Psychotherapeutic interventions in learning disability: focus on cognitive behavioural therapy and mental health

Paul Willner

Abstract

Cognitive behavioural therapy (CBT) assumes that psychological disorders are characterized by distorted or dysfunctional thinking, and can be treated by working with the patient to modify thinking in the direction of more realistic or adaptive evaluations of events. CBT has been evaluated extensively and is now the first-line treatment of choice for many psychological disorders. It is increasingly being used with people with learning disabilities, although the evidence base with this population is relatively weak, consisting largely of case studies and case series. There are also controlled trials in anger and depression, for which all published studies report significant clinical improvements that are well maintained over 3–6-month follow-up periods. There are many barriers to engagement with CBT for people with learning disabilities, which reflect limitations of ability and motivation. The limitations of ability reflect the fact that people with learning disabilities have to cope with cognitive deficits in addition to the cognitive distortions that are the target of CBT interventions. If barriers to treatment are recognized, significant steps can be taken to increase accessibility by adapting the therapy. Adaptations include involving carers, simplifications of the delivery of therapy (e.g. by using simple language and a slower pace), and simplifications of the model (e.g. by the therapist adopting a more directive, less collaborative, approach). If the current policy of increasing access to psychological therapies is extended to people with learning disabilities, it is likely that evidence will also accrue to support the use of other psychotherapeutic approaches.

Keywords adaptations; barriers to treatment; cognitive behavioural therapy; increasing access; mental health; people with learning disabilities

Introduction

Cognitive behavioural therapy (CBT) is a system of psychological therapy that aims to develop more adaptive cognitions and behaviour, and so alleviate distress, by changing cognitions such as thoughts, attitudes, and beliefs. The cognitive model of psychopathology was developed initially in 1976 by Beck and colleagues.[1] It assumes that:

- People's emotions and behaviour are influenced by their perceptions of events, i.e. thoughts, images, and other cognitive mediating processes affect behaviour
- Psychological disorders are characterized by distorted or dysfunctional thinking (some examples of cognitive distortions are shown in Box 1)
- How people feel is determined by the way in which they construe situations rather than by the situations *per se* (or, as Shakespeare described it 350 years earlier: 'There is nothing either good or bad but thinking makes it so'); and therefore…
- Mood and behaviour can be improved by working with the patient to modify thinking in the direction of more realistic or adaptive evaluations of events.

A number of approaches have been developed by therapists working within a broad CBT framework. The common feature is that treatment is based on a cognitive formulation that (1) seeks to explain the symptoms displayed and (2) guides the choice of therapeutic activities. CBT is typically time-limited, problem-oriented and present-focused. It takes a collaborative approach in which the client is encouraged to take active control of the therapy, and uses a scientific method (e.g. behavioural experiments) to examine the evidence relating to thoughts and beliefs. Much of the work is done by the client as 'homework'. Sessions are structured, such that a typical session would involve: reviewing the client's state, setting an agenda for the session, reviewing homework, setting session targets, setting homework, and reviewing the session. When applying CBT to 'special populations', such as children or people with intellectual disabilities, these practical aspects of CBT are negotiable: the essential feature of CBT is the cognitive behavioural formulation and the therapeutic activities that flow from it.

Following the early demonstration of the effectiveness of CBT for the treatment of depressive disorders, the approach was rolled out across the board, and CBT has now been demonstrated to be effective, in the general population, for the treatment of a wide range of psychological disorders, including anxiety disorders (generalized anxiety disorder, panic, social phobia, obsessive–compulsive disorder, post-traumatic stress disorder), psychosis, eating disorders, relationship problems, personality

Some examples of cognitive distortions (after Beck 1976)[1]

- 'All or nothing thinking'—seeing things as black or white
- Over-generalization—of negative events
- Mental filter/bias—dwell on the negatives, ignore the positives
- Jumping to conclusions—e.g. fortune telling (assuming that things will turn out badly); mind reading (assuming people are reacting negatively in the absence of supporting evidence)
- Magnification and minimization—no sense of proportion
- Emotional reasoning—e.g. 'I feel stupid so I must be stupid'
- Labelling—identifying with your shortcomings
- Personalization—'It's all my fault'

Box 1

Paul Willner *DPhil DSc CPsychol FBPsS is Emeritus Professor of Psychology, Swansea University, and Consultant Clinical Psychologist, Abertawe Bro Morgannwg University NHS Trust, UK. Conflicts of interest: none declared.*

disorders, forensic issues (aggression and sexual offending), and substance abuse. In the UK, CBT is now recommended by the National Institute for Clinical Excellence (NICE) as first-line treatment for a rapidly expanding range of psychological disorders, and widening access to CBT for people with mental health problems is seen as a major policy priority by the Department of Health, which has allocated £170 million to train up 3600 CBT therapists.

CBT for people with learning disabilities

It has been estimated that some 25–40% of people with learning disabilities have additional mental health problems, and the Department of Health has drawn attention to the fact that the National Service Framework for Mental Health applies to all adults, which implies that '*a person with a learning disability should be able to access services and be treated in the same way as anyone else, with reasonable adjustments being made*'.[2] This is an enlightened position that, until recently, was not recognized even within services for people with learning disabilities. Traditionally, people with learning disabilities have received psychopharmacological or behavioural interventions aimed at controlling their behaviour rather than promoting psychological health. Psychotherapists 'disdained' to treat people with learning disabilities, who, it was thought, would be unable to benefit, and only in the 1990s did this situation start to change.

As a result of this late start, and also because of the difficulty of conducting clinical trials within a small population, the evidence of the effectiveness of CBT in people with learning disabilities is limited, consisting largely of case studies and case series. There is now a relatively large, case-based literature describing successful outcomes for CBT in small numbers of people with mild-to-moderate learning disabilities presenting with a variety of mental disorders, including anxiety, depression, anger, post-traumatic stress disorder, obsessive–compulsive disorder, sexual offending, and psychosis.[3,4] However, the evidence from controlled trials is sparse.

The most developed evidence base is in relation to anger. Several controlled trials in people with mild-to-moderate learning disabilities have now been published, in which CBT for anger has been compared with a waiting-list control condition – although these studies have typically been relatively small and not fully randomized. They include seven studies of anger management groups in community settings and one series of studies of individual treatment in a forensic setting,[5] as well as a single study of individual therapy in a community setting.[6] The published studies are fully consistent in reporting that anger interventions are effective in helping people with learning disabilities to manage their anger better, and that treatment gains are maintained at 3- or 6-month follow-up.[5] There is also evidence that treatment gains generalize across settings. There is little information as to which are the crucial components of the intervention. However, one recent study reported a significant correlation between decreased anger reactivity and increased usage of anger coping skills, thus providing some evidence that the specific psycho-educational content of the anger management curriculum is intrinsic to its effectiveness.[7]

The anger literature has recently been supplemented by two small controlled trials in depression.[8,9] These studies demonstrated that, in people with relatively mild (but clinical) levels of depression, a brief group-based intervention resulted in a significant decrease in both depression scores and the occurrence of negative automatic thoughts, confirming that the intervention engendered cognitive change in addition to clinical improvement. Interestingly, the intervention was as effective when delivered by support staff using a treatment manual [9] as when delivered by trained therapists.[8]

Barriers to treatment

The recent Department of Health position paper identified several barriers to people with learning disabilities accessing psychological therapies, including social restriction, challenging behaviour, failure of general practitioners to diagnose mental health problems, and resistance from mental health services.[6] However, assuming that a referral is made, there are also a number of factors that make engagement with therapy difficult for people with learning disabilities. Limited verbal ability, psychological-mindedness (particularly in relation to the understanding of emotions and the mediating role of cognitions), and self-efficacy, are all likely to present significant barriers. In addition, people with learning disabilities may have had little experience in reporting emotions, giving opinions, or decision-making; they may be skilled at 'covering up' their difficulties, and may have developed the strategy of acquiescing to suggestions made to them with no intention to follow through. There may also be motivational barriers to treatment, including the functionality of some psychological presentations, maladaptive beliefs promoting resistance to change, the intellectually challenging nature of cognitive therapy, and external factors such as inappropriate settings. And, although people with learning disabilities do self-refer, the referral is often made under pressure from a third party.[10]

A useful distinction can be drawn between two sources of difficulty in engaging with cognitive therapy. In addition to the cognitive distortions (inaccuracies in the content of thoughts, assumptions, and beliefs) that, in the cognitive model, characterize psychological disorders, people with learning disabilities also have cognitive deficits. These are deficiencies in the processes by which information is acquired and processed, which, in addition to limited verbal ability, may include: impairments of episodic and/or prospective memory such as problems in projecting the self into past or future situations and temporal confusion; unidentified sensory deficits; short attention span; and executive dysfunction.[11] These cognitive deficits create barriers to treatment in two ways: by inhibiting engagement, and by increasing the difficulty of psychotherapeutic activities aimed at correcting cognitive distortions, such as challenging thoughts or generating alternative ways of thinking about situations.

Engagement with therapy can be promoted by involving carers to support the therapy. There is evidence that the outcome of CBT for anger is improved if clients are accompanied in the therapy session by a carer,[12] and carers can provide invaluable support for compliance with homework completion, which is a significant problem for CBT therapists and important for positive outcomes. However, carers may themselves display a range of limitations of ability and motivation, similar to those displayed by clients, which need to be recognized and, where possible, addressed, in order for their involvement to be effective.[10] Carers are aware that their