A Manual of Cognitive Behaviour Therapy for People With Learning Disabilities and Common Mental Disorders

Therapist Version

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A training guide to help professional therapists in treating people with communication and cognitive problems in CBT

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Part I

An Overview of Cognitive Behaviour Therapy for Treating People with Learning Disabilities

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Chapter 1
An Introduction to the Use of CBT in People with Learning Disabilities

The World Health Organization defines *learning disability* as "a significant impairment of intellectual ability" (i.e. IQ less than 70) and "difficulties in social and adaptive functioning" that are present from childhood (WHO, 1993). Recent studies have shown that this population is vulnerable to depression and anxiety (Azam et al, 2009) with reported prevalence rates of 6.6 percent and 3.8 per cent for affective and anxiety disorders respectively (Cooper et al, 2007a). Incidence rates of 7.7 per cent and 1.5 per cent respectively have also been reported (Smiley et al, 2007b). Unfortunately, learning disability has historically been considered an exclusion criterion for psychotherapy, leaving those suffering from such disorders few (if any) options for treatment.

There has of late been a growing interest, both within the psychotherapeutic community and in the broader social sphere, in developing psychological therapies specifically designed for people with learning disabilities and providing them with the same services the general population has access to. For example, Valuing People (2001)—a UK government white paper designed to improve the lives of people with learning disabilities—states that those with learning disabilities should have the same access to healthcare as people without disabilities do. Movements like this in conjunction with the ever-growing body of research that supports the use of cognitive-behavioural therapy (CBT) as an effective treatment for depression, anxiety, and other psychological disorders has led a few pioneering therapists to use CBT with clients who have learning disabilities. We will review the history of the use of CBT in this population momentarily. As you will see, the use of CBT for the treatment of depression and anxiety in people with learning disabilities to date has been limited to single case studies and small group settings. However, with a few modifications in therapeutic approach and communication style these early attempts have indicated CBT may be a successful intervention for those with learning disabilities (Lindsay et al, 1993; Lindsay et al, 1997; McCabe et al, 2006; McGillivray et al, 2008). Even so, there have not yet been any attempts to evaluate CBT on a larger scale for this population using randomised controlled trials, and no therapeutic protocols have been developed that outline best practices for tailoring CBT for use with people who have learning disabilities.

This manual is an attempt to bridge that gap. It describes the process of treating depression and/or anxiety disorders in people with mild to moderate learning disabilities using CBT[1]. It is

[1] While this manual describes the treatment of depression and anxiety disorders, it excludes depression with psychotic features as well as obsessive-compulsive disorder.

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designed for therapists who have CBT training, but have little to no experience with clients who have learning disabilities. For CBT interventions to be successful with people who have these kinds of disabilities, they need to be made more accessible and modified appropriately to cater to their cognitive abilities and complex communication needs. This manual provides instructions on how to do that, and outlines a therapeutic protocol that can be applied in treatment.

In this chapter we will begin with a review of depression, anxiety, the cognitive behavioural approach to therapy, and the therapeutic relationship. For many of you this will be review; however, the information presented will be contextualised to the learning disability population so we encourage you to read it. We will then follow up with a brief review of the use of CBT in people with learning disabilities, and we will close with an overview of adaptations and specific considerations that need to be kept in mind to successfully apply the model for these types of clients. In Chapter 2 we will focus on communication, since it is such a critical component of treating people with learning disabilities, and explain how you can modify your communication in the therapeutic setting to more effectively address the needs of these clients. Then, in Part 2, we will provide a three-part protocol for treating anxiety and depression in people with learning disabilities and outline specific emotional, behavioural, and cognitive techniques you can use with this population.

Depression and Anxiety in People with Learning Disabilities

Depression and anxiety are relatively common psychiatric disorders whose definitions and symptoms are well-defined and well-known by most psychotherapists. However, the features of these disorders tend to present themselves in relatively specific ways in people with learning disabilities. Therefore, a brief review of the definitions and symptoms of each and a short overview of the most prominent features in those with learning disabilities are warranted.

Depression[2]

The National Institute for Mental Health (NIMH) defines major depressive disorder as “a combination of symptoms that interfere with a person’s ability to work, sleep, study, eat, and enjoy once-pleasurable activities” (NIMH website). Symptoms of depression include (extracted from Andrews & Jenkins, 1999):

- Feeling miserable. This misery lasts at least a week or two, where the feeling is present most of the day and varies in its intensity.
- Loss of interest or pleasure in daily activities.
- Loss of appetite (and excessive weight loss).
- Loss of energy.

[2] Some of the information in the sections that follow has been repeated in Chapter 4, where we discuss psychoeducation.

- Loss of sleep even when exhausted. Sleep is usually restless and the individual wakes up earlier than usual. (Some people may sleep more than usual.)
- Loss of interest in sex.
- Persistent worrying about things that are not important.
- Slowed and inefficient thinking, with poor concentration.
- Recurring unpleasant thoughts, particularly of guilt (of being a bad person and wishing to die[3]).
- Slowed activity and speech.
- Fearfulness (of people and places). This often leads to withdrawal from family, friends, and everyday activities.

People with learning disabilities are often unable to express their feelings easily in words, and use behaviour to communicate with others. The emotional experience the person with a learning disability has is often most obvious in its behavioural correlates. It is, therefore, critical to take behaviour as well as mood into account in these clients. Sudden changes in behaviour (or mood) and/or a client's inability to engage in activities he or she could previously accomplish are important signs that the client may be depressed.

It is also worth noting that depression is sometimes linked to low self-esteem in people with mild and moderate learning disabilities. Methods for tracking behavioural changes and assessing self-esteem will be outlined in Part 2.

Anxiety

According to the National Institute of Mental Health, "Anxiety is a normal reaction to stress. It helps one deal with a tense situation in the office, study harder for an exam, or keep focused on an important speech. In general, it helps one cope. But when anxiety becomes an excessive, irrational dread of everyday situations, it has become a disabling disorder" (http://www.nimh.nih.gov). Symptoms of anxiety disorder include (extracted from Andrews & Jenkins, 1999):

- Nervousness or restlessness
- Trembling
- Trouble falling or staying asleep
- Sweating
- Poor concentration
- Palpitations
- Frequent urination

[3] The issue of suicide and suicidal ideation as well as methods for addressing this in people with learning disabilities will be addressed in Part 2.

- Muscular tension
- Easily fatigued
- Irritable mood
- Light-headedness or dizziness
- Hyperventilation
- Shortness of breath
- Depressed mood

Behavioural correlates of anxiety disorder include hyperventilation, aggression, increased irritability, avoidance behaviour, self-injury, and unnecessary motor activity. These are particularly prominent in people with learning disabilities. Symptoms such as excessive worrying, avoidance of potentially feared stimuli, and common physiological signs such as feeling of choking and palpitations may not be reliably diagnosed or even reported in people with learning disabilities.

Irritability is a particularly common behavioural correlate to both anxiety and depression in these clients and challenging behaviour is a key atypical feature of either condition. Relaxation techniques for reducing arousal and coping skills for reframing cognitions to provoking situations are useful interventions in these cases, and we will discuss how to integrate them into treatment later in the book.

For now, let us turn our attention to the aetiology of these conditions and review the similarities and differences in the development of depression and anxiety between those with learning disabilities and the normal population.

Biopsychosocial Influences on the Development and Alteration of Depression and Anxiety in People with Learning Disabilities

The presentation of depression and anxiety can be triggered (and therefore altered) by the biological, psychological, and social make-up and circumstances of each individual according to the type and severity of his or her learning disability. Any factors that influence the client's presentation of depression and/or anxiety must be considered in treatment. A comprehensive review of all the potential factors that contribute to the development and presentation of these illnesses would be impossible. However, it is worth examining each of the three major spheres of influence—biological, psychological, and social—and the specific ways they may contribute to the development of depression and/or anxiety in people with learning disabilities.

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Biological Factors

We know that genetic predisposition and other biological factors play a role in the development of depression and anxiety disorders in the normal population. These factors likely play a role in the causation of common mental disorders, i.e. depression and anxiety, in those with learning disabilities as well. Certain genetic conditions or pervasive developmental disorders are associated with common affective disorders (Kim et al, 2000; Myers et al, 1991). One notable biological factor that likely increases the risk of depression in this population is physical disability. It is well-recognised that physical illness and physical disorders are predisposing factors to the development of depression in the normal population. It stands to reason this is an important causative element in the development of depression in people with learning disabilities as well, especially since physical disability is so common in this population (Prasher, 1999).

Psychological Factors

It is a core tenet of this book that the development of depression and anxiety in people with learning disabilities is likely mediated, at least in part, by psychological influences. This protocol was developed to help you recognise these factors and treat them appropriately. A growing body of evidence supports this approach.

While there are many psychological models that offer explanations as to how depression (and anxiety) develops, three are particularly relevant to our discussion here:

- The cognitive-behavioural model (Beck et al, 1979)
- The self-control model (Rehm 1977, 1981)
- The learned helplessness model (Peterson & Seligman, 1981)

The Cognitive-Behavioural Model of Depression

The traditional model of cognitive-behavioural therapy (on which this protocol is primarily based) proposes that an *activating event* (A), in association with an individual's *beliefs/thoughts* (B), can elicit certain emotional and/or behavioural *consequences* (C). While there are a number of potential points where a therapist can intervene in this sequence (including cognitive, emotional, and behavioural techniques), what is ultimately at stake is challenging and/or altering the underlying belief(s) that create the tether between activating event and emotional or behavioural consequences.

Beck's (Beck et al, 1979) model suggests that these core beliefs, or *schemas,* are the root of depression (and anxiety) and that they often perpetuate pain-inducing and self-defeating attitudes and behaviours despite evidence that the beliefs themselves are false. The process by which this happens can be described as follows.

Core beliefs developed in early childhood are typically deep-rooted and rigid. New experiences are filtered through these beliefs and only information that supports them is retained, thus the schema is reinforced. The type of schema employed by any given individual governs the way they interpret their experience. When the core belief is irrational, it leads to one of a number of thinking style errors. These errors in thinking are usually primitive, limiting, and, in the case of depression, negative. As a result, the individual's view of the world is distorted, low mood, and the associated negative thinking and feeling are further perpetuated; this in turn influences behaviour negatively; and the sufferer may eventually become caught in a downward spiral of automatic negative thoughts they are no longer capable of challenging. These automatic negative thoughts occur in one of three domains—the self, the world, and the future. This is known as the *cognitive triad*.

A negative view of the self causes the individual to understand him- or herself as inherently inadequate, unintelligent, or incapable. He or she thinks that unpleasant experiences or events occur as a result of personal inadequacies. This leads to self-criticism and feelings of worthlessness, and often the individual starts to believe that he or she will never be happy or satisfied because of his or her lack of some specific set of attributes. A negative view of the world leads an individual to believe the world itself presents obstacles that are too difficult to overcome and makes impossible demands that he or she is unable to fulfil. As a result, even benign experiences may be interpreted as adverse or threatening. A negative view of the future results in the individual believing that any current difficulties being experienced will continue forever or that the future only holds hardship and frustration. One typical outcome is the belief that any task undertaken will be met with failure (Beck et al, 1979).

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Below you will find an illustration of the cognitive-behavioural model of emotional disorders and how this chain of events typically occurs (Figure 1).

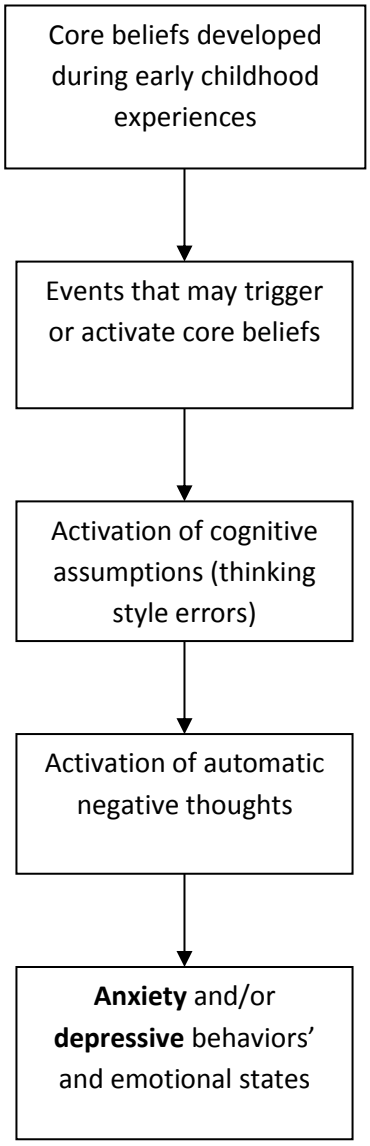

Figure 1: Cognitive-behavioural Model of Anxiety and Depression (based on Beck et al, 1979)

Though Beck's model was originally developed to explain how depression and other emotional disturbances occur in the normal population, it seems to apply to people with learning disabilities as well. For example, we know that people with learning disabilities who are diagnosed with depression hold more negative views of the self than members of this population who do not have depression. Interestingly, there are no significant group differences in negative views of the world and the future. However, this may be because people with learning disabilities usually do

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not have a positive view of the world or the future regardless of psychiatric diagnosis (Esbensen & Benson, 2007)[4].

While the cognitive-behavioural model forms the core theoretical foundation for the treatment protocol found in this book, there are two other conventional models of depression we find useful in understanding depression and anxiety in people with learning disabilities. Both have cognitive and behavioural components, and both fit with Beck's model as well as our own approach to treatment. We would like to briefly review each of these before moving on to the social factors that may influence the development of emotional disorders in people with learning disabilities.

The Self-Control Model of Depression

The self-control model of depression (Rehm 1977, 1981) explains depression as a cognitive-behavioural deficit in self-control. The control an individual has over his or her behaviour is divided into three processes:

- **Self-monitoring—**The individual selectively attends to negative aspects of experience or events instead of the positive and assesses immediate outcomes rather than long-term results.
- **Self-evaluation—**The individual constantly evaluates him- or herself using harsh and very strict standards. Furthermore, the individual will attribute positive outcomes to external factors and negative outcomes to internal factors.
- **Self-reinforcement—**The individual provides him- or herself with insufficient positive reinforcement and excessive punishment.

Each of these processes describes common psychological patterns in people who have learning disabilities who also suffer from depression and adds another dimension to our understanding of the aetiology of the disease in this population.

The Learned Helplessness Model of Depression

Psychological factors such as learned helplessness may also contribute to depression illnesses in people with learning disabilities (Prasher, 1999). Like the self-control model of depression, the learned helplessness model of depression (Peterson & Seligman, 1981) sees control as a central feature in the development of the disorder. However, in this model the emphasis is on the individual's perceived ability to influence (or control) his or her reality, the expectations that develop out of these perceptions, and the attributions the individual makes regarding why particular events are or are perceived to be uncontrollable.

[4] It is worth noting that it still behooves the therapist to address and treat negative views of the world and the future in this population to achieve results.

When an individual develops the belief that he or she does not have control over a given situation, the person may extrapolate this experience to other situations in his or her life. Thus the individual learns that he or she is helpless. The degree to which this sense of helplessness infiltrates the person's life is contingent on what he or she attributes the experienced lack of control to. If the lack of control is attributed to internal, stable, and/or global qualities, the feeling of helplessness is more likely to be generalised to other areas of the person's life. If the lack of control is attributed to external, unstable, and/or specific qualities, helplessness may not be experienced or it may be felt only in specific situations. In either case, once the helplessness is learned it leads to an expectation of adversity and the prediction of negative outcomes in future situations. Greater expected adversity and uncontrollability leads to greater negative motivational and cognitive deficits.

We know that people with learning disabilities are likely to acquire feelings of helplessness, as underachievement in their academic and personal lives is usually attributed to their learning disability (Reed, 1997). We also know that learned helplessness can be an aetiological factor in depressive disorder (Abramson et al, 1978). Therefore, it's logical to conclude that learned helplessness may be a major factor in the development of depression in those with learning disabilities. This adds yet another perspective to our understanding of the disease in this population.

Social Factors

The social isolation model, which stems from the social learning theory, posits that limited or lack of social contact may result in depression (Prasher, 1999). This may be a factor in the development of depression in those with learning disabilities, since many of them operate in limited social circles and the social interactions they do have may be stunted by their disability.

Additional social factors that may contribute to depression for people with learning disabilities include health morbidity, unemployment, stigmatisation, low income, and few intimate relationships (Prasher, 1999). Even though there are no definite causational links between these factors and depression, the feelings that these situations elicit are likely factors in the aetiology of depression. For example, not having an intimate relationship may result in the individual feeling lonely (Prasher, 1999). Furthermore, changes such as moving to a different home or day centre may trigger feelings of depression or anxiety for someone with learning disabilities. Loss, such as a death of a close family member/friend or a change in his/her support worker, may have a similar effect.

What we have reviewed in the last few pages outlines many of the likely aetiological factors that lead to depression in people with learning disabilities; however, more research is needed. As Prasher notes:

> *At present, more work is needed to investigate aetiological factors of depression in people with learning disability. Research in the field of molecular genetics will have a significant impact, when 'candidate' genes which increase the risk of depression are identified. Community care will enable researchers to investigate the social influence and social consequences of depression. The potential for prevention of depression in at least some individuals with learning disability remains to be explored.* (Prasher, 1999, p. 449)

We believe the modified form of CBT outlined in this manual is a step toward preventing depression and/or anxiety in some people with learning disability regardless of the specific aetiological focus. Whether learned helplessness, self-control, social isolation, biological predisposition, or some other cause is responsible for the development of the disorders, ultimately cognition and behaviour are at stake and it is therefore reasonable to assume that a CBT-oriented therapy has the potential to help at least part of this population stabilise their mood, resume a more normal life, and engage in society in productive ways. The research to date bears out this hypothesis.

A Brief History of CBT Treatment in People with Learning Disabilities

While controlled trials to prove the usefulness of CBT for the treatment of depression in people with learning disabilities are only now beginning, the use of this therapeutic modality has already seen some limited success in this population. To date, CBT has been used in the treatment of people with mild to moderate learning disabilities who suffer from anger (Rose et al, 2000; Gulbenkoglu et al, 2006); psychosis (Kirkland, 2005); obsessive-compulsive disorder (Willner & Goody, 2006); anxiety (Lindsay et al, 1997); and depression (Lindsay et al, 1993; McCabe et al, 2006; McGillivray et al, 2008). We will briefly review two of these studies to illustrate the overall effectiveness of this approach.

McCabe et al (2006) and McGillivray et al (2008) reported on group-based CBT treatment programs for depression in people with learning disabilities. McCabe et al (2006) developed a five-week program in which the participants covered one to two key areas and were allowed time to discuss, understand, and develop skills in these areas. The program was designed to enhance social skills, promote participation in social activities, and identify and change negative cognitions. Participants were taught how to self-monitor their moods and thoughts, and were trained to self-reinforce adaptive behaviours. Emphasis was placed upon reshaping cognitive distortions and on developing a more positive interpretation of events. Techniques such as modelling, role-play, and structured feedback were used to develop these skills. McGillavary et al (2008) trained staff members in a manualised CBT program, which was administered over twelve weeks. The program was divided into three modules (feelings, thoughts, and social skills) and

was designed to help participants develop/improve social skills and teach them how to recognise and link thoughts, feelings, and behaviours through individualised concrete examples, repetition, and role-play. Both studies showed significant improvements in behavioural and cognitive manifestations of depression. Positive changes in scores of depression, social comparison ratings, and negative automatic thoughts were reported and maintained over time (assessed at a three-month follow-up).

These studies indicate that a modified form of CBT may be a feasible and effective approach for the treatment of depression, anxiety, and other mood disorders in the broader population of people with learning disabilities. Now let us turn our attention to a high-level overview of what such a modified form of CBT would look like. Details on how to apply this approach and the specific modifications in technique required will be discussed in more depth in Part 2.

CBT for People with Learning Disabilities

As most of you are aware, CBT is a collaborative approach where a client works with a therapist to identify links between his or her thoughts and feelings in order to alter maladaptive cognitions in the “here and now”. The therapist provides strategies for the client to effectively cope with situations and reduce distress, identify thinking style errors, and consider alternative explanations for beliefs.

Several studies have concluded that people with learning disabilities have the necessary prerequisite skills to engage in many of the interventions associated with CBT (Dagnan et al, 2000; Joyce et al, 2006; Sams et al, 2006). These skills include the ability to link situations to emotions (Dagnan et al, 2000); the capacity to differentiate between thoughts, feelings, and behaviour (Sams et al, 2006); and an aptitude for correctly identifying emotions (Joyce et al, 2006). Sams et al (2006) found that as the identification of behaviours and feelings is linked to verbal ability (measured using the BPVS) and the identification of thoughts is associated with general IQ, thoughts, feelings, and behaviours are more likely to be understood and correctly identified by people with higher verbal ability and IQ. Dagnan, et al (2000), found that people with mild learning disabilities perform better when linking situations directly to emotions than they do when attempting to link the triad of beliefs, emotions, and situations (Dagnan et al, 2000).

This is all to say that while CBT appears to be effective in people with learning disabilities, some approaches and techniques may not be appropriate. For example, in conventional cognitive interventions, guided discovery is used to examine underlying core beliefs. In these cases, therapists often adopt a formal approach such as schema-focused work (Kuyken et al, 2009; Young et al, 2003). This approach is unlikely to be feasible with people in whom in-depth abstract thought is limited or impaired. Kroese et al (1997) has pointed out that in people with learning disabilities, the individual’s level of comprehension, level of expression, ability to self-report, and

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self-regulation skills are important factors in their suitability for CBT. What this suggests is that the specific approach and techniques used are contingent on each individual's cognitive capacity. Remember that learning disability happens on a continuum. Those with mild forms of impairment will require different treatment than those with more severe impairment. While cognitive factors such as frequency of negative automatic thoughts, self reproach, and feelings of hopelessness are all seen in people with learning disabilities who feel depressed (Nezu et al, 1995), in contrast to people in the normal population, those with mild to moderate learning disabilities will have more difficulty in understanding cognitive mediation, especially as the complexity of the task increases (Dagnan et al, 2000). People with severe forms of learning disability may not be able to understand this kind of intervention at all, and in such candidates CBT may not be the most effective or desirable form of intervention.

This is why we suggest a more pragmatic approach in the application of CBT to people with learning disabilities. The first step any therapist should undergo is evaluating each client individually to assess whether or not he or she has the prerequisite cognitive skills to undergo therapy. We outline how to make this initial assessment and suggest tools for doing so in Chapter 3.

For those clients who are qualified for CBT interventions, the therapist must learn how to effectively adapt treatment to people with learning disabilities. Typically this means being more specific and didactic and presenting key concepts in extremely concrete ways. Providing extra support in the form of visual aids such as pictures, drawings, and signs for certain tasks such as mood monitoring, presenting temporal concepts, and identifying automatic negative thoughts is particularly effective. To this end we suggest the use of images such as those in the Photosymbols collection and have included many examples of these in the worksheets you will find in Part 3 of this manual. Other modifications include taking therapy at a slower pace, using repetition, and encouraging "*overlearning"* in some scenarios. These techniques will likely enhance the client's engagement and motivation in therapy. We outline specific methods for modifying classic CBT techniques such as identifying thoughts, feelings, and thinking styles; linking thoughts, feelings, and behaviour; verbal processing; visual processing; role-play; and a host of other techniques in the relevant chapters in Part 2. Previously modified CBT interventions for this population have also included sections on psychoeducation and relaxation training. We have followed this approach and offer suggestions on how to address psychoeducation and offer modified relaxation techniques for people with learning disabilities in Chapters 4 and 6 respectively.

Regardless of the level of disability or the amount of technical modification necessary, every therapist should keep the following characteristics and approach in mind as he or she enters treatment with people who suffer from learning disabilities.

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Therapist Characteristics and the Therapeutic Approach

Warmth

The therapist should convey warmth by being encouraging and offering lots of positive reinforcement where appropriate. The therapist will need to show an empathic approach coupled with an informal and friendly attitude towards the client. These qualities are, in some ways, even more important in treating people with learning disabilities, as they will improve response and motivation to engage in therapy.

Genuineness

The therapist needs to be honest with the client without being too harsh or judgmental. When treating people with learning disabilities it is particularly important to be careful that the client doesn't misinterpret directness as criticism, hostility, or rejection. This can be especially tricky, as people with depression are more likely to focus on the negative.

The Importance of Rapport

As in all therapeutic relationships, the client has to feel secure and trust the therapist. In some cases it can be difficult to establish trust in people with learning disabilities because these clients are more likely to have had a variety of negative experiences with therapists, social workers, and/or other authority figures. You may find clients who have developed distorted ideas and representations of therapists or authority figures in general from previous experiences. Overcoming this hurdle is essential to effective treatment. With time and patience it can be done, but it may take perseverance on your part to establish trust.

> Therapists who tested this protocol found that some people with learning disabilities have significant trust issues. For some, there is considerable selective attention to past negative encounters with people who have threatened or bullied. For others, significant trauma from past life experiences and the memories and emotions that trauma holds can inhibit the development of trust and the experience of safety. The difficulties that result can be very delicate. Therefore, this is an important area to consider in the process of treatment.

The Therapeutic Alliance

In carrying out CBT with clients who have learning disabilities the therapist may be required to adopt a more didactic role (as noted above). However, this needs to be done without being coercive or dismissive. To this end, challenging the person's beliefs too early in treatment is not recommended. Rather, the therapist should slow the pace of therapy and offer several possible answers to questions the client may otherwise find difficult, yet do this without 'leading' the client.

The key here is to be vigilant of the client's expressions and other nonverbal cues. Communicating with people who have learning disabilities (both verbally and nonverbally) can be

challenging for therapists who have little or no previous experience working with this population. However, learning the necessary skills to effectively communicate with those who have learning disabilities is essential for effective treatment. That is why we have focused on helping the therapist develop a specific set of communication skills in Chapter 2.

Accurate Empathy

The therapist needs to try to understand how the client regards him- or herself and his or her world. By doing this, the therapist gains a sense of what the client may be experiencing. As the therapist develops empathy that is reasonably accurate, the therapist will be able to understand how the client feels, understands, and responds to events (Beck et al, 1979). This is essential both for developing rapport and for effectively treating the client.

Cultural Sensitivity

Being sensitive to cultural differences and taking them into account during sessions is extremely important. There is considerable variation in the way mental health disorders such as depression and anxiety are perceived and understood in different cultures. The treatment model in this protocol is flexible and can accommodate racial, cultural, and gender differences and issues. However, you must be sensitive to these issues to use the protocol to that end[5].

The Role of the Caretaker/Support Worker

Yet another important modification in the use of CBT in this population is the role of caretakers and/or support workers in the process of therapy. The involvement of a caretaker or support worker is essential in assisting the client to move successfully through the program outlined in this book, and it is especially critical when it comes to the completion of homework tasks (an important part of treatment that we will discuss in detail in Part 2). Kazantis & Anderson (2008) found that for people with mild learning disabilities, having a caretaker or support worker in the session with the client helped to provide greater continuity and these people were subsequently better able to assist participants in practicing skills outside the session. For this reason, when possible we recommend that a caretaker or support worker be involved in the intervention and come to sessions with clients.

Caretakers or support workers should assist the client with homework assignments and help the client bring this material into sessions.

[5] It is also worth noting that the therapist should try not to book sessions on religious holidays such as Eid, Diwali, or others so as to avoid missed appointments. Other events such as Ramadan should also be taken into account, as observance may affect concentration in the sessions or affect the tasks that the service user needs to do between the sessions. Note that Ramadan is a religious month in the Islamic calendar where the individuals fast (do not eat or drink) from sunrise to sunset for up to 29 days.

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Amongst the therapists who tested this protocol, there was universal agreement on the critical importance of the support worker as a part of the therapeutic process. Each commented on the role this person played and the improvement in continuity between sessions that resulted from this involvement.

The inclusion of an additional person in sessions represents an interesting challenge to therapists in that you need to be cautious of and regulate the involvement of the caretaker or support worker to ensure that the client doesn't become dependent on or rely too heavily on this person during the course of treatment. The aim of CBT is to empower individuals to be "their own therapist". The hope is that over the course of therapy the individual will learn to use CBT techniques independently as and when they are required. If a client relies too heavily on his or her caretaker or support worker, he or she may not successfully integrate CBT techniques as coping mechanisms in daily life. Therefore, the therapist needs to continually reinforce and draw boundaries around the specific role the caretaker or support worker has during the treatment process.

Having a caretaker or support worker in sessions will also bring up confidentially issues that need to be addressed before treatment begins. Confidentiality ensures that information disclosed to the therapist is not shared with a third party unless appropriate and agreed upon beforehand. It is an essential element of the therapeutic process that allows the client to build trust in the therapist.

The therapist, therefore, needs to establish how much and what information the client is willing to disclose to the caretaker or support worker before bringing this person into the room. This is very important, as the client may not feel comfortable discussing certain topics or issues in the presence of a third party. If not addressed properly, these kinds of issues may hinder treatment. Research has shown that in the presence of others (in the group setting), successful treatment depends on individuals feeling safe enough to disclose personal information (Lasky & Riva, 2006). The therapist therefore needs to take an active role in determining what the client is willing to share with the caretaker or support worker, and then must reassure the client that this person will respect his or her confidentiality.

When it comes to treating people with learning disabilities—whether you are discussing confidentially issues, identifying automatic negative thoughts, role-playing, or engaging in any other part of the therapeutic process—the key is to learn how to properly communicate with this special population. It is to that subject that we must now turn our attention.

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Chapter 2
Communicating with People Who Have Learning Disabilities in the Therapeutic Setting

People with learning disabilities have complex communication needs. Clients may have difficulty forming sentences, have a reduced understanding of key and abstract concepts, his or her speech may be unclear, or the client may need increased time to process and retrieve information. Furthermore, a person with learning disabilities is likely to have reduced vocabulary (Burnip, 2002), and he or she will probably be more susceptible to suggestibility and may tend to change his or her answers to questions when provided with negative feedback (Clare & Gujonsoon, 1993; Everington & Fuller, 1999). This is all further complicated by the fact that linguistic and cognitive abilities vary considerably from person to person within this population.

What's more, people with learning disabilities have a lifetime of experiences that have allowed them to mask their difficulty in understanding and following verbal communication by drawing on social skills and set phrases that they know are contextually appropriate responses, even if they do not fully understand what is being communicated. This can lead to the illusion that the client has understood something that was said in the therapeutic setting when, in fact, this may not be the case.

If the purpose of CBT is to help the client "learn from his or her psychotherapeutic experience" and "begin to incorporate many of the techniques of the therapist"—that is, to "become his or her own therapist" as it were—these difficulties in communication represent a challenge that must be addressed and overcome to successfully apply the CBT model in this population. You will need to properly modify the way you communicate to meet the needs of individuals with learning disabilities so that you can pitch the material presented at an appropriate level and allow the concepts of CBT to be more accessible.

One of the first steps in bridging this gap is to complete a thorough assessment of a client's cognitive and linguistic abilities in the early sessions of therapy. We will outline precise recommendations on how to conduct this kind of investigation in the next chapter as we begin to review the treatment protocol we recommend. However, it is best to equip yourself with the skills to address communication issues before therapy begins. Therefore, in this chapter we will outline some of the most common communication difficulties people with learning disabilities face and provide you with tips and strategies to address these issues.

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Understanding People with Learning Disabilities: On the Problems with Vocabulary, Verbal Ability, and Speech

Even people with mild learning disabilities will generally have a more limited vocabulary and will acquire fewer and less complex words than the general population (Winn & Baron, 2009). In addition, the ability to form complete, grammatically correct sentences varies within this population—some may be able to do this while others may not. These issues will impact your communication with clients who have learning disabilities from the ground up. You may find they have difficulty finding the words to express certain thoughts and feelings. Similarly, if the language you use is too complex, the client may not follow what you are saying. Difficulties in processing and retrieving information (like word-finding difficulties) may mean that it takes more time for these clients to respond verbally. And, if the client cannot form complete sentences, you may sometimes find it difficult to understand the meaning of what has been said.

Speech itself may represent another communication barrier that needs to be overcome, since physical disability or anatomical differences can result in a variety of speech-related difficulties. For instance, the anatomical differences found in people with Down Syndrome—low muscle tone of the tongue, small mouth, and high palate—results in the characteristic alterations in pronunciation in this population (Kelly, 2000). A person with cerebral palsy may have *dysarthric speech*—weakness in the speech musculature and difficulties with breath support. Other causes of speech difficulties may include *dyspraxia*—difficulties executing voluntarily and on command the neurological sequence of muscle contractions required to produce individual sounds and words (Murdoch, 1990); and *dysfluency*—impairment in the ability to produce smooth, fluent speech—a problem that most often arises when someone feels under pressure to perform or respond and where there may be a need to synthesise many different cognitive tasks to arrive at a conclusion.

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The following tips will help you overcome some of these basic difficulties with communication. Note that these tips are based on Winn & Andrea Baron, 2009.

Tips to Help You Understand People with Learning Disabilities

1. **If you do not understand what a client says, it is important that you do not pretend to have understood.** Try to make the client feel at ease while acquiring the information you need. You might say, "Sometimes it is difficult for me to understand; could you say that again, please?"
2. **Give the person plenty of time to respond; you might have to wait longer than you'd expect.** Remember, these clients do not necessarily take longer to respond because they are unwilling or unable to answer questions, but because it takes them longer to process information.
3. **Make sure you listen carefully.** Pay special attention to speech patterns and pronunciations that are difficult for you to make out.
4. **Make sure you look at the person when he or she is talking.** Body language (more on this below) and watching the words being formed may help you comprehend what is being said.
5. **If you still cannot understand, ask the client if it is okay to ask the support worker for help with communication.** While this is not a technique you want to rely on consistently, it can help in cases where repeated efforts at communication fail.
6. **Be aware of other things that may affect communication.** This could include hearing impairment, visual impairment, physical and mental health issues, epilepsy, medication, time of day (is the client a "morning person") general mood, interest in the topic, and more.

As you become more familiar with a particular client's communication style, pronunciation, and verbal patterns, you will likely be able to "tune in" to his or her speech and find it easier to understand.

Being Understood by the Client: Presentation of Key Concepts, Abstract Thought, and Contextualizing Communication

The majority of people with learning disabilities will have some difficulty understanding what you say to them at least some of the time. How often this is a problem and the degree of misunderstanding will vary from individual to individual depending on the severity of the disability. While assessment can help tease out how much of a challenge this will be in therapy, there are a few simple guidelines that will help facilitate good communication with these clients.

First, try to stick with simple, straightforward, everyday language and limit the number of key concepts or ideas you communicate to no more than three per sentence. While some may be able to understand more complex verbiage and sentence structure, most people with learning

Second, keep to concrete examples as much as you can, and either avoid disabilities will better comprehend simple sentences and language, reword, or break down complex abstract ideas when possible. While people with learning disabilities may be able to understand simple abstract ideas such as “What are you doing today?” or “How are you feeling right now?” Complex abstract concepts and questions that revolve around inference or emotions in the context of time are likely to be more difficult for them. You will typically want to avoid questions like “What would happen if you …?” “What would it feel like if you …?” or “What did it feel like when …?” These lines of questioning are unlikely to be easily accessible by someone with a learning disability.

Let’s look at an example. Imagine you are discussing the events of the day with a client and he or she says, “I couldn’t find my shoes” in a tone that indicates some sadness and/or frustration around this event. Rather than asking, “How did you feel when you misplaced your shoes?” which would likely be too complex, the interaction may be broken down as follows:

Client: *I couldn’t find my shoes.*

Therapist: *Tell me what happened.*

Client: *I put them in the wrong place.*

Therapist: *How did that make you feel?*

You will note in this example, we have deconstructed the “big” question “How did it feel when you misplaced your shoes?” into two component parts so that the action and the feeling are addressed separately. If you think through what you want to say carefully before saying it, in most cases you will be able to find ways like these to communicate your thoughts or questions in a simpler manner.

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Finally, make sure you contextualise the information you are attempting to share with the client as often as possible. Contextualising communication will often enable a person with a learning disability to understand what has been said and respond appropriately even if the words aren't fully comprehended. Good caseworkers use context as communication constantly. For example, imagine it's the end of the day and time for the bus to come to collect Peter from the day centre. Peter has had his afternoon drink, which he has as part of his routine each day before the bus comes. The other service users are all getting their coats, and when Peter's case worker asks him to "Please go and get your coat and put it on, as it's cold outside today", Peter is able to follow this verbal request, get his coat, and put it on. Peter is relying on his routine and the behaviour of the people around him to understand the verbal request. You can use similar methods in your practice.

There is one important caveat to note regarding the reliance on context. As mentioned earlier in this chapter, people with learning disabilities may give appropriate verbal and/or non-verbal responses to questions or comments while not completely understanding what has been said. This is not an attempt at deception; it is simply the product of learned behavioural responses that come from a lifetime of managing social situations.

It is important that you are mindful of this potential pitfall and ensure that clients understand what you have said by regularly asking them to summarise or repeat what has been discussed during sessions. If clients cannot sufficiently summarise the topic at hand, it's an indication that they may *not* have understood, despite what they say or what their body language tells you. Don't hesitate to reiterate what you have said or look for new ways to communicate the information you are trying to share if you face this situation. While some people will find it difficult to summarise or repeat back what has been said to them generally, most will eventually be able to do this with a genuine understanding of what has been communicated.

In addition to the above, here are a few more strategies you can employ when communicating with people who have learning disabilities to help them better understand you. Again, the following is based on Winn & Andrea Baron, 2009.

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Tips to Help People with Learning Disabilities Understand You

1. **Speak slowly using everyday words.** This means simple grammar, short sentences, and plain English—no jargon.
2. **Think about how to ask questions.** Open-ended questions can be more difficult for this population. Yes or no questions are also unhelpful, as clients may respond the way they think you want them to. The best method is usually to stick with short, simple either/or questions: Do you like tea or orange juice? Do you feel happy or sad? However, make sure the client is not simply repeating the last thing you said by confirming what has been communicated.
3. **Link your explanation with everyday things.** This is especially important if you need to talk about more abstract concepts like time. "Take your tablet at breakfast, lunch, and dinner" is more easily understood than "Take your tablet three times a day."
4. **Write the key information down**. Then share the written information with the client's support person; that way they can go through it together after the session.

In addition to these tips, there are two more strategies you may consider employing with people who have learning disabilities: the use of pictures or symbols and a strong focus on non-verbal communication. Let's deal with each of these in turn.

Using Picture and Symbols to Communicate

If verbal communication presents a barrier, we encourage you to incorporate pictures or symbols to help clients express themselves and/or understand what you are saying. This is an excellent and simple method that can vastly improve communication in difficult situations. As you will see in Parts 2 and 3, we have included pictures throughout the worksheets in this manual. These are from the Photosymbols collection, the primary symbol resource for many of the organisations that produce easy-to-read information for people with learning disabilities. Clients often find the information communicated in these images easier to recognise and understand because they are photorealistic and in colour[6]. Photosymbols work well in the therapeutic setting because they are

[6] Using full colour is important. Please make sure you print and photocopy in colour when duplicating information from this workbook or when using the Photosymbols collection.

simple and because extraneous details often found in photographs have been removed. You can learn more about the Photosymbols collection at www.photosymbols.com.

Focus on Non-verbal Communication

You are likely aware that non-verbal communication such as body language, facial expressions, gestures, signing, tone, pitch and intonation, and behaviour all play an important role in conveying messages. Body language has been found to provide up to 55 percent of the information in a given communication (Argle, 1970). This is quite fortuitous when working with people who have learning disabilities, because they tend to be keyed into non-verbal communication as a method of both expression and comprehension.

When working with these clients, try to tune in to what their body and other mechanisms of non-verbal communication are telling you. Learn to interpret this silent language and you are likely to find it conveys much more than the person's words do. Conversely, you can use your body, facial expressions, etc. to communicate information to your clients. In some cases, you will find communicating this way enhances their ability to understand your verbal exchanges. So become aware of your non-verbal communication and make sure it accurately reflects what you are saying. Make sure to be active with your body and use lots of non-verbal feedback like nodding your head and changing your facial expression to indicate you are listening and that you understand (or don't understand) what has been said.

Using these concepts and techniques to enhance your ability to communicate with people who have learning disabilities is essential. If a client finds it difficult to understand what has been said, it is likely he or she will become distracted or unmotivated to participate in sessions. This may make treatment more problematic and less successful. By learning about and integrating the strategies above at the very outset of treatment, you can minimise communication difficulties and provide the client with a better experience in therapy

Before we close this chapter, there are two final issues we need to address that are related to communication: verbal problems specific to certain learning disabilities, and the difficulty of suggestibility.

Idiosyncratic Communication Issues Specific to Certain Populations with Learning Disabilities

In some cases you may encounter clients with very specific, idiosyncratic verbal difficulties that are associated with their particular learning disability. For example, *echolalia* or *echoed speech* where a person repeats words or sentences spoken by others is often found in people with autism (though you may find it in people with other learning disabilities as well). If a client is

affected by this he or she may immediately repeat a word or phrase that has just been said. For example, if you say, “Mary’s coming today” the person may start saying “today” or even repeat the entire phrase over and over again.

A similar, but slightly different, difficulty that some people with learning disabilities have is called *perseveration*. This is where the individual continues to talk about a distressing event or subject that is of interest to him or her when it is no longer appropriate. The person may repeat the same words over and over again or may continue discussing the same topic with slight alterations.

In cases like these, it can be extremely difficult to break the client out of these patterns and engage him or her in anything other than what he or she wishes to discuss. Interestingly, his or her ability to communicate about the topic at hand may be extremely misleading about his or her ability to communicate in general. The client may discuss these issues with much greater or much less eloquence than he or she is capable of in everyday life. This can be a challenge, especially when you are trying to assess the individual’s overall communication abilities, so it is important to be aware of these issues before entering therapy.

Whether you are facing echoed speech or perseveration, the key is patience. It may be useful to suggest a break, or if attempts at distracting the client fail, it may be worth considering a shorter session. Occasionally it helps to draw a “contract” with the client. Agree to a short two- to three-minute talk on the subject he or she wishes to discuss, then go back to the topic at hand in therapy. Continue to encourage the client to come back to his or her session next time.

Another problem you are likely to face when treating people with learning disabilities is a hesitation to openly express thoughts, feelings, ideas, and beliefs. Many people who have learning disabilities have come to believe that what they are saying is either incorrect, unimportant, or both. Luckily, a recent study points toward a way to overcome this problem. The use of “Socratic questioning is a helpful way of overcoming this obstacle where, by a series of questions, [the person] is helped to explore, reassess and challenge his or her beliefs” (Stallard, 2002, pg. 21). We encourage you to employ Socratic questioning in cases like this, and draw out your clients’ thoughts and feelings. When doing this, always remember that questions need to be simple and direct. For example, instead of asking “What did you do yesterday?” you should ask, “What did you do yesterday after you got back from the day centre?”

Finally, it is worth noting that cultural “rules” can come into play with this population just as they do in people who do not have learning disabilities. Be sensitive to any cultural issues the person may have particularly with regard to eye contact, personal space, and gestures that may have different meanings than what you are accustomed to. Make sure you check what language the person is most familiar with and employ an interpreter as necessary.

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Addressing Suggestibility

As we noted at the beginning of this chapter, studies have concluded that even people with mild learning disabilities are much more susceptible to *leading questions* than the normal population. It appears this link between higher suggestibility and learning disabilities may have to do with memory. Beail (2002) linked poorer memory to higher suggestibility. The studies cited earlier in this chapter offer further support to this tether between memory and suggestibility, as each found that memory recall was poorer in people with learning disabilities.

While suggestibility is always an issue a good therapist is paying attention to, it represents a particular challenge in treating people with learning disabilities. Throughout this chapter we have shown how to simplify communication; reduce abstraction in language; contextualise your thoughts; and use pictures, symbols, and non-verbal communication as methods for more effectively relating to your clients. All of this must be done while avoiding leading questions and keeping suggestibility at a minimum throughout treatment. Focus on making sure clients understand what has been said and give clear instructions without leading them. Doing this and using the other strategies and tips in this chapter should set the stage for quality communication starting with the very first sessions of therapy. In the next chapter we will outline what these early sessions might look like and provide you the tools needed to assess your client's communication and cognitive abilities.

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Part II

Protocol for Treating Depression and Anxiety in People with Learning Disabilities

Chapter 3

The Early Sessions (Sessions 1–4)

The treatment process is divided into three phases. These are:

- Early/initial phase (sessions 1–4)
- Middle phase (sessions 5–14)
- Final phase (sessions 15–20)

In this chapter we will describe the initial phase and outline the items you need to cover in these first sessions with the client.

Goals of the Initial Phase[7]

During the initial phase of therapy, you should seek to achieve the following:

1. Complete a language assessment and evaluate the client's suitability for CBT.
2. Explain the role and extent of involvement of the support worker in therapy to the client.
3. Address the reasons the client has been referred for treatment.
4. Describe the CBT model of treatment and the importance of homework.
5. Confirm that the client will attend all therapy sessions.
6. Provide psychoeducation.

We will review the first five goals above in the remainder of this chapter. Psychoeducation is a larger topic and requires more in-depth analysis; therefore, we have dedicated Chapter 4 to that subject specifically.

[7] Each of the goals outlined in this chapter is in the "Checklist of Topics Covered During Treatment" worksheet, which you will find in the Appendix of this manual. We encourage you to fill out this worksheet at the end of each session during the entire course of treatment. It will allow you to easily track what you have covered, take notes, and assess what still needs to be addressed during therapy.

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Assessment and Screening of Language, Cognitive Skills, Motivation, and Suitability for CBT

At the outset of treatment it is essential to make an assessment of the client's language and cognitive abilities. This will allow you to identify whether or not the client is an appropriate candidate for CBT, adjust your communication as necessary to fit his or her specific linguistic capabilities, and establish a foundation for you and the client to make the most out of the time spent in therapy. The assessments we recommend follow below. However, what ultimately use to assess your clients is up to you.

Cognitive Level and Language Skills

There is an excellent tool that will help you assess language skills in people with learning disabilities. It is the Test for the Reception of Grammar (Bishop, 2003). The latest version of the test is called the TROG-2 and has been standardised on a group of 792 children from ages four to sixteen and seventy adults from ten regions across the United Kingdom. The test takes approximately fifteen to twenty minutes to administer.

Determining the client's vocabulary level and grammar comprehension will help you select appropriate materials for the individual and tailor your own communication style to fit his or her needs. It will also be one of the factors that allows you to determine the individual's suitability for CBT. Research has shown that performance on language tests correlates well with an individual's ability to identify and label emotions, one of the key prerequisites for successful treatment (Joyce et al, 2006). A low score on these tests may indicate the individual needs specialised treatment or that aspects of the CBT intervention may be less successful.

Memory

It is also useful to carry out a few short and easily administered tests to determine the extent to which the client is able to process and retain information. The Logical Memory sub-test of the Wechsler Memory Scales-III (Wechsler, 1997) involves recalling short stories and can be used to assess both short-term and longer-term retention of information. In addition, the Word Lists sub-test involves recalling words from four separate lists which are read out by the therapist and will provide an indication of the efficacy of the individual's working and short-term memory functions.

Reading Ability

A number of adults with learning disabilities have reading difficulties. In these cases, it's likely the individual will not be in a position to make independent use of written materials (i.e. homework), and therapy will either need to be adjusted as necessary or the client will need to rely on his or her support worker for assistance. To determine a client's reading ability, we recommend administering the Schonell Graded Word Reading Test (Schonell, 1972). The test provides a reading age and an indication of the level of complexity of written material the client will be able to understand.

Writing Ability

Similarly, a number of adults with learning disabilities experience difficulties with writing. Therefore we recommend assessing potential problems in this area in advance as well. In order to test writing ability, the client can simply be asked to copy out a few sentences presented by the therapist, and then asked to generate a few sentences of his or her own. If the client is unable to do this effectively, it is likely that any self-monitoring will be problematic and alternative means of feedback may need to be considered.

Attentional Control

Some people with learning disabilities have poor impulse control and other attentional difficulties. These clients may find it difficult to maintain focus during sessions and concentrate on the task at hand and/or become easily distracted by extraneous stimuli in the immediate environment. Observe the client's responses to the tests outlined above. If he or she is unable to maintain focus during the test or incapable of completing the tasks presented, particular consideration will need to be given to the therapeutic environment and the way therapy is structured and paced to optimise the client's ability to understand and benefit from it.

Perception of Control and Self-efficacy

A client's perceptions about how much he or she controls and influences events in life are particularly important in CBT. If the client does not feel in control of his or her feelings or believes him- or herself to be incapable of effective positive changes in thought and behaviour, it is more likely therapy will be unsuccessful. Assessing and addressing these underlying beliefs before treatment begins is critical. This can be done by considering the client's responses to general questions regarding his or her experiences with decision making and taking control, such as:

- Could you tell me who decided what you were going have to eat last night?
- When you last bought clothes, who chose them?
- If someone knocks on the door, who answers it?
- If someone phones, who takes the call?
- If you see someone fall over in the street, what would you do?
- If you are feeling unhappy about something at the day centre, what would you do?

Answers like "I did" or other positive responses that represent the client's ability to take initiative are indicative of an *internal locus of control*—the individual believes that events can occur or change as a result of his or her actions. Answers such as "I don't know" or references to other people taking action suggest an *external locus of control*—the client believes that events are

random or controlled by others. An external locus of control or a reduced sense of self-efficacy will need to be addressed in the early phases of therapy if treatment is going to be successful.

Insight

Most clients with learning disabilities who come to therapy are referred by caregivers, family members, support workers, or health professionals. They rarely come of their own accord. Therefore you will need to assess the client's motivation and willingness to engage in therapy. It is important that the client wants to change and is willing to try CBT as a means of overcoming depression and/or anxiety if treatment is going to succeed. You should explore the client's understanding of his or her illness (more on this below) and discuss whether he or she thinks a "talking therapy" could help.

Biopsychosocial Factors

Finally, you will need to consider any biopsychosocial factors that have a bearing on the individual's mental health. (See Chapter 1 for a more detailed explanation of considerations you need to make in this realm.) Some of information may be in the case notes and referral. If not or if more is needed, it is essential that you discuss these factors with the client and support worker, whose role in the therapeutic process should be discussed with the client in these early sessions as well. Let us now turn our attention to this matter.

Explain the Role of the Support Worker

In Chapter 1 we discussed why it is important to include a support worker in the therapeutic process when treating clients with learning disabilities and explained the complications that need to be resolved when incorporating an additional person in therapy. All of this needs to be discussed with the client and the support worker in these early sessions. Here is what we recommend.

Begin therapy with just you and the client in the room. Once the assessments are completed and when it is appropriate, introduce the idea to the client of including the support worker. At this time you should discuss:

- Why including the support worker is useful
- The extent to which the support worker will need to participate in sessions and homework
- How much information the client is comfortable sharing with the support worker
- Confidentiality issues—that the support worker will abide by the rules of confidentiality but that he or she has a duty to report disclosures made by the client that indicate risk to self or others

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Once you have reached an understanding with the client regarding these issues, the support worker should be brought into therapy and you should review these issues with him or her as well. It is particularly important that a frank discussion regarding confidentiality and its limitations happen when all three of you are in the room together.

At this time, you should also provide the support worker with the *Carers guide* (in the CD provided) that accompanies this protocol. It contains information about:

- What CBT is and how it works
- Why homework is important and how the support worker can best help the client with assignments
- Communicating with people who have learning disabilities
- Psychoeducation on depression and anxiety, including symptoms and what to look for
- The structure of the sessions over the course of treatment

The support worker should read this manual in its entirety within the first few weeks of receiving it.

Address the Reasons the Client Has Been Referred

Once the support worker has been introduced, the next topic that should be addressed is the reason the client was referred to therapy. As we mentioned above, clients with learning disabilities rarely refer themselves for psychological treatment. Changes in behaviour and symptoms of depression and/or anxiety are usually noticed by and are cause for concern for people around the client. The client may not share these concerns or may not believe that the problem requires help. It is of great importance that you explain and elicit the client's understanding of the emotional and behavioural difficulties he or she faces. This typically happens in three steps.

Step 1: Orient the Client

This consists of a simple introductory statement, such as "I am seeing you because I hear you feel sad/scared/worried/etc."

Step 2: Explore the Presenting Complaint in More Detail

After introducing the reason for the referral you may then go into a more detailed discussion of the problems your client faces. You may use information in the referral and/or ask the client for his or her views on the matter. In either case, it is essential that you keep this discussion simple, specific, and focused so that the client develops an understanding of the issues at hand. Ask the client to repeat back his or her understanding of what you have said, as necessary. (See Chapter 2 for strategies on how to do this.)

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Step 3: Ask the Client to Rate His or Her Distress

It is also helpful to obtain the client's perception of how much the problem affects him or her. You can do a depression and anxiety assessment, but this needs to be kept very simple. The normal questionnaires used to assess depression and anxiety typically will not be comprehensible for people with learning disabilities. We recommend that you use pictorial diagrams to estimate the extent of the problem. These have been included in the worksheets for clients in Part 3 of this manual. Give the client "Resource 1—My Cognitive Behavioural Therapy (CBT) Book and Personal Details" and ask him or her to fill in the appropriate details.

Describe CBT and the Importance of Homework

After you have discussed the reason the client has been referred and he or she understands the reason for the referral the natural next step is to explain what CBT is, how it works, the rationale for treatment, what the aim will be, what the rules of therapy are, and how important homework is during the process.

Clearly this can be complex material to cover, and it may be challenging to ensure that a person with learning disabilities understands the fundamentals of treatment. However, it can be done, and we will provide you some tips on how to best communicate this information in a moment—but first a word on homework.

Homework

As you are likely aware, homework tasks are an essential part of CBT, and homework compliance is associated with improvements in treatment outcomes (Kazantis, Deane & Ronan, 2000). Homework provides the client with an opportunity to practice new skills and incorporate them into his or her daily routine. It is an important part of treatment for people with learning disabilities just as it is for the normal population. However, when assigning homework to these clients, there are a few things to keep in mind.

Research shows that there are several factors that affect a client's compliance with homework tasks. These include the client's ability to complete the assignment and the task's characteristics (Kazantis, Deane & Ronan, 2004). This means you should tailor assignments according to the client's needs. Homework should be relevant to the topics covered in a given session and should help the client build on the skills and behaviours practiced during therapy. It should encourage the client to engage in the kinds of changes necessary while still being realistic and manageable for a person with learning disabilities. Furthermore, homework should be assigned in graded steps so that the degree of difficulty slowly increases over the course of treatment and each assignment builds one after another to provide continuity from session to session.

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Improving compliance with homework can be further achieved by:

- **Involve the client in deciding what tasks he or she will be doing outside the session.** Most clients find tasks more enjoyable and useful if they are involved in this decision-making process.
- **Setting tasks that provide a no-lose situation.** While you want to encourage the client to complete all homework tasks, being "successful" at homework is not what's at stake here. Keep in mind and work to make the client understand that homework is a skill-building process and that there are no "failures".
- **Confirm that the client clearly understands what the task entails.** As above, understand that the task is of key importance in compliance.
- **Confirm that the client clearly understands the *rationale* for the task.** This is slightly different from understanding the task itself. Since homework should be a method for resolving symptoms it is important to help the client understand how each assignment is a part of that process.
- **Inform the client about benefits and importance of doing the homework tasks.** Explaining to the client the specific benefits he or she may achieve through homework is likely to encourage the client to complete a given assignment.

As homework is completed the following questions adapted from the "Homework Rating Scale" (Kazantis, Deane, & Ronan, 2005) should be kept in mind:

- How well did the client understand what to do?
- How well did the client understand the reason for doing the task?
- How well did the client do in completing the task?
- How much of the task was the client able to do?
- How difficult/easy did the client find the task?
- How much did the client enjoy the task?
- How well did the task match the goals of therapy?
- How much did the task help the client gain control over his or her problems?
- Did the task help the client progress in therapy?

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Some therapists have found that clients with learning disabilities have difficulties with self-reporting. This can make assessing improvement in therapy or experience with homework challenging. The involvement of the support worker can be helpful in this regard.

In most cases, the therapist will need to consult with the support worker, whose function is to encourage the client to complete his or her homework, regarding these points. To help ensure that homework is completed it is also useful to confirm that the support worker understands what the homework tasks entail and how he or she can best help the client to complete the tasks.

What to Do with Incomplete or Partially Completed Homework

At times the client may partially complete the homework task or not attempt it at all. Incomplete/incorrect homework can provide as much, if not more, information as homework tasks that are completed successfully. If the client has left the task incomplete it can be used as a topic for discussion within the session to bring up issues that may be at stake. Understand that the client's reasons for not doing the task will provide you with further useful information for treatment. There may be a number of reasons a client does not complete homework. These include:

- The client may have found it more difficult than he or she initially thought.
- There may have been extraneous circumstances beyond their control that precluded the client from completing the task.
- The client may not attempt the task for fear of doing it "wrong". (See above about creating "no-lose situations".)

If the homework task was not completed, you should ask the support worker to fill out the "Resource 2—Checklist of Reasons for Not Completing the Homework Tasks" (adapted from Beck et al, 1979) in Part 3. The checklist can then be brought into the next session and you can go over it with the client (and support worker as needed) and address any issues with homework.

How to Integrate Homework into Treatment

We recommend you begin homework and develop a regular rhythm with it from the very outset of therapy (in the first session if possible). This will set the stage for the client to successfully complete assignments that are more complex in later sessions (especially in the middle sessions when the tasks and objectives become slightly more complex). We have provided a set of worksheets in Part 3 of this manual, and we will outline how we recommend you use these worksheets during treatment. However, you should regularly assess whether or not assignments help the client to progress in therapy. If the order outlined in this manual does not appear to

serve a particular client, do not hesitate to alter the order or nature of the assignments as necessary. Simply make sure you are providing appropriate assignments at appropriate times, and make sure you explain to the client why it is important that he or she complete homework assignments.

In addition to the materials already mentioned in the early session you may consider covering the following homework assignments:

- **Creating a list of issues or problems that the client would like to address during therapy.** The worksheet "Worksheet 1—I Want to Talk to the Therapist About …" in Part 3 of this manual can be used for this exercise. Having such a list at the outset of therapy is helpful, as it provides you a point of reference over the course of therapy and allows you to weave the specific problems the client wishes to addresses into sessions.

- **Completing a weekly activity schedule (WAS).** You can use "Worksheet 2—What Do I Do in a Week" worksheet for this. The WAS allows you to see how much/little the client is currently doing and what tasks he or she is engaging in. This information may inform your choices in therapy and it can also be referred to later in the treatment process and compared to other WAS worksheets as a concrete example of how the client is progressing during treatment.

As we mentioned above, before assigning homework, you should explain why it is important to the therapeutic process and outline the other elements of CBT treatment mentioned above. Here is how we recommend you address these issues.

Structure the sessions where this conversation occurs so that it allows for short breaks from time to time to give the client a chance to ask questions about anything he or she may not understand, refocus and regain attention and concentration, and review material as necessary. As always, when communicating with people who have learning disabilities it is advisable to stay away from overly abstract explanations (this is particularly important when you are explaining what CBT treatment is and how it works). It also bears remembering that asking the client to summarise what has been discussed in his or her own words is a useful strategy for ensuring comprehension. Make sure you address any misconceptions or misunderstandings about therapy in a sensitive manner and reinforce anything that the client has understood correctly.

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In addition, the following worksheets will help provide the client with a better understanding of some of the fundamentals of CBT:

- Info Sheet 1—What Is Cognitive Behavioural Therapy?
- Info Sheet 2—Linking Thoughts, Feelings, and Behaviours for Depression
- Info Sheet 3—Linking Thoughts, Feelings, and Behaviours for Anxiety
- Info Sheet 4—Linking Thoughts, Feelings, and Behaviours for Anger

Confirm the Client Will Attend All Sessions

The final item you will need to cover during the initial phase of treatment is a commitment from the client to attend all the sessions offered (up to twenty). Be aware that depression and anxiety can cause a lack of motivation to do anything or seek help. The client may seem reluctant or even hopeless about the prospects of treatment. Assuming you can overcome this and acquire a commitment to stick with the sessions early on, it's possible that motivational problems will return later in therapy[8]. Therefore it is important that you help the client maintain motivation throughout therapy.

We recommend you use motivational interviewing (MI) to encourage the client "try out" CBT. Strategies for improving and/or maintaining the client's motivation for treatment (Miller & Rollnick, 1991) include:

- **Developing discrepancy:** You can identify the gap between where the client is and where he or she wants to be in a positive manner. Keep reminding the client of the goals that he or she has set out to achieve during therapy while being sensitive to his or her concerns about the efficacy of treatment.
- **Avoid arguments:** Conflict over resistance to treatment is generally counterproductive. It can distract the therapist from the goal of motivating individuals towards change, whilst at the same time increasing the client's distance from and lack of motivation to engage in therapy.
- **Support self-efficacy:** Clients who are able to see themselves progressing, believe in their ability to make changes, and perceive recovery as successful are more likely to achieve their goals. This can be difficult for people with learning disabilities as they may lack confidence in themselves or have self-efficacy deficits. Provide clients with learning

[8] Surprisingly, motivational problems are actually most problematic toward the end of treatment (Anderson & Kazantzis, 2008).

disabilities with plenty of positive feedback over the course of treatment and regularly take notice of their improvements.

In addition to these MI techniques, it's also extremely useful to create a timetable of weekly activities the client engages in, including scheduled therapy sessions. Set the day and time of sessions at the beginning of treatment, and create a timetable the client (and support worker) can refer to as needed to remind him or her of scheduled appointments.

Summary of the Initial Phase of Treatment

By the end of the initial phase of treatment (session 4) you should have answers to the following questions:

- What skills does the client possess that will help him or her?
- Does the client understand what treatment entails?
- What materials and tasks can help the client to practice and improve these skills?
- Does the client have any concerns or worries about the treatment?

This is valuable information, as it sets the stage for the remainder of treatment. We will outline how to handle the middle and final phases of treatment in the chapters that follow. However, before we move into that material we must first turn our attention to psychoeducation and how to address people who have learning disabilities.

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Chapter 4

Psychoeducation

One of the objectives of the early sessions of therapy is to provide the client with psychoeducation regarding depressive and anxiety disorders. The purpose of this process is to enable the client to cope better with these disorders by providing greater knowledge and understanding of the symptoms. In this chapter we will review the basics of psychoeducation for people with learning disabilities and outline special strategies we recommend when working with this population.

Psychoeducation of Depression

As we reviewed in Chapter 1 the symptoms of depression include (the following has been extracted from Andrews & Jenkins, 1999):

- Feeling miserable. This misery lasts at least a week or two, where the feeling is present most of the day and varies in its intensity.
- Loss of interest or pleasure in daily activities.
- Loss of appetite (and excessive weight loss).
- Loss of energy.
- Loss of sleep even when exhausted. Sleep is usually restless and the individual wakes up earlier than usual. (Some people may sleep more than usual.)
- Loss of interest in sex.
- Persistent worrying about things that are not important.
- Slowed and inefficient thinking, with poor concentration.
- Recurring unpleasant thoughts, particularly of guilt (of being a bad person and wishing to die).
- Slowed activity and speech.
- Fearfulness (of people and places). This often leads to withdrawal from family, friends, and everyday activities.

You will need to explain each of these symptoms to clients using the communication strategies we have provided in earlier chapters. In Part 3 you will find a sheet that provides information about the reasons and symptoms of depression and a worksheet that will help you and the client identify thoughts, feelings, and behaviours that arise when the client feels depressed.

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These are:

- Info Sheet 5—What Is Depression?
- Worksheet 3—When I Feel Depressed I …

In addition to these worksheets we recommend the picture book *Feeling Blue* published by the Royal College of Psychiatrists website (Royal College of Psychiatry, 2009). In the book a character named Ron has lost interest in the things he usually enjoys. This pictorial story will be a good fit for many clients with learning disabilities and provides an easy-to-comprehend visual and textual representation of how depression develops and how it can be healed. *Feeling Blue* is available online at: http://www.rcpsych.ac.uk/publications/booksbeyondwords/bbwonlineversions/feelingblue/bluecover.aspx

The therapist, client, and support worker should review these materials and fill out the symptoms worksheet together. Once complete, the client will be able to take the worksheet and refer to it when he or she needs to. We also recommend that you review these worksheets and the client's symptoms and behaviours at the end of the treatment in order to help him or her catch and address any relapse as soon as possible.

Always keep in mind that people with learning disabilities are often not able to express their feelings easily in words and use behaviour to communicate with others. It is very important to watch for any sudden changes in behaviour or mood as important signs of depression. For example, if the individual is not able to do things that he or she could previously do, this is an indication that further action may need to be taken or treatment extended. It's also important to reiterate that depression is linked to low self-esteem in people with mild and moderate learning disabilities, so any fluctuations in self-esteem should be considered possible signs that problems may be developing or recurring. Self-esteem problems—often linked to a lifetime of criticism and bullying—are quite common amongst this population. Therefore, it's likely you will encounter self-esteem issues and the resultant negative feelings low self-esteem inspires in sessions. If problems like these arise, make sure you address self-esteem with the client and help him or her understand its connection to depression and its relevance to treatment. It may be necessary to revise worksheets to refine and update the thoughts, behaviours, and feelings that are linked to a client's depression as symptoms like these arise. Consider this an ongoing work in process over the course of the therapeutic relationship.

By taking this approach and working with the client to increase his or her knowledge about depression and exploring how the client feels and behaves when he or she is depressed, you will set the stage for the client to eventually become his or her own therapist and for healing to occur.

Addressing Suicidal Thoughts and/or Parasuicidal Behaviour

Suicidal thoughts and wishes are common in depression, and the therapist will need to address them when and if they arise. It is important to understand why the client is having such thoughts and use intervention strategies to overcome them promptly. Begin by exploring the motivation for the suicidal thoughts and/or parasuicidal behaviour. This information will inform you as to how you should proceed (Beck et al 1979). Common reasons include for suicidal thoughts/behaviour include (from Beck et al, 1979):

- **The desire to escape from life.** In this case, you should focus on and address the client's feelings of hopelessness and lack of positive feelings.
- **Social isolation.** Developing appropriate social interventions is essential in these cases.
- **A distorted or pathological view of self or others.** When this is the case you should help the client to identify and work through his or her misconceptions and irrational beliefs.
- **To influence or manipulate others.** You should focus on helping the client understand and work through his or her desire to manipulate or influence others.

Once the motivation for the suicidal behaviours or ideation has been addressed, you will need to employ some techniques to help the client cope with these suicidal thoughts and actions. The first strategy we recommend is asking the client to list his or her reasons to live and contrast those with his or her reasons not to live. During this exercise you should elicit specific, concrete examples from different aspects of the client's life (including their personal, social, and family lives). For depressed clients it may initially be difficult for them to think of reasons to live at this point in time. If this is case, we recommend encouraging the client to explore reasons he or she would have considered it worthwhile to continue living at a time when he or she was happier. However, you will need to determine which of these past reasons are still valid in the present and which will continue to be valid in the future (Beck et al, 1979). After valid reasons for living have been identified, it is useful for the client to rate each reason. This helps put a quantitative assessment on otherwise abstract material.

The worksheet "Worksheet 4—Good and Bad Things in My Life" in Part 3 will facilitate this entire exercise and provide a place for you and the client to write down the answers that are developed during the session. We recommend writing down all of the legitimate responses that are developed as well as the rating for each. This allows the client to refer to this material in the future, as individuals who are suicidal are likely to forget, ignore, or discount the value of their positive reasons for living, particularly when they are in a bout of suicidal ideation.

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Performing this exercise with individuals who have suicidal thoughts will allow the client to view such thoughts more objectively, ideally making the rationale for the thoughts or behaviours seem less absolute and/or compelling (Beck et al, 1979). It will also allow the client to think in a less dichotomised (black and white) manner. All of this is useful as a first step in getting past suicidal thoughts and behaviour.

In addition to the exercise above, we recommend undertaking a number of additional intervention strategies with the client in order to reduce the occurrence of suicidal thoughts. These include but are not limited to:

- Brainstorming and applying solutions to personal problems.
- Focusing attention away from the suicidal thoughts—providing distractions.
- Developing behavioural strategies the client can use when suicidal thoughts reappear. Writing these down on flashcards can provide the client an easy way to access the strategies when in the midst of suicidal ideation. Behavioural strategies may include:
    - Calling a friend or a family member.
    - Visiting a friend or a family member.
    - Going out for a walk at his or her favourite park or place.
    - Having his or her favourite food.

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Suicidal Behaviour Checklist

The following behaviour strategies checklist for therapists (adapted from Marsha Linehan, 1993) may also be helpful.

1. Assess the risk of suicide and parasuicide.
2. Get the client and the support worker to remove lethal items from the client's living space.
3. Empathically instruct the client not to commit suicide or engage in parasuicide.
4. Hold and reiterate the view that suicide is not a good solution.
5. Generate hopeful statements and solutions for coping with suicidal thoughts.
6. Discuss the risks of a particular client's parasuicidal behaviour and contribute to a risk management plan. This is the responsibility of the entire clinical team.
7. Make sure the client and support worker are aware of appropriate services available.

As always, we recommend the support worker be brought into these conversations as much as possible. It is important for the support worker to reinforce the points discussed above and those brought up during therapy outside the therapeutic setting as needed to make the work done in the clinical setting stick. It's also important that the support worker disclose any knowledge of suicidal thoughts or intent on the part of the client. This helps provide a more complete understanding of how severe the problem is.

In the most severe cases, the client may need to be referred for an emergency evaluation by a mental health professional.

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Psychoeducation of Anxiety

In addition to psychoeducation regarding depression, it is also important for you to educate the client about the symptoms of anxiety disorders as needed. We reviewed the following symptoms in Chapter 1 (as extracted from Andrews and Jenkins, 1999). These should be shared and discussed with the client. Common symptoms of anxiety include:

- Nervousness or restlessness
- Trembling
- Trouble falling or staying asleep
- Sweating
- Poor concentration
- Palpitations
- Frequent urination
- Muscular tension
- Easily fatigued
- Irritable mood
- Light-headedness or dizziness
- Hyperventilation
- Shortness of breath
- Depressed mood

In addition to the above, there are a number of behavioural correlates that commonly appear in people with learning disabilities who suffer from anxiety disorders. These include:

- Aggression
- Increased irritability (see the special note on irritability below)
- Avoidance behaviour
- Self-injury
- Unnecessary motor activity

It's important to be aware of these behavioural correlates and discuss them with the client as well as the symptoms of anxiety disorder outlined above. For some people with learning disabilities these behavioural correlates will be more prominent than their cognitive counterparts. So recognising them and helping the client to understand the relationship between behaviour and anxiety is of particular importance. On the other hand, symptoms such as excessive worrying,

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avoidance of potentially feared stimuli, and physiological signs such as feelings of choking and palpitations may not be reliably diagnosed or even reported in people with learning disabilities.

One of the best ways to educate this population about anxiety is through the use of “body maps”. We recommend using an informational body map to illustrate common physiological symptoms associated with anxiety as well as a blank version that allows the client to point to and discuss physical symptoms he or she experiences when feeling anxious.

> Using body maps to help clients with learning disabilities familiarise themselves with the ways in which the body reacts to stress was a very effective method according to some therapists who tested this protocol.

Body maps are particularly useful as you work to help the client attribute normal explanations to his or her anxiety symptoms and separate psychological symptoms from bodily sensations. For all people with anxiety disorders, bodily sensations can be misinterpreted as an approaching physical or mental catastrophe such as fainting, a heart attack, or death. This “catastrophising” can lead to increased anxiety and worry (Butler & Fennell, Hackmann, 2008), thus creating a negative feedback loop in which clients can easily become trapped. This kind of extreme reaction to an event is particularly prominent in people with learning disorders and should be addressed carefully and consistently.

During the early sessions when you are educating the client about anxiety you should use and fill out the following worksheet in Part 3 of this manual:

- Info Sheet 6—What Is Anxiety?
- Info Sheet 7—Signs of Anxiety (Body Map)
- Worksheet 5—When I Get Anxious I Feel (Body Map)

As with the depression worksheets discussed above you need to fill these out during sessions with the client and loop the support worker into this process as necessary. Having a tangible takeaway with written information is as important when addressing anxiety as it is when addressing depression. In both cases, the client can refer back to these materials as needed outside the therapeutic setting.

We recommend you review this material at the end of treatment in order to help catch and prevent relapse.

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A Special Note on Irritability

Irritability is a very common behavioural correlate of depression and anxiety in people with learning disabilities, and challenging behaviour is a key atypical feature of either condition. Relaxation techniques can help reduce arousal, whilst coping skills can help reframe cognitions to provoking situations. We suggest you remain particularly attentive to irritability issues with these clients, work to help them understand the link between their irritable feelings and their underlying depressive or anxiety disorder, and cope with these feelings in real time using the techniques described here. The following techniques and considerations may also help.

Working on Anger with People Who Have Learning Disabilities

From a CBT perspective you need to understand the specific problems that drive the client's anger. Ask the client to keep an anger diary for a week so you and the client can begin to make the link between his or her triggers and the resultant thoughts and feelings. The more the client can understand the links between what triggers his or her anger and how he or she responds to it the more the client will feel able to manage it.

Examples of Triggers in People with Learning Disorders

1. Problems with communicating feelings
2. Feeling misunderstood
3. Feeling scared or intimidated
4. Believing that they can't trust themselves due to past experiences (e.g. a past example of reacting to a situation with anger and physical aggression and worrying it might happen again)

The therapist should be aware that in many cases, situations where the client is experiencing anger are related to the individual's appraisal of the given situation. The client will often have demand-driven rules in his or her head about how others should think and behave. This may fuel emotional responses. For example, one client described how people often repeated things when around him and how he felt angry that these people seemed to assume he was stupid. He believed that people should not make assumptions about his intelligence and began to shout at them as a defence. In this case, a gentle exploration by the therapist examining the client's assumptions about what others may or may not be thinking and also questioning whether others should always behave in a reasonable way was undertaken. This considerably lessened the client's anger. Processes such as these need to be undertaken very sensitively without invalidating the client's experience.

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Depending on severity, clients with learning disabilities may find it hard to link situation or triggers with the resultant thoughts and feelings they elicit. For many people with learning disabilities focusing on physiological responses may be more helpful. For example, you may want to help the client think about a recent situation where he or she felt angry, where he or she was when this occurred, and the situation out of which the anger arose. Once you have developed the full scenario together, ask the client where he or she felt the anger in his or her body during this situation. This will help to give the client a physical experience feeling anger and help him or her realise there is a physiological response when anger arises. Once the client is able to recognise where he or she feels the anger, the individual can then put this skill into practice when in trigger situations.

It may also be helpful to agree to a way for the person to start noticing anger on a scale. You may use a number scale like the following:

- Not angry = 0
- Getting angry = 5
- Very angry = 10

You could also use an anger dial, a volcano (so the more angry the person get the more likely the volcano will erupt), or a traffic light system (red represents anger, etc.). Any useful method for rating the anger that the client can understand will likely be helpful.

Additional strategies you may employ to help the client manage anger could include:

- Role-play to help the client try out new behaviours.
- Gently challenge dysfunctional assumptions and help the client to come up with a more balanced view of a given situation.

You may also provide the client with some simple behavioural interventions he or she can use when dealing with anger.

These may include:

- **Walking away.** Encourage the client to get some distance from the anger-making event.
- **Get calm.** The client can engage in pleasurable and relaxing activities such as having a bath, listening to his or her favourite piece of music, or watching his or her favourite TV programme when anger arises.

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- **Rethink.** After the client is calm, encourage him or her to ask the following questions:
    - Does my angry response foster a good relationship with the person I am angry with?
    - Do I have other options instead of anger?
    - When the client is calmer, he or she can then engage in these alternative responses.

Whatever methods you utilise, the key is to understand that there are two parts to the anger management process. One is to help the person recognise what he or she is feeling. The second is to help him or her feel confident enough to communicate it effectively. Because communication is often difficult for people with learning disabilities, you may need to spend more time on helping the client to label what he or she is feeling.

It is also important to make sure the client has understood what you are explaining. It can help to ask the client to repeat back what has been discussed in the session. This will help you notice any gaps in understanding before he or she leaves the session. Always be aware that clients with learning disabilities may agree with what you are saying or reiterate pieces of it without fully understanding the task or concept. It's important to take the time necessary to ensure adequate understanding.

> According to one therapist who worked with this protocol, all the clients she saw expressed anger regarding unfairness about the way they were treated in the past. This is an area you may want to consider when addressing anger, irritability, and the way these emotions influence anxiety and depression.

A Special Note on Medication

Some of your clients may already be taking medication for anxiety disorders and/or depression. These medications are usually antidepressants such as selective serotonin reuptake inhibitors (SSRIs)—examples include sertraline and fluoxetine—and anxiolytics such as benzodiazepines or beta-blockers.

You may discuss wish to provide some education on how medication can help people with depression and anxiety disorder. A good website that provides information on numerous psychiatric drugs in accessible format is the University of Birmingham's "LD Medication Guidelines" page at http://www.ld-medication.bham.ac.uk/medical.htm. This site also contains an accessible template on "When and How to Use Your Medication", which is very useful for people with learning disabilities.

It is important for you to also liaise with the prescriber as treatment may require changes in the client's medication regime, and to stay in the loop about any changes in medication the prescriber may recommend. Furthermore, you should also be aware of any side effects of medication your client is taking that may affect treatment. For example, a client may have difficulties concentrating during the session due to medications he or she is taking.

This concludes the module on psychoeducation. In the next chapter we will outline the protocol for the middle sessions of therapy and the specific interventions we recommend you take during these critical sessions.

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Chapter 5

The Middle Sessions (Sessions 5–14)

In the first sessions the focus was psychoeducation and assessment. Once these tasks are completed, it's time to move into actively altering the client's depressed/anxious thoughts, feelings, and behaviours. The middle sessions are designed for this and are the stage of treatment where the client engages actively in CBT and starts to discuss and work through his or her problems. During this time you will work with the client to generate new, more adaptive ways of thinking and behaving. The general goals of these sessions are to:

- Discuss and work through different life situations and how to better manage them.
- Manage anxiety and depression.
- Discuss relaxation techniques and healthy living.
- Explore the client's thoughts, feelings, and behaviours and establish the links between them. (We will provide more information on linking thoughts, feelings, and behaviours in Chapter 6.)
- Train the client to use alternative techniques to cope with negative thoughts and unhelpful behaviours. (Specific cognitive interventions and behavioural interventions will be dealt with in Chapters 7 and 8 respectively.)
- Explore additional skills that will encourage the client to use CBT techniques independently. (We will address assertiveness skills and social skills specifically in Chapter 9.)

In this chapter we will review the format of these middle sessions, discuss the relaxation skills and healthy living techniques you should share with the client, and provide some recommendations regarding the midpoint review. Then in the following three chapters we will cover the specific interventions you need to employ as outlined above.

Format of the Middle Sessions

Developing a consistent format and structure during these middle sessions is important. Knowing what to expect will help clients with learning disabilities stay focused and relaxed. What follows is the format we have found to be most effective.

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Set the Agenda

At the beginning of each session you should set an agenda. This should be done in conjunction with the client. A good way to start sessions is with simple questions like “How have you been since the last session?” Such an inquiry helps the client open up and discuss items he or she wishes to address during the session while also providing you with an opening to go over the learning points from the previous session as well as any homework tasks that have been assigned. Addressing these items early in the session will help you and the client develop the agenda for the time you are together.

If the client has difficulty expressing him- or herself or is hesitant to open up to such questions, he or she may be given a number of choices about items you may wish to address together during the session. These choices should be simple, straightforward, and not too complicated. You can also use the worksheet “Worksheet 6—What We Will Do Today” as needed to help set the agenda.

Review the Previous Session

Once the agenda has been set you should briefly review the main ideas that were covered in the previous session. This helps create continuity between the sessions and offers an opportunity to address any specific points, interventions, and ideas you wish to drive home that were discussed in your previous work together.

Review Homework

The next step is to review homework. You should set aside about ten minutes at the beginning of each session to go over homework tasks from the previous session(s). Inquire about the client’s experience with the homework, not just about the tasks assigned. Clients should be encouraged to give both positive *and* negative feedback. One way to facilitate this is by using the “Homework Rating Scale” in Part 3. This offers a non-threatening, non-confrontational way for the client to honestly assess how he or she felt about the task(s). Of course, direct verbal inquiry regarding the client’s level of enjoyment and overall experience with homework is also important.

You will need to discuss any difficulties that the client may have experienced while attempting to complete homework tasks and address these as needed. Refer to Chapter 3 for more information on homework tasks and how to address any difficulties that arise.

Since a support worker will ideally be helping the client with his or her tasks, it is also important to ask for the support worker’s feedback on how the homework went, how much the client seemed to enjoy it, and the client’s overall willingness to engage in the tasks at hand.

Discussing and Addressing Problems: Setting Goals and Working Toward Resolution

Once the above objectives have been completed, the bulk of the remainder of the session should be allocated to discussing and addressing and problems the client would like to explore. These

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problems may be items the client comes into the session with or they may be items that come up during your discussion about the homework. Refer back to the agenda created earlier in the session, update it as needed if you and client wish to spend additional time and specific problems related to homework, confirm with the client that all target complaints have been identified, then set goals to tackle these problems during the session. The number of goals addressed in a session will depend on the client's abilities and the simplicity of the goals you have set. Generally, no more than three goals can be adequately handled in a given session. Understand that ability levels vary considerably amongst people with learning disabilities. Moreover, ability levels may also vary within the individual based depending on the skill the person is attempting to acquire or execute. It is therefore important that you closely assess each goal in this regard.

It is important that you and the client work together to create goals that are:

- **Specific:** Goals need to be simple and precise, not involving too many components and rules.
- **Realistic:** The goals need to be achievable for the client and they need to involve solutions that he or she can utilise independently.
- **Can be monitored:** It is essential for the goal to be observable, so the client can see and recognise the changes taking place. The goal could be as simple as meeting at a day-care centre or sitting next to someone on a bus. Being able to see changes helps maintain motivation during therapy. Identifying strategies that work for the client versus those that don't is also useful.
- **Positive:** Positive language may help encourage change in the client. For example, you should model goals as an opportunity to "develop new skills" or "improve extant skills", not as a way to "avoid mistakes" or "overcome personal failings".
- **Time-limited:** As CBT is a structured therapy; goals need to be achievable in certain time limits. This is also important for people with learning disabilities to keep them involved and focused. Typically, one or two attempts to manage a particular goal are sufficient. After that it is important to consider whether some of the work done can be transferred to another goal. For example, it has become apparent that generalising is very difficult for people with learning disabilities. So it is important to allow some time for the client to get used to a task and rehearse it again with the support worker as needed.

Once the goals have been set, you and the client should work together to identify concrete behaviours and/or concrete events that indicate the client has successfully achieved the goal. If we continue with the examples of sitting next to someone on the bus mentioned above, the

concrete evidence this goal has been achieved would be the client reporting that he or she has, in fact, sat next to someone on the bus. The worksheet “Worksheet 7—My Goal” in Part 3 will help you facilitate establishment of goals as well as the concrete evidence that said goals have been achieved.

Establishing Homework Task(s) for the Next Session

You will want to set aside about ten minutes at the end of the session to discuss the homework to be completed for the next session. Homework tasks should be relevant to the client and to the topics discussed in the session. Please refer to Chapter 3 for guidelines on setting homework tasks. Take the time to explain and rehearse the homework task(s) with the client. Enlist the support worker’s assistance as needed to encourage the client to complete the homework task(s) in time for the next session.

Session Summary and Mutual Feedback

It helpful to spend the last few minutes of the session going over the main points you and the client discussed. When possible, end with a simple message for that the client can take with them as they leave therapy for the day. You may even wish to write this message down and give it to the client.

We also recommend taking some time to explore any misconceptions that may have arisen during the session. Over the course of each session you will want to summarise main points and work to reinforce the topics being covered. Similarly, you should regularly check in with the client and ask him or her to summarise what you have discussed to ensure understanding. When misconceptions arise, make sure you address them at the time they arise and at the end of the session. Going through this process is especially important with people who have learning disabilities, as it can be difficult to make sure what has been addressed in the session has been adequately understood. As you review and investigate client’s level of understanding, be wary of responses which seem designed to please you or make you think understanding has taken place.

It’s also useful to have a discussion with the client about how the session went. Both of you can share your ideas and opinions about the session. Keep this positive and provide the client with positive feedback and reinforcement about the progress that is being made.

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Remind the Client of the Next Session

Before you part ways you should remind the client and the support worker of the time and date of the next session. This will help reassure the client that the sessions are regular and that your work together is not at an end.

Obviously, there are many possible concepts, skills, and techniques you may introduce and explore over the course of these critical middle sessions. We will provide specifics on some of what you may include in the chapters that follow. However, two topics you will definitely need to address are relaxation and healthy living. We would like to briefly discuss those now.

Relaxation and Healthy Living

Over the course of the middle sessions it is critical that you introduce, discuss, and reinforce the importance and benefits of healthy living and relaxation techniques in maintaining good mental health. When treating people with learning disabilities, such an introduction is particularly important, as many will not be familiar with the topic. What follows is brief set of suggestions on what you may wish to address as well as a few tools you can take advantage of to assist in the process.

Reducing Anxiety and Stress Levels: Using Relaxation Techniques

As most therapists are aware, educating clients about and training them in the use of relaxation techniques such as deep breathing, visualisation, and progressive muscle relaxation can be very helpful in reducing anxiety and stress levels and maintaining overall health. When practiced regularly, these activities lead to a reduction in everyday levels of stress and boost feelings of joy.

However, introducing these techniques to people with learning disabilities can present a challenge unless handled appropriately. Taking a person with learning disabilities through a complex regime of progressive muscle relaxation or long visualisation exercises is typically not useful. This is why the Camden Learning Disabilities Service has developed a fifteen-minute *Easy Relaxation* CD for people with learning disabilities that provides instructions on simple breathing and muscle relaxation techniques. If you choose to provide this to your client, he or she can use it at home with the help of his or her support worker.

Whether you use the CD or other simplified relaxation techniques, you should discuss the techniques and why they are useful in the early part of the middle sessions. Once introduced, these techniques should be added to the client's daily schedule. The support worker may be enrolled to reinforce the use of these techniques by reminding the client to do them or providing materials (such as the aforementioned CD) for this purpose. Review the techniques as needed and ask the client about his or her experience with them in subsequent sessions.

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Healthy Living Techniques

You should also discuss other healthy living techniques that will help reduce stress and increase overall feelings of joy with the client. These may include:

- **Reducing caffeine:** Caffeine is a stimulant and can stay in the system for a long time. Too much caffeine can make individuals feel restless, anxious, and irritable. It can also inhibit quality sleep and cause headaches, abnormal heart rhythms, or other problems. You may suggest that the client moderate caffeine intake and avoid drinks containing caffeine starting in the mid-afternoon. Tea, coffee, energy drinks, many soft drinks, and chocolate contain caffeine.
- **Improving sleep habits:** Good sleep habits are essential for physical and mental health. To improve sleep habits we recommend you encourage clients to create a sleep schedule, avoid napping during the day, and establish a pre-bedtime routine to help the client realise it is getting close to bedtime. Work with the client and the support worker to decide what may be included in such a routine. Examples include having a warm bath, listening to relaxing music, having a glass of warm milk, or other activities that help the client relax.
- **Promoting exercise:** Regular exercise can improve mood and is good for sleep. Exercise in the morning can help the client feel good throughout the day and relax in the evening. Make sure to keep exercise gentle and encourage the client to avoid exercising close to bedtime as this stimulates the body and is bad for sleep. Exercise should be added to the client's daily schedule.

It is worth noting that the Camden Learning Disabilities Service has also developed a 35-minute *Canned Health* CD for people with learning disabilities that provides information on healthy living and covers topics such as healthy eating, walking, sleep, working, the importance of being with friends, laughter, and hydration.

The Midpoint Review

Approximately halfway through the treatment programme you will need to spend a session or two reflecting with the client and the support worker about progress being made in treatment and the client's goals for the remainder of treatment.

A good way to start this process is by asking the client to fill out a WAS form. This can be discussed and compared to the WAS produced in the early sessions to provide a concrete guide regarding improvements made up to this point in therapy. These improvements can be concretised by helping the client focus on particular thoughts, events, behaviours and/or situations where he or she has successfully used the skills acquired in therapy to address otherwise threatening or emotionally disturbing situations. Take the time to provide the client with

an overview of the skills you have covered in previous sessions, and practice them with the client as necessary to reinforce learning. This help the client have a clear understanding of what has been covered and the successes he or she has made during therapy.

You should also discuss how close the client is to meeting the goals that were established early in the therapeutic process, how he or she feels about meeting these goals, what parts of the goals may need further work, and what, if anything, needs to be added to the original list of goals.

This review will set the stage for the final sessions where you will close the loop, reinforce the techniques and skills learned, and end therapy with the understanding that the client has acquired the needed knowledge to "become his or her own therapist". In Chapter 10 we will review how these final sessions should look. But before we get to that, let's look at the additional skills and topics you need to address during these middle sessions.

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Chapter 6
Linking Thoughts, Feelings, and Behaviours

A key part of CBT is helping the client to understand the links between his or her thoughts, feelings, and behaviour. As we explained in Chapter 1 the traditional model of CBT proposes that an *activating event* (A), in association with an individual's *beliefs/thoughts* (B), can elicit certain emotional and/or behavioural *consequences* (C). While there are a number of potential points where a therapist can intervene in this sequence (including cognitive, emotional, and behavioural techniques), what is ultimately at stake is challenging and/or altering the underlying belief(s) that create the tether between activating event and emotional or behavioural consequences.

Clients with learning disabilities often have a difficult time with this part of treatment unless it is addressed in a specific sequence. For these clients it is advisable to start with their emotional responses, help them understand how thoughts arise from these feelings, and then add in the behavioural link as a final step.

In this chapter we will review a method for linking thoughts, feelings, and behaviours that starts from the emotional response and describe some specific nuances you may need to consider when working with people who have learning disabilities.

Using the techniques in this chapter to establish the links between thoughts, feelings, and behaviours has proved very useful according to the group of therapists who tested this protocol.

Begin by Discussing and Identifying Feelings

Rather than starting with a conversation about how a particular thought or situation makes the client feel, for people with learning disabilities it is generally more useful to begin by having a simple discussion about feelings. Try to understand what the client means when talking about different emotions. To do this, you may start by asking what the client is feeling in the present moment. As it will likely be difficult for many clients with learning disabilities to verbalise a description of their feelings when asked, you can offer the client a list of feelings to choose from (in written or verbal form), encourage the client to draw his or her feelings, or ask him or her to identify the feelings from a series of pictures like the ones provided in "Resource 3—Image Bank" in Part 3. You may also find it useful to do a role-play of different emotions with the client and/or support worker to help the client accurately understand and identify various emotional states.

Role-play has proven to be a very effective technique throughout the therapeutic process with people who have learning disabilities, according to therapists who tested this program.

Make sure to target simple emotions and keep any verbal descriptions or definitions of feelings simple and personalised to the client. The following is a list of different emotions and alternative words that can be used to describe particular emotional states. Focus in on emotions and terms the client resonates with when sharing this information.

- **Sad:** Depressed, down, tearful, blue
- **Anxious:** Agitated, bothered, edgy, frightened, nervous, nervy, restless, worried, scared
- **Angry:** Aggressive, annoyed, bad-tempered, complaining, cross, irritated
- **Ashamed:** Humiliated
- **Disappointed:** Frustrated, let down
- **Embarrassed:** Awkward, humiliated, uncomfortable
- **Guilty:** At fault, in the wrong
- **Hurt:** Devastated, harmed, injured, offended, wounded
- **Jealous:** Green-eyed, envious
- **Love:** Admiring, adoring, fond

Once you are confident the client is able to accurately identify his or her emotions, the next step is to make the thought-feeling link.

> Some clients with learning disabilities actually have an enhanced awareness of their own emotions and the emotions of others. These clients are typically remarkably sensitive to the feelings and emotional responses of those around them. For example, they can often detect whether or not people like them. One explanation may be that these clients have developed this ability to protect themselves against threats such as criticism and attack by others. For this reason they may be hyper-vigilant where emotional responses are concerned. It is important to keep this in mind as you proceed with therapy.

Establishing the Thought-Feeling Link

Establishing the link between feelings and thoughts can be challenging for people with learning disabilities. The key to successfully accomplishing this is staying simple and concrete. Start by explaining that sometimes people have unpleasant feelings and dwell on them or avoid thinking about them. Since this is likely to be an experience the client has had, this will be a nice segue into the clink between feeling and thinking.

Next, work with the client to establish a set of examples from the client's personal experience in which the client felt a particular emotion and a particular thought arose as a result. The simpler and more explicit you can keep the examples, the more likely you are to effectively communicate the relationship between thinking and feeling. Develop a significant set of problem areas that have come up the client's past, and try to ensure that the client can identify the feeling that arose and the thought that came up as a result of this feeling. Keep in mind that "trying not to think about it" is a thought.

Assuming that the above links can be established and the client is sufficiently cognitively advanced, you may wish to explain at this point that the goal of CBT is to help the client carry on and live a good quality of life in his or her daily life in spite of these feelings. The feelings and the thoughts the individual generates may or may not be reduced over time, but by identifying the relationships the client can still live well. This discussion, if it is possible, will segue nicely into the behavioural component. As always, it is essential to keep these concepts as simple and straightforward as possible to ensure the greatest understanding.

Establishing the Relationship Between Thoughts, Feelings, and Behaviours

The final step is to help the client bring the links together and understand the relationships in the cognitive triad. While a full explication of core beliefs is unlikely to be useful to these clients, it is important for you to explain that there is a relationship between negative thoughts/beliefs, that these thoughts and beliefs are at the core of the "unwanted" feelings, and that thoughts and feelings have led to the client's behaviour.

> While establishing the link between negative thoughts and unwanted feelings is important and the techniques for linking thoughts, feelings, and behaviours in this chapter useful, the therapists who tested this protocol found that unnecessarily focusing on negative thinking for too long was detrimental to the therapeutic process. Clients with learning disabilities easily get "caught" in negative thinking and sometimes have a hard time breaking free of the cycle. So be wary about the amount of time you spend on negative thinking.
>
> One option in this regard is to take an ACT approach—where you help the client focus on negative thinking as process, not content, and try to help him or her cease engaging with individual negative thoughts. For more on ACT see *Acceptance and Commitment Therapy: An Experiential Approach to Behaviour Change.*

Using a visual to help explain these relationships can be very useful. Figure 6.1 shows a diagrammatic representation (modified from Willson & Branch, 2006) of the links between a trigger event, "*I think people look at me in a 'funny way'*", and its connections to the core belief at the centre and associated emotions, behaviours, and physical sensations at the periphery. You

can use this, or a simplified version of it, to help when you are explaining the relationships between thoughts, feelings, and behaviours.

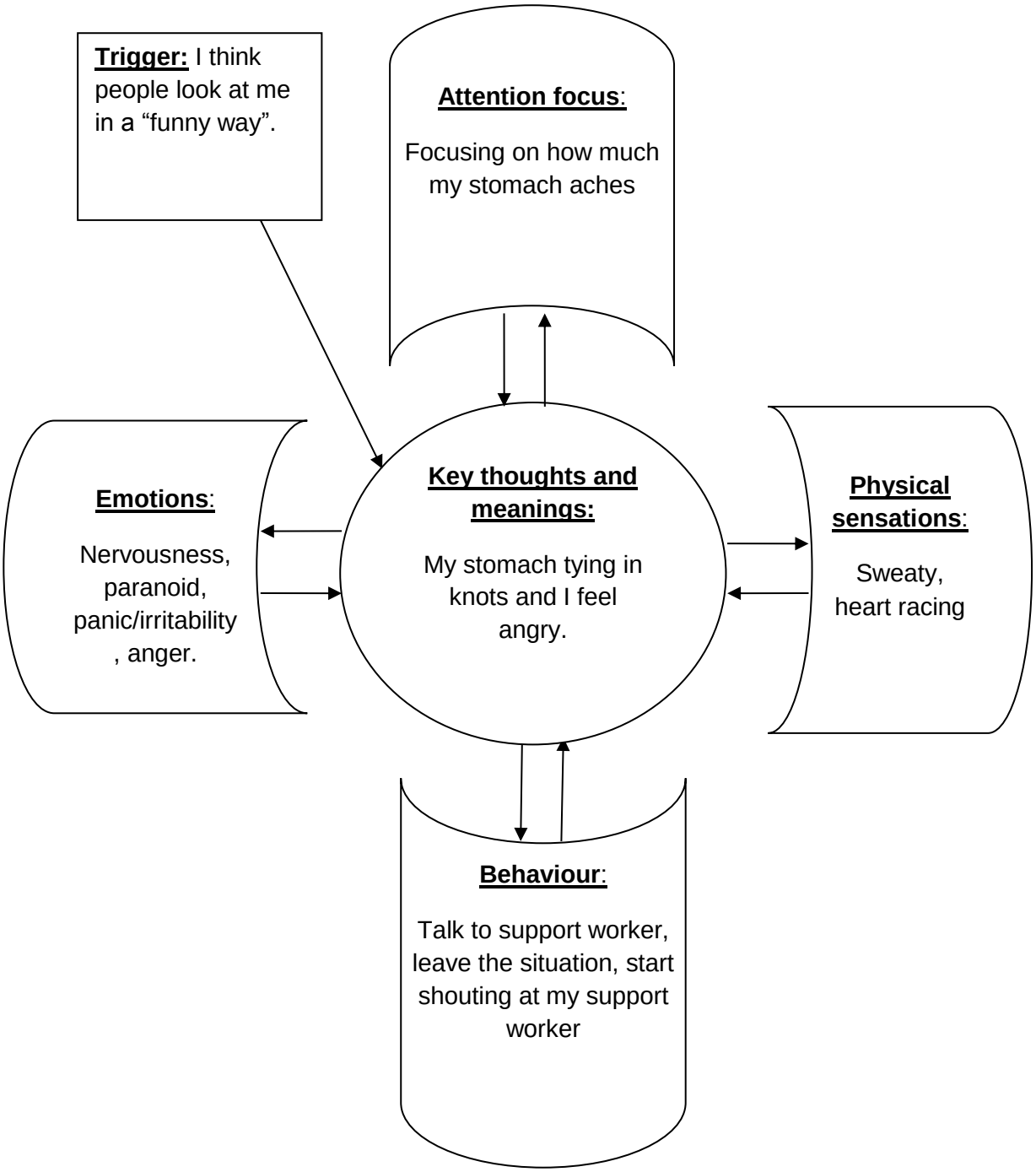

Figure 6.1: Linking Thoughts, Feelings, and Behaviours

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In addition to a didactic explanation of the relationships in the cognitive triad, it's essential to qualify this against the client's own experience. We encourage you to ask the client to keep a simplified "Worksheet 8—Thoughts and Feeling Diary" like the one in Part 3. After the client tracks his or her thoughts and feelings for a certain period of time, you can then begin to discuss the relationship between the trigger events the client experienced, the beliefs activated, and the emotional and behavioural consequences. The following worksheets in Part 3 will further facilitate this process:

- Worksheet 9—Thoughts, Feelings, and Behaviours
- Worksheet 10—Good Times
- Worksheet 11—Bad Times

According to all the therapists who have used these techniques with clients who have learning disabilities, a "Worksheet 8—Thoughts and Feelings Diary" and identifying good and bad times are extremely effective ways to help clients identify what they enjoy and what they find difficult. They are also useful in helping the client plan enjoyable activities to lift his or her mood.

Review the client's "Worksheet 8—Thoughts and Feelings Diary" during sessions and talk through the various relationships between thoughts, feelings, and behaviours with him or her. Again, all of this material needs to be kept as simple as possible. Use lots of repetition so that the client becomes familiar with the links between the trigger, thoughts, feelings, and behaviour. A flip chart may be used with simplified language to give examples.

Here is a sample of how this dialogue might occur:

Therapist: *"In your diary, you said you felt sad yesterday…. Where were you?"* (This enables you to identify the mood state and the possible trigger.)

Client: *"I went to the shop."*

Therapist: *"Were you sad before you went to the shop?"*

Client: *"No, but the man shouted at me."*

Therapist: *"So you went to the shop, the man shouted at you, and you felt sad."* (Reiterating this way helps the client understand and make the links between the sequence of events.)

Client: *"Yes."*

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Therapist: *"So that upset you. Why was that?"*

Client: *"It's not nice to shout. It scared me.*" (Several approaches could be used here, but challenging the evidence at this stage may not be helpful, as it might invalidate the client's feelings.)

Therapist: *"So the man shouted…. What did you think would happen?"*

Client: *"I might get into trouble…. He might call the police."* (There is evidence of a thinking style error here, but rather than challenge it you might proceed further using the downward arrow technique.)

Therapist: *"So what did you think would happen if the man called the police?"*

Client: *"They may tell me off and I might get taken to the police station."* (At this point you may explore the anticipated outcome and challenge the fortune-telling.)

Therapist: *"Have you ever had the police talk to you? Could they be nice? How do you know that they might not take your side?"*

Once the client has been given time to consider alternatives, you can then demonstrate how his or her ways of thinking are linked to the feelings experienced and illustrate that if the client thought differently, the emotional responses may be different. For example:

Client: *"I talked to a policeman one time before and he was really nice to me."*

Therapist: *"So if a policeman showed up yesterday, he may have been nice to you?"*

Client: *"I guess so."*

Therapist: *"If he were nice to you, how would you feel then?"*

Client: *"I would feel happy."*

Conversations of this nature may need to happen many times before the client fully begins to recognise that his or her thoughts, feelings, and behaviours are linked. We encourage you to continue having these much-needed conversations with the client as often as necessary to help instil this understanding. During the middle sessions, getting the client to see, as fully as possible, the relationship between thinking, feeling, and behaving should be a top priority.

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Chapter 7
Specific Cognitive Techniques

Over the course of treatment you will want to employ a range of techniques to help the client recognise and reframe problematic thinking patterns. Helping the client explore and address maladaptive cognitions which might be leading to feelings of depression and anxiety is essential if the client is going to heal.

While there are any number of interventions that may be used, including verbal processing, visual processing, role-play, and others, in this chapter we have focused on adapting a handful of relatively complex CBT techniques so that they can be more successfully used with clients who have learning disabilities. We encourage you to try some of these techniques in addition to your normal cadre of strategies when working with people who are learning disabled.

Identifying and Challenging Key Thinking Style Errors

While it is not absolutely necessary, nor even realistic, for clients with learning disabilities to understand all the thinking style errors, it is appropriate for you to help the client understand particular thinking patterns and ask questions that will challenge the client's way of thinking. The aim here is to help the client identify not only the content of what he or she is thinking but also the process of how he or she is thinking.

The following chart outlines key thinking style errors and typical methods that are used to treat them. You can explain some of these to the client as necessary, but you will need to simplify the terminology and keep the information contextualised to the client's personal experience for the best results.

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Thinking Style Errors and Useful Treatment Methods

Thinking style error	Method
Black-and-white thinking	Visual analogue scales
Labelling	Imagery
Mental filtering	Positive data logs
Disqualifying the positive	Challenging
Mind-reading experiments	Role-plays/behavioural
Emotional reasoning	Flash cards, challenging—feelings not fact
Catastrophising	Reframing beliefs; pros/cons
Masturbatory thinking	Helping with preferences
Overgeneralisation	Pie charts
Personalisation and blame	Role-plays
Fortune-telling	Considering alternatives
Low frustration tolerance	Preferences

People with learning disabilities will likely have difficulties identifying their thinking styles and understanding that some of their thoughts may not be logical or helpful. Furthermore, it may be difficult for people with learning disabilities to recognise that they have control over their thoughts. To break through this, it is helpful for you to *gently* challenge the assumptions the client makes about specific situations and explore alternative possibilities which may explain said events while you are working together.

The following materials will facilitate this process:

- Worksheet 12—Unhelpful Ways of Thinking
- Worksheet 13—"How I Am Thinking" Diary
- Worksheet 14—A Different Way of Thinking

Using the Survey Method to Challenge Beliefs

You may use the “Survey Method” to help some clients challenge beliefs. Try the following:

Set three questions the client should ask up to ten people they know and trust. These questions should revolve around an irrational belief. For example, a client may hold the belief that the reason he or she is still at home at the age of twenty-five is because he or she is backward. You might set the following three questions for the client to ask other people:

1. How long was it before you left home?
2. Would you prefer to stay at home or leave home?
3. Why might people take a long time to leave home?

Hearing objective answers to these questions from trusted resources may help the client realise that his or her underlying belief is inaccurate.

It is also possible to introduce props in this exercise. For example, one of the therapists testing this protocol had a client who believed that people did not like her because she was often angry (incidentally, this woman had been severely abused in her past). The therapist took two photos of the client, one while she was looking angry and bad-tempered and another while she was happy and smiling. She then asked the client to take the photos and survey people using the following questions:

1. Which photo do you like more?
2. In which photo do I look more approachable?
3. Why do you like one photo over the other?

The responses the client received helped her realise that people did not inherently dislike her, but that her presentation made it more or less difficult for people to engage with her.

Schemas Work

It is understood that negative schemas (attitudes and assumptions) are formed due to an individual’s negative experiences in childhood such as parental criticism, criticism from teachers, and peer rejection. When a new experience presents itself to an individual holding negative schemas, this experience is incorporated into the framework of the schema and reinforces the negative core beliefs. Common negative schemas in people who have learning disabilities include:

- I’m a failure. (Negative view of the self)

- Everyone thinks I'm stupid. (Negative view of the world)
- I'll never be good at anything. (Negative view of the future)

Obviously, beliefs of this nature can impact behaviour and mood. Classically this is an area that a CBT therapist would work on with a client. Whether you will be able to include schemas work in therapy with people who have learning disabilities depends very much on the individual's level of functioning.

Therapists have found this to be a particularly difficult area for some clients with learning disabilities. Because some people with learning disabilities have a hard time generalising, analysing core beliefs, assessing patterns, and working to alter them can be challenging. Assess your client's ability in this area before you attempt schemas work.

Even if the client is not capable of schemas work it is important for you to be aware of some common schemas that develop for people with learning disabilities. Many of these clients develop negative schemas around the following:

- Criticism
- Bullying
- Rejection
- Poor self-worth

People with mild to moderate learning disabilities may be able to engage in schemas with a few modifications. First, you can develop case conceptualisations that help clients tether their past experiences to their present experiential state and assist them to identify how negative core beliefs and thinking style errors may contribute to their current unhappiness or anxiety.

To make up such a case conceptualisation, work with the client and the support worker to identify long-standing cognitive and behavioural patterns. Once this has been established you can then write up the case conceptualisation in *very* simple terms and give it to the client to take away and study. Here is a sample case:

Amy always compared herself negatively to her sister and holds a core belief that she is unlovable and that she will fail at anything that she tries. As a result of these beliefs, Amy avoids new challenges and social contacts. (Adapted from Scior, 2009).

In subsequent sessions the main points may be discussed with the client and the support worker. During such sessions you may wish to explore and collect evidence that challenges the client's

negative thoughts and beliefs about him- or herself and highlights his or her thinking style errors. You may also encourage the client to try new activities and evaluate the changes in her moods and thoughts, with the aim of ultimately shifting her cognitions and dismantling negative schemas.

The following additional materials designed to help with schemas work (in cases where it can be used) have been included in Part 3:

- Worksheet 15—My Good Thoughts About Me
- Worksheet 16—My Thoughts About Me That Are Not Nice
- Worksheet 17—My Worrying Thoughts About Me
- Worksheet 18—My Worrying Thoughts About Things That Will Happen
- Worksheet 19—My Good Thoughts About Things That Will Happen
- Worksheet 20—Core Beliefs
- Worksheet 21—My Core Beliefs

The following case study may further help you understand how schemas work may be applied with clients who have learning disabilities.

Case Study

Background: Robert is a 48-year-old man with mild learning disability. He lives independently. Robert has had a difficult relationship with his parents, especially his father. He was put in care from the age of ten when his parents returned to Jamaica. We have been working together for nine sessions.

Identified Problems:

- Feels very tense when around new people. When Robert approaches someone or someone approaches him, he becomes very anxious and is aware of tension in his back and feet. To manage this he avoids meeting new people and has a very limited social group.
- Feels angry very quickly, and has not been able to manage it well.
- Avoids eating. Robert reports never feeling hungry.

Goals:

- Feel more confident in new and old situations; this could be a meeting at a day centre or sitting next to someone on the bus.
- Learn to recognise anger and develop strategies to manage it.
- Regulate eating pattern by eating three meals per day and using picture cues to remind him to do so.

Identified Assumptions:

- People will think I am strange.
- People will be able to see that I am anxious.
- I will have to hide what I am feeling or people will avoid me.

Core Beliefs:

- I am different.
- People cannot be trusted.

Treatment:

- Understanding symptoms of depression
- Identifying where he feels anxiety in his body
- Behavioural experiment/graded task assignment—asking someone for the time, sitting next to a new person, saying something at a day centre meeting. (For more information on behavioural experiments see Chapter 8.)
- Diary keeping
- Positive data log—identifying when good things happen, like someone saying something nice or enjoying a film.

Robert has been very engaged in CBT. He reports in sessions that he finds the agreed goals helpful. Although he cannot identify changes in his thought process, he is able to recognise changes in his physiological arousal (i.e. feeling less tension in his back and shoulders). He has identified that when he does the things he has previously avoided he becomes more confident in dealing with them.

Therapist Reflection: Before I started on the project I was concerned that I would not be able to do CBT with this client group due to their learning disabilities. I thought it would be hard to communicate and they wouldn't understand. However, I realise these were my assumptions, and my experiences have shown me that I was wrong. I have seen that the people I have worked

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with have engaged in the therapy, have been open to the possibility of change, and have been willing to give it a try. They are a positive and inspiring group of people who we could learn a lot from regarding living in difficult circumstances and overcoming adversity.

Addressing Anxiety States

An event perceived as catastrophic can lead the client to adopt s*afety-seeking behaviours*—precautions used to avoid or escape situations that are anxiety provoking. To clients who experience anxiety, these behaviours are logically linked to a perceived threat, though this is often not the case. The real problem with these safety-seeking behaviours is that they play an important role in maintaining anxiety disorders (Salkovskis, 1991) because they focus on negative consequences (like death, illness, or embarrassment) as means of avoiding the distress or threat at hand. To help the client heal, you need to explore, identify, and change these behaviours.

As a first step, you can use the cognitive model of panic illustrated in Figure 7.1 below to help the client understand how anxious feelings, catastrophic thoughts, and problem behaviours are linked.

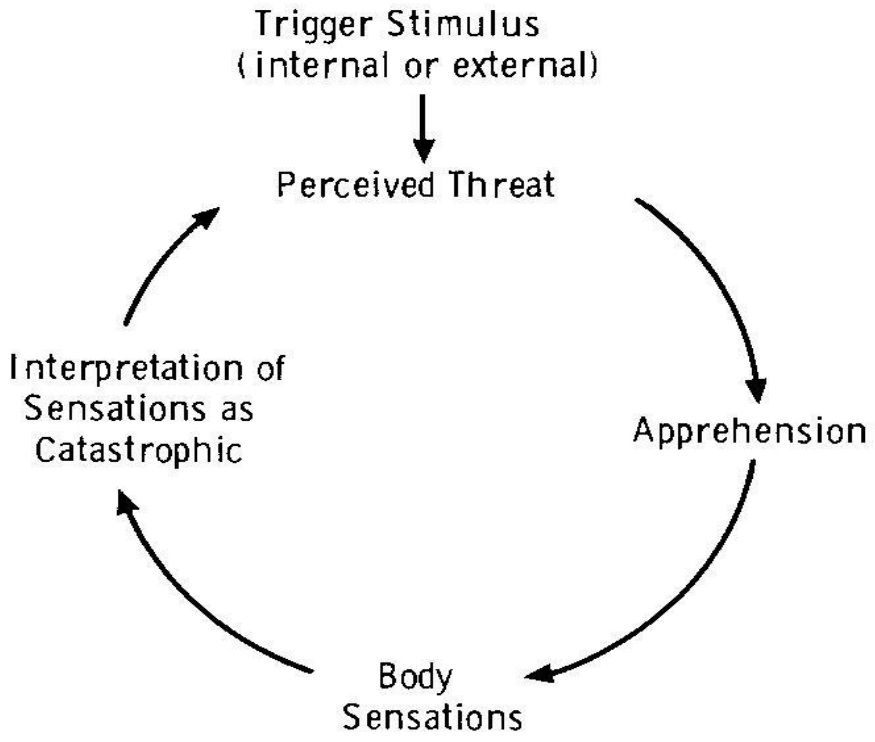

Figure 7.1: A Cognitive Model of Panic Attacks

(Permission from Behaviour Research and Therapy, 24, p. 463, D. M. Clark, A Cognitive Approach to Panic, Copyright 1986, Pergamon Journals Ltd)

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Once the connections between the anxious feelings and the behaviours that result are better understood by the client you can follow through with this by generating individualised behavioural experiments to help the client see the harmless causes of his or her feared symptoms. This can be done within the therapeutic setting. For example, you may encourage the client to breathe deeply as if he or she were trying to stay calm in an anxious situation. The client may discover that this actually makes him or her quite dizzy and intensifies anxiety. You can then reassure the client that nothing bad is going to happen (e.g. he or she is not going to faint) and that the response—being dizzy—is expected and transient. When the dizziness does, in fact, pass, the client will see for himself or herself that the feared stimuli were non-threatening.

Additional worksheets provided in Part 3 that will help address anxiety states include:

- Worksheet 15—My Good Thoughts about Me
- Worksheet 17—My Worrying Thoughts about Me
- Worksheet 18—My Worrying Thoughts about Things That Will Happen
- Worksheet 19—My Good Thoughts about Things That Will Happen

Guided Discovery

The final cognitive intervention we will address in this chapter is guided discovery. The rationale behind this technique is to provide the client an opportunity to learn how to overcome problems that he or she has not come across before by applying his or her skills to such situations. This technique can be particularly useful, as it offers the client a real, applicable takeaway from sessions.

Start by working with the client and support worker to develop a cache of real-life, but fictional situations the client typically finds him- or herself in. Once this has been established, you will want to consider a range of emotional states which the client may have experienced in these settings. For example, you may come up with a list like the following:

- Shopping for groceries—client feels anxious, awkward, and edgy because he or she is afraid of doing something wrong.
- Travelling on the bus—client feels sad and a little humiliated because he or she thinks people are looking at him or her funny.
- Walking around in the local area and seeing a couple together—client feels admiring and envious of the two people together.

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After the list of situations and related emotions has been developed your aim will be to get the client to shift to healthier ways of expressing and/or experiencing these emotions. This may include challenging thinking styles, working with core beliefs, addressing anxiety states, or a variety of other techniques to change the cognitions associated with the feeling. For example, the client may feel scared in the grocery store because he or she is afraid of making a mistake and of the possible social consequences involved. You may challenge such thinking and help the client realise that even if a mistake is made, that doesn't mean social consequences will necessarily result.

On the other hand, there are cases where the client should be encouraged to view his or her emotional reactions as normal and realise that they are feelings everyone experiences from time to time in day-to-day life. For example, many people have felt the pang of jealousy when seeing a happy couple together. This is not an uncommon emotional experience. That said, it's important to help people with learning disabilities clearly distinguish between grades of emotional severity and their related, appropriate responses in the home, in public, at work, etc. For example, you may need to point out that acting out jealous feelings when seeing a happy couple together is not an appropriate response. Likewise, becoming physically aggressive when irritated, fleeing a situation when panicked, or staying in bed all day when sad are not appropriate (or useful) behavioural responses.

By helping the client change his or her thinking style, address cognitive distortions, work through negative schemas, and develop alternative behaviours in potentially provoking situations, you offer the client real strategies he or she can use to alter the underlying thoughts that lead to problems in life. The next step is addressing behaviour. We will turn our attention to this issue in the next chapter.

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Chapter 8
Specific Behavioural Techniques

Ultimately the purpose of CBT is to change behaviour. While cognitive interventions are an important step in treatment, behavioural techniques often provide the best results—especially in people who have learning disabilities.

> According to therapists who tested this protocol, the behavioural elements are far more consistently effective than the cognitive elements. While both are essential pieces of CBT, for this population it would appear the behavioural elements are more amenable to short-term intervention.

Here again, there is a broad array of potential interventions to choose from. However, in this chapter we have provided guidelines for using three specific behavioural techniques to treat people with learning disabilities: the use of positive reinforcement, graded tasks, and behaviour experiments. Let's review each in turn.

Utilising Positive Reinforcement

A lot of conventional treatment paradigms for treating people with learning disabilities use positive reinforcement. Indeed, the premise is developed from work by Rehm (1977) and Seligman (1975). There are three key points these researchers raise that are extremely applicable in this context:

1. It is important to provide people with depression lots of praise, as they tend to focus on negative aspects of themselves.
2. Helping depressed people identify positive events is an essential step in the healing process, as they are likely to view all events as negative.
3. Fundamentally, you need to work toward encouraging people who are depressed to *be nice to themselves,* as they have likely internalised negative voices and this, in part, drives the depression.

> Therapists who tested this protocol found they used positive emotional reinforcement often and to great effect. According to one, "This helps a lot to make the person feel listened to and understood".

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We encourage you to consider these points and bring plenty of positive reinforcement into the therapeutic setting. This isn't only a matter of verbally reinforcing the client. Get the client to engage in behaviours that are positive. This will reinforce the client's ability to identify and participate in positive events in life. One excellent activity is to ask the client to create a list of positive things he or she might enjoy doing, add these to the client's WAS, and then ask client to rate the events based on how much he or she enjoyed doing them. Follow up by discussing the events in the next session. Encourage the client to add enjoyable events into next week's schedule and/or come up with a new list of events to try.

Assigning Graded Tasks

Graded task assignments that expose the client to adverse events which elicit either anxiety or sadness can be used to help the client confront potentially difficult life problems and develop resilience in these areas. The key here is to prepare a list of situations of gradually increasing difficulty, assign these tasks over time, and then ask the client to complete each task and monitor his or her mood or anxiety while completing the task *without running away or engaging in safety behaviours*. Safety behaviours are those behaviours aimed at preventing the feared consequence from happening. This final point is the essential message you need to communicate when assigned such exercises. The client *must* stay with the situation until the anxiety reduces or the mood improves. The biggest problem with exposure paradigms is that the client is liable to leave the provoking situation when it reaches its emotional peak. This negative reinforcement makes it much more difficult for the client to engage in the provoking event the next time around. This is why you must be particular careful in developing a graded list of tasks that will take the client through an increasing set of provoking situations.

For these kinds of exercises to be successful a support worker almost always has to be involved both in the development of the assignments as well in the execution of the tasks. The support worker should encourage the client to stay with the emotionally loaded situations without becoming a crutch. This can be a delicate balance and it may be necessary for you to discuss all of this with the support worker in some detail before the graded task assignments begin.

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Pleasure Predicting Experiments

Pleasure predicting experiments aim to challenge fortune-telling and encourage the client to see that predictions he or she makes are also excessively biased by emotions. These experiments also help the client challenge emotional reasoning and encourage the client to stop "buying into" what his or her mind is telling him or her. To complete these experiments with your client, carry out the following steps.

- Ask the client to describe activities he or she enjoyed prior to becoming depressed.
- List these activities.
- Ask the client to predict how much he or she believes the said activity would be enjoyable now, on a scale of 0-100 percent.
- As the client to engage in the activity.
- At follow-up ask the client to rate how much he or she *actually* enjoyed the activity.

A sample worksheet you could use to facilitate these experiments follows.

Mastery Pleasure Predicting Sheet

		Prospective	Retrospective	
Time	**What do you have planned?**	**How much do you predict you will enjoy this activity?** **(0-100%)**	**How much did you actually enjoy this activity?** **(0-100%)**	**What have you learned from this?**
Morning (Specify time)	*Nothing, I will just see what happens.*	*30%*	*10%*	*I felt bored and upset, as my life is going nowhere.*
Afternoon (Specify time)	*Going swimming* *3pm*	*30%*	*60%*	*The way I feel is not always a helpful guide about what to do.*
Evening (Specify time)	*Go and visit my friend Melanie* *7pm*	*60%*	*30%*	*What I predict is not always accurate.*
Other Comments, Trends, Conclusions, etc.	*Doing nothing does not help, and I need to test out my beliefs rather than assume what is going to happen.*			

Typically, pleasure-predicting experiments are most effective when the client is at his or her best. We recommend that you assess the client's mood and target this kind of behavioural experiment to be undertaken around this time.

Designing and Executing Behavioural Experiments

Perhaps the most useful of all behavioural interventions when treating people with learning disabilities are behavioural experiments. Behavioural experiments help clients test beliefs, recognise negative thoughts and replace them with more positive ones, and build strategies to cope with difficulties appropriately. As long as you keep a focus on helping the client recognise the links between his or her thoughts, feelings, and behaviour, these experiments can also be a wonderful way to reinforce an understanding of the relationships among the cognitive triad.

> One therapist who tested this protocol found behavioural experiments a particularly useful aspect of treatment for people with learning disabilities. According to her, testing out beliefs with behavioural experiments gave clients an easy way to recognise some of the contradictory aspects of their thinking.

We feel the easiest way to illustrate how to use behavioural experiments with people who have learning disabilities is to provide examples of the kinds of experiments appropriate for this population. Therefore the rest of this chapter will provide a series of case vignettes you can use as a guideline when developing your own experiments.

> When it is possible and realistic, video feedback may be useful to demonstrate changes in behaviour. Videos can also help reinforce the belief that a given client is able to cope with a wide variety of situations.

Case Vignettes That Illustrate Behaviour Experiments

Case Vignette 1

Problem: Doreen has been depressed. She has a low mood, loss of energy, and little motivation. Her carers complain that she is lazy.

Target cognition: I am lazy and I never do anything to look after myself. (This belief has been reinforced by people at Doreen's day centre.)

Alternative perspective:

Doreen: When I do things I begin to feel better.

Prediction: Doreen will progressively avoid activities unless some intervention takes place.

Experiment: Doreen's therapist explains that inactivity is a symptom of depression. The therapist shows Doreen and the support worker how to monitor her activity levels by using a WAS form. Doreen and her support worker start to record what Doreen does over the next three days and discuss it in the next session.

Results: Doreen realised that she does complete some activities and is, therefore, not as lazy and disengaged as described.

Reflection: The therapist challenges Doreen's belief that she does nothing and is lazy. Doreen looks pleased.

Further work: Doreen feels encouraged and agrees to bring in the WAS for the next session. The support worker is instructed on how to help Doreen fill out the WAS and encourage her to keep up with activities. Doreen discovers that she does increasingly more than she thought.

Case Vignette 2

Problem: Adam spends a lot of time in bed or sitting, doing nothing, which he does not like. His carers say that his quality of life is poor but he does not feel motivated to change. He tends to mull over things all the time and becomes depressed.

Target cognition: I'm too tired. I should wait do things until I feel better.

Alternative perspective: The therapist challenges Adam's belief by noting that waiting hasn't worked and pointing out that his carers think Adam is not getting the most out of his life.

Therapist: "What do you do when you are down?"

Adam: "I lie on my bed until I feel better."

Therapist: "But you say that you do not like 'doing nothing'. So lying in bed doesn't help you."

The therapist then engages the client in finding activities he or she likes.

Therapist: "Okay, so I have a list here of going to the shops, speaking to the lollipop lady, going to the zoo, taking the neighbour's dog for a walk. Let's pick one of these…. Hmmm, which one?"

Adam: "Taking the dog for a walk."

Therapist: "Okay, when do you normally lie on your bed?"

Adam: "In the morning."

Therapist: "Great. Now, with the help of a friend or carer, can you ask the neighbour if you can take the dog for a walk tomorrow morning and then come and tell me how it went?"

Adam: "Okay."

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Predictions: Adam will resist walking the dog when the time comes.

Experiment: Adam's therapist suggests that Adam do the following with the help of his support worker:

1. Go to bed if he feels tired or depressed, but fill out his "Worksheet 8—Thoughts and Feelings Diary" to record how he felt after doing so.
2. If he feels tired or depressed subsequently, he is to resist the urge to go to bed and take the dog for a walk instead. He can then fill in his "Worksheet 8—Thoughts and Feelings Diary" again after walking the dog.

Results: Adam got depressed and went to bed the next morning. However, the following day, with the help of his support worker, he went to walk the dog when he felt tired.

Reflection: Adam felt much better after walking the dog. His carers saw an improvement in his mood and encouraged him to join in more activities. He did, and when he saw how many more smiley faces he got he was pleased and said that he liked going out.

Further work: The support worker is advised to help Adam plan his daily activities in advance (using a WAS). If Adam does at least 50 percent of his daily activities, he gets to do one *extra nice* activity that he's chosen. After each activity, Adam is encouraged to fill in his "Worksheet 8—Thoughts and Feelings Diary". Therapy continues until Adam's diary contains a range of activities Adam is happy with. The support worker is then advised to continue prompting Adam to find new activities to engage in and review his schedule. Over time Adam gets more and more smiley faces to help remind him of how much better he feels after doing something.

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Case Vignette 3

Problem: Andrew becomes very anxious and has temper tantrums when his routine changes.

Target Cognition: When things change, I don't know what is going to happen and I am not going to have control over anything.

Alternative perspective: Just because something is new doesn't mean it is bad.

Experiment: The therapist works to help Andrew identify key thoughts about maintaining a routine. They break down his daily routine in small ways and discuss what may happen following each change that happens through his day. In session they work through examples of times when his routine may change unexpectedly and the potential outcomes.

Andrew and his support worker are advised to try out some of these scenarios to see how Andrew will react. Andrew is asked to record how he feels after each activity is tried.

Results: With the help of his support worker, Andrew tries some of the scenarios. He sticks with them and is able to reduce his anxiety by exposing himself and using the strategies he developed with his therapist.

Reflection: Reviewing the diary in the session, Andrew feels encouraged that he is able to deal with changes in his routine without feels anxious.

Further work: Andrew will continue to discuss how things go for him when he feels anxious at subsequent sessions.

Case Vignette 4

Problem: Rosy worries about everything. She thinks that she does not have enough money in the bank and that no one can help her.

Target cognition: If I worry about things, I will be able to prevent negative things from happening.

Alternative perspective: I don't have control over events, and worrying will not keep me safe.

Experiment: The therapist helps Rosy to learn how to catch herself worrying as soon as possible. With the help of her support worker, Rosy and the therapist develop alternative responses to Rosy's anxious thoughts. The therapist encourages Rosy to try these out when she begins to feel worried. Furthermore, the therapist asks Rosy to try to think about why she is worried and put this into words.

Results and Reflection: With the help of her support worker, Rosy is able to "push out" worrying thoughts and engage in the alternative activities planned in the session. By doing this she is able to learn a "process-based" approach to coping with worry, instead of trying to combat individual

worrisome thoughts. Consequently, Rosy is able to see that worry about things does not affect the outcome of future events. Furthermore, her support worker helps Rosy keep a diary regarding why she feels worried.

Further work: The therapist reviews Rosy's record of why she feels worried in order to identify key topics and core beliefs that need to be addressed.

Case Vignette 5

Problem: Ambia started work as a trainee receptionist at a day centre for people with learning disabilities. She was happy with this but very quickly became worried about her performance and increasingly asks her co-workers for reassurance to the degree that this has affected her performance.

Target cognition: I will make mistakes and get fired.

Alternative perspective: If I make a mistake I can talk to my manager and he or she will be able to sort it out for me; I won't be fired for one mistake.

Predictions: The more I talk to my manager the more confident I feel, and will be able to talk to my manager if I am worried about something. If I ask for reassurance when I am anxious, it makes me feel more worried, not less worried.

Experiment: The therapist spends some time finding out what Ambia was worried about in her workplace. Ambia revealed that she was afraid she would make mistakes and get fired. Ambia and the therapist worked out examples of situations that made her feel uncertain. They also put together some flash cards that summarised the bad points about asking her colleagues for constant reassurance.

The therapist then asked Ambia and her support worker to engage in a role-play in which the support worker took on the role of Ambia's supervisor. During the role-play Ambia's therapist encouraged her to discuss her fears about making mistakes in front of her supervisor, and they worked on building up Ambia's confidence so she could rely on her own skills more.

Results: The role-play helped Ambia deal with similar situations in the workplace. Even though she initially felt anxious about not seeking reassurance, the flash cards helped her remember the negative consequences of doing so.

Further work: With the help of her support worker, Ambia was asked to keep positive data logs to help her remember and focus on things that went well during her workday.

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Case Vignette 6

Problem: Margaret believed that nothing and no one could help her overcome her depression. However, her therapist managed to persuade her that it was worth trying to engage in therapy to see if it would help in some way.

Target cognition: Seeking help in talking therapy will not help me overcome depression.

Alternative perspective: If I work with my therapist on my problem, it might help me to feel better.

Prediction: If I record my moods and plan some enjoyable activities, I will start to feel better.

Experiment: Margaret's therapist asked her to rate how depressed she felt on a scale from 0 to 10 (10 being very depressed). The therapist then asked Margaret to talk about her problems for a few moments and rate how depressed she felt after talking. Next the therapist asked Margaret to discuss her participation in a singing/music group in some detail. Finally, the therapist asked Margaret to rate how she felt after talking about the singing group she was a part of.

Results: The therapist was able to show Margaret that she became more depressed when she thought about her problems but became less depressed when she thought about other things. They agreed to carry on with more sessions to see how they could apply similar techniques to other difficulties that Margaret experienced.

Reflection: The therapist then helped Margaret make the mood-thinking link demonstrated by the experiment. By explaining that she had higher mood ratings when she was thinking about things she enjoyed and lower ratings when she was thinking about her problems, the therapist showed Margaret that thinking influenced her feeling.

Further work: Margaret should keep monitoring her moods and building up enjoyable activities.

Case Vignette 7

Problem: Terry believed that he was no good and that he would never achieve anything.

Target cognition: I have a learning disability and I am a failure.

Alternative perspective: I may have a learning disability but that does not make me a failure; there are some things I can do well.

Prediction: Terry could learn to have more compassion for himself with training.

Experiment: The therapist suggested Terry think about what his close friend, Barry, would say about Terry when such negative thoughts came up. Terry was instructed to ask himself, "What would Barry do or say if he were with me now?" The therapist also worked with Terry and his support worker to put together a "Worksheet 8—Thoughts and Feelings Diary" for Terry. Terry

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was instructed to record both good and bad thoughts he had about himself. Both strategies were aimed at helping Terry increase his positive thinking, which would act as a reinforcer.

Further work: It might help to add that Terry was encouraged to think about himself in a more compassionate way by his client and by using flash cards with what Barry would say written on them. It helped to keep a daily positive data log to remind Terry of some of the good things in his life.

Results and reflection: It made Terry feel much better to think about what Barry would say about him, as he knew Barry always found positive things to say. This helped Terry see that treating himself more kindly was having a positive effect on his mood and better understand the negative impact of self-criticism.

Case Vignette 8

Problem: Michael split up with his girlfriend (she left him) and he became increasingly withdrawn and irritable. He did not want to engage in any activities and felt that there was no point in anything.

Target cognition: My life is useless; there is no point in trying to go out and enjoy myself.

Alternative perspective: It is okay to feel sad when a relationship ends; that doesn't mean I will always be sad.

Prediction: I won't be able to enjoy myself because I am too sad.

Experiment: The therapist found out about some social occasions that were coming up and asked Michael what he thought about attending them. Michael was sceptical and said no, but in the end he was persuaded by his support worker to go. Before leaving the session Michael was also asked to predict how much he would enjoy himself at these events by rating them.

Results: He reported back to the therapist that he had enjoyed going out and had met a few people he knew from college. When asked to rate his enjoyment it was higher than he had predicted. He also signed up to go on another outing outside London and started making plans with his support worker for finding day activities.

Typically, the interventions illustrated in this chapter will have a positive impact on people who are depressed. As mentioned before, behavioural experiments are particularly important, and we encourage you to use them throughout the middle sessions of therapy. Doing so may elicit substantial changes in depressed and anxious clients.

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Chapter 9
Additional Skills

At this stage we have reviewed all of the primary interventions you need to undertake with depressed and anxious clients who have learning disabilities. The cognitive and behavioural interventions in the preceding chapters form the core of therapy. However, there are a few additional skills you may want to help clients with learning disabilities acquire. Many people in this population benefit from some assertiveness training and developing social skills. In this chapter we will review these additional skills and provide recommendations about how to integrate them into therapy. You should not spend undue time on these areas, but each is worth addressing with most clients who have learning disabilities.

Assertiveness Training

Many people who have learning disabilities find it difficult to speak up for themselves. Those who do often do so in inappropriate ways. Assertiveness training can benefit many with learning disabilities, and it may help your attempts to mitigate your client's anxiety and depression. Lack of assertiveness can lead to both anxious and depressed states. What's more, learning to be assertive will provide the client the confidence he or she needs to use the skills learned in therapy to better cope with stressful situations.

Any good course in assertiveness starts with an explanation of what assertive communication is, and the difference between it and aggressive or passive communication. As you are likely aware, passive communication is when the person's own feelings and needs are disregarded and the individual says and does things to please others. People who communicate passively typically speak in an apologetic manner, and this often results in others disregarding what the individual is saying. On the other end of the spectrum is aggressive communication. This is when a person does not take into account other peoples' feelings and needs and assumes a stance of dominance. Both of these forms of communication are typically ineffective. Assertiveness lies in the middle of these two extremes and is defined by a firm explanation of personal needs that takes into account other peoples' feelings. The advantage of communicating this way is that you are more likely to get what you need or desire out of a given situation and you come away from these scenarios with a more positive feeling about yourself.

Here is an example of each of these forms of communication based on a common scenario.

Situation: A client goes to a doctor who suggests that he or she start taking medication for a health condition.

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Passive response: The client agrees to take the medication even though he or she does not want to and doesn't understand why it may be needed. The client does not question the doctor's decision, as he or she believes that the doctor always knows best.

Aggressive response: The client gets angry about the prescription, thinks that doctor is useless, and blames him or her for constantly prescribing more medication. The patient walks out of the consultation, slamming the door behind him or her.

Assertive response: The client lets the doctor know that he or she would prefer not to take medicines, explains why, and asks for alternative options. The client and the doctor discuss the situation and the client clearly expresses his or her concerns, worries, and needs while still listening to and considering the doctor's professional medical opinion.

To help the client more fully understand the differences between passive, aggressive, and assertive communication, we recommend you utilise the "Info Sheet 8 - Assertiveness Scale" in Part 3. It is a good visual that helps illustrate that these forms of communication lie on a continuous scale and it helps the client identify that assertiveness lies between being passive and aggressive.

In addition we recommend that you illustrate what each of these forms of communication looks like. You may do this through role-play or example. Show the client what a person looks like with each form of communicating (i.e. what body language they are using) and how they sound (i.e. tone of voice and examples of what may be said).

When undergoing assertiveness training you want to make sure to cover (based on Nezu & Nezu, 1991):

- Voice intensity (loud vs. quiet)
- When to respond (impulsive vs. appropriate)
- Duration of response (focused vs. lengthy)
- Eye contact
- Body language (threatening vs. appropriate)
- Ability to listen (listening to others vs. talking constantly)

For people with learning disabilities, you may also want to spend some time reviewing situations where the client would benefit from assertive communication. For example, find out if he or she is being bullied or teased at times when it is important to express emotions and feelings.

The following worksheets in Part 3 will provide additional useful exercises if you choose to undergo an assertiveness training module with the client:

- Worksheet 22—How to Be More Assertive: Aggressive to Assertive
- Worksheet 23—How to Be More Assertive: Passive to Assertive
- Worksheet 24—How I Can Be More Assertive.

Social Skills Training

Social skills training is particularly helpful for clients who have low self-esteem or are afraid of negative evaluation by themselves or others. For people with learning disabilities, such negative views may be the result of having been teased or bullied in the past. Social skills training can be empowering and help the client overcome these negative perceptions.

Social anxiety arises as people self-monitor their feelings and see themselves as being negatively evaluated by others (Clark & Wells, 1995). Therefore, the first step in social skills training is to break this cycle of perpetual self-evaluation and expected negative evaluation by others. To do this we recommend you help the client focus externally. This will help the person realise that his or her peers do not necessarily see him or her negatively, and they may actually feel compassionate and wish to help.

Once this is achieved you should engage in actively helping the client to improve his or her social skills and encourage the client to engage in social interactions. Social skills training you may wish to focus on could include:

- Role-plays of social situations
- Behavioural experiments that get the client to engage with people around them
- Reframing thoughts so that clients don't automatically assume people perceive them negatively
- Picking up on positive stimuli from the people around them by keep records in positive data logs
- Working to help the client understand that others may be empathic

It is also worthwhile to spend few minutes in the session addressing social skills, reminding the client that it is important to develop friendships. Creating a list of friends is a particularly useful exercise. It may also be useful for you to provide the client with information on community resources (leisure activities, recreational groups, and social groups) and to encourage him or her to utilise them.

The following worksheets in Part 3 will facilitate the acquisition of social skills and encourage the client to develop friendships:

- Worksheet 25—Important People in My Life
- Worksheet 26—Things People Like About Me

This concludes the interventions you will need to employ in the middle sessions of therapy. In the next chapter we will outline the final sessions and explain how to end therapy.

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Chapter 10

The Final Sessions (15–18)

After fourteen sessions using the techniques described in the previous chapters, you should begin to see some improvement in the client's condition. At this point it is time to begin phasing out therapy. The aim of these final sessions is to:

- Summarise the key points covered in the treatment.
- Go over the main skills and strategies covered.
- Bring the treatment to an end.
- Address and put in place measures for relapse prevention.

Each of these items can loosely be separated into issues addressed while ending treatment and what happens after treatment. In this chapter we will present information on each of these phases and help you set the stage for the client to successfully take away what has been learned in therapy.

Ending Treatment: Steps to Take

It is important to prepare the client for the end of the treatment to avoid issues such as feelings of rejection or anxiety. This can be done by bringing the treatment to an end in a gradual and systematic way during the last three or four sessions and reminding the client that the number of sessions was set and agreed upon at the beginning of therapy and that this time has now come to an end.

At this time you will want to review and discuss what the client learned in therapy. Ask the client to list strategies he or she has learned and utilised to cope with depression and anxiety and discuss ways in which the client can continue to use these techniques to manage future situations and events.

You will also want to discuss how the client feels about the treatment process and address any concerns he or she may have. Acknowledging and working through any negative feelings the client may have about ending treatment is especially important. Talking about the client's fears and concerns is useful, as it will help provide a sense of closure, which is very important.

You may also ask the client to reflect on or explore answers to questions such as:

- What do you think you have learned from these sessions?

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- How do you think therapy has helped you?
- Did you enjoy (and what did you enjoy about) the treatment?
- What have you learned about managing depressive thoughts?
- What have you learned about managing anxiety?
- What strategies do you now have to deal with depression and anxiety? How can you use these strategies to better manage depression and anxiety?
- In what ways can you continue to improve your depression and anxiety management skills? Are there specific areas that need improvement?

Therapists testing this protocol found that in some cases proper termination of therapy with clients who have learning disabilities took several sessions. Client with learning disabilities may take additional time to adjust to and cope with feelings of sadness at breaking the therapeutic bond. Termination of therapy should be given longer as needed in each individual case.

After Treatment: Relapse Prevention

Before the client leaves therapy, the two of you, with the help of the support worker, should develop an overall plan for managing the client's anxiety and depression on an ongoing basis. Create a list of problems/situations that the client thinks may cause his or her symptoms to recur. Then develop a list of cognitive and behavioural strategies to deal with them. We also suggest you explain how to recognise and identify early signs of relapse to both the client and the support worker. You may need to review specific parts of this protocol with the client and the support worker to adequately cover this material. Make sure you identify any support services the client can take advantage of and who he or she should get in touch with when the strategies learned in therapy are not adequate.

Before the close of the last session you should provide the client with a handout of the key points, skills, and strategies that were covered in treatment to help him or her remember the information as needed in the future. The following materials (found in Part 3) will be useful:

- Worksheet 27—Things I Learned in CBT
- Worksheet 28—Important Things to Remember from My Work with the Therapist
- Resource 4—CBT Certificate

The general goal should be for the client to leave therapy feeling positive about his or her ability to take what has been learned and use it to successfully cope with depression and anxiety in the future. The client now has the opportunity to become his or her own therapist.

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Part III

Accessible CBT material

- Info sheets
- Resources
- Worksheets

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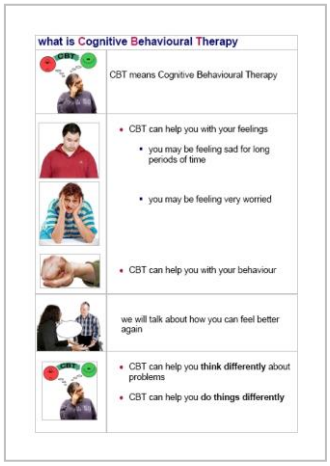
Information Sheets



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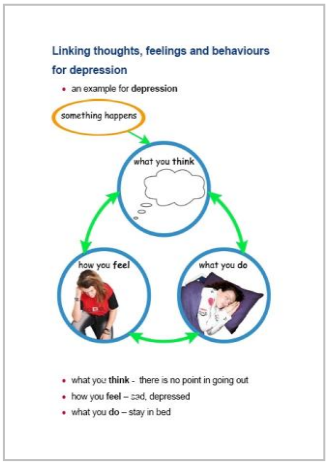

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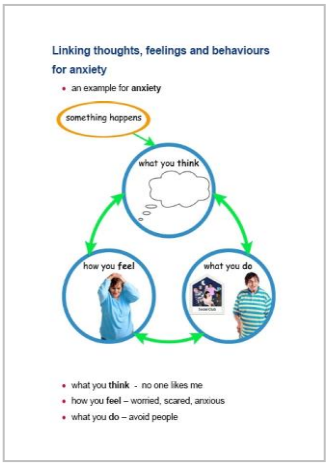

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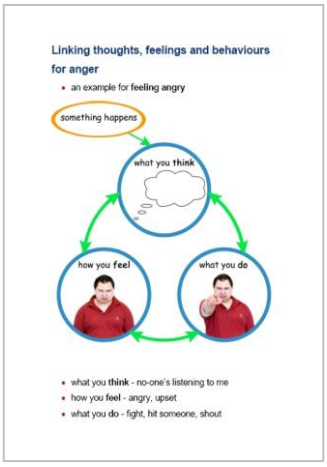

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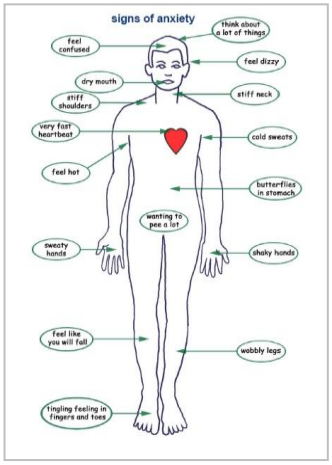

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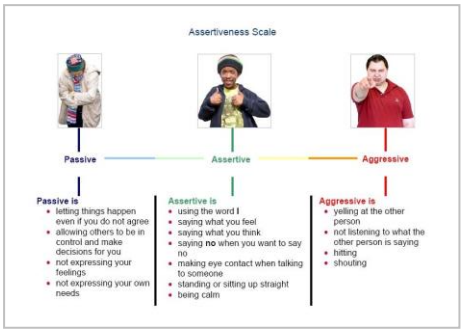

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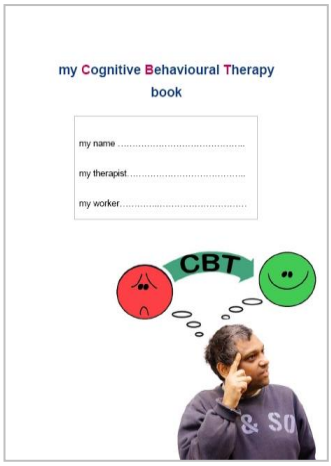

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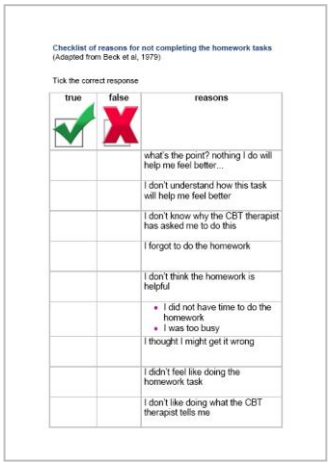

Resource 2

Resource 3

Worksheets

Worksheet 1

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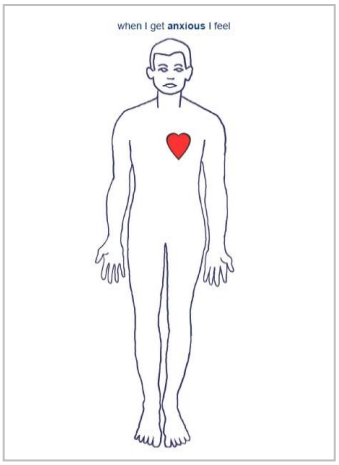
Worksheet 4



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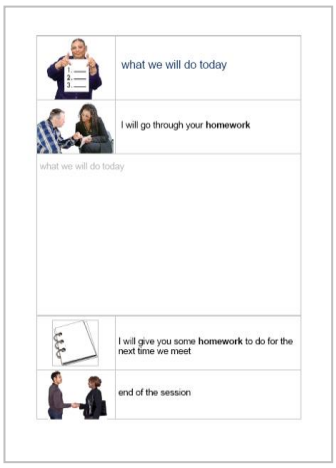

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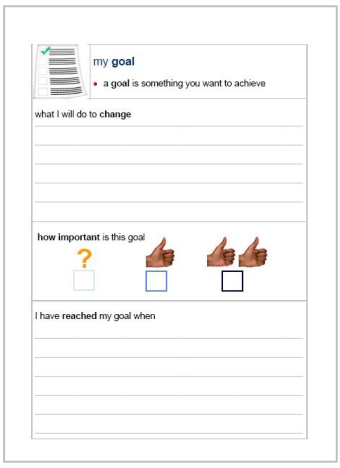

Worksheet 7

Worksheet 8

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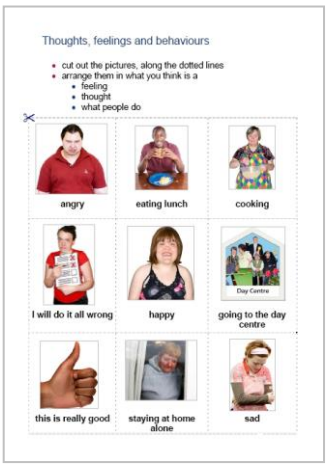

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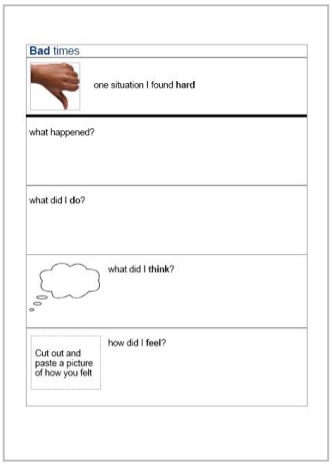

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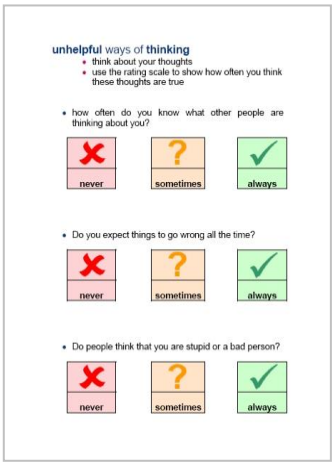

Worksheet 12

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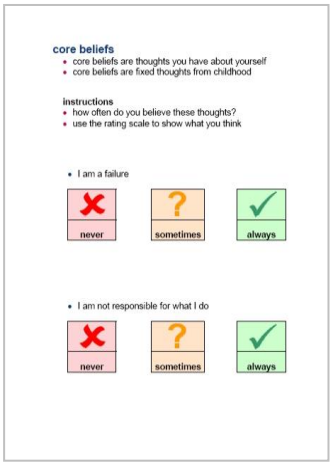

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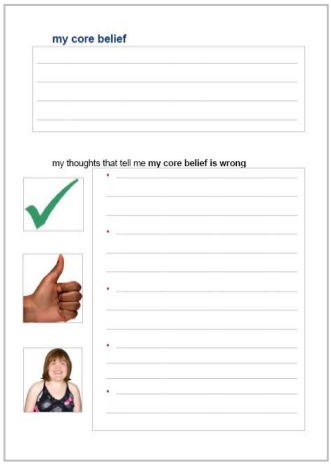

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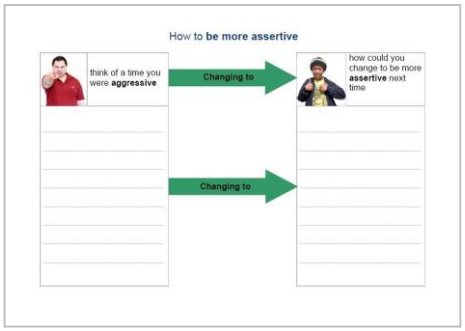

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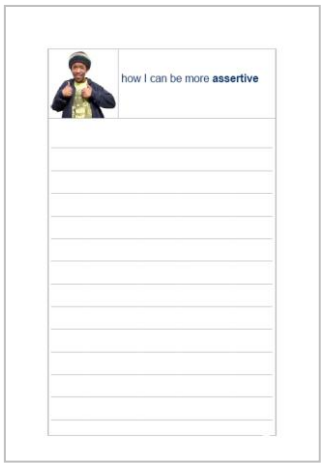

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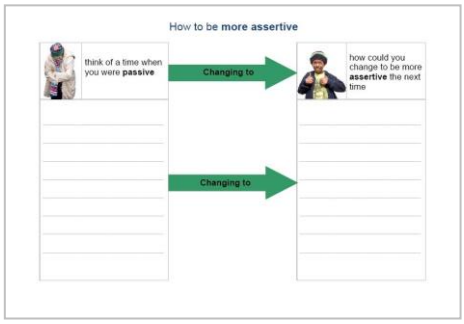

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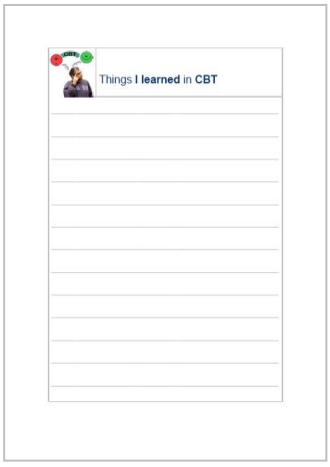

Worksheet 27

Worksheet 28

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A Manual of Cognitive Behaviour Therapy for People with Learning Disabilities and Common Mental Disorders

Therapist Version

This manual provides a step-by-step cognitive behavioural therapy (CBT) approach to treating common mental disorders in people with mild to moderate learning disabilities. The treatment describes a three-part protocol for treating anxiety and/or depression and outlines specific emotional, behavioural, and cognitive techniques that the therapist can use with this population. Case vignettes and detailed examples are used throughout the manual to illustrate the process of therapy, from the introduction of CBT and initial assessments to case conceptualization, treatment planning, intervention, and termination.

The authors also provide expert advice on building collaborative therapeutic relationships and modifying communication in a therapeutic setting to ensure that CBT is accessible to people with mild to moderate learning disabilities. An array of accessible material including worksheets, handouts, therapeutic exercises and homework tasks are provided in the manual to aid/support clients as they progress through therapy.

The manual offers both theoretical and practical guidance for trained CBT therapists in becoming more skilled and confident clinicians in modifying and adapting CBT for people with learning disabilities.

"The CBT manual has been a helpful resource in beginning to bridge some of the communication difficulties and facilitate more effective communication between therapist and service user. I found that the manual was flexible in meeting the needs of the individual clients as it broke down the CBT process i.e. problems, goals, diary keeping, behavioural experiments, positive log etc. It was clear and concise and designed in way that was both easy to understand and visually stimulating." **Lorna Vincent, CBT therapist**.

"I believe that CBT is a good and user friendly way to use as a tradition. The service users were able to work in all 3 systems and the manual is an excellent resource both for the therapist and the client. It provides a visual way of communicating, which is valuable when using guided discovery, for example." **Matt Broadway-Horner, CBT therapist.**

"*The therapist showed me different ways of dealing with my emotions. The therapy was really good because I was able to deal with things that have happened to me and try to build up my confidence which I never had before."* **Participant 09, Randomised Controlled Trial.**

"My advice to people, a [CBT] therapist like this one is the best one, because [its] having someone totally different, sort of teaching you a different way of how to go about life." **Participant 10, Randomised Controlled Trial.**

"I would recommend the therapy because first definitely I could see a lot more confidence in [the client]." **Carer, Randomised Controlled Trial.**

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