

COGNITIVE-BEHAVIOURAL THERAPY FOR PEOPLE WITH LEARNING DISABILITIES

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Abstract. A substantial literature now exists that indicates that cognitive-behaviour therapies are effective for a wide range of psychological problems (See Hawton, Salokovskis, Kirk, & Clark, 1989). However, it is only very recently that cognitive-behaviour therapists have considered people with learning disabilities as suitable clients for this particular approach. The present paper describes some of the challenges that are encountered when applying cognitive-behaviour therapy to this client group.

Keywords: Learning disabilities, cognitive-behaviour therapy, self-report, self-regulation, cognitive deficits.

Introduction

Cognitive-behaviour therapists make the assumption that psychological problems are at least in part caused by cognitive dysfunction and that psychological well-being can be improved by teaching new, and more adaptive, ways of thinking. People with learning disabilities are more likely to experience psychological problems than the general population (e.g. Sevin & Matson, 1994) and have consequently a greater need for psychotherapeutic services. Yet, there appears to be a “therapeutic disdain” (Bender, 1993) towards those with intellectual deficiencies that goes as far back as Freud who stated that psychoanalysis is not suitable for “those patients who do not possess a reasonable degree of education and a fairly reliable character” (Freud, 1953, p. 263).

Why this therapeutic disdain?

Bender (1993) postulates that therapists are reluctant to engage in one-to-one therapy with people with learning disabilities, not because these clients are unsuitable for therapy but rather because the therapists fear and dislike having to intimately relate to them. Thus, until recently, this client group has almost exclusively received pharmacological or behavioural interventions, usually aimed at controlling or changing behaviour rather than improving psychological well-being. Treatment goals were mostly without recourse to the clients and only discussed with immediate carers. The meaning of people’s overt behaviours was rarely explored. Lovett (1985) in his book

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Cognitive counselling and persons with special needs provides an excellent critique of traditional behavioural approaches for people with intellectual disabilities and challenging behaviour. He observes that carers and professionals often describe the challenging behaviours of their clients in seemingly objective but meaningless ways (e.g. attention-seeking) without specifying the possible motivation or emotion driving that behaviour (e.g. wanting to make more friends or feeling bored or lonely), thus ignoring the meaning of the behaviour and labelling a person's wish for human contact in a negative way.

Some data reported by Harper and Wadsworth (1993) illustrate this point. A group of 43 adults with learning disabilities, who had recently experienced a significant loss, were asked how they expressed grief and dealt with their loss. A group of 100 carers and professionals were also asked their views of how people with learning disabilities cope and respond during grief. The participants with learning disabilities reported mainly *emotions*, such as loneliness, anxiety, sadness, depression, dislike of their new residential place, worry about not being able to locate the grave, or inadequate income. Only a small percentage of responses concerned *behaviour*. The carers and professionals, on the other hand, reported largely on behaviours or somatic symptoms such as crying, sleep problems, hostility towards others, passivity and poor hygiene. Very few responses concerned emotions. It seems, therefore, that although clients can report on their psychological state, carers often ignore these in their descriptions and almost exclusively concentrate on observable symptoms.

A further reason why so little psychotherapeutic work has been undertaken with these clients may be related to issues of power and self-determination. Lovett (1985) stressed the importance of self-determination, especially through creating a collaborative relationship, rather than an authoritarian one between the therapist and the client. However, when clients have an intellectual disability, they are more likely to be seen as passive recipients of services (e.g. Lowe, 1992). Yet, one of the underlying assumptions of cognitive-behaviour therapy is that the client is centrally involved in determining therapy goals and the methods by which these will be achieved. Therefore, there has existed a mismatch between the traditional view that people with learning disabilities are passive and unable to make decisions, and the active role that cognitive-behaviour therapists expect of their clients. Indeed, an overview by Harchik, Sherman and Sheldon (1992) of 59 studies of self-management techniques for people with learning disabilities showed that clients were not involved in the design of the procedures, and the treatment goals were exclusively concerned with social control and an increase in performance in academic and work settings. Success was measured in terms of the eradication of challenging behaviours and/or a change in productivity. The psychological well-being of the client was rarely mentioned as an outcome measure.

It appears that cognitive-behaviour therapy for people with learning disabilities has so far concentrated on cognitive process rather than cognitive content. Kendall (1985) made the important distinction between two types of cognitive dysfunction – cognitive deficits and cognitive disorders. The former refer largely to the problems in cognitive processing whereas the latter are concerned with cognitive content. The earlier cognitive-behaviour therapies emphasized cognition as a process, i.e. they addressed the deficits in the manner in which people collect information, interpret the world and resolve problems. The aim of self-instructional training (Meichenbaum, 1975), for

example, is to rote-learn and internalize a set of explicit self-instructions that are to replace or override “maladaptive” thoughts. It is this type of therapy that has so far been mainly applied to people with learning disabilities. Approaches that have focused on identifying the actual content of thoughts and assumptions, such as Beck’s (1976) cognitive therapy and Ellis’ (1973) rational-emotive therapy, have been rarely used. Both these approaches assume that the content of the distorted cognitions must be made explicit by the client and questioned by the therapist before “guided discovery” can take place. That is, awareness and evaluation of the cognitive content is necessary in order to ‘learn to view thoughts and beliefs as hypotheses whose validity is open to the test’ (Beck, Rush, Shaw, & Emery, 1979).

It is perhaps because cognitive deficits (relevant to process) are by definition more prominent in people with learning disabilities that these therapies have been so widely employed. Cognitive deficits are more easily identified, (task)-analysed, and measured as this can be achieved by observing overt behaviour and there is no need for self-report. When attempts are made to access cognitive content (i.e. to ask “what is the person thinking?”), however, some type of self-report is an essential part of the measurement procedure. Cognitive distortions involve complex, abstract concepts, often related to emotional states. To report on these may be problematic for a client who also has cognitive deficits. Moreover, therapists who address cognitive distortions with their clients can expect complex outcomes where causal links are difficult to make in the absence of valid and reliable self-reports. For this reason, it is more challenging to be a proper, “scientist-practitioner” who can add to the existing body of scientific knowledge (Jones, Miller, Williams, & Goldthorp, 1997). There are, however, some recent and notable examples (e.g. Dagnan & Chadwick, 1997; Lindsay, Neilson, & Lawrenson, 1997) of therapists who have reported clinical outcome studies that address cognitive distortions and use self-report.

In order to be able to apply the more complex therapies that address cognitive content, it is necessary to address the following questions:

- a) Can people with learning disabilities report on their own cognitions in a valid and reliable manner?
- b) Can deficits in comprehension and expression of abstract concepts be overcome?
- c) Can deficits in self-regulation be overcome?

Some empirical data exist that are relevant to these questions and that will be briefly described below.

Can people with learning disabilities self-report?

Self-reports of people with learning disabilities have been considered to have only limited use by a number of authors (e.g. Balla & Zigler, 1979) because of the greater likelihood that factors such as social desirability (including acquiescence and dependency), memory problems, recency effects, anxiety and incomprehension threaten their validity. However, it has also been shown that such pronounced effects can be overcome by applying a number of minor modifications in the construction of self-report materials. For example, the use of pictorial materials instead of, or in addition to,

auditory presentation can be used to aid understanding and memory (Kabzems, 1985). Open-ended rather than yes/no questions can avoid acquiescence (e.g. Sigelman, Budd, Winer, Schoenrock, & Martin, 1982) and inserting a probe after each question in order to elicit examples or further detail from the client will establish whether the item has been understood and answered in a valid way.

Jahoda, Markova and Cattermole (1988) described an approach that attempts to collect valid and reliable data regarding self-concept and the experience of stigma in people with learning disabilities. The interviewer spent approximately 12 hours prior to the interview with each interviewee in order to gain their confidence and presumably to reduce interfering variables such as social desirability, anxiety and incomprehension. They found consistent response patterns that indicated that the participants had awareness of the stigma attached to being “handicapped” and had developed a “cognitive-emotional” awareness of themselves in relation to other people.

Lindsay, Michie, Baty, Smith and Miller (1994) presented people with mild and moderate learning disabilities with a battery of independent (but related) self-report measures. They found a high degree of convergent validity in the responses, indicating a stable and reliable “cognitive system” related to emotion. Some studies have attempted to establish validity by using third party reports. For example, Benson and Ivins (1992) found that staff usually rate clients as “angrier” than clients rate themselves. They attribute these results to a response bias (denial, changeability or fatigue) on the part of the clients. However, an alternative explanation could be that staff over-reported, possibly because the clients’ anger induces stress responses in staff (e.g. Lally, 1993), which may have biased their judgements regarding the individual and the range, severity and frequency of the individual’s angry responses. Benson and Ivins’ general conclusion is that people with learning disabilities can self-report on emotional states when slightly modified questions are used.

Thus, it appears that self-report can be valid and reliable in people with learning disabilities. However, the therapist will always need to introduce some checking procedures in order to detect when self-report falls below acceptable standards.

Can the deficits in comprehension and expression of abstract concepts be overcome?

There is a wealth of evidence to suggest that people with learning disabilities are often unclear or confused about even basic concepts relevant to the psychotherapeutic setting. It is therefore important to assess people’s understanding of concepts related to causes and consequences of cognitions, affect and behaviour, particularly where cognitive-behaviour therapy is concerned. For example, Reed (1997) describes the problems that people with learning disabilities have with recognizing and expressing basic emotions such as “happy” and “sad”.

A number of studies have investigated the conceptualization of death in people with learning disabilities and have found that the cognitive understanding of death (e.g. understanding its irreversibility and universality) is patchy in a substantial number of adults with moderate to severe learning disabilities (e.g. Harper & Wadsworth, 1993; McEvoy, 1989). Confusion about the irreversibility and universality of death may lead to more severe and prolonged emotional disturbance after the death of a relative or friend because the person with learning disabilities may be waiting for the death “to

cease”, or may feel angry with the deceased and deserted if they perceive death as optional rather than inevitable.

One of our own studies (Stenfert Kroese, Cushway, & Hubbard, 1998) found that some people with learning disabilities have confused conceptualizations of dreams. For example, out of a sample of 60 adults with mild and moderate learning disabilities, 12 stated specifically that dreams are external events (e.g. happening in/under the bed), and 14 participants consistently stated that two people sleeping in the same room could share the same dream. This indicates that a substantial number of people with learning disabilities are either unclear or inaccurate about the non-physical, private and individuated nature of dreams.

These are just a few examples to illustrate the necessity of careful assessment of clients' knowledge and comprehension of general and specific issues related to therapeutic processes, as well as their ability to express complex abstract concepts.

Can deficits in self-regulation be overcome?

Whitman (1990a, b) defines mental retardation (the North American term for learning disabilities) not as the problem of learning per se, but a problem of generalizing acquired skills to new situations and of discriminating between appropriate and inappropriate situations in which to execute these learnt behaviours. These deficits are, according to Whitman, closely associated with a failure to transfer from an external to an internal locus of control. This transfer in turn is said to be largely dependent on the development of language, as language enables “inner speech” and therefore allows the individual to develop “rule-governed” behaviour (Vigotsky, 1962).

In addition, many authors have commented on the lack of self-regulation in people with learning disabilities due to experiential deprivation (e.g. Shapiro, 1981; Zigler & Balla, 1982; Whitman, 1990a). Children and adults with learning disabilities are often exposed for long (and sometimes indefinite) periods to segregated institutional settings where there are few external motivating factors. That is, the physical environment is bereft of stimulation, interactions with carers are brief and inconsistent, and carers' expectations of the person are low. This will result in motivational disorders because the normal developmental process where individuals set goals and performance standards for themselves does not occur. Moreover, the experience of a long history of failure will discourage the individual from trusting their own cognitive resources (Zigler & Balla, 1982), resulting in dependency and apathy and negative self-attributions that in turn lead to low self-esteem.

The question for the cognitive-behaviour therapist is whether these inherent and acquired motivational disorders can be ameliorated by means of psychotherapeutic sessions alone. Bettelheim (1960) in his book *The informed heart* describes how, through his experiences as a concentration camp inmate, and as a post-war immigrant in the U.S.A., he came to reject the assumption that changes in personality can occur independently from the social context. Thus, “. . . psychoanalysis is by no means the most effective way to *change* personality. Being placed in a particular type of environment can produce much more radical changes, and in a much shorter time.” (p. 18) And even if change can be achieved through therapy, the long-term benefits will only be realised if the client enters into a “reasonable” world after therapeutic change has

occurred, and newly acquired coping techniques are acceptable to others and result in positive outcomes for the client. This may be the most challenging task for therapists who aim to help their clients with learning disabilities to achieve a long-term increase in psychological well-being. Gunzberg (1994) observed that: "There seems to be little justification for initiating therapy . . . merely in order to learn or to prove that it has value, unless it can be reinforced and followed up by concrete achievements. The therapist must, therefore, have some definite administrative power and some weight in the decisions concerning the future life of his patients." (pp. 722–723).

Recent service developments have improved living conditions and the opportunities for clients to be protected from abuse and neglect and to be involved in making choices for themselves. However, despite lengthy policy documents vowing allegiance to O'Brien's (1987) five accomplishments (community presence, community participation, choice, respect, competence) people with learning disabilities are still largely passive recipients rather than active consumers of support services (e.g. Simons, 1995). If self-regulation is seen in the light of empowerment and the opportunity (as opposed to the ability) to practise self-determination, people with learning disabilities are still more disabled by the external, material and political barriers that are put in their way than by their inherent disabilities. Some (e.g. Johnstone, 1995) would even argue that support services are not only remarkably ineffectual but are in fact the main cause of peoples' psychological problems.

It is therefore important for clinical as well as ethical reasons to assess the influence of current environmental factors on the psychological distress of the client before cognitive-behaviour therapy is offered. If, after this assessment, it is concluded that the client is exposed to unacceptable living conditions, the therapist may well need to consider whether, in addition to clinical skills and knowledge, "some definite administrative power" (Gunzburg, 1974) is needed to enable long-term positive change.

Conclusions

Some tentative steps have been taken by cognitive-behaviour therapists interested in cognitive content to adapt their approaches to people with learning disabilities. Such interventions are only possible if (1) the client is allowed and enabled to provide reliable and valid self-reports; (2) the client's knowledge and understanding of abstract concepts is assessed and the therapist is prepared to take on a didactic role if comprehension of concepts such as death are inaccurate or confused; and (3) self-regulation (and therefore generalization and maintenance of therapeutic gain) is encouraged by ensuring that the client lives in a world where human rights are respected and where self-determination is encouraged.

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