MENTAL RETARDATION AND EMOTIONAL DISORDERS:

ASSESSMENT AND PSYCHOTHERAPY

Sol R. Rappaport

INTRODUCTION

People with mental retardation[1] who have behavioral/emotional difficulties have historically been denied (or not provided with) psychotherapy (Cushin, Szymanski, & Tanguay, cited in Reiss, Levitan, & Szyszko, 1982). Jacobson (1983) indicates that 33 percent of dually diagnosed people need more frequent or intensive services than they receive. This lack of psychotherapeutic services has occurred for a number of reasons. First, it was believed that people with mental retardation had a limited intellectual capacity which prevented them from being successful in psychotherapy (Szymanski & Kiernan, 1983). Second, there has been little attention paid to the psychodynamics of people with mental retardation (Panigua & De Fazio, 1983). Related to this, many professionals did not recognize that people with mental retardation can have mental illnesses; there has been a tendency to underestimate the prevalence of emotional problems in this population (Panigua & De Fazio, 1983). Finally, people with

Advances in Special Education, Volume 9, pages 119-146.

ISBN: 1-55938-691-6

mental retardation have not received services in part because there have been too few therapists trained in working with people with mental retardation (Cushin, Szymanski, & Tanguay, cited in Reiss, Levitan, & Szyszko, 1982). Unfortunately, many psychiatrists, psychologists, social workers, and other counselors still erroneously believe some previously stated fallacies to be true.

This chapter will mainly address the assessment process and techniques of psychotherapy with people with mental retardation. The prevalence of mental illnesses in people with mental retardation (dual diagnosis), training curriculums, and legal issues will be briefly addressed. Before discussing assessment and psychotherapy of people with mental retardation, as well as other issues, it is vital to fully understand the extent to which people with mental retardation are affected by mental illnesses and to dispel many of the myths regarding people with mental retardation.

MYTHS

Myth 1: Mental retardation causes people to have a mental illness.

Response 1: While many people with mental retardation have a mental illness, they do not get them because they have mental retardation.

Myth 2: People with mental retardation do not experience the same emotions or intensity of emotions as people without mental retardation.

Response 2: People with mental retardation do experience the same emotions and intensity of emotions as other people (Prout & Cale, 1994).

Myth 3: People with mental retardation do not have the cognitive abilities to benefit from psychotherapy.

Response 3: People with mental retardation do have the ability to benefit from psychotherapy. However, depending on their cognitive abilities the psychotherapist may have to alter their style of psychotherapy and break some of the traditional modes of psychotherapy. Also, as far back as 1948 (Thorne) there was literature indicating that psychotherapy is appropriate for people with mental retardation.

Myth 4: People with mental retardation who demonstrate behavioral problems do so because they have mental retardation.

Response 4: No. While many people who have mental retardation have behavioral problems, they do not have them because they have mental retardation. People with mental retardation have behavior problems for the same reasons that other people have behavior problems. Some of the reasons are because they (a) have not learned that a behavior is not socially acceptable, (b) have not been taught more acceptable behaviors, (c) have a

mental illness, (d) have difficulty coping with stress, or (e) demonstrate behavior problems as a functional way of adapting to their environment.

PREVALENCE RATES

There is much controversy regarding the accuracy of the prevalence rates of mental illness in people with mental retardation. This controversy centers around issues of selection bias and diagnostic imprecision (Crabbe, 1989). While there are flaws in the research, there is a consensus based on numerous studies which have concluded that people with mental retardation have a higher rate of psychiatric disorders than people without retardation (Small, 1989; Tanguay, cited in Tanguay & Russell, 1991). Matson (1992) found an overall prevalence rate of 41.7 percent for people with mild and moderate mental retardation. Menolasino (cited in Crabbe, 1989) estimates the prevalence rate is 20 percent to 35 percent for people living in the community and 60 percent for people living in institutions. Reiss (1985) gives a more conservative estimate of between 10 percent and 15 percent of all children with mental retardation and 15 percent and 20 percent of adults with mental retardation. Research will likely continue to show a large variance in the prevalence rates of mental illness in people with mental retardation as different criteria and assessment devices are used in the diagnostic process.

Numerous research studies have addressed the frequency of specific emotional problems in people with mental retardation. Jacobson (1982) found that 13.5 percent of people with mental retardation demonstrate significant antisocial behavior. This study included children and adults in numerous types of residential settings. McNally (1991) cites studies assessing the frequency of neurotic disorders and found ranges of 9 percent to 26 percent of people with mental retardation. A more recent study (Harris, Alessandri, & Gill, 1991) reports that 16.6 percent of people with mental retardation have an anxiety disorder. Matson (1992), using the PIMRA with adults with mild or moderate mental retardation, found a rate of 19.3 percent for adjustment disorders, 14.2 percent for personality disorders, 13.3 percent for somatoform disorders, 9.2 percent for affective disorders, and 9.1 percent for schizophrenia.

Depression tends to be underdiagnosed in people with mental retardation (Charlot, Doulette, & Mezzacappa, 1993). However, within the population of people with mental retardation depression occurs more often in people with mild retardation than in people with severe retardation (Reiss, 1985). Recent research (Mattes & Amsell, 1993) suggests that the Dexamethasone Suppression Test (DST) may be useful in diagnosing depression in people with mental retardation. This test may be especially useful for people with severe and profound mental retardation due to their communication difficulties.

Pary (1993) reports that for hospitalized adults with mental retardation 17.3 percent had a diagnosis of paranoid schizophrenia. The second most common diagnosis Pary found was atypical psychosis (7.2%). Contrary to this, Reiss (1985) states that active psychosis is much less common than schizoid behavior in adults with mental retardation. Therefore, there is still uncertainty surrounding the frequency with which specific mental illnesses occur in people with mental retardation. Finally, without addressing mental illness per se, Mulick, Hammer, and Dura (1991) reported that the rate of behavior problems increases as the degree of mental retardation increases. These authors also state that as a settings restrictiveness increases (i.e., where the person lives) the rate of behavior problems will also increase.

ASSESSMENT

Completing assessments of people with mental retardation involves taking into account certain factors which are often not considered when evaluating people without mental retardation. People with mental retardation have reduced communication, cognitive, and conceptual abilities (Szymanski, 1977). Because of these difficulties, diagnosticians must adapt their approach to the client's level of functioning in order to obtain accurate information. Evaluators must also consider other reasons for a person's behavioral/emotional problems than those that are ordinarily considered for people without mental retardation.

Evaluators must be more active when interviewing people with mental retardation in regards to eliciting information. Specific rather than general questions should be asked (especially with people with moderate or severe mental retardation). Also, people with mental retardation often wish to please others and are highly susceptible to suggestibility (Szymanski, 1977). Interviewers must try to avoid leading questions or demonstrating nonverbal behavior which suggests a certain response.

Behavior as Communication

While most people can indicate what they are thinking, feeling, and needing, people with mental retardation, especially those in the moderate to severe range, have difficulty verbally communicating these. Therefore, they often express their thoughts, feelings, and needs through actions. For example, physical illnesses may be communicated through disruptive behavior.

> A 26-year-old female with severe mental retardation became physically aggressive for about two days every month or two. As the pattern of when the aggression occurred was evaluated it became clear that it occurred during her menstruation. When she became aggressive the physician prescribed motrin (as needed). This almost immediately stopped the physical aggression.

People with mental retardation who have poor verbal communication often use behavior as a method of communication. When evaluating a client for the possibility of an emotional disturbance, it is vital to assess how much (if any or all) of the behavior is a way of letting their thoughts, feelings, or needs be known versus being a symptom of a psychiatric disturbance. If the former is found to be true then the examiner must evaluate whether the person knows or can be taught more socially acceptable ways of communicating their thoughts, feelings, or needs. Often it will take longer for someone with mental retardation to learn new behaviors (Jakab, 1982) due to deficits in memory and other cognitive difficulties. It is important for examiners to be patient and not to automatically view this as resistance or defensiveness.

Four Factors in the Assessment Process

When assessing a person with mental retardation for psychopathology, interviewers must often rely on other people's accounts of the client's behavior since many people with mental retardation have difficulty describing their own behavior and emotions. Sovner (1986) refers to this difficulty in thinking abstractly and in communicating as *intellectual distortion.* Due to this intellectual distortion it is almost impossible for an evaluator to identify psychotic features in people with an IQ below 50 (Corbett, cited in Szymanski, 1977).

Sovner discusses three other factors associated with mental retardation which influence the diagnostic/assessment process. *Psychosocial masking* refers to people with mental retardation's limited social skills and life experiences which often result in a presentation style of appearing bland and unsophisticated (Szymanski, 1977). When this occurs examiners must be careful not to overlook the possibility that a psychiatric disorder does exist even though the person's symptoms are not described with as much flavor as is often found in people with a mental illness who do not have mental retardation.

Cognitive disintegration, Sovner's third factor, is one of the most important concepts to keep in mind when evaluating people with mental retardation. When people with mental retardation experience stress the results can be cognitive disintegration, or poor information processing and disorganization of thoughts. This disorganization, and at times poor reality testing, under stress often appears as psychotic-like symptoms. Thus, many people who have difficulty processing information under stress get misdiagnosed as having schizophrenia (Szymanski, 1977). Therefore, a bizarre presentation in a person with mental retardation must be scrutinized carefully to assess whether the presentation is due to psychosis (or another psychiatric disorder) or cognitive disintegration. Sovner's final factor is *baseline exaggeration.* Pre-existing cognitive deficits and maladaptive behaviors often increase in severity when

a person is experiencing stress. This baseline exaggeration of behaviors must be evaluated closely to determine how much of the person's current difficulties are an exacerbation of symptoms and how much are due to new symptoms. When an exacerbation of symptoms occurs, it is important to assess whether one is observing the beginning of a psychiatric disorder. Examiners must not rule out the possibility of a more severe emotional disturbance solely based on a person not presenting new symptoms.

Other Factors in the Assessment Process

When evaluating people with mental retardation the diagnostician must carefully consider whether the use of immature defenses are due to a poor ability to conceptualize information (which may be due to an evaluator asking questions the client does not understand), or to psychopathology (Szymanski, 1977). Difficulty following a conversation during the evaluation or in observations may be due to cognitive limitations rather than a thought disorder. Related to this, when assessing the possibility of schizophrenia it is important to remember people with mental retardation who have schizophrenia do not use sophisticated defenses (Reiss, 1985). Their psychotic episodes are ordinarily precipitated by what most people would consider ordinary events (Reiss, 1985). Finally, the evaluator must not allow the client's limited cognitive abilities to overshadow the possibility of an emotional disorder (Reiss, Lentan, & Szyszko, 1982).

Medical Assessment

When a referral is received for an evaluation due to an increase in problematic behaviors, it may be important to have the person evaluated by a physician. Typically, a physician will complete a routine examination (Nezu, Nezu, & Gill-Weiss, 1992). A neurological exam may also be done, especially if the person is demonstrating psychotic-like behaviors or is experiencing a sudden decrease in cognitive abilities. Routine blood tests are also often completed (Nezu et al., 1992). Depending on the physical and behavioral characteristics of the person, a test for Fragile X Syndrome may also be conducted. If there is a possibility of a depressive disorder, the dexamethasone suppression test (DST) may be a useful diagnostic tool (Mattes & Amsell, 1993). Overall, the purpose of the referral to a physician is to make sure there is not something physically wrong with the person which they are unable to verbally communicate themselves.

Mental Status Examination

A standard part of any evaluation is the completion of a mental status exam. This is necessary in order to make an accurate diagnosis and to formulate an

appropriate treatment plan (Small, 1989). When completing a mental status exam on a person with mental retardation, it will be difficult to use a structured, traditional mental status exam due to the person's difficulty understanding the questions and/or due to distractibility and poor communication (Small, 1989). It may be necessary to have several short sessions (rather than one long session) and to observe the person in their own surroundings (Small, 1989). It is also important to obtain a detailed family history from relatives. During the interview the examiner needs to assess the following areas: appearance, orientation, speech delivery and speech content, thinking, attention, concentration, memory, intellectual functioning, emotional state, insight, and special preoccupations and perceptual experiences (Lezak, cited in Nezu, Nezu, & Gills-Weiss 1992). Throughout this evaluation process the examiner must always take into consideration the effects of the person's mental retardation on the above areas.

Questionnaires

During the process of an evaluation it is helpful to use assessment instruments which have normative data on people with mental retardation. One such scale is the Psychopathology Instrument for Mentally Retarded Adults (PIMRA) (Matson, Kazdin, & Senatore, 1984). The PIMRA was developed using criteria from the DSM-III. This instrument assesses seven areas of psychopathology. These areas are affective, psychosocial, anxiety, somatoform, schizophrenic, adjustment, and personality disorders. The PIMRA is a reliable and useful measure of evaluation for these areas of psychopathology in adults with mental retardation.

The SRDQ, or Self-Report Depression Questionnaire (Reynolds & Baker, 1988), is another assessment measure designed for use with people with mental retardation. This test is appropriate for high-functioning people with retardation since it assesses depression through self-report. A third scale is the Dementia Mood Assessment Scale (Sunderland et al., 1988). This is a 24-item questionnaire designed to focus on mood and functional capacities (Tanguay & Russell, 1991). Other scales which are often used with people with mental retardation include the Aberrant Behavior Checklist (Aman, Singh, Stewart, & Field, 1985), Emotional Disorders Rating Scale for Developmental Disabilities (Feinstein, Kaminer, Barrett, & Tylenda, 1988), and the Reiss Screen (Reiss, 1988). The fact that the devices just described are reliable and valid adds support to the belief that psychiatric disorders in high-functioning people with mental retardation do not appear significantly different than in people without retardation.

Final Determinations

During the process of a diagnostic evaluation the examiner must determine whether a mental illness exists. This, at times, is difficult since the categories

in the DSM-IV are not inclusive for describing or classifying behavioral/emotional problems in people with mental retardation. With this in mind there are principles evaluators should consider to assist them in determining whether a mental illness exists in a person with mental retardation. These principles are as follows (Sovner & Hurley, 1989):

1. People with mental retardation demonstrate the full range of mental illnesses.
2. Psychiatric disorders typically are demonstrated through maladaptive behaviors.
3. An acute mental illness may be exhibited by an exaggeration of longstanding problematic behaviors.
4. "The clinical interview is rarely diagnostic" (p.11).

This final principle is the most important. When an adult without mental retardation goes to a physician he or she is able to describe to them the illness. For example, he or she can tell the physician that they feel nauseous, have a headache, and feel dizzy. If the physician did not have this information he or she would have a more difficult time making a diagnosis since he or she would have to rely on observations and reports from others. When a psychiatrist, psychologist, social worker, or other counselor completes an evaluation on a person with mental retardation, he or she must consider the possibility that the person is not accurately able to describe their internal thoughts and feelings. Like the physician, this makes the process of determining whether or not a mental illness exists more difficult. It also indicates the importance of obtaining information from other sources as well as from observations.

PSYCHOTHERAPY

When conducting psychotherapy with people with mental retardation, the approaches/techniques used in sessions have to be adapted to fit the needs of the client. There are two types of changes which need to occur. The first are general adaptations which must be taken into consideration when working with a person with mental retardation. Some of these relate to the first session or goal setting while others are pertinent to therapeutic sessions in general. The second are unique issues (and at times techniques) that are relevant for people with mental retardation rather than general changes in the therapists style or approach.

Adaptations in Psychotherapy

After briefly reviewing indications for psychotherapy for people with mental retardation, alterations in the therapeutic approach which must be considered

when seeing a client with mental retardation in psychotherapy are presented. These adaptations are relevant to both individual and group psychotherapy. While these adaptations are vital for the successful treatment of people with mental retardation, it is important to respect and value those with mental retardation as people. For many people with mental retardation the therapist's respect for them and value in them can be extremely therapeutic. This is especially true for those clients who do not feel they have received this respect from other people.

Indications for Psychotherapy

Prior to beginning psychotherapy it must be determined whether a client is appropriate for psychotherapy. Psychotherapy can be done with people who function above a six-year-old level of cognitive development (Prout & Cale, 1994). People who function below this level may benefit from professional interventions, but may not be appropriate for individual psychotherapy (of course, there are always exceptions). Once it is determined a client has the cognitive functioning to benefit from psychotherapy the choice of techniques and goals will depend on their level of cognitive development (Szymanski, 1980). People functioning in the low moderate range of mental retardation are likely to require more behavioral techniques and the teaching of specific behaviors in a concrete manner than people who have mild mental retardation.

The factors which influence decisions regarding whether a person with mental retardation is appropriate for psychotherapy are essentially the same as for people without mental retardation. People with mental retardation are appropriate for psychotherapy when there is an emotional/behavioral disturbance affecting their functioning, when they have the ability to form a relationship with the therapist, when they have a desire to change or at least a willingness to assess whether changing their behavior would be helpful, and when they are able to communicate sufficiently (verbally or nonverbally).

First Session(s)

When seeing a client for the first time it is important not to assume the client wants to be there, or even knows whey he/she is at the office. Most people with mental retardation enter psychotherapy at the request or requirement of someone else. It is vital for the therapist to ask the client the reason that he/she thinks they are there (Tanguay & Russell, 1991). It is also important to ask the client what he/she thinks will happen during the sessions. Does the client view seeing the therapist as a punishment? A good question to assess some of the above (as well as family or agency dynamics) is "what did *name* tell you about why you are here?" Regardless of what the client tells the therapist, it is important for the therapist to be honest with the client and tell

the client what he or she was told about the client's difficulties. To avoid having the client view therapy as a negative event, as well as to indicate to the client that psychotherapy is not just about problematic behaviors, it is helpful to tell the client something positive that they were told about them. Therefore, it is not only important to ask about problems, but to also ask about relative strengths. If the client has been in psychotherapy before, the therapist should find out what the client liked and disliked about the treatment (Hurley & Hurley, 1986).

Aside from evaluating what the client and family/agency view as the reasons for the client being in psychotherapy, it is necessary to begin the process of educating the client about psychotherapy. The therapist will likely need to indicate that psychotherapy is not a punishment (Pondilla, 1993). The therapist must also inform the client about the length of each session, the frequency of sessions, as well as the payments (a subject most therapists initially feel uncomfortable with and one in which they rarely receive training). The client also needs to be educated about what occurs in the psychotherapy session. Some clients have little or no preconceived ideas about psychotherapy. Part of this process includes teaching them that they must be active in psychotherapy. This is often difficult for them to understand since they are often used to having other people control their lives and make decisions for them.

Issues of confidentiality must also be addressed. People with mental retardation who live (or have lived) in group homes or institutions may have difficulty initially trusting a therapist since they are often used to having a treatment team (sometimes called interdisciplinary team) inform each other of all aspects of the client's life. If the therapist works for a residential facility he or she may encounter staff who become upset that psychotherapy is confidential. It is recommended that therapists inform people who work with the client about the boundaries of confidentiality prior to the start of psychotherapy. The client must also be informed of this. Finally, since people with mental retardation have more difficulty remembering information than people without mental retardation, it is necessary to repeat/review much of the information discussed in the first session (and other sessions) in later meetings.

Goals of Psychotherapy

When working with people with mental retardation it is vital to have the psychotherapy goal oriented. The goals need to be more specific than in psychotherapy with people without mental retardation. They also may be simpler goals (Abel, 1953) depending on the client. For example, an initial goal of psychotherapy with a 35-year-old male with mental retardation who is angry may be to have him or her identify the emotion as anger. While for most adults

this may seem trivial, with people with mental retardation the goals often need to be more basic (at least initially).

The goals encountered in psychotherapy may at times seem more unusual than those found in people without mental retardation.

> A 24-year-old male with moderate mental retardation was having difficulty ejaculating during masturbation. It appeared that this frustration led him to insert objects into his penis. The low frequency of this behavior suggested that artificially created rewards and consequences would not be useful in reducing this behavior (after all, what consequence could be created that would be worse than the naturally occurring consequence of pain from inserting a paperclip into a penis). The approach used was to teach him to complete the masturbation with the intent that this would reduce his dysfunctional (and dangerous) behavior. Unfortunately, towards the end of the treatment the client moved to another state. It is unclear whether his insertion of objects was stopped.

There are certain goals therapists will repeatedly find a need to address with many people with mental retardation. Some of these goals are teaching people acceptable ways of expressing anger (and other emotions), and helping people separate from overprotective parents (Tanguay & Russell, 1991). Other goals include helping the client recognize their strengths, gain impulse control, and set realistic goals for themselves. Some clients present with issues of low self-esteem (Bregman, 1991).

At some point during psychotherapy it may be important to address the issue of what it means to the client to have mental retardation.

> A 22-year-old female with mild mental retardation moved from an institution with little contact in the community to an apartment in a large apartment complex in the community. With the one exception, her behavior did not appear different when she was in her apartment as compared to living in the institutional setting. The exception is that she refused to leave her apartment to go to a shopping mall, grocery store, or other place in the community. She did not appear depressed and the staff assumed her refusal to go out was based on being oppositional to staff. During psychotherapy it became known that the client withdrew from going out in the community because she realized for the first time that she was not like other people and wanted to be like them. At this point the goal of psychotherapy switched to helping the client accept that she is different and to explore these differences.

When setting goals in psychotherapy, it may be helpful to develop contracts which can be reviewed on a regular basis. There are two purposes for using contracts. First, since they are regularly reviewed, it helps both the therapist and client remain on the task of working towards the goals. The second advantage of using a contract is that it reminds the client that he or she is an active participant in psychotherapy and that he or she has responsibility toward working at achieving the goals. Finally, therapists must be patient in working towards a client's goals because they may take longer to reach than when working with people without mental retardation.

Flexibility

Doing psychotherapy with people who have mental retardation requires the therapist to be flexible in ways with which they may not be accustomed. It may also require the therapist to violate therapeutic norms that they may have been taught during graduate school. Sessions often will be shorter than the typical 50 minutes. Sessions may need to be 30 minutes, or even 15 minutes long depending on the client's level of attention. Sessions may also need to occur more frequently than the traditional once each week. If sessions are closer together, the likelihood of the client remembering information from session to session increases, which will in all likelihood increase learning.

The therapist must be willing to change approaches when the ones being used are not beneficial. For example, if a therapist tries to teach a client impulse control by teaching muscle relaxation and deep breathing, they may have to alter their strategy if this is not helping. Hopefully, the therapist would use other approaches in conjunction with the relaxation and deep breathing so that changing the approach would not seem disjointed to the client.

Therapists must be willing to leave the comfort of their own office and go into the client's world. Sessions may include observing the client practice a skill in their own environment. These live observations can be used as teaching opportunities as well as a chance for the therapist to evaluate the effectiveness of what has been addressed in previous therapy sessions.

> A 32-year-old male was being seen in psychotherapy because of his becoming angry easily and responding to this anger by not responding to other people, raising his voice in anger, and/or telling people to leave him alone. In psychotherapy it became clear that he became angry when people interrupted him, spoke too fast, or requested more of him than he could remember. He responded to these situations by becoming angry. It also became evident that he became angry because in these situations he was unable to process the information as quickly as other people were expecting. When this occurred he became frustrated and would at times become quiet. Other people responded to this as though he was ignoring them when in fact he was trying to process the information. If he became very frustrated he would respond by becoming angry, raise his voice, and tell people to leave him alone. As a part of the psychotherapy the therapist went to his vocational training center following a session where he reported being angry at one of the staff who worked there. During the therapist's observations it was noticed that the staff person spoke fast and at times told the client to do things without assessing whether or not the client understood the request. The therapist used this opportunity to meet with the client and the staff person to do role playing. As a result the staff person obtained a better understanding of this client's processing difficulties and the therapist had an opportunity to observe the client and address psychotherapy issues in a real life situation. Finally, during future sessions the therapist and client role played how the client can ask staff at the vocational training center to speak slower.

A part of being flexible includes doing what the staff in the above example was taught. Psychotherapists must often speak at a slower rate and in shorter sentences to allow the client time to process the information presented.

Concreteness/Specificity/Rephrasing

Psychotherapists must be more concrete and specific when speaking with people with mental retardation. Concreteness refers to using words which have physical boundaries. For example, if a client does not understand the concept of time then it will likely be frustrating for them if the therapist asks them at what time they eat dinner. If a client does not indicate that they do not understand the questions and the therapist does not assess the client's understanding of the questions, psychotherapy may come to an impasse. The therapist may become frustrated and feel the client is being oppositional. The client may become frustrated and lower their level of motivation in psychotherapy as well as their faith in the therapist. Therefore, therapists must regularly check whether a client understands what is asked or said to them. This is best done by requesting they rephrase what was said to them to make sure the therapist knows the client understood what was said. By doing this regularly the therapist will learn more about how concrete he or she must be when talking with the client. This may decrease the client's frustration level and result in an increase in the client's motivation. Finally, two other reasons for having a client rephrase (not repeat) questions/statements are (a) people with mental retardation are often socialized not to be assertive or say when they are confused, and (b) many clients can repeat (not rephrase) what was said without understanding it.

Aside from using concrete words and asking the client to rephrase questions/statements, it is also important to ask specific questions. General questions will lead to frustration for the therapist and some amusing answers from clients. For example, during a psychiatric evaluation a 20-year-old female was asked how she slept at night. She responded by saying "with my eyes closed." "Did you wake up during the night last night" would have been a more specific question. A series of related questions could then be asked following this to obtain a better understanding of how the client sleeps at night.

Specificity also refers to not taking definitions for granted. For example, when a client says they are mentally retarded the therapist should ask what they mean by mental retardation. Communication problems will develop in psychotherapy if the client and therapist do not use the same meaning for words.

Directiveness/Limit Setting

Psychotherapists need to be more directive when doing psychotherapy with people who have mental retardation (Hurley, 1989; Russell, 1989). Therapists who are nondirective are often perceived by clients as uninterested and uncaring. In being directive the therapist often needs to structure sessions and provide the topics for discussion (based on the needs of the client). While there

are clients who will bring in their own topics for discussion, many clients need the therapist to help them maintain goal directiveness in sessions.

In the psychotherapy session the therapist must often prevent the client from demonstrating disruptive behaviors. The limits are placed on the client not because they are more aggressive, but because they may be overactive or may not know a more appropriate behavior (Szymanski, 1980). Limits should be brief, clear, positive, and concrete. For example, it is better to say "we must sit quietly so that people can work in their offices without being disturbed" than "don't be loud."

Therapeutic Activities

Since there is a need to be concrete, specific, and structured, certain activities will be useful in psychotherapy to help clients with their emotional and/or behavioral problems. Role playing (Schramski, 1984) is a useful technique to help clients practice new skills before using them in their own environment. Board games may be a helpful tool to assist clients in discussing sensitive issues as well as learning social skills and anger management skills. Games and role playing also help clients maintain their attention and interest in psychotherapy. Another useful strategy is to videotape parts of sessions and replay them for the client (Hurley & Hurley, 1987). This may help the client learn how they sound/appear to other people. The use of puppets (Kelly, 1981) and picture books designed to assist in communication (Jageman & Myers, 1987) are also tools which can help clients achieve their goals in psychotherapy.

Symbolic Interaction Therapy (Caton, 1988) is an activity oriented approach to psychotherapy designed specifically for adults with mental retardation. This approach involves role playing, mutual storytelling, and social skills training. While this approach can be used in full, therapists may find it helpful to include aspects of this approach in their therapy.

Countertransference Issues

Therapists working with clients with mental retardation often encounter specific countertransference issues which must be addressed. Therapists may become overprotective of their clients and have rescue fantasies (Bregman, 1991). These defensive maneuvers may be a response to feeling guilt about not being able to cure the client. The therapist may become overprotective as stated previously, display a lack of limit setting in therapy, or place inappropriate expectations on the client.

> A 37-year-old female was in psychotherapy for issues related to impulse control. In psychotherapy this client repeatedly placed their face about 8 inches away from the therapist's face when they spoke to each other (this only occurred while standing by each

other—typically before or after sessions). The therapist felt their personal space was violated and thus felt uncomfortable. For 5 weeks the therapist did not say anything to the client because he was afraid of hurting the client's feelings and because he believed the client did not know that she was standing too close. The therapist eventually discussed the issue with the client. The client has since been taught about personal space and how far to stand away from someone when speaking.

In this example the therapist's own issues initially interfered with his ability to teach the client an important social skill. When psychotherapy was terminated, it was clear this client taught the therapist more than the therapist taught her.

Summary

Numerous issues related to general approaches in psychotherapy have been presented and discussed. Almost all of them depend heavily on the therapist's ability to match their approach to the client's cognitive and social developmental levels. With a general knowledge of cognitive development, a therapist can modify their behavior (in the ways described in this chapter) to accommodate the client's cognitive abilities (Prout & Cale, 1994). Of course, some trial and error is inevitable. Social development is also important to consider. Twelve year olds who cognitively function like seven year olds still have to cope with issues of puberty. In fact, it may be harder for them to cope with these issues since they do not have the cognitive abilities to fully understand what is happening.

Specific Issues in Psychotherapy

People with mental retardation enter psychotherapy for a variety of reasons. While many of the reasons are not unique to people with mental retardation, some are specific to this group of people. This section describes some issues which therapists may encounter which are relatively unique to people with mental retardation. Issues which are not specific to people with mental retardation will also be discussed, but only in reference to how the issue interacts with mental retardation. For example, many people have low self-esteem, however, there are some issues related to mental retardation that affect self-esteem. These types of issues will also be discussed.

Self-esteem

People with mental retardation are often subjected to unusual looks in the community as well as rude remarks by neighbors. They often are aware of how they are different from other people and usually perceive the differences

as negative. They also have more difficulty with social skills which makes it harder for them to make friends. Many people withdraw and choose not to try to make friends because they feel awkward in social situations or because they are acutely aware of being different from other people. As a result, people with mental retardation may have a low self-esteem. In psychotherapy it is often important to assess a person's feelings about having mental retardation and help them cope with this. Building self-esteem may also mean teaching social skills so the person can more effectively function in social situations.

Sexual Abuse and Sex Offenders

People with mental retardation are more vulnerable to sexual abuse because of being overdependent on adults around them (Tharinger, Horton, & Millea, 1990). They are also more vulnerable because they often have a desire to "fit in" and be accepted by others. This desire to fit in and gain acceptance may lead to coerced participation in sexual activities since many people with mental retardation will do many things to earn approval from others (Tharinger, Horton, & Millea, 1990). Therefore, when issues of sexuality are discussed in psychotherapy it is vital to address the preceding issues. Sex education, assertiveness training, and processing the client's feelings about these issues may be necessary in psychotherapy.

At the other end of the spectrum is the client who is sexually abusive towards others. One of the difficulties with this group of people is that caretakers and other people at times fail to recognize that a person with mental retardation has sexually abused another person (Sgroi, 1989). When confronted with a client who has sexually abused another person, it is important to assess whether the client understood that what was done was wrong and illegal. For example, without excusing the behavior, it is necessary to assess whether a person who molested a fourteen-year-old person understands that fourteen year olds cannot legally consent to sex (even if they verbally agree to it). Therefore, a thorough assessment of the person's knowledge of sexuality must be assessed. Interventions for people with mental retardation who sexually abuse other people include an educational component (see Huntley & Benner, 1993) as well as more traditional therapy for sexual abusers.

Relaxation Training

People with mental retardation can benefit from relaxation training (see Cautela & Groden, 1978). It is specifically helpful for reducing anxiety and as part of self-control training for anger management. When teaching people with mental retardation to relax their muscles, the therapist will typically need to show the client how. Modeling and practicing relaxed behaviors seems to be more effective than teaching the tension/release cycles with people who have

moderate or severe mental retardation (Lindsay & Baty, 1989). People with mild mental retardation may respond better than lower functioning people to being taught tension/release cycles, but will still benefit from modeling. The client's ability for visual imagery needs to be assessed carefully to determine whether this technique will be useful. They often have more difficulty with visual imagery than people without mental retardation. Finally, due to distractibility, the length of each session may be shorter than those during relaxation training.

Death/Grieving

People with mental retardation are often unprepared for coping with grief and frequently receive little help during the grieving process (Deutsch, 1985). When seeing a client in psychotherapy who experiences a death of a relative or friend, it is important to ask the client what he or she understands about death. The therapist must not assume the client understands death is irreversible. Clients may also perceive it as a punishment to them or feel nobody is left who loves them. Since people with mental retardation have smaller social networks than people without mental retardation, the death of a friend may have a great impact on their social system.

In psychotherapy it is important to prepare the client for a funeral, wake, or other event related to the death. Behavioral rehearsal and role playing may help them learn what to say or do at one of the events (Yanok & Beifus, 1993). Role playing may also help them more concretely understand their own feelings of grief. Adults often do not know how to tell people with mental retardation about death; a therapist can be helpful to both the family and the client in this regard (see Miller & Rotatori, 1986).

Family Issues

The role of the family takes on special significance when working with people with mental retardation. Parents may feel anger, guilt, sorrow, denial, or acceptance of their child. Initially, parents often follow the sequence of denial, grief, guilt, and then anger (Berliner, 1986). As time progresses, parents may experience all of the above emotions/thoughts at one time or another. Therapists should not assume feelings of guilt and anxiety are always pathological (Szymanski, 1977). In fact, feelings of denial may be an effective and healthy approach for coping with stress (Browder, Jones, & Patton, 1990).

While at times these feelings are not pathological, the parent's response to the feelings may affect their child's ability to function optimally. When this occurs parents need to be included in the therapeutic process. Furthermore, while most parents stop (or at least significantly decrease) worrying about providing and caring for their child once they have graduated from high school

or college, parents of children with mental retardation must continue to struggle with these issues past that age. In fact, it often increases as the parents become older. They become concerned with who will care for their child after their own death.

Other common issues which arise that indicate the need for family intervention include issues related to the family being overprotective of the person with mental retardation. Often, there are mixed messages in the family in that as the person with mental retardation seeks emancipation he or she may exhibit regressive tendencies (Paniasua, & De Fazio, 1983). Issues around sexuality also tend to be of a concern to parents of adults (and adolescents) with mental retardation.

A common complaint of parents is that professionals do not view the parents as positive resources (American Psychiatric Association, 1989). Therefore, when working with parents it is important to recognize that they have valuable information about their child and may need to be included in some decisions. Also, since some decisions affect the family it can be helpful to discuss the particular issue with the family to decrease the likelihood that the family will sabotage the work. Therapists need to remember families have powerful influences on individual members and a person with mental retardation is not excluded from this.

Group Psychotherapy

Conducting group psychotherapy with people with mental retardation requires the therapist to alter their techniques in the ways previously described. Rather than review these adaptations or address group processes in general, issues specific to leading groups for people with mental retardation will be presented.

When conducting group psychotherapy for people with mental retardation, the group size typically needs to be smaller than when leading groups for people without mental retardation. If a group is led alone, it is recommended that membership be confined to four to six members. If it is co-led, groups of six to eight people are appropriate. Group psychotherapy sessions should be brief and if possible meet more frequently than groups for people without mental retardation (Brown, 1994). Thirty to forty-five minute sessions two to three times each week is recommended.

In order to maintain the client's attention and to keep all group members on the task of psychotherapy, it is best not to have too wide a range of intelligence levels in the group (Szymanski & Rosefsky, 1980). Group members should also be chosen based on having somewhat similar socio-developmental levels. That is, it is not wise to have a group where one person is going through puberty, two are dealing with issues of aging, and one is having a "mid-life" crisis. While the intelligence and socio-developmental levels should not vary

too greatly, some heterogeneity of client personalities and difficulties are not only acceptable, but often are recommended (unless a group is designed for a specific problem, such as social skills development). However, it is best not to include people who are disruptive and who do not respond to peer pressure when asked to stop disruptive behaviors. Furthermore, when leading a group it is important to have a set of clear and simple rules for client behavior in the group (Brown, 1994). These rules should be reviewed on a regular basis. Having the rules posted or having pictures/drawings depicting acceptable and unacceptable behavior posted is also helpful.

People with mental retardation often have difficulty with social skills (Welch & Sigman, 1980). Group psychotherapy gives the therapist an opportunity to have group member practice these skills with each other. It is also useful to have members give feedback to each other about their behavior. A byproduct of working on social skills often is that it improves self-esteem and self-confidence of the clients.

One of the greatest advantages of group psychotherapy is that it gives people with mental retardation the opportunity to receive support and give support to others. For example, group psychotherapy presents a good opportunity for clients to discuss with each other what it means to have mental retardation. It gives them the opportunity to evaluate their beliefs among other people with similar difficulties. The group also allows clients to share experiences around how they feel viewed by their community. Clients often benefit from learning that other people have the same concerns as them. Often the therapist will have to bring this subject up since many clients feel awkward mentioning it. When a therapist or client does address this issue, clients are often surprised to find that other people have been ridiculed about being different or having mental retardation. Many clients who were initially quiet will speak about this issue. Other issues which may be beneficial to discuss in groups include issues of emancipation from the family and feelings of lack of control in their lives. For example, many people do not get to choose where or with whom they live. Providing and receiving support in a group setting may increase clients' self-worth as well as increase their sense of support. It is likely that these are some of the reasons why Williamson and Byrd (1980) state that group psychotherapy may be better than individual psychotherapy for clients with mental retardation (specifically, mild retardation).

TRAINING CURRICULUM

There are programs designed specifically to be used in group settings to teach people with mental retardation a variety of skills. The most common programs used address anger management, social skills, and sex education. While these programs were developed to be used in psychotherapy/psychoeducational

groups they can also be easily modified for use in individual psychotherapy. When being used in individual psychotherapy, it is common to use only a few lessons from a curriculum to help a person with a specific issue. The following is a brief review of some of the programs used with people with mental retardation.

Sex Education

People with mental retardation are often viewed as being asexual and therefore not in need of sex education. As this erroneous belief has begun to change in the past decade, programs to teach sex education have been developed. The program used at St. Coletta's of Illinois, a private residential facility for adolescents and adults with mental retardation, is the Lifefacts Sexuality (Stanfield & Cowardin, 1992). This program addresses physiology, development of relationships, dating, masturbation, intercourse, contraceptives, pregnancy, hygiene, and sexually transmitted diseases.

At St. Coletta's of Illinois the 27-lesson program was modified into a 16-lesson program by excluding information believed to be less relevant for the clients at the agency. The therapists who led the groups have also modified the program to create an eight session sex-education program for younger children with mental retardation. Finally, the therapists have taken specific exercises and lessons and used them in individual psychotherapy sessions when issues arose related to sexuality and relationships. Since there are a few sex education programs published, therapists must evaluate the different ones available to determine which one best fits their needs. Regardless of which one is chosen, it will likely be a valuable tool in individual psychotherapy, group psychotherapy, and individual or group psychoeducational training.

Anger Management

Most anger management programs are based on a cognitive-behavioral approach to treatment. While these programs are designed to teach anger management, the skills taught are useful in other areas of the people's lives. For example, Benson (1986) believes people taught anger management skills may have more self-confidence and a greater willingness to discuss personal problems. Anger management programs typically include teaching problem-solving skills. For example, they will teach people to define the problem, think of solutions, evaluate the solutions, implement a solution, and evaluate its effectiveness. Programs for anger management also include relaxation training and self-monitoring. One of the programs which has been used at St. Coletta's of Illinois in a modified form is a 15-session program developed by Benson (1992). At St. Coletta's of Illinois the program has been shortened to an 8- to 12-week program. There is less of an emphasis placed on relaxation training

and more on self-instructional training and problem solving skills. Review and repetition of previously taught material is a vital part of the modified program.

Social Skills

The role of poor social skills in the development of emotional problems has received minimal attention by professionals (Reiss, 1985). However, by improving people's problem solving skills and increasing social understanding it may be possible to decrease the risk of developing an emotional disturbance. At the very least it will likely help a person with mental retardation and emotional problems function better in social and employment situations.

Numerous programs have been developed to teach social skills to children and adults with mental retardation. These programs typically include the topics of body language, listening skills, following directions, use of positive feedback, problem solving, accepting consequences, anger management, sharing, and compromise. Many programs make use of activity sheets and role playing. Board games developed for social skills training can also be used as a part of a structured curriculum. As with curriculums for sex education and anger management, psychotherapists may use the entire curriculum, or use parts of it, to suit their needs.

Research suggests social skills training is not only beneficial, but may be more effective than psychotherapy in improving social skills (Matson & Senatore, 1981). This is not to say psychotherapy is not beneficial, but if social skill deficits are present, the use of a specific program will likely be more helpful than psychotherapy in teaching these skills. Research also indicates the use of active rehearsal in social skills training increases the effectiveness (both maintenance and generalization) of the training (Matson & Kazdin, cited in Matson & Fee, 1991).

Program Evaluation

Regardless of which program or the type of program used, it is important to evaluate the effectiveness of the training. This is most easily accomplished when the training is done in a group format. The purpose is not just to know whether the clients learned to name the genitalia or improved their social skills, but to add information to the growing body of literature regarding what training methods are most effective for people with mental retardation. As this body of literature increases, issues of what types of training methods are most effective for higher versus lower functioning people with mental retardation will become clear.

PSYCHOTROPIC MEDICATIONS

In the 1950s and 1960s, the withdrawal, self-injury, and physical aggression seen in some people with mental retardation was considered to be

representative of a psychotic process (Crabbe, 1989). As a result, antipsychotics were often administered to people with mental retardation who displayed some or all of these behaviors (Crabbe, 1989). However, it is now know, that people with mental retardation suffer from the full range of mental illnesses (Menolasino, cited in Crabbe, 1989). This change in understanding will likely lead (and probably has begun to lead) to the increased use of antidepressants, anxiolytics, and other non-antipsychotic medications.

Psychotropic medications are used to serve one of two purposes: they can be used as a chemical treatment or a chemical restraint (Crabbe, 1989). As a chemical restraint, psychotropic medications should only be used in an emergency basis as a way of protecting people from injury (Crabbe, 1989). As a chemical treatment, psychotropic medications are prescribed on a daily basis (Crabbe, 1989). The use of psychotropics as a chemical treatment can both assist in decreasing a person's problematic behaviors and allow them to learn new, more functional behaviors.

Regardless of whether medication is used as a chemical restraint or chemical treatment, it is important for the person with mental retardation, the staff/family who work/live with the person with mental retardation, and the prescribing physician to communicate and work together regarding a person's treatment plan. Many physicians rely on reports from people who live/work with a person with mental retardation in making decisions regarding initiating, increasing, or decreasing psychotropic medication. It is also important that this group of people have the same goal in treating a person with mental retardation. For example, confusion can develop if the physician's goal is to use medication to decrease a problematic behavior just enough to keep the person from entering a psychiatric hospital, while the family's or staff's goal is to sedate the person so they do not have to encounter any problematic behaviors. Therefore, it is vital for the person with mental retardation, the staff/family who work/live with the person, and the physician to openly communicate about the goals and methods of treating a person with psychotropic medication.

Finally, recent research has begun to delineate the current pattern of psychotropic use in people with mental retardation. Pary (1993) reports that the use of psychotropic medication increases as a person becomes older. This increase in usage may be a result of a lack of systematic tapering of medication or because as individuals with mental retardation age they are also more likely to develop a psychiatric disorder (Pary, 1993). Harper and Wadsworth's (1993) research suggests people living in congregate care settings are more likely to receive psychotropic medication than people living in smaller group care settings. They found this to be true even when similar types and frequencies of behavioral difficulties occurred in both settings. They conclude that there are environmental factors independent of individual characteristics that affect the physician's decision to prescribe medication for problematic behaviors

Some of these may relate to the tolerance level of staff who work with the people with mental retardation. Finally, Luchins, Dojka, and Hanrahan (1993) report findings regarding the effects of decreasing psychotropic medications in people with mental retardation who reside in a state facility for people with mental retardation. First, Luchins and colleagues report that the presence of a psychotic disorder was associated with an increase in use of antipsychotics. On the other hand, the absence of a psychotic disorder was associated with a large decrease in dosage of antipsychotic medication. Second, people with mental retardation who were administered non-antipsychotic medications (e.g., lithium, carbamazepine, buspirone, and propanolol) to manage problematic behaviors had a decrease in the usage of antipsychotic medications. The trend to use these alternative medications instead of antipsychotics is advantageous for the people who take them since the long term effects of antipsychotic medication can have signifcant and severe deleterious effects.

LEGAL ISSUES

States vary regarding their requirements of informed consent for psychotherapy. Grisso (cited in Morris, Niederbuhl, & Mahr, 1993) describes three factors that must be considered when determining a person's ability to give informed consent. The person must be knowing (understand the information about psychotherapy), intelligent (have the ability to assess the risks and benefits of psychotherapy), and voluntary (no coercion to participate). While this definition is clear, measuring each of these three factors is difficult. For example, how would professionals measure the ability to assess the risks and benefits of psychotherapy? Even if these three factors could be measured quantitatively, what criteria would be used for passing? Does someone who can answer 80 percent of the questions in these three areas meet the requirements for informed consent? If so, does this mean that someone who scores 79 percent does not have the ability to give informed consent? If this were true, would the courts (or relatives) have to be contacted in order to obtain permission for psychotherapy for someone who scores below 80 percent.

Given that there is no current test to measure informed consent, therapists must be cautious in determining whether a person with mental retardation can give informed consent. When working with young children, it is likely that informed consent from the guardian is sufficient. However, when working with adults with mental retardation the issue becomes blurred. For example, assume a 28 year old with mild mental retardation enters psychotherapy and the therapist evaluates the three factors just described and determines that the person meets the three requirements. This is a common scenario. The situation becomes difficult when someone comes forward on behalf of the client and

states that because of the mental retardation he or she is not able to give consent. A court battle might ensue which, regardless of who is correct, can be financially draining for a psychotherapist or agency.

Another situation where there are no clear guidelines relates to an adult client who is high functioning and has someone else as their guardian. In these cases, it is best to obtain informed consent from both the client and the guardian. If the client does not want the guardian to know about the psychotherapy, it is recommended that this be discussed with the client and that the therapist inform the client that he/she must obtain the guardian's consent. This last recommendation may be bypassed (although it is highly recommended that it not be) if state laws allow a client to be seen without their guardian's consent. In conclusion, it is important for psychotherapists to consider legal issues, such as informed consent, when working with people with mental retardation. Extra caution often has to be taken to assure the client's rights (as well as the therapists liability) are protected.

LOOKING TO THE FUTURE

People with mental retardation continue to be underserved by mental health professionals. The challenge for the future is not only to increase services for people with mental retardation, but to improve them. In order to achieve this, more mental health professionals need training in the assessment and treatment of people with mental retardation. The first step might be to have graduate schools in psychology and social work offer students a class in providing mental health services to people with mental retardation. Second, at a more societal level, people must be educated (especially legislatures who direct public funds) about the rights that people with mental retardation have regarding mental health services. It must also be stressed to them that people with mental retardation benefit from these services. Third, mental health professionals must involve themselves in research. Specifically, research needs to address how emotional disturbances affect people with mental retardation, how to better assess for emotional disturbances in people with mental retardation, and how to best provide psychotherapeutic services. Finally, mental health professionals must continue to advocate for people with mental retardation both in the psychotherapy session as well as outside of it.

SUMMARY

People with mental retardation are more likely than people without mental retardation to experience emotional disorders. In the past few decades it has become more apparent that people with mental retardation are appropriate for mental health services. Unfortunately, there is a shortage of professionals

trained to evaluate and treat people with mental retardation who also have emotional disorders or problems of living. To make the reader aware of this situation, prevalence rates, and myths professionals may have about people with mental retardation, the assessment and psychotherapeutic process of people with mental retardation were discussed. Regarding assessment, suggestions were given for how to interview clients with mental retardation. Also, issues of how to differentiate between a true emotional disorder and a person with mental retardation who presents an emotional disorder due to difficulties in language and cognitive abilities were presented. Next, the chapter emphasized the use of a mental status exam, medical assessment, and structured questionnaires in the evaluative process. Once this evaluation is completed, psychotherapy may be warranted for some people with mental retardation.

This chapter discusses how a psychotherapist must alter their approach when treating people with mental retardation. Specifically, issues of flexibility, concreteness, directiveness, and the types of activities used in sessions were presented. Special considerations in conducting the first session, developing goals, and doing group psychotherapy were also addressed. Aside from general principles of how a psychotherapist must adapt their therapeutic style/technique, specific issues relevant for people with mental retardation was presented in relation to how to address these in psychotherapy. Finally, group curriculums designed for teaching a variety of skills, the use of psychotropic medications, and concerns/issues regarding informed consent were presented.

NOTE

1. Throughout this chapter the phrase "people with mental retardation" or "clients with mental retardation" will be used instead of the more common phrase "mentally retarded people." The reason for this change of words is that the phrase "mentally retarded people" suggests mental retardation is the defining characteristic of people with mental retardation without considering that they may have other important characteristics. Furthermore, since we do not label someone with cancer as a cancer person (we say they have cancer) and we do not call someone with cerebral palsy a cerebral palsy person (we say they have cerebral palsy), why would we call someone with mental retardation a mentally retarded person? Many people will disagree with this change of words and may believe it is a minor point. However, I believe that by labeling someone as a mentally retarded person we are more likely to think of them as mentally retarded rather than as a person with mental retardation who also has other defining characteristics.

REFERENCES

Abel, T. M. (1953). Resistances and difficulties in psychotherapy of mental retardates. *Journal of Clinical Psychology, 9*(2), 107-109.

Aman, M. G., Singh, N. N., Stewert, A. W., & Field, C. J. (1985). The aberrant behavior checklist: A behavior rating scale for the assessment of treatment effects. *American Journal of Mental Deficiency, 89*, 485-491.

American Psychiatric Association. (1989). *Treatments of Psychiatric disorders. A task force report of the American Psychiatric Association* (volume 1). Washington, DC: American Psychiatric Association.

Benson, B. A. (1986). Anger management training. *Psychiatric Aspects of Mental Retardation Reviews, 5*(10), 51-56.

Benson, B. A. (1992). *Teaching Anger Management to Persons with Mental Retardation.* International Diagnostics Systems.

Berliner, A. K. (1986). Overcoming obstacles with the mentally retarded. *British Journal of Mental Subnormality, 32*(62), 42-48.

Bregman, J. D. (1991). Current developments in the understanding of mental retardation part II: Psychopathology. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*(6), 861-872.

Browder, D. M., Jones, E. D., & Patton, J. R. (1990). Family issues. In J. R. Patton, M. Bierne-Smith, & J. S. Payne (Eds.), *Mental Retardation* (pp. 429-459). Columbus, OH: Merrill Publishing Company.

Brown, D. T. (1994). Group counseling and psychotherapy. In D. C. Strohmer & H. T. Prout (Eds.), *Counseling and psychotherapy with persons with mental retardation and borderline intelligence* (pp. 195-234). Brandon, VT: Clinical Psychology Publishing Co., Inc.

Caton, J. (1988). Symbolic interactional therapy. *Psychiatric Aspects of Mental Retardation Reviews, 7*(2), 7-12.

Cautela, J.R., & Groden, J. (1978). *Relaxation: A comprehensive manual for adults, children, and children with special needs.* Champaign, IL: Research Press Company.

Charlot, L. R., Doucette, A. C., & Mezzacappa, E. (1993). Affective symptoms of institutionalized adults with mental retardation. *American Journal on Mental Retardation, 98*(3), 408-416.

Crabbe, H. F. (1989). *A Guidebook for the use of psychotropic medication in persons with mental illness and mental retardation.* Hartfort, CT: Department of Mental Retardation.

Deutsch, H. (1985). Grief counseling with the mentally retarded clients. *Psychiatric Aspects of Mental Retardation Reviews, 4*(5), 17-20.

Feinstein, C., Kaminer, Y., Barrett, R. P., & Tylenda, B. (1988). The assessment of mood and affect in developmentally disabled children and adolescents: The emotional disorders rating scale. *Research in Developmental Disabilities, 9*, 109-122.

Harper, D. C., & Wadsworth, J. S. (1993). Behavioral problems and medication utilization. *Mental Retardation, 31*(2), 97-103.

Harris, S. L., Alessandri, M., & Gill, M. J. (1991). Training parents of developmentally disabled children. In J. L. Matson & J. A. Mulick (Eds.), *Handbook of mental retardation* (pp. 373-381). Elmsford, NY: Pergamon Press.

Huntley, C., & Benner, S. M. (1993). Reducing barriers to sex education for adults with mental retardation. *Mental Retardation, 31*, 215-220.

Hurley, A. D. (1989). Individual psychotherapy with mentally retarded individuals: A review and call for research. *Research in Developmental Disabilities, 10*(3), 261-275.

Hurley, A. D., & Hurley, F. J. (1986). Counseling and psychotherapy with mentally retarded clients: I. The initial interview. *Psychiatric Aspects of Mental Retardation Reviews, 5*(5), 22-26.

Hurley, A. D., & Hurley, F. J. (1987). Psychotherapy and counseling II: Establishing a therapeutic relationship. *Psychiatric Aspects of Mental Retardation Reviews, 4*(4), 15-20.

Jacobson, J. W. (1982). Problem behavior and psychiatric impairment within a developmentally disabled population I: Behavior frequency. *Applied Research in Mental Retardation, 3*, 121-129.

Jacobson, J. W. (1983). Persons with emotional disturbance and mental retardation. *American Psychologist, 38*(3), 352-353.

Jageman, L. W., & Myers, J. E. (1987). A conceptual model for counseling adult mentally retarded persons. *Journal of Applied Rehabilitation Counseling, 18*(1), 17-21.

Jakab, I. (1982). Psychiatric disorders in mental retardation: Recognition, diagnosis and treatment. In I. Jakab (Ed.), *Mental retardation* (pp. 270-326). New York: Karger.

Kelly, J. A. (1981). Using puppets for behavioral rehearsal in social skilss training with young children. *Child Behavior Therapy, 3*, 61-64.

Lindsay, W. R., & Baty, F. J. (1989). Group relaxation training with adults who are mentally handicapped. *Behavioural Psychotherapy, 17*, 43-51.

Luchins, D. J., Dojka, D. M., & Hanrahan, P. (1993). Factors associated with reduction in antipsychotic medication dosage in adults with mental retardation. *American Journal on Mental Retardation, 98*(1), 165-172.

Matson, J. L. (1992). Assessing psychopathology in adults with mental retardation. In J. L. Matson (Chair), *Assessing Psychopathology in Adults with Mental Retardation.* Symposium conducted at the meeting of the American Association of Mental Retardation, New Orleans, May.

Matson, J. L., & Fee, V. E. (1991). Social skills difficulties among persons with mental retardation. In J. L. Matson & J. A. Mulick (Eds.), *Handbook of mental retardation* (pp. 468-488). Elmsford, NY: Pergamon Press.

Matson, J. L., Kazdin, A. E., & Senatore, V. (1984). Psychometric properties of the psychopathology Instrument for mentally retarded adults. *Applied Research in Mental Retardation, 5*, 81-89.

Matson, J. L., & Senatore, V. (1981). A comparison of traditional psychotherapy and social skills training for improving interpersonal functioning of mentally retarded adults. *Behavior Therapy, 12*, 369-382.

Mattes, J. A., & Amsell, L. (1993). The dexamethasone suppression test as an indication of depression in patients with mental retardation. *American Journal on Mental Retardation, 98*(3), 354-359.

McNally, R. J. (1991). Anxiety and phobias. In J. L. Matson & J. A. Mulick (Eds.), *Handbook of mental retardation* (pp. 413-423). Elmsford, NY: Pergamon Press.

Miller, J. H., & Rotatori, A. F. (1986). *Death education and the educator.* Springfield, IL: Charles C. Thomas.

Morris, C. D., Niederbuhl, J. M., & Mahr, J. M. (1993). Determining the capability of individuals with mental retardation to give informed consent. *American Journal on Mental Retardation, 98*(2), 263-272.

Mulick, J. A., Hammer, D., & Dura, J. R. (1991). Assessment and management of antisocial and hyperactive behavior. In J. L. Matson & J. A. Mulick (Eds.), *Handbook of Mental Retardation* (pp. 397-412). Elmsford, NY: Pergamon Press.

Nezu, C. M., Nezu, A. M., & Gill-Weiss, M. J. (1992). *Psychopathology in persons with mental retardation: Clinical guidelines for assessment and treatment.* Champaign, IL: Research Press Co.

Paniagua, C., & De Fazio, A. (1983). Psychodyamics of the mildly retarded and borderline intelligence adult. *Psychiatric Quarterly, 55*(4), 242-252.

Pary, R. J. (1993). Acute psychiatric hospital admissions of adults and elderly adults with mental retardation. *American Journal on Mental Retardation, 98*(3), 434-346.

Pondilla, A. M. (1993). Counseling needs of individuals with mental retardation. *Psychology in Mental Retardation and Developmental Disabilities, 18*(3), 10-13.

Prout, H., & Cale, L. (1994). Individual counseling approaches. In D. C. Strohmer & H. T. Prout (Eds.), *Counseling and psychotherapy with persons with mental retardation and borderline Intelligence* (pp. 103-142). Brandon, VT: Clinical Psychology Publishing Co., Inc.

Reiss, S. (1988). The reiss screen for maladaptive behavior test manual. Orland Park, IL: International Diagnostic Systems.

Reiss, S. (1985). The mentally retarded, emotionally disturbed adult. In M Sigman (Ed.), *Children with emotional disorders and developmental disabilities* (pp. 171-192). Orlando, FL: Grune & Stratton.

Reiss, S., Levitan, G. W., & Szyszko, J. (1982). Emotional disturbance and mental retardation: Diagnostic overshadowing. *American Journal of Mental Deficiency, 86*(6), 567-574.

Reynolds, W. M., & Baker, J. A. (1988). Assessment of depression in persons with mental retardation. *American Journal on Mental Retardation, 93*, 93-103.

Russell, A. T. (1989). Psychiatric treatment in mental retardation. *Psychiatric Annals, 19*(4), 184-189.

Schramski, T. G. (1984). Role playing as a therapeutic approach with the mentally retarded. *Psychiatric Aspects of Mental Retardation Reviews, 3*(7-8), 25-32.

Sgroi, S. M. (1989). *Vulnerable populations: Sexual treatment for children, adult survivors, offenders, and persons with mental retardation* (volume 2). Lexington, MA: Lexington Books.

Small, A. M. (1989). Mental retardation. In L. K. G. Hsu & M. Hersen (Eds.), *Recent developments in adolescent psychiatry* (pp. 368-391). New York, NY: John Wiley & Sons.

Sovner, R. (1986). Limiting factors in the use of DSM-III criteria with mentally ill/mentally retarded persons. *Psychopharmacology Bulletin, 22*(4), 1055-1059.

Sovner, R., & Hurley, A. D. (1989). Ten diagnostic principles for recognizing psychiatric disorders in mentally retarded persons. *Psychiatric Aspects of Mental Retardation Reviews, 8*(2), 9-14.

Stanfield, J., & Cowardin, N. (1992). *Lifefacts sexuality*. Santa Barbara, CA: James Stanfield.

Sunderland, T., Altman, I. S., Yount, D., Hill, S., Tarlot, P., Newhouse, P., Mueller, E., Mellow, A., & Cohen, R. (1988). A new scale for the assessment of depressed mood in demented patients. *American Journal of Psychiatry, 145*, 955-959.

Szymanski, L. S. (1977). Psychiatric diagnostic evaluation of mentally retarded individuals. *Journal of the American Academy of Child Psychiatry, 16*, 67-87.

Szymanski, L. S. (1980). Individual psychotherapy with retarded persons. In L. S. Szymanski & P. F. Tanguay (Eds.), *Emotional disorders of mentally retarded persons* (pp. 131-147). Baltimore, MD: University Park Press.

Szymanski, L. S., & Rosefsky, Q. B. (1980). Group psychotherapy with retarded persons. In L. S. Szymanski & P. F. Tanguay (Eds.), *Emotional disorders of mentally retarded persons* (pp. 173- 194). Baltimore, MD: University Park Press.

Szymanski, L. S., & Kiernan, W. E. (1983). Multiple family group therapy with developmentally disabled adolescents and young adults. *International Journal of Group Psychotherapy, 33*(4), 521-534.

Tanquay, P. E., & Russell, A. T. (1991). Mental retardation. In M. Lewis (Ed.), *Child and adolescent psychiatry: A comprehensive textbook* (pp. 508-516). Baltimore, MD: Williams & Wilkins.

Tharinger, D., Horton, C. B., & Millea, S. (1990). Sexual abuse and exploitation of children and adults with mental retardation and other handicaps. *Child Abuse and Neglect, 14*, 301-312.

Thorne, F. C. (1948). Counseling and psychotherapy with mental defectives. *American Journal of Mental Deficiency, 52*(3), 263-271.

Welch, V. O., & Sigman, M. (1980). Group psychotherapy with mildly retarded, emotionally disturbed adolescents. *Journal of Clinical Child Psychology, 9*, 209-212.

Williamson, W. W., & Byrd, E. K. (1980). Some suggested counseling techniques in moving toward placement for persons with mental retardation. *Journal of Applied Rehabilitation Counseling, 17*(4), 48-50.

Yanok, J., & Beifus, J. A. (1993). Communicating about loss and mourning: Death education for individuals with mental retardation. *Mental Retardation, 31*(3), 144-147.