessed using Cahill et al.'s (2010) checklist. No controlled studies were found during the searches, suggesting that research in the psychoanalytic and psychodynamic sphere has yet to follow the progress made in research with the general population and with CBT with people who have IDD. However, if viewed in relation to Salkovski's hourglass model (1995), studies are beginning to populate the levels before this. Of the studies reviewed, those that employed case series/group designs were assessed to be the highest quality across all subscales. No studies utilised a control group, however, Bichard et al. (1996) and Beail (1998) used a comparison of some form. The case study, single case design and the more explorative service user satisfaction studies provided

some measure of quality; however, as they did not include a comparison group they were considered to be a lower level of evidence (National Institute of Clinical Excellence [NICE], 2004).

The overall quality of the studies reviewed was poorer than the quality of studies utilising CBT, reviewed by Nicoll et al. (2013) using the same quality assessment framework. Quality rating scores for CBT research in Nicoll et al.'s review ranged from 15 to 29 ($M = 23.8$), and overall the studies addressed 74.6% of the checklist quality criteria with no less than 62% of checklist criteria being addressed across all subscales. Quality rating scores for psychoanalytic and psychodynamic research in this review ranged from 7 to 21 ($M = 12.2$), and overall the studies addressed only 38.5% of the checklist quality criteria, although some studies addressed up to 60% of the quality criteria on certain subscales. Comparing the quality ratings of the studies in the current review and Nicoll et al.'s (2013) review indicates that the research conducted into the effectiveness of CBT for clients with IDD is currently of a higher quality.

The studies reviewed offer evidence for both short- and longer term psychotherapy with individuals with IDD, but, there are large discrepancies in length of therapy, limiting comparison of the effectiveness of different durations of therapy. However, in a secondary analysis of the Beail et al. (2005) study, Beail, Kellett, Newman, and Warden (2007) found some evidence of a dose-effect relationship, in that recipients of different lengths of treatment made most gains in the earliest sessions as has been previously found in the general population (Hansen, Lambert, & Forman, 2002). Unfortunately, as this was a naturalistic study, the reasons for providing different lengths of treatment were not investigated. Also, few studies include follow-up data, but those that do suggest improvements are maintained. However, the small amount of follow-up data limits the inferences that can be made about the long-term impact of psychotherapy. This is unfortunate as research with the general population shows that psychodynamic psychotherapy has enduring effects (Shedler, 2010). Historical examination of robustness and assessment of internal reliability using a quality-rating tool evidenced an increasing integrity in the outcome measures being utilised. Only 3 of the 13 studies utilised standardised measures and they did not produce consistent findings. These measures had been developed for use with the general population rather than specifically for people who have IDD. Thus, their reliability and validity may be questionable. More psychotherapy outcome measures need to be adapted or specific scales developed for use with clients with IDD to improve the quality of research with this population.

Reporting of IQ across the studies was variable. Improving this will allow researchers to begin to evaluate the effectiveness of psychodynamic psychotherapy for specific levels of IDD and the adaptations needed to make it accessible to people of differing levels of IDD. Participants in all the studies reviewed were able to communicate verbally to some level. Individuals with limited or no verbal communication are not represented in the current body of research.

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The small sample sizes, substantial male bias, variety of presenting problems and variability in the level of intellectual disability resulted in poor *External Validity* scores. Whilst these factors may be a realistic representation of the clinical setting, it limits the generalisability of the findings. The difficulty faced when researching this population is that within each subset of presenting problems, or level of IDD, the numbers of referrals are extremely small. A national, multicentre initiative may need to be undertaken to allow for discrete groups within clients with IDD to be analysed as independent variables. However, this is a major undertaking and may not be feasible in view of high cost and resource implications of such studies. The only study so far on this scale has been of CBT for anger in people who have IDD (Willner et al., 2013). However, significant compromises had to be made; for example the therapy was delivered in groups randomised to treatment or no treatment, and the 12 session intervention was delivered by support workers in day centres, who had minimal training in following a manualised approach. The study received a grant for nearly one million pounds sterling, but many of those involved volunteered their time. No change was found on the primary outcome measure, but some change was noted on secondary measures. They found that the intervention cost was more than the treatment-as-usual cost. However, they were not able to determine whether the additional cost of the gains on secondary measures was offset by savings elsewhere in the care and support system (Felce et al., 2015).

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Review critique

The many previous reviews of psychodynamic and psychoanalytic psychotherapy with people who have IDD have not taken a systematic approach and used quality rating assessments. The use of Cahill et al.'s (2010) quality checklist provided a consistent template for appraising the studies and allowed comparison with Nicoll et al.'s (2013) systematic review of CBT, the hourglass model and the hierarchy of evidence. However, even though the checklist was adapted to suit practice-based evidence, it was still unresponsive to the details of uncontrolled studies. The low score on the *Internal Reliability* sampling subscale highlights this. As none of the studies were controlled, a floor effect was created on this subscale in understanding the development of research around interventions. The quality assessment framework chosen for this review placed more weight on research that would sit within Phase two and three of Thornicroft et al.'s (2011) schema. It fails to evaluate the studies that sit within the discovery phases (zero and one) of Thornicroft et al.'s (2011) schema. The view that more highly controlled studies provide a higher quality of evidence is widely held and informs the development of guidelines (e.g. NICE). If, however, we are to view research in terms of Thornicroft et al.'s (2011) schema we need to begin to view all research as a necessary and important part of a whole process and the tools used to assess research quality

need to reflect this. We also need to take into account that conducting high quality RCT's in small populations has many challenges.

The three service user studies included in this review also highlight the disadvantages of using the quality rating assessment chosen for this review. Increasing importance is being placed on involving service users in the planning, delivery and evaluation of services. Services frequently evaluate if clients have improved, but are also focused on how satisfied service users are with the service they receive. Qualitative methods (Beail & Williams, 2014) provide a valuable insight into people with IDD's experience of psychotherapy. Yet, as these studies are based on subjective feedback, assessing these qualitative methods against the parameters of the Cahill et al. (2010) tool devalues the findings such studies have to offer, as more weight is placed on objective measures. This is evidenced by the fact Khan and Beail's (2013) study is considered the highest quality service user study, which was largely due to their use of quantitative measures. However, Khan and Beail emphasise the importance of the inclusion of open-ended, qualitative questions to illicit dissatisfaction, which were not captured by questionnaires

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Conclusion

The results of this review indicate that evidence is emerging to show that psychoanalytic and psychodynamic psychotherapy can be effective in reducing psychological distress in individuals with an IDD. Research is beginning to advance from the descriptive case study, but no controlled studies have been published. In comparison to the cognitive-behavioural psychotherapy research with clients with IDD, studies in this area were of poorer quality. This review has highlighted the evidence for the effectiveness of psychoanalytic and psychodynamic psychotherapy, despite over 30 years of application in practice (Jackson & Beail, 2013), is still limited. There is a need for more research at all levels of evidence, but in particular there needs to be methodologies with greater control and comparison to furnish the current conceptualisation of evidence-based practice. Further, particular consideration should be paid to participants' level of IDD and presenting problem to begin to develop an understanding of what works for whom. Development of outcome measures, specifically for use with clients with IDD, should also be a focus of future research. This review highlights the caution that should be taken when assessing the quality of research with a quality rating tool. The specific tool chosen for this review was deemed to be most appropriate for less controlled, practice-based evidence. However, it still lacked sensitivity to the uncontrolled or qualitative nature of the studies reviewed here. In order to overcome this issue, studies could be rated within their own subgroup of design, or a more comprehensive tool, which covers strengths and weaknesses of all designs rather than considering the design itself to be a weakness, should be developed.

Disclosure statement

All papers were reviewed by the first author with validation checks by a doctoral student due to the second author's contribution to the literature reviewed.

References

Akobeng, A. K. (2005). Understanding randomised controlled trials. *Archives of Disease in Childhood, 90*, 840–844. doi:10.1136/adc.2004.058222

Alim, N. (2010). Therapeutic progressions of client and therapist throughout a course of psychodynamic therapy with a man with mild learning disabilities and anger problems. *Advances in Mental Health and Learning Disabilities, 4*, 42–49. doi:10.5042/amhld.2010.00

Barkham, M., Hardy, G. E., & Startup, M. (1996). The IIP-32: A short version of the Inventory of Interpersonal Problems. *British Journal of Clinical Psychology, 35*, 21–35. doi:10.1111/j.2044-8260.1996.tb01159.x

Beail, N. (1995). Outcome of psychoanalysis, psychoanalytic, and psychodynamic psychotherapy with people with intellectual disabilities. *Changes, 13*, 186–191.

Beail, N. (1998). Psychoanalytic psychotherapy with men with intellectual disabilities: A preliminary outcome study. *British Journal of Medical Psychology, 71*, 1–11. doi:10.1111/j.2044-8341.1998.tb01363.x

Beail, N. (2001). Recidivism following psychodynamic psychotherapy amongst offenders with intellectual disabilities. *The British Journal of Forensic Practice, 3*, 33–37. doi:10.1108/14636646200100006

Beail, N. (2003). What works for people with mental retardation? Critical commentary on cognitive-behavioural and psychodynamic psychotherapy research. *Mental Retardation, 41*, 468–472. doi:10.1352/0047-6765

Beail, N. (2010). The challenge of the randomized control trial to psychotherapy research with people with learning disabilities. *Advances in Mental Health and Learning Disabilities, 4*, 37–41.

Beail, N. (2016). *Psychological therapies and people who have intellectual disabilities*. Leicester: British Psychological Society.

Beail, N., Kellett, S., Newman, D. W., & Warden, S. (2007). The dose effect relationship in psychodynamic psychotherapy with people with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities, 20*, 448–454.

Beail, N., Warden, S., Morsley, K., & Newman, D. (2005). Naturalistic evaluation of the effectiveness of psychodynamic psychotherapy with adults with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities, 18*, 245–251. doi:10.1111/j.1468-3148.2005.00223.x

Beail, N., & Williams, K. (2014). Using qualitative methods in research with people who have intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities, 27*, 85–96. doi:10.1111/jar12088

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

Bichard, S., Sinason, V., & Usiskin, J. (1996). Measuring the change in mentally retarded clients in long-term psychoanalytic psychotherapy. *The Draw-a-person test. NADD Newsletter, 13*, 6–11.

Buck, J. (1948). The H-T-P technique, a qualitative and quantitative scoring method. *Journal of Clinical Psychology Monograph Supplement, 5*, 1–120.

Cahill, J. (2014). Clinically representative research in the psychological therapies: An emerging paradigm. *Research in Nursing, 18*, 97–111. doi:10.1177/1744987112465079

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Cahill, J., Barkham, M., & Stiles, W. B. (2010). Systematic review of practice-based research on psychological therapies in routine clinic settings. *British Journal of Clinical Psychology, 49*, 421–453. doi:10.1348/01446659X470789

Campbell, N. C., Murray, E., Darbyshire, J., Emery, J., Farmer, A., Griffiths, F., … Kinmonth, A. L. (2007). Designing and evaluating complex interventions to improve health care. *British Medical Journal, 334*, 455–459.

Carlsson, B. (2000). Psychoanalytic Psychotherapy with intellectually disabled adults – evaluation by using projective tests: A collaboration project between a psychiatric clinic and the services for mentally handicapped. *NADD Bulletin, 3*(5), Article 3. Retrieved from http://thenadd.org/modal/bulletins/v3n5a3~.htm

Centre for Reviews and Dissemination. (2009). *Systematic reviews: CRDs guidance for understanding reviews in health care*. York: University of York.

Commission for Health Improvement. (2002). *The experience of service questionnaire handbook*. London: Author.

Critical Appraisal Skills Programme. (2006). *Critical appraisal skills programme: Making sense of evidence*. Oxford: Public Health Resource Unit.

Davis, C., Kellett, S., & Beail, N. (2009). Utility of the Rosenberg self-esteem scale. *American Journal on Intellectual and Developmental Disabilities, 114*, 172–178. doi:10.1352/1944-7558-114.3.172

DeGroef, J., & Heineman, E. (1999). *Psychoanalysis and mental handicap*. London: Free Association Books.

Derogatis, L. R., Lipman, R. S., & Covi, L. (2007). *Symptom checklist: SCL – 90*. Zurich: Psychiatric University Hospital Zurich.

Derogatis, L. R., & Spencer, P. M. (1993). *Brief symptom inventory: BSI*. Upper Saddle River, NJ: Pearson.

Downs, S. H., & Black, N. (1998). The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of health care interventions. *Journal of Epidemiology & Community Health, 52*, 377–384. doi:10.1136/jech.52.6.377

Felce, D., Cohen, D., Willner, P., Rose, J., Kroese, B., Rose, N, … Hood, K. (2015). Cognitive behavioural anger management intervention for people with intellectual disabilities: Costs of intervention and impact on health and social care resource use. *Journal of Intellectual Disability Research, 59*, 68–81. doi:10/1111/jir.12112

Fletcher, R. J. (1993). Individual psychotherapy for persons with mental retardation. In R. J. Fletcher & A. Dosen (Eds.), *Mental health aspects of mental retardation* (pp. 327–349). New York, NY: Lexington Books.

Fletcher, R. J. (2011). Introduction. In R. J. Fletcher (Ed.), *Psychotherapy for individuals with intellectual diability* (pp. 1−9). New York, NY: NADD Press.

Flynn, A. (2012). Fact or faith? *Current Opinion in Psychiatry, 25*, 342–347. doi:10.1097/YCO.0b013e328355e196

Frankish, P. (2016). *Disability psychotherapy*. London: Karnac.

Hamelin, J., Travis, R., & Sturmey, P. (2013). Anger management and intellectual disabilities: A systematic review. *Journal of Mental Health Research in Intellectual Disabilities, 6*, 60–70. doi:10.1080/19315864.2011.637661

Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The psychotherapy dose effect and its implications for treatment delivery services. *Clinical Psychology: Research and Practice, 9*, 329–345.

Higgins, J. P. T., & Altman, D. G. (2008). Assessing risk of bias in included studies. In J. P. T. Higgins & S. Green (Eds.), *Cochrane handbook for systematic reviews of interventions* (pp. 187−241). Chichester: John Wiley and Sons.

Ho, P. M., Peterson, P., & Masoudi, F. (2008). Evaluating the evidence: Is there a rigid hierarchy? *Circulation, 118*, 1675–1684.

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Jackson, T., & Beail, N. (2013). The practice of individual psychotherapy with people who have intellectual disabilities. *Psychoanalytic Psychotherapy, 27*, 1–16. doi:10.1080/02668734.2013.798680

James, C., & Stacey, J. (2014). The effectiveness of psychodynamic interventions for people with learning disabilities: A systematic review. *Tizard Learning Disability Review, 19*, 17–24. doi:10.1108/TLDR-10-1012-0009

Kellett, S., Beail, N., Bush, A., Dyson, G., & Wilbram, M. (2009). Single case experimental evaluations of psychodynamic and cognitive-behavioural psychotherapy: Examples of methods and outcomes. *Advances in Mental Health and Learning Disabilities, 3*, 36–44. doi:10.1108/17530180200900038

Kellett, S., Beail, N., & Newman, D. W. (2004). The factor structure of the Brief Symptom Inventory: Intellectual disability evidence. *Clinical Psychology and Psychotherapy, 11*, 275–281.

Kellett, S., Beail, N., & Newman, D. (2005). Measuring interpersonal problems in people with mental retardation. *American Journal on Mental Retardation, 110*, 136–144. doi:10.1352/0895-8017

Kellett, S., Beail, N., Newman, D., & Frankish, P. (2003). Utility of the Brief Symptom Inventory in the assessment of psychological distress. *Journal of Applied Research in Intellectual Disabilities, 16*, 127–134. doi:10.1046/j.1468-3148.2003.00152.x

Kellett, S., Beail, N., Newman, D., & Mosley, E. (1999). Indexing psychological distress in people with an intellectual disability: Use of the symptom checklist-90-R. *Journal of Applied Research in Intellectual Disabilities, 12*, 323–334. doi:10.1111/j.1468-3148.1999.tb00088.x

Khan, M. M., & Beail, N. (2013). Service user satisfaction with individual psychotherapy for people with intellectual disabilities. *Advances in Mental Health and Intellectual Disabilities, 7*, 227–283. doi:10.1108/AMHID-06-2913-0046

Kragh, U. (1969). *Manual till DMT. Defence mechanism test*. Stockholm: Skandinaviska Testforlaget AB.

Landis, J. R., & Koch, G. G. (1977). The measurement of observer agreement for categorical data. *Biometrics, 33*, 159–174. doi:10.2307/2529310

MacDonald, J., Sinason, V., & Hollins, S. (2003). An interview study of people with learning disabilities' experience of, and satisfaction with, group analytic therapy. *Psychology and Psychotherapy: Theory Research and Practice, 76*, 433–453. doi:10.1348/147608303770584764

Merriman, C., & Beail, N. (2009). Service user views of long-term individual psychodynamic psychotherapy. *Advances in Mental Health and Learning Disabilities, 3*, 42–47. doi:10.1108/17530180200900020

National Institute of Clinical Excellence. (2004). *Reviewing and grading evidence. Guideline development methods*. London: Author. Retrieved from http://www.nice.org.uk/niceMedia/pdf/GDM_Chapter7_0305.pdf

Newman, D., & Beail, N. (2005). Analysis of assimilation during psychotherapy with people who have mental retardation. *American Journal on Mental Retardation, 110*, 359–365. doi:10.1352/0895-8017

Newman, D., & Beail, N. (2010). An exploratory study of the defence mechanisms used in psychotherapy by adults who have intellectual disabilities. *Journal of Intellectual Disability Research, 54*, 579–583. doi:10.1111/j.1365-2788.2010.01250.x

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

Nicoll, M., Beail, N., & Saxon, D. (2013). Cognitive behavioural treatment for anger in adults with intellectual disabilities: A systematic review and meta-analysis. *Journal of Applied Research in Intellectual Disabilities, 26*, 47–62. doi:10.1111/jar.12013

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Nilsson, A. (1995). Differentiation between patients with schizophrenia and borderline disorders in the Percept-genetic Object-Relation Test, PORT. *British Journal of Medical Psychology, 68*, 287–309. doi:10.1111/j.2044-8341.1995.tb01837.x

O'Driscoll, D. (2009). Psychotherapy and intellectual disability: A historical view. In T. Cottis (Ed.). *Intellectual disability, trauma and psychotherapy* (pp. 9−28). London: Routledge.

Oei, T. P. S., & Green, A. L. (2008). The Satisfaction with Therapy and Therapist Scale – Revised (STTS-R) for group psychotherapy: Psychometric properties with confirmatory factor analysis. *Professional Psychology: Research and Practice, 39*, 435–442. doi:10.1037/0735-7028.39.4.435

Perry, J. C. (1990). *The defence mechanisms rating scale manual* (5th ed.). Cambridge, MA: J.C. Perry.

Prout, H. T., & Nowak-Drabik, K. (2003). Psychotherapy with persons who have mental retardation: An evaluation of effectiveness. *American Journal on Mental Retardation, 108*, 82–93. doi:10.1352/0895-8017

Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton: Princeton University Press.

Roth, A., & Fonagy, P. (2005). *What works for whom? A critical review of psychotherapy research*. London: Guildford.

Salkovskis, P. M. (1995). Demonstrating specific effects in cognitive and behavioural therapy. In M. Aveline & D. Shapiro (Eds.), *Research foundations for psychotherapy practice* (pp. 191–228). Chichester: Wiley.

Salvadori, A., & Jackson, T. (2009). A structured account of short-term psychodynamic psychotherapy with a man with learning disabilities. *Advances in Mental Health and Learning Disabilities, 3*, 31–35. doi:10.1108/17530180200900037

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist, 65*, 98–109.

Sinason, V. (1992). *Mental handicap and the human condition: New approaches from the Tavistock*. London: Free Associations.

Stiles, W. B., Elliott, R., Llewelyn, S. P., Firth-Cozens, J. A., Margison, F. R., Shapiro, D. A., & Hardy, G. E. (1990). Assimilation of problematic experiences by clients in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 27*, 411–420. doi:10.1037/0033-3204.27.3.411

Thornicroft, G., Lempp, H., & Tansella, M. (2011). The place of implementation science in the translational medicine continuum. *Psychological Medicine, 41*, 2015–2021. doi:10.1017/S0033291711000109

Vereenooghe, L., & Langdon, P. (2013). Psychological therapies for people with intellectual disabilities: A systematic review and meta-analysis. *Research in Developmental Disabilities, 34*, 4085–4102. doi:10.1016/j.ridd.2013.08.030

Wells, K., & Littell, J. H. (2009). Study quality assessment in systematic reviews of research on intervention effects. *Research on Social Work Practice, 19*, 52–62.

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

Willner, P., Rose, J., Jahoda, A., Stenfert Kroses, B., Felce, D., Cohen, D., … Hood, K. (2013). Group-based cognitive-behavioural anger management for people with mild to moderate intellectual disabilities: Cluster randomised controlled trial. *The British Journal of Psychiatry, 203*, 288–296. doi:10.1192/bjp.bp.112.124529

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