Chapter 22

Modifications Of Cognitive Behaviour Therapy And Counselling For Individuals With Intellectual Disabilities

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Introduction

Individual psychotherapeutic interventions for children and young people with intellectual disabilities have traditionally focused on using behavioural strategies to reduce psychological distress and maladaptive behaviours. However, recently there has been increasing interest among clinicians in the application of Cognitive Behaviour Therapy (CBT) for this client group. Despite this interest, there is a lack of research evidence to support CBT as an effective intervention for children with intellectual disabilities, and many clinicians have had to rely on the adult literature for useful information. This chapter will therefore discuss how applicable CBT is for children and adolescents with intellectual disabilities, the modifications necessary for adapting any kind of individual therapy for this client group, and will provide some practical ideas for clinicians who may be considering using CBT with this client group.

What Is Cognitive Behaviour Therapy (CBT)?

CBT is based on the theory that psychological issues (such as anxiety and depression), or behavioural problems arise as a result of cognitive deficits and cognitive distortions (Stallard, 2002). The aim of CBT is to identify and correct these deficits and distorted patterns of thinking and thus to alleviate the psychological or behavioural problem (Dagnan & Lindsay, 2004).

What Skills Are Needed For Cognitive Behaviour Therapy (CBT)?

In considering the suitability of CBT for children and young people with intellectual disabilities it is important to ask, a) what skills are needed in order to engage in CBT, and b) do children with intellectual disabilities have these skills? CBT requires an

ability to systematically identify, challenge, and generate alternative ways of thinking (Stallard, 2002). Do children with intellectual disabilities have this degree of cognitive maturity?

Theory of mind research indicates that by age 4 to 6 years, children start to take into account others' desires and beliefs in predicting how a particular situation affects emotions (Howlin, Baron-Cohen, & Hadwin, 1999). For example, Katie knows her sister *wants* a doll for her birthday but *believes* she is getting a car and will be sad. This is also true for children with intellectual disabilities who at age 5 years (non-verbal mental age 38 months) have been shown to predict the emotion of a character in a story, if they have been given the character's belief (Phillips, Gomezt, Baron-Cohen, Laat, & Rivieret, 1995). Similarly, theories of cognitive development suggest that by middle childhood (7-12 years) children enter the concrete operational stage, which means their understanding of their own and others' emotional states improves, although they still have difficulty with abstract reasoning (Vernon, 1989). However, during adolescence children gradually shift into the formal operational thinking stage (11-15 years) in which they are able to think more abstractly, and are better at predicting logical consequences (Vernon, 1989).

Despite the slower cognitive progress of the child with intellectual disabilities, there is nevertheless a progress in adolescence into the formal operational thinking stage. This suggests that CBT maybe more suitable for adolescents with intellectual disabilities than for younger children. In support, Durlak, Fuhrman, and Lampron (1991) in their meta-analytic review of CBT for children found that the child's age is an important factor in relation to efficacy of treatment. Results indicated that CBT was more effective with children in the formal operation stage (aged 11 years plus).

However, it was not clear whether younger children struggled because they lacked the cognitive skills or if the intervention was not pitched at the right developmental level.

What Are The Developmental Considerations When Using CBT?

In adapting CBT for children with or without an intellectual disability there are a number of developmental issues that should be considered. This is particularly important because childhood is a period of skills acquisition, and there will be times when the child will not have acquired the relevant skills to engage in CBT (as discussed previously). In reviewing the literature it appears that developmental considerations are often overlooked, with the assumption that children at all stages of development can be catered for within a single treatment approach.

A further developmental consideration that is often overlooked is the *context* of the child and the impact that this has on the development of cognitions and beliefs, as well as variations in the manifestation of problems. This includes the possible influence of families, peers, and schools. It is likely that these contextual factors will have more relevance when working with children with intellectual disabilities compared to typically developing children, because such children and their families are often involved with a range of agencies from a young age.

The role of parents is also important. Parents have the potential to act as facilitators in helping their children with intellectual disabilities apply the skills learnt in therapy to the home environment. It is therefore crucial that any CBT approach includes collaboration with the child's family. However, therapists need to be aware that parental beliefs (i.e., how they understand their child's difficulties) will impact on how they manage their child's psychological and behavioural problems (Drinkwater & Stewart,

2002). Research has begun to identify the links between how parental beliefs influence the development of a child's cognitions (Garber & Robinson, 1997). A number of CBT studies include a family component in the treatment, such as *The Cool Kids* (Rapee et al., 2005) program for anxiety, discussed later in the resource section.

Assessing Suitability Of CBT For Individuals With An Intellectual Disability

The approach to assessing whether a child or young person is suitable for CBT varies across clinicians, ranging from highly standardised assessments to clinical judgement (Haddock & Jones, 2006). The difficulty for clinicians is in deciding whether their client has the basic intellectual skills necessary to grasp the core concepts of CBT. Dagnan, Chadwick, and Proudlove (2000) developed a protocol of five tasks, which progressively assess an individual's ability to identify different emotions and to discriminate among thoughts, feelings, and behaviours. This protocol is outlined in Table 22.1 and may be useful to clinicians wishing to undertake a structured assessment.

[Insert Table 22.1 here]

As a minimum standard it is suggested that clinicians assess their client's overall intellectual functioning and their receptive and expressive language abilities. Research indicates that people with learning disabilities who have higher intellectual functioning and a good receptive vocabulary are more likely to understand the cognitive model, based on their ability to identify different emotions and to discriminate thoughts, feelings, and behaviours (Swanson, 2001). When working with adolescents it may be

helpful to pay particular attention to how they perform on verbal abstract reasoning and visual reasoning tasks. For example, the Similarities subtest from the Wechsler Intelligence Scale for Children (WISC-IV) (Weshler, 2003).

Stallard (2002) in his book *Think Good - Feel Good* discussed a less standardised approach for assessing the basic skills required for children to engage in CBT. This approach relied heavily on clinical judgement and can be flexibly applied (see Table 22.2). Haddock and Jones (2006) consulted with a group of expert clinicians using CBT with clients with intellectual disabilities. The main exclusion criteria identified were limited or no language skills, lack of willingness to participate, autism and psychosis.

[Insert Table 22.2 here]

How To Adapt Therapy For Individuals With Intellectual Disabilities

When adapting CBT for children and adolescents with intellectual disabilities the components and style of CBT needs to be appropriate to the developmental level of the child. Obviously, individual differences will play a large role in treatment outcome. The difficulty for clinicians is that researchers rarely report how they have adapted the components of CBT for children and young people. However, the ideas outlined in Table 22.3 may be useful to clinicians working with children with intellectual disabilities.

[Insert Table 22.3 here]

Firstly, there are some general principles that should always be considered when counselling a child or young person with an intellectual disability. It is important that clinicians appropriately adjust their vocabulary and tailor their interventions according to the child or young person's level of comprehension, e.g., avoid jargon and psychological wording (Barrett, 2000). The use of puppetry or hands on materials (e.g., balloons, art supplies) rather than purely verbal strategies will reduce the language demands.

When using CBT with individuals with intellectual disabilities one of the main difficulties for clinicians is how to present abstract concepts using more understandable examples. Haddock and Jones (2006), in an attempt to reach practitioner consensus in the use of CBT for individuals with a learning disability, noted that overcoming such a difficulty was reported to be complex by all of the clinicians interviewed. They found that some practitioners often tried to avoid abstractions completely, whereas others tried to explain abstract concepts with concrete examples or used visual aids, role-plays, vignettes and puppets to support the explanation of abstract concepts.

The use of comic strip conversations (Gray, 1994) is also a useful technique for visually presenting an abstract concept. Comic strip conversations are a way of visually illustrating an interaction between two or more people that would otherwise be difficult to explain. They may be used instead of, or in combination with, social story telling. Comic strip conversations can be used to help define social terms and/or to identify what people might be thinking or feeling in different situations. In comic strip conversations, verbal information and explanation is enhanced by simple stick men, drawings and colour.

When working with younger children it is important that concepts and strategies are presented at an appropriate developmental level. For example, anger could be described as a volcano that builds up and erupts, or the metaphor of a MP3 player playing in the child's head to describe automatic thoughts. However, when working psychotherapeutically with younger children the focus is more likely to be on the behavioural component of CBT.

The literature suggests a need for key modifications to ensure children with learning difficulties are taught effectively. These learning strategies include the use of behavioural techniques and augmentative and alternative communication (AAC) strategies to help an individual learn new skills. Behavioural techniques include modelling, rehearsal, feedback and reinforcement as key approaches. AAC strategies refer to supplementary methods or visuals tools that are used to support or extend an individual’s existing communication system (Beukelman & Mirenda, 2005).

CBT typically involves asking clients to undertake ‘homework’ tasks to gather information outside of clinical sessions. Clinicians should ask themselves whether the homework task is really necessary, as young people often fail to complete such tasks, even if you call it something else! If the task is necessary, for example, if it helps to generalise skills learnt in therapy to the home situation, the importance of the task should be openly discussed in the session. A careful explanation of the rationale of the task may help, focusing on how the task will be used in therapy when completed, is likely to be helpful. If there are difficulties completing the task it may be useful to explore any automatic thoughts associated with the homework. Haddock and Jones (2006) reported that ‘homework’ had very negative connotations for people who often had a very difficult educational background.

What CBT Resources Are Available?

There are unfortunately no specific CBT resources available to clinicians interested in using cognitive behaviour techniques with children who have intellectual disabilities. However, there are a number of excellent manual based programs and books that experienced clinicians may find useful as a guide to adapting therapy for children with intellectual disabilities. These are outlined in the following sections.

Anxiety Disorders

The *Cool Kids Anxiety Program* (Rapee et al., 2005) is a ten session CBT program that is available from the Emotional Health Clinic (formerly the Macquarie University Anxiety Research Unit in Sydney, Australia). The program is designed to help children aged 7-16 years manage their anxiety and can be conducted either in a group or individual format. The program includes parent and child workbooks to accompany all of the sessions. It also includes a manual for therapists describing in detail how to conduct each session of the program. However, Macquarie University strongly recommend that clinicians who wish to conduct the program attend one of their training workshops. There is also a *Cool Kids Anxiety Program (School Version)* that is designed to be run in school by school counsellors and related mental health workers.

The book, *OCD in Children and Adolescents: A Cognitive-Behavioural Treatment Manual* (March & Mulle, 1998), is designed to help clinicians treat children and adolescents with Obsessive Compulsive Disorder using CBT, specifically in relation to exposure plus response prevention. It is the result of over fifteen years of research exploring how CBT can be used effectively to treat OCD. It has been used with

children aged 4+ years and has been shown to be applicable across a broad range of ages and abilities. There is an accompanying book titled, *Talking Back to OCD: The Program That Helps Kids and Teens Say 'No Way' and Parents Say 'Way to Go'* (March & Benton, 2007) that is a guide for parents who are comfortable in the self-help mode.

For very young children the book, *Up and Down the Worry Hill: A children's book about obsessive-compulsive disorder and its treatment* (Wagner, 2004) may be a more developmentally appropriate resource. The book emphasises that many people experience OCD, and discusses its causes, effects and treatment options. It may also help prepare children to engage in treatment, as it describes CBT in a child friendly manner.

Building Positive Self-esteem

The book titled *Cool Connections with Cognitive Behavioural Therapy: Encouraging Self-esteem, Resilience and Well-being in Children and Young People Using CBT Approaches* (Seiler, 2008) can be used by a range of mental health professionals. It is designed to positively modify the everyday thoughts and behaviours (i.e., reduce feelings of anxiety and depression) of children and young people aged 9 to 14. The workbook includes step-by-step guidelines on how to use the materials appropriately with a mixture of games, handouts, home activities and therapeutic exercises.
Friends for Life (Barrett, 2004, 2005) for school-aged children and young people, and *Fun Friends* (Barrett, 2007a, 2007b) for young children, are designed to help children and young people deal with feelings of fear, worry, and depression by building resilience and self-esteem. The program is designed to be used in schools but can easily

be used with individual clients. It teaches cognitive and emotional skills in an easily understood child friendly format. It is the only childhood anxiety prevention program acknowledged by the World Health Organization (WHO), and has 8 years of comprehensive validation across several countries and languages using rigorous randomised control studies (WHO, 2004).

Anger Management

The book titled, *Exploring Feelings: Cognitive Behaviour Therapy to Manage Anger* (Attwood, 2004) is one of two 'Exploring Feelings' programs. The two programs were designed to explore and manage anxiety, and the other to explore and manage anger. The original program was developed to be delivered in a small group to children with Asperger's syndrome aged 9-12 years, and to be delivered in a small group. However, the workbooks can easily be modified to be used with individual children with developmental disabilities.

Understanding Own And Other People's Feelings

Think Good, Feel Good (Stallard, 2002) is a practical CBT workbook for children and young people. The materials have been developed by a consultant clinical psychologist and have been trialled extensively in clinical work with children and young people presenting with a range of psychological problems. This resource is also helpful for clinicians as it explains the basic theory and rationale behind CBT and how the workbook should be used. The book is available in print and as a downloadable resource (as an eBook) on the internet. There are ten modules which can be used as a complete program, or adapted for individual use.

What Works When With Children and Adolescents: A Handbook of Individual Counselling Techniques (Vernon, 2002) is a practical handbook designed for counsellors, social workers, and psychologists in schools and mental health settings. It offers over 100 creative activities and effective interventions for clinicians undertaking individual counselling with children.

My Book Full of Feelings: How to Control and React to the Size of your Emotions (Jaffe & Gardner, 2006) is an interactive workbook for children with social disabilities, including autism spectrum disorders. It is designed as a teaching tool for parents and professionals to help the child become more aware of their own emotions, and then learn how to manage their feelings. The book uses a pyramid graphic that children can easily use to point out how they are feeling, and the intensity of that feeling.

Conclusion

There are a number of reviews that provide encouraging evidence for the efficacy of CBT in adults with intellectual disabilities (Taylor, Lindsay, & Willner, 2008) and for the value of CBT as a therapy for use in children and young people who have a range of disorders (Christie & Wilson, 2005). However, there is still considerable work to be done to evaluate its effectiveness for children and young people with intellectual disabilities.

The language and cognitive skills required to engage with CBT suggest that it may not be suitable for children and young people with moderate to severe intellectual disabilities. However, clinicians wishing to use CBT should undertake a detailed assessment of the individual’s abilities, and consider the necessary modifications to

therapy (e.g., developmental considerations). This will ensure that many of the therapeutic challenges can be addressed thus making CBT a promising treatment option for individuals with intellectual disabilities.

Table 22.1

Measures For Assessing Suitability For Cognitive Behaviour Therapy

Measure	**What the assessment involves**
The British picture Vocabulary Scale (BPVS-II) (Dunn, Whetton, & Burley, 1997)	Receptive language ability
Emotion recognition (Dagnan & Proudlove,1997)	Individuals are presented with five pictorial facial expressions, and asked to indicate which face represents a stated emotion.
Differentiating emotions and events (Reed & Clements, 1989).	Six simple scenarios are described and individuals are asked to identify whether in that situation they would feel happy or sad. Responses are verbal or by pointing to either a happy or sad face.
Differentiating emotion, given a scenario and belief, using Evaluative Beliefs Scale (Chadwick, Trower & Dagnan, 1999)	Five scenarios are presented twice, once with a positive belief and once with a negative belief and clients are asked 'Do you feel happy or sad?'
Identifying the belief (Dagnan, Chadwick & Proudlove, 2000)	Five scenarios are presented twice, with the associated emotion and individuals are asked to choose the belief.

(Adapted from Dagnan, Chadwick, & Proudlove 2000)

Table 22.2

Assessing The Basic Skills Required To Engage In CBT

Key Task	Method	Example
Accessing and communicating thoughts	Direct questioning	Interviewing the child about their thoughts. For example asking the child to describe 'what were you thinking?' or 'what thoughts were running through your head at the time?'
	Indirect approach	Children can be asked to describe a recent difficult situation, or draw it. Clinicians should note whether the child is able to describe what happened and some of their thoughts about the event.
	What might someone else be thinking?	The child can be provided with a set of situational scenarios e.g. birthday party, from which they can choose what the thoughts might be e.g. I love cake.
	Thought Bubbles	In this approach the child is presented with cartoons or pictures and asked to suggest what the characters may be thinking.
Generating alternative attributions	Hypothetical situations	The child is presented with a set of hypothetical situations to assess whether he/she is able to identify

		explanations for events (Doherr et al. 1999). For example, a child in the playground shouts ‘hello’ at his friend, but his friend just runs past. The child is then asked to think of as many different explanations as possible for what has happened.
	Generative cartoons	The child can be given a set of cartoons and asked to write or draw as many ideas as possible about what the characters may be thinking.
	Puppets and play	A difficult situation can be acted out, and the child asked to suggest what each of the puppets may be thinking about the situation.
Awareness of emotions	Identify and express emotions	If the child is unable to provide a verbal description of how they are feeling they may be able to draw instead. Quizzes and games can also be used to assess whether the child can identify how others’ feel.
Thoughts, feelings and events	Linking thoughts feelings and	This could be a card task where different feelings have to be matched with different thoughts or acted out

events	using puppets.

(Adapted from Stallard, 2002).

Table 22.3

Adaptations Of Psychotherapy Techniques

Adaptation	**Definition/Example**
Simplification	Reduce usual technique in complexity; breakdown interventions into smaller chunks, shorter length of sessions.
Language	Reduce level of vocabulary, sentence structure and length of thought. Use short sentences; use simple words.
Activities	Augment typical techniques with activities to deepen change and learning. Add drawings, homework assignments.
Developmental Level	Integrate developmental level into presentation of techniques and material. Use games; assess development into relevant social issues.
Directive methods	Because of cognitive limitations, one must be more direct. Outline treatment goals, progress and give extra 'visual' guides.
Flexible methods	Adjust usual techniques to suit cognitive level and lack of progress. Draw from other modalities.
Involve caregivers	Use family, support staff to help with change. Assign homework or rehearsals at home with the help of staff or family.
Disability/rehabilitation	Issue of disability must be addressed within

approaches	treatment; therapist must raise issues and support positive self-view

(Adapted from Hurley, 1989; Whitehouse, Tudway, Look, & Kroese, 2006).