Cognitive therapy

WILLIAM R. LINDSAY *reveals how much psychologists can do to help with emotional problems even when communication is difficult.*

MANY people with learning disabilities are suffering from emotional disorders, such as anxiety and depression. There are uncertainties about the level of disorder in this population, but it is likely that it often remains undiagnosed (Prosser, this issue).

Psychologists may also often fail to realise how much can be done to help people with learning disabilities once their disorder is recognised.

Emotional disorders in these clients may present as chronic restlessness, increased irritability, psychomotor agitation, novel or increased behaviour problems, self-injury, screaming and spontaneous crying, mood disturbance or loss of interest (Meins, 1995).

People with a learning disability are often brought up in relatively protected environments, either with their own families or in an institutional setting. Either way, they may not have had the same opportunities as others in the general population to develop coping skills for dealing with emotion.

This, in turn, would lead to sets of maladaptive and dysfunctional cognitions which would militate against adaptive coping. For example, if someone approaches a situation thinking 'I am too nervous, I've never done this', the thoughts may prevent the development of relevant coping strategies.

Several authors have found that emotional problems in adults with a learning disability are associated with poor social skills and poor social support (e.g. Benson *et al*., 1985; Reiss & Benson, 1985; Helsel & Matson, 1988). It would certainly seem that people with a learning disability are more likely to experience a lack of social support compared to others in the community.

Assessment of emotion

Previously, it may have been assumed that the impoverished cognitive and linguistic capacities of people with mild and moderate learning disabilities provide insurmountable difficulties when using self-report to investigate their emotional experiences. Therefore, clinicians and researchers have often asked carers and relatives. A reasonably extensive literature has developed on emotional problems of clients using standard interviews and symptom check-lists filled out by significant others.

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However, Nadarajah *et al*. (1995) demonstrated that informants can have different perceptions from those of the person with learning disabilities and can completely miss the significance of an event for them. These authors found that direct, semi-structured interviewing of individuals with a learning disability is a far superior method, as non-verbal cues of emotion can be identified.

Lindsay *et al*. (1994) assessed the convergent validity of various assessments for anxiety and depression in people with mild and moderate learning disabilities. A remarkable degree of convergence was found in their responses to these various assessments. In addition, assessments of emotions correlated significantly with the neuroticism scale of the Eysenck–Withers personality inventory (Eysenck & Withers, 1965), but not with the extraversion scale. This study indicated not only a high degree of consistency but also validity in the clients' responses in relation to emotion.

Recent developments in assessment techniques have moved towards more reliable and systematic methods of asking clients to judge the extent and nature of their cognitive and emotional difficulties.

Kazdin *et al*. (1983) and Helsel and Matson (1988) used graded multiple-choice options, accompanied by a bar graph which was a pictorial representation of the answers. The graph was graded from the largest bar — indicating a great deal of emotion — to no bar at all, indicating no emotion (e.g. no anxiety).

Others have used pictures of buckets from full to empty as a pictorial aid to expressing the amount of emotion felt by respondents (Bramston & Bostock, 1994). Dagnan and Chadwick (1997) described a procedure with a client whereby he simply held his hands apart to indicate the amount of anger he would experience in different situations.

Reporting work on a Zung self-rating anxiety scale and self-rating depression scale (Zung, 1965, 1971), Lindsay and Michie (1988) found that standard presentations produced very low reliability scores. But by simplifying the language and concepts used and simplifying the response choices, they found that respondents could use the assessments with a high degree of reliability.

These studies demonstrate that if therapists take some care, then reliable and valid assessments of the feelings and thoughts of people with a mild and moderate learning disability can be gathered. Any assumption that this is a population with a less stable cognitive system than the general population would seem to be unfounded.

Treatment studies

When I was conducting work on social skills training, it became apparent to me

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that some individuals altered their cognitive strategies, self-image and confidence rather than their level of skill (Lindsay, 1986). It therefore seemed appropriate to address this in therapy.

Self-instructional training (Meichenbaum, 1977) was employed since it is a relatively simple and straightforward technique. It was originally developed with and for children, and seemed eminently suitable to be adapted for clients with mild and moderate learning disability.

This training involved developing internal dialogues to help overcome performance difficulties and social anxieties and to supplant self-criticism or self-doubt with self-reinforcement..

The success of this work (Lindsay, 1991) led to attempts to address more complex emotional problems using strategies developed from Beck *et al*. (1979) (see later). These approaches were simplified to take account of some of the main problems presented by clients' intellectual disability. These include a tendency to forget what happened in previous sessions, and the difficulty of carrying out homework tasks and recording emotionally troubling events through lack of literacy skills.

There is now an increasing number of anecdotal reports and single case studies that suggest the possible success of psychological treatment for emotional difficulties such as depression, anxiety and anger in people with mild and moderate learning disabilities (e.g. Matson, 1982; Lindsay *et al*., 1997*a*; Black *et al*., 1997).

However, while acknowledging that their case reports indicate some initial success, these authors are cautious in their conclusions because of the lack of systematically conducted controlled outcome studies.

As a jobbing clinical psychologist using cognitive behaviour therapy to work with people who have learning disabilities, I have, in collaboration with colleagues, adapted and developed several treatment methods to be suitable for this client group. As with all therapeutic approaches, they change and evolve over the years. But some remain sufficiently similar in principle and practice to allow clients to be grouped as a clinical cohort.

I will report here briefly on four groupings, to give a flavour of the value of cognitive therapy with these clients.

1. *Anxiety* The elements of Beck's cognitive therapy (Beck *et al*., 1979) were considerably revised and simplified for use with this client group. The essential principles, components and procedures have been maintained as far as possible. The therapist and client follow familiar procedures as follows:

- Set an agenda;
- Develop an awareness of the role of underlying beliefs in determining thought;
- Establish the relationship between thoughts, experiences of anxiety and behaviour;
- Monitor automatic thoughts;
- Determine the content of underlying beliefs and assumptions through themes in automatic thought;
- Test the accuracy of cognitions and challenge maladaptive beliefs;
- Generate alternative cognitions and adaptive automatic thoughts;
- Practise these thoughts during therapy sessions, role plays and *in vivo* sessions;
- Review the evidence to contradict maladaptive beliefs and construct new underlying assumptions about the self;
- Establish homework assignments to review maladaptive cognitions and test out new underlying assumptions and adaptive automatic thought.

While these procedures may sound complicated, the authors already cited have reported a wealth of case examples illustrating the ways in which they can be simplified.

For example, a key feature of cognitive therapy is that clients monitor and record their thoughts. Because of problems with literacy skills, all of this work is done using pictures and diagrams of emotion to ease understanding and promote the ability to complete records. While the resulting record is less sophisticated, it is often ample for detailed analysis during the subsequent treatment session.

The 15 individuals in this cohort were referred from 1989 to 1996. All were assessed on a revised version of the Beck Anxiety Inventory (BAI) or the Zung Anxiety Scale (ZAS). They also reported the frequency and intensity of cognitions relevant to the anxiety disorder.

One client developed a series of negative thoughts that resulted in him misconstruing many noises in his house as evidence of people trying to break in and harm him, even though no one had ever done so. When he went out, he suffered from panic attacks and associated anxiety-inducing cognitions such as 'everyone is looking at me' and 'I look odd'. Therefore, he experienced panic attacks both when he stayed in and when he went out. He resolved this maladaptive dilemma by setting fire to his house.

At baseline, there was an average BAI score or ZAS score of 75 per cent of the total scale. This constituted a significant degree of anxiety, and the reported intensity and duration of the clients' cognitions reflected this. Treatment lasted an average of 23 sessions (range 15–47). Following treatment, there was a

statistically significant improvement in the self-report measures of anxiety and cognitions to around 40 per cent of total score. This improvement was maintained at six-month follow-up (Lindsay *et al*., 1997*a*).

2. *Depression* It is interesting that, despite there being more research on the incidence of depression in people with learning disabilities, the number of referrals I receive for problems associated with depression are far fewer than those associated with anxiety or anger problems.

Five clients, referred from 1990 to 1996, received treatment based on the model of cognitive therapy developed by Beck *et al*. (1979), but in simplified form (Lindsay & Olley, 1998). Clients filled out the Beck Depression Inventory (BDI) or Zung Depression Scale (ZDS) and reported on the intensity and frequency of cognitions relevant to their particular problem.

One client, for example, reported depressive fears of being the only person left in the world ('everyone older than me will be dead, and everyone younger than me will die of AIDS'). Several clients reported thoughts that everyone disliked them.

At baseline, on average, clients responded to the BDI or ZDS with around 50 per cent of the total score. This indicated a moderate level of depression. Their reporting of relevant cognitions was, in general, consistent with a high level of reported depression at around 75 per cent of the individual's highest score. Following treatment, there was a considerable reduction in both scores to around 25 per cent. This was maintained until follow-up from two to six months later.

The numbers in this cohort do not allow for statistical comparison between baseline scores and post-treatment scores. However, the trends are highly supportive of the trends seen in clients treated for anxiety.

3. *Anger* Treatment for lack of anger control has been based on principles developed by Novaco (1986) and adapted for people with mild and moderate learning disabilities (Black & Novaco, 1993; Lawrenson & Lindsay, 1998). These simplifications of treatment keep within a cognitive mediation framework for anger. This emphasises the relationship between physiological arousal, behavioural responses and environmental circumstances.

The cognitive mediation determines the individual's reaction to a combination of these circumstances. For example, clients may misconstrue anxiety-provoking or embarrassing situations as instances where others are being threatening, so giving rise to anger or aggression. They may also misconstrue feelings such as disappointment or anxiety as anger, and may accordingly act in an aggressive manner.

Treatment involves three stages of cognitive preparation, skill acquisition and practical applications of coping skills discussed during treatment. Cognitive restructuring, relaxation (arousal reduction) and coping skills are employed as major elements throughout treatment. Again, outcomes have been successful, this time with 13 clients (e.g. Lindsay *et al*., 1998*b*).

4. *Sex offenders* We develop treatments for people who are referred to our department. With the advent of deinstitutionalisation and community care for people with learning disabilities, there are fewer hospital places for sex offenders who, 10 or 15 years ago, would be locked in a hospital ward. Therefore, increasing numbers are referred as outpatients or day patients.

The importance of cognitive distortions and subsequent cognitive therapy for offenders is now well documented (Marshall *et al*., 1991; Ward *et al*., 1997). I have developed some cognitive treatments for sex offenders with a learning disability. To assess the outcome of these treatments, we have also developed assessments for cognitive distortions.

Essentially, the assessment reviews attitudes that are consistent with sex offending; for example, 'women who dress in a short skirt with no bra want to have sex' or 'flashing at a woman is a good way to show her you want to have sex'.

My colleagues and I have treated 24 men referred between 1990 and 1996 and convicted of offences against women, exhibitionism and offences against children (e.g. Lindsay *et al*., 1998*a*).

All three groups showed a similar pattern. Before treatment, there was a high level of attitudes consistent with offending (around 80 per cent of total score). These scores reduced to levels of around 30 per cent after one year of treatment. For every group, tests indicated this reduction to be statistically significant.

The important issue here is that, again, a treatment which is designed to impinge on the cognitions of people with learning disabilities has shown some success.

Conclusions

There may have been obstacles that have deterred clinical and research workers from addressing cognition and emotion in people with mild and moderate learning disabilities. However, there is overwhelming evidence that these individuals experience emotional problems. In addition, there is evidence that cognition and emotion in this client group vary in a consistent and understandable manner.

We have now overcome many of the technical problems, and there is really no longer any logical excuse to avoid conducting cognitive therapy and research with people with a mild or moderate learning disability.

Undoubtedly, technical problems remain for people with severe and profound learning disabilities, since they have significantly greater impoverishment of cognitive and linguistic systems. However, there are some reports of success with interpersonal psychological therapies for this client group, as opposed to psychological treatment employing behavioural modification (e.g. Lindsay *et al*., 1997*b*). As a profession, a development of these treatments would seem a real and exciting possibility.

The data referred to here on the treatment of over 50 individuals show a powerful and lasting clinical effect

following a form of cognitive therapy. This is true across four types of problems and a diverse clinical population. My hope is that recent publications and this special feature in *The Psychologist* will prompt an increasing number of psychologists to do justice to a fascinating clinical area.

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