

## “Talking” psychological therapies with people who have intellectual disabilities

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RADiANT – 30 July 2021

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**NHS**  
Coventry and  
Warwickshire Partnership  
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## Mental Health

- “Mental health is a state of wellbeing, in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.”

- World Health Organization, 2004



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## Mental Disorders

- “Mental disorders represent disturbances to a person’s mental health that are often characterized by some combination of troubled thoughts, emotions, behaviour and relationships with others. Examples of mental disorders include depression, anxiety disorder, conduct disorder, bipolar disorder and psychosis.”

- World Health Organization, 2004



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Figure 1 Contributing factors to mental health and well-being



World Health Organization, 2012

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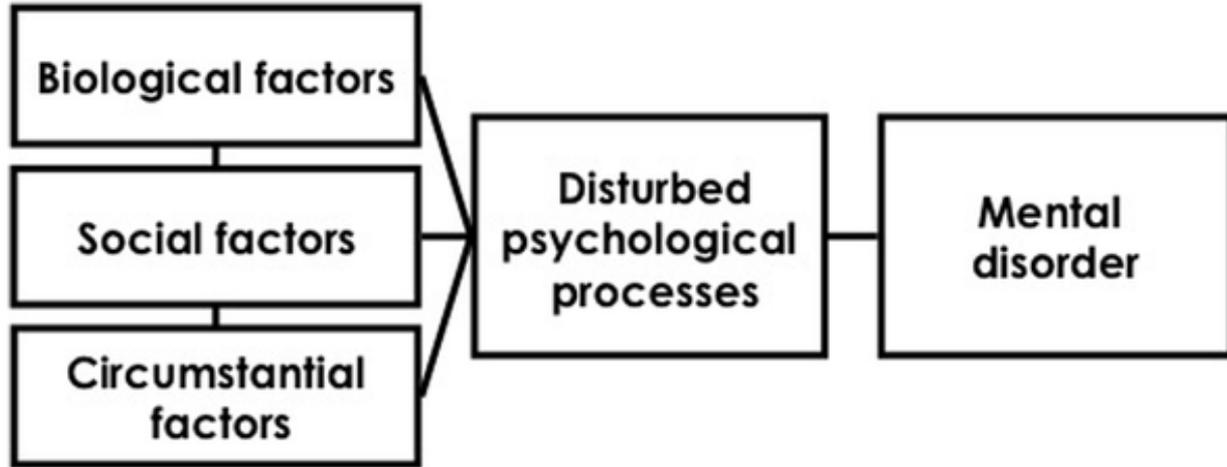


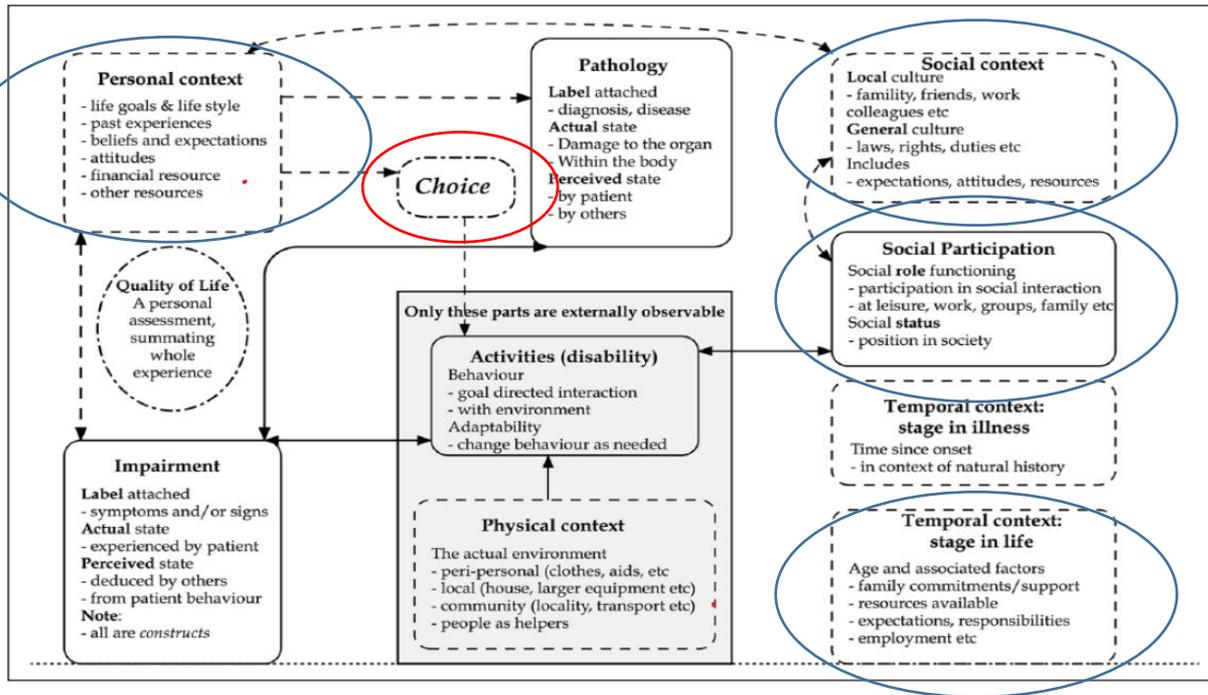
**Table 1** Mental health determinants

<i>Level</i>	<i>Adverse factors</i>		<i>Protective factors</i>
Individual attributes	Low self-esteem	↔	Self-esteem, confidence
	Cognitive/emotional immaturity	↔	Ability to solve problems and manage stress or adversity
	Difficulties in communicating	↔	Communication skills
	Medical illness, substance use	↔	Physical health, fitness
Social circumstances	Loneliness, bereavement	↔	Social support of family & friends
	Neglect, family conflict	↔	Good parenting / family interaction
	Exposure to violence/abuse	↔	Physical security and safety
	Low income and poverty	↔	Economic security
	Difficulties or failure at school	↔	Scholastic achievement
	Work stress, unemployment	↔	Satisfaction and success at work
Environmental factors	Poor access to basic services	↔	Equality of access to basic services
	Injustice and discrimination	↔	Social justice, tolerance, integration
	Social and gender inequalities	↔	Social and gender equality
	Exposure to war or disaster	↔	Physical security and safety



World Health Organization, 2012





Wade and Halligan, 2017

**Figure 2.** Holistic, biopsychosocial model of illness: components of importance.

Comment on figure:

**Text** = one of four levels concerning the person.

**Text** = one of four contextual domains.

**Text** = a construct outside model-not accessible.

**Text** = direct influences. Note that they are two-way.

**Text** = indirect influences.

Note:

1. Pathology, impairment, personal context, and choice are all within the person and are not directly observable.
2. Activities and physical context are both directly observable.
3. Social participation and social context concern meaning and require interpretation or inference of observed actions or situations.
4. Temporal context is a given, but is often overlooked.
5. Potentially there are relationships and influences between all variables, and many can be reciprocal.



## Mental Illness

- Rates of mental illness are higher for people with intellectual disabilities
  - 36% of kids with intellectual disabilities had a mental illness compared to 8% of those without an intellectual disability (Emerson and Hatton, 2007).
  - 15.7 to 40.9% of adults with intellectual disabilities have been estimated to have a mental illness (Cooper et al., 2018).
  - Global mental illness for people with intellectual disabilities has been estimated to range from 16 to 54% (Rojahn and Meier, 2009).

## Therapy

- Treatment fidelity or integrity (Fairburn & Cooper, 2011)
  - this is often seen as:
    - Treatment adherence – using the correct therapy procedures
    - Treatment competence – how well the procedures are implemented
    - Treatment differentiation – not including extraneous or proscribed elements

## Therapy

- Therapist competence (Fairburn & Cooper, 2011)
  - Do therapists have the knowledge and skills needed?  
In this context:
    - Knowledge and skills about therapy
    - Knowledge and skills about intellectual and other developmental disabilities
    - Knowledge and skills about mental health presentations

## Therapist Factors

- Variability in outcome due to therapists has been estimated to be up to 10%.
- Therapists who are rated as having better interpersonal behaviours have better outcomes (Schottke et al. 2017)
- Therapists who engage in self-practice of CBT may have greater technical and interpersonal skills (Davis et al. 2015)
- In a trial comparing CBT and IPT for depression, therapists accounted for 1 to 12% in outcome. The difference between CBT and IPT disappeared when this was taken into account (Kim et al. 2007)

## Therapist Factors

- Empathy
- Skilfulness
- Alliance
- Ability to deal with alliance problems
- Positive Regard
- Warmth
- Genuineness
- Persuasiveness
- Verbal ability
- Ability to enhance hope or expectations

Anderson et al. (2016)



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## Can people with intellectual disabilities take part successfully in talking therapies?

- Historically, an assumption they cannot (Hurley et al. 1996).
  - Problems with cognitive flexibility and learning.
  - Difficulties with communication.
  - Unable to understand the models underpinning cognitive behavioural therapy.



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## What are some of the things you need to understand in order to take part in cognitive behavioural therapy?

- Communicate.
- Form a therapeutic relationship or alliance.
- Motivation to change.
- Flexibility of thought.
- Perspective taking and mentalisation.
- Understanding the cognitive model
  - Recognise a thought, feeling or behaviour.
  - Understand the difference between thoughts, feelings and behaviours.
  - Understand the interaction between thoughts, feelings and behaviours – cognitive mediation.
  - Accessibility of automatic thoughts.
- Record experiences.
- Learn.



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## Short-term Cognitive Therapy Rating Scale

- Accessibility of automatic thoughts
  - Awareness and differentiation of emotion
  - Personal responsibility for change
  - Buy in with the cognitive rationale
  - Alliance within and outside of therapy
  - Problem chronicity
  - Psychological processes that reduce anxiety and promote a positive self-view
  - Capacity to work in-depth on a particular issue
  - Whether the person believes that CBT will be helpful
- There is evidence that scores on this scale relate to treatment outcome (Safran et al. 1993; Myhr et al. 2007; Renaud et al. 2013; 2014).



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## Short-term Cognitive Therapy Rating Scale

- Comprises two-factors:
  - Capacity for participation in cognitive-behaviour therapy
    - Psychological processes that reduce anxiety and promote a positive self-view
    - Accessibility of automatic thoughts
    - Awareness and differentiation of emotions
    - Capacity to work in-depth on a particular issue
  - Attitudes relevant to the process of cognitive-behaviour therapy
    - Whether the person believes that CBT will be helpful
    - Personal responsibility for change
    - Buy in with the cognitive model
    - Alliance out of session
- Renaud et al. (2014) demonstrated that capacity for participation in cognitive-behaviour therapy predicted treatment outcome in a sample of 256 patients, rather than Attitudes



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## Challenges when working with people with intellectual disabilities

- Initial problems may arise in the assessment phase when mental health problems are not recognised as distinct from the IDs (Reiss, Levitan, & Szyszko, 1982) or misdiagnosed as challenging behaviour (Azam, Sinai, & Hassiotis, 2009).
- For those who continue to receive psychological therapy, being uninformed about the grounds for their referral may negatively impact upon their motivation to engage in therapy; hence, affecting treatment outcomes (Willner, 2006).



## Challenges when working with people with intellectual disabilities

- Likewise, difficulties in establishing a therapeutic alliance may lead to clients engaging in a dependency-inducing relationship rather than taking ownership of the therapeutic process (Brechin & Swain, 1988; Jahoda et al., 2009).
- Furthermore, the perceived level of cognitive functioning may pose an additional barrier when therapists are more likely to use the cognitive aspects of CBT with more abled clients only (Willner, 2006).



## What do we know about whether people with intellectual disabilities can take part in therapy?

- Ability to link situations and feelings is associated with verbal ability (Reed & Clements, 1989; Joyce et al. 2006; Oathamshaw & Haddock, 2006).
- People with IDs find it difficult to identify thoughts, feelings and behaviours; generally, feelings/emotions are easier (Oathamsaw & Haddock, 2006; Quakley et al. 2004).
- Cognitive mediation – much more difficult for people with IDs were able to identify a mediating belief (Dagnan & Chadwick, 1997). When the task is incongruent, even more difficult (Dagnan et al. 2000; Joyce et al. 2006).



## What do we know about whether people with intellectual disabilities can take part in therapy?

- Stott et al. (2017) reviewed the literature about measuring readiness to take part in cognitive behaviour therapy for people with intellectual disabilities.
- They included 12 studies. There is a lack of well developed valid and reliable tools to assess readiness to take part in cognitive behaviour therapy for people with intellectual disabilities.
- While it seems sensible, there really isn't that much evidence that specific training in skills leads to improved outcomes.

## Skills training

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British Journal of  
Clinical Psychology



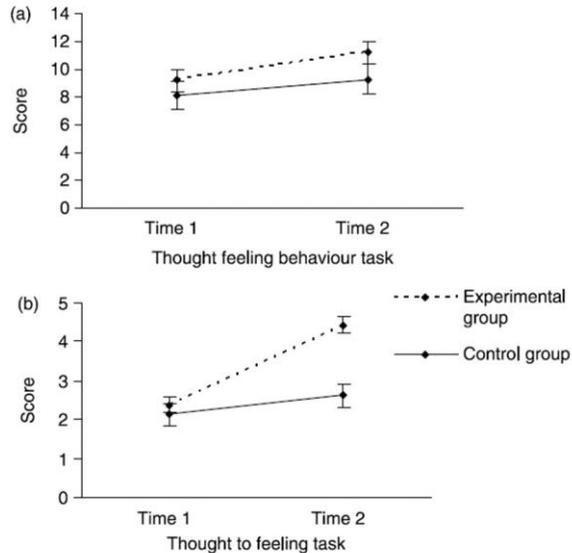
### Does training improve understanding of core concepts in cognitive behaviour therapy by people with intellectual disabilities? A randomized experiment

Melanie Bruce , Suzanne Collins , Peter Langdon , Stephanie Powlitch , Shirley Reynolds  

First published: 24 December 2010 | <https://doi.org/10.1348/014466509X416149> | Citations: 17



## Skills training



- 34 were randomised to relaxation or taught about identifying thoughts, feelings and conditions and took part in a discussion about specific situations where a feeling would be triggered by a thought.

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# Skills training



Behaviour Research and Therapy  
Volume 71, August 2015, Pages 10-19



Behaviour Research and Therapy  
Volume 76, January 2016, Pages 13-23



Can a computerised training paradigm assist people with intellectual disabilities to learn cognitive mediation skills? A randomised experiment

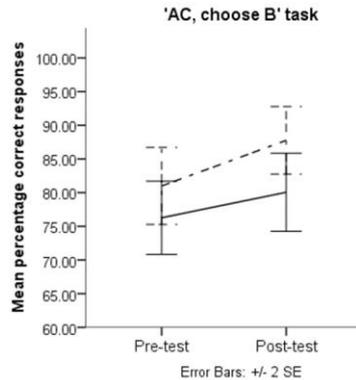
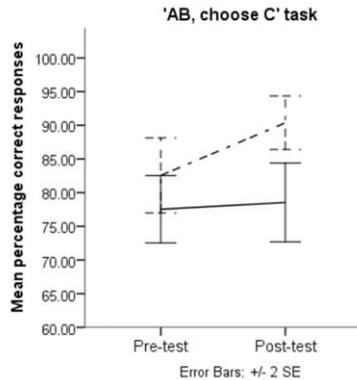
Leen Vereenooghe <sup>a</sup>, Shirley Reynolds <sup>b</sup>, Lina Gega <sup>a</sup>, Peter E. Langdon <sup>c, d, e</sup>

Using computers to teach people with intellectual disabilities to perform some of the tasks used within cognitive behavioural therapy: A randomised experiment

Leen Vereenooghe <sup>a</sup>, Lina Gega <sup>b</sup>, Shirley Reynolds <sup>c</sup>, Peter E. Langdon <sup>d, e, f</sup>



## Skills training



65 randomised to computerised training or an attention control condition. Researchers were blind to allocation.

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## Skills training

### *BTFQ Total*

Intercept	21.152 (6.345)	-	3.334**	
Pre-test BTFQ	.737 (.112)	.759	6.577***	
IQ	-5.852 (3.949)	-.169	-1.482	.543
Intervention	7.589 (3.635)	.219	2.088*	.580

*Notes.* IQ, split at mean of 53.10 and categorised as low or high; \*,  $p < .05$ ; \*\*,  $p < .01$ ; \*\*\*,  $p < .001$ ;  $R^2$ , applies to regression model that includes this predictor and all of the above.

- 55 randomised to computerised training or an attention control condition. Researchers were blind to allocation.
- Specific training in linking thoughts, feelings, and behaviours.



# Skills training

Research in Developmental Disabilities 34 (2013) 4085–4102



ELSEVIER

Contents lists available at [ScienceDirect](#)

## Research in Developmental Disabilities



Review article

### Psychological therapies for people with intellectual disabilities: A systematic review and meta-analysis

Leen Vereenooghe<sup>a</sup>, Peter E. Langdon<sup>a,b,\*</sup>

<sup>a</sup> Department of Psychological Sciences, Norwich Medical School, University of East Anglia, Norwich, United Kingdom

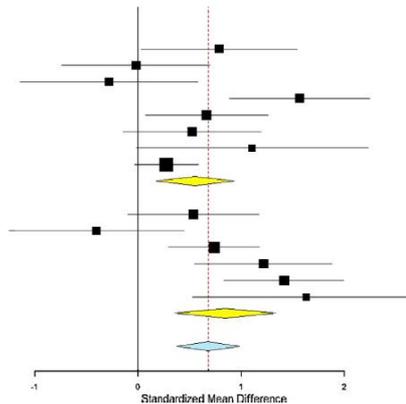
<sup>b</sup> Broadland Clinic, Hertfordshire Partnership University NHS Foundation Trust—Norfolk, United Kingdom



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# Skills training

Studies	Estimate (95% C.I.)
Haglilassis et al. (2005)	0.787 (0.031, 1.543)
Hassiotis et al. (in press)	-0.021 (-0.736, 0.695)
Matson & Senatore (1981)	-0.282 (-1.142, 0.579)
McCabe et al. (2006)	1.568 (0.885, 2.250)
McGillivray et al. (2008)	0.666 (0.073, 1.260)
Taylor et al. (2005)	0.527 (-0.141, 1.196)
Willner et al. (2002)	1.108 (-0.017, 2.233)
Willner et al. (2013)	0.275 (-0.035, 0.585)
<b>Subgroup Randomised (I<sup>2</sup>=62%, P=0.010)</b>	<b>0.555 (0.179, 0.932)</b>
Lindsay et al. (2004)	0.537 (-0.097, 1.172)
McGaw et al. (2002)	-0.401 (-1.248, 0.447)
Rose et al. (2005)	0.738 (0.296, 1.180)
Rose et al. (2006)	1.215 (0.549, 1.882)
Rose et al. (2009)	1.415 (0.833, 1.997)
Taylor et al. (2004)	1.630 (0.531, 2.729)
<b>Subgroup Non-randomised (I<sup>2</sup>=69%, P=0.006)</b>	<b>0.846 (0.355, 1.337)</b>
<b>Overall (I<sup>2</sup>=67%, P=0.000)</b>	<b>0.682 (0.379, 0.985)</b>



Study or Subgroup	Control			Experimental			Weight	Std. Mean Difference IV, Random, 95% CI	Std. Mean Difference IV, Random, 95% CI
	Mean	SD	Total	Mean	SD	Total			
<b>2.1.1 Randomised</b>									
Cooney et al. (2017)	22.39	11.45	23	17.17	9.1	24	6.3%	0.50 [-0.08, 1.08]	
Haglilassis et al. (2005)	97.36	21.27	14	81.13	18.85	15	5.5%	0.79 [0.03, 1.55]	
Hartley et al. (2015)	35.38	3.31	8	22.5	2.34	16	2.6%	4.63 [2.96, 6.29]	
Hassiotis et al. (2013)	54.93	11.48	15	54.67	13.11	15	5.7%	0.02 [-0.70, 0.74]	
Klein et al. (2018)	2.61	0.84	33	2.78	0.99	30	6.7%	-0.18 [-0.68, 0.31]	
Lindsay et al. (2015)	1.38	0.74	12	0.55	0.33	12	4.9%	1.40 [0.49, 2.31]	
Maston & Senatore. (1981)	125.3	27.2	10	131.7	13.5	10	5.0%	-0.29 [-1.17, 0.60]	
McCabe et al. (2006)	12.8	4.23	15	5.71	4.54	34	5.8%	1.57 [0.88, 2.26]	
McGillivray et al. (2008)	16.15	13.81	27	8.45	6.69	20	6.2%	0.67 [0.07, 1.26]	
Taylor et al. (2005)	70.7	16.29	20	62	15.92	16	5.9%	0.53 [-0.14, 1.20]	
Willner et al. (2002)	2.1	0.45	7	1.28	0.87	7	4.0%	1.11 [-0.05, 2.26]	
Willner et al. (2013b)	47.8	14.81	85	41.5	29.15	77	7.3%	0.28 [-0.03, 0.59]	
<b>Subtotal (95% CI)</b>			<b>269</b>			<b>276</b>	<b>65.8%</b>	<b>0.72 [0.30, 1.14]</b>	
Heterogeneity: Tau <sup>2</sup> = 0.40; Chi <sup>2</sup> = 52.57, df = 11 (P < 0.00001); I <sup>2</sup> = 79%									
Test for overall effect: Z = 3.33 (P = 0.0009) <b>g = 0.53; 95% CI [0.20, 0.85], z = 3.18, p = 0.001</b>									
<b>2.1.2 Non-randomised</b>									
Lindsay et al. (2004)	28.5	8.83	14	22.03	12.86	33	6.1%	0.54 [-0.10, 1.17]	
McGaw et al. (2002)	5.12	1.01	12	5.58	1.21	10	5.1%	-0.40 [-1.25, 0.45]	
Rose et al. (2005)	102.9	12.7	36	93.7	12.1	50	6.9%	0.74 [0.30, 1.18]	
Rose et al. (2008)	101.8	14.01	21	84.15	14.48	20	5.9%	1.22 [0.54, 1.89]	
Rose et al. (2009)	101.8	9.8	21	84.97	12.61	41	6.3%	1.41 [0.83, 2.00]	
Taylor et al. (2004)	26	3.17	8	17.56	6.04	9	4.0%	1.63 [0.49, 2.77]	
<b>Subtotal (95% CI)</b>			<b>112</b>			<b>163</b>	<b>34.2%</b>	<b>0.84 [0.35, 1.33]</b>	
Heterogeneity: Tau <sup>2</sup> = 0.25; Chi <sup>2</sup> = 16.01, df = 5 (P = 0.007); I <sup>2</sup> = 69%									
Test for overall effect: Z = 3.36 (P = 0.0008)									
<b>Total (95% CI)</b>			<b>381</b>			<b>439</b>	<b>100.0%</b>	<b>0.75 [0.43, 1.08]</b>	
Heterogeneity: Tau <sup>2</sup> = 0.35; Chi <sup>2</sup> = 73.99, df = 17 (P < 0.00001); I <sup>2</sup> = 77%									
Test for overall effect: Z = 4.53 (P < 0.00001)									
Test for subgroup differences: Chi <sup>2</sup> = 0.14, df = 1 (P = 0.71), I <sup>2</sup> = 0%									

**g = 0.64; 95% CI [0.36, 0.92], z = 4.50, p < 0.00001**

Fig. 2. Forest plot of estimated treatment effect of psychological therapy for people with IDs. Horizontal lines represent the confidence standardised mean difference (black squares) of each study. The size of the black square is indicative of the study's sample size. The cent indicates the effect size for that subgroup analysis, while the width of the diamond covers the 95% CI. The vertical dashed line and bottom the overall size and its corresponding 95% CI.

# Psychological Therapies

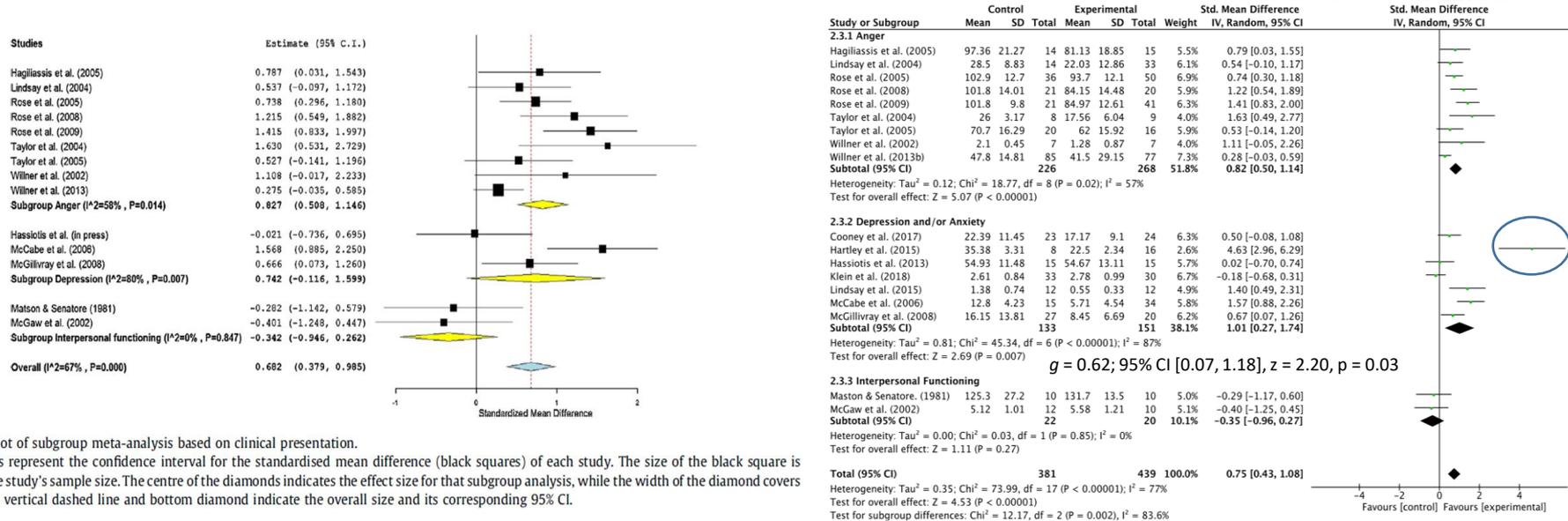


Fig. 4. Forest plot of subgroup meta-analysis based on clinical presentation. Horizontal lines represent the confidence interval for the standardised mean difference (black squares) of each study. The size of the black square is indicative of the study's sample size. The centre of the diamonds indicates the effect size for that subgroup analysis, while the width of the diamond covers the 95% CI. The vertical dashed line and bottom diamond indicate the overall size and its corresponding 95% CI.

**g = 0.64; 95% CI [0.36, 0.92], z = 4.50, p < 0.00001**



## Summary

- People with IDs may find some aspects of CBT difficult.
- This relates to cognitive ability, including communication.
- It may be possible to remedy aspects of these difficulties; however, we still know very little.
- Talking psychological therapies appears to be associated with a moderate effect size.
- People make adaptations, but again, we know very little about effectiveness - session length, inclusion of carers, inclusion of illustrations, increased number of sessions, simplification of concepts and language, changing content etc.

## What next?

- Do we need more “social” in therapy?
- Should we focus increasingly on behavioural psychotherapies?
- We need to know what adaptations to therapy work.



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- 161 adults with intellectual disabilities were randomised to Guided Self-Help or Behavioural Activation.
- No difference between the groups at 12-months.
- Within group improvement was significant for both groups.
  - Behavioural Activation: 4.2-point decrease on the GDS-LD
  - Guided Self-Help: 4.5-point decrease on the GDS-LD

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**Comparison of behavioural activation with guided self-help for treatment of depression in adults with intellectual disabilities: a randomised controlled trial**

*Andrew Jahoda, Richard Hastings, Chris Hutton, Sally-Ann Cooper, Dave Dagnan, Ruiqi Zhang, Alex McConnachie, Nicola McMeekin, Kim Appleton, Rob Jones, Katie Scott, Lauren Fulton, Rosie Knight, Dawn Knowles, Chris Williams, Andrew Briggs, Ken MacMahon, Helen Lynn, Ian Smith, Gail Thomas, Craig Melville*





**BEAMS-ID**  
Behavioural Interventions to Treat Anxiety in  
Adults with Autism and Moderate to Severe  
Intellectual Disabilities



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## What next?

- Mental illness is a public health priority for people with intellectual disabilities? Should we be working in a way to prevent the development of mental illness? Do we need to intervene more at the societal level?
- What about technology?

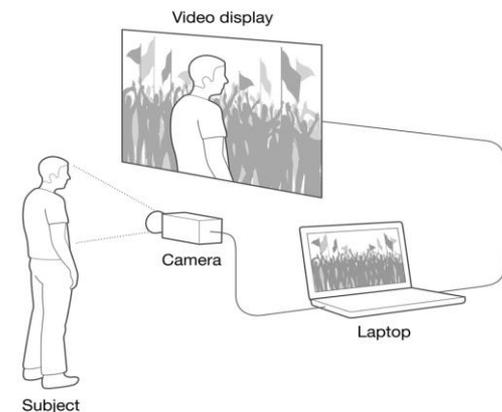


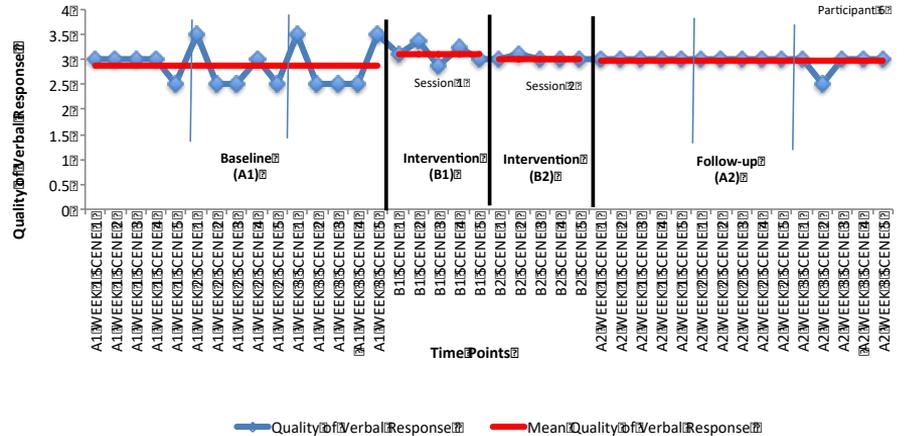
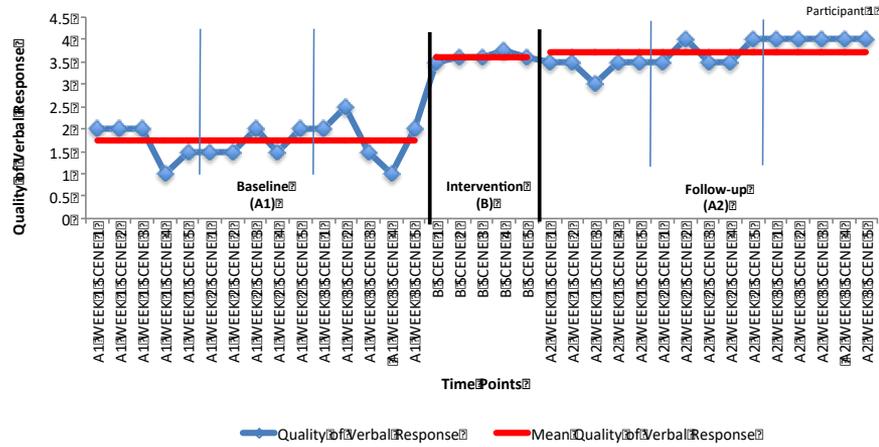
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2 x Participants	A <sub>1</sub> 1 week	B 1 x dose	A <sub>2</sub> 1 week
2 x Participants	A <sub>1</sub> 1 week	B 2 x doses	A <sub>2</sub> 1 week
2 x Participants	A <sub>1</sub> 2 weeks	B 1 x dose	A <sub>2</sub> 2 weeks
2 x Participants	A <sub>1</sub> 2 weeks	B 2 x doses	A <sub>2</sub> 2 weeks
2 x Participants	A <sub>1</sub> 3 weeks	B 1 x dose	A <sub>2</sub> 3 weeks
2 x Participants	A <sub>1</sub> 3 weeks	B 2 x doses	A <sub>2</sub> 3 weeks

*Note.* A<sub>1</sub> = baseline assessment phase; B = intervention phase; 1 x dose = one session of participation in 8 VI videos; 2 x doses = 2 sessions of participation with the same 8 VI videos from previous session; A<sub>2</sub> = follow-up phase; shaded area = different durations of baseline phases.





For all 12 participants:  $z = -2.35, p = .02; d = .89$



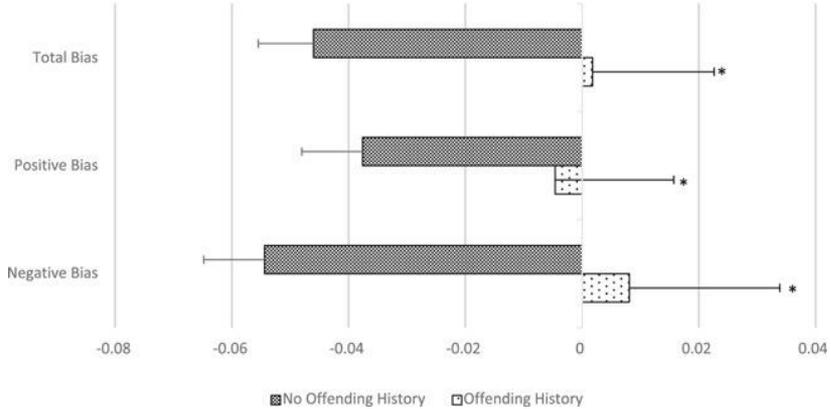
# AGGRESSIVE BEHAVIOR

RESEARCH ARTICLE |  Open Access |  

**Attentional bias toward negative and positive pictorial stimuli and its relationship with distorted cognitions, empathy, and moral reasoning among men with intellectual disabilities who have committed crimes**

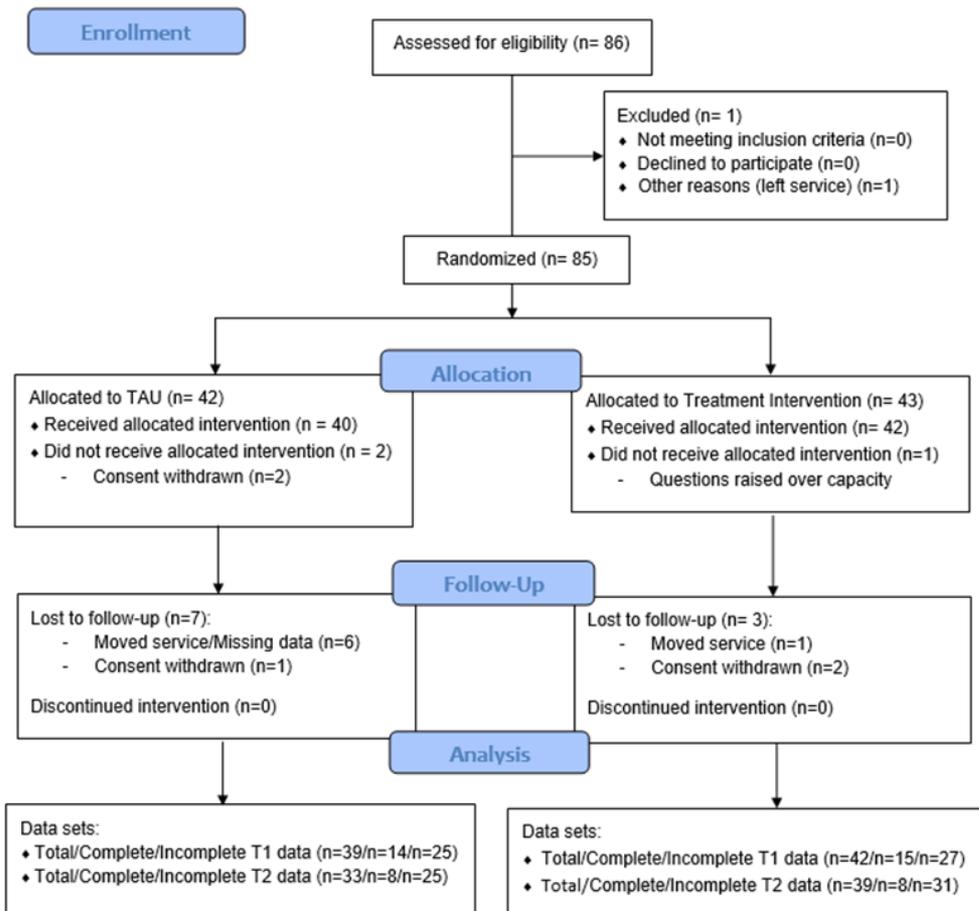
Susan A. Sadek, Matthew R. Daniel, Peter E. Langdon 

First published: 17 June 2020 | <https://doi.org/10.1002/ab.21908> | Citations: 1



## CONSORT 2010 Flow Diagram

### EQUIP



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**JARID**

Journal of Applied Research in Intellectual Disabilities

Journal of Applied Research in Intellectual Disabilities 2013, 26, 167-180

**bild**

Published for the British Institute of Learning Disabilities

## An Evaluation of the EQUIP Treatment Programme with Men who have Intellectual or Other Developmental Disabilities

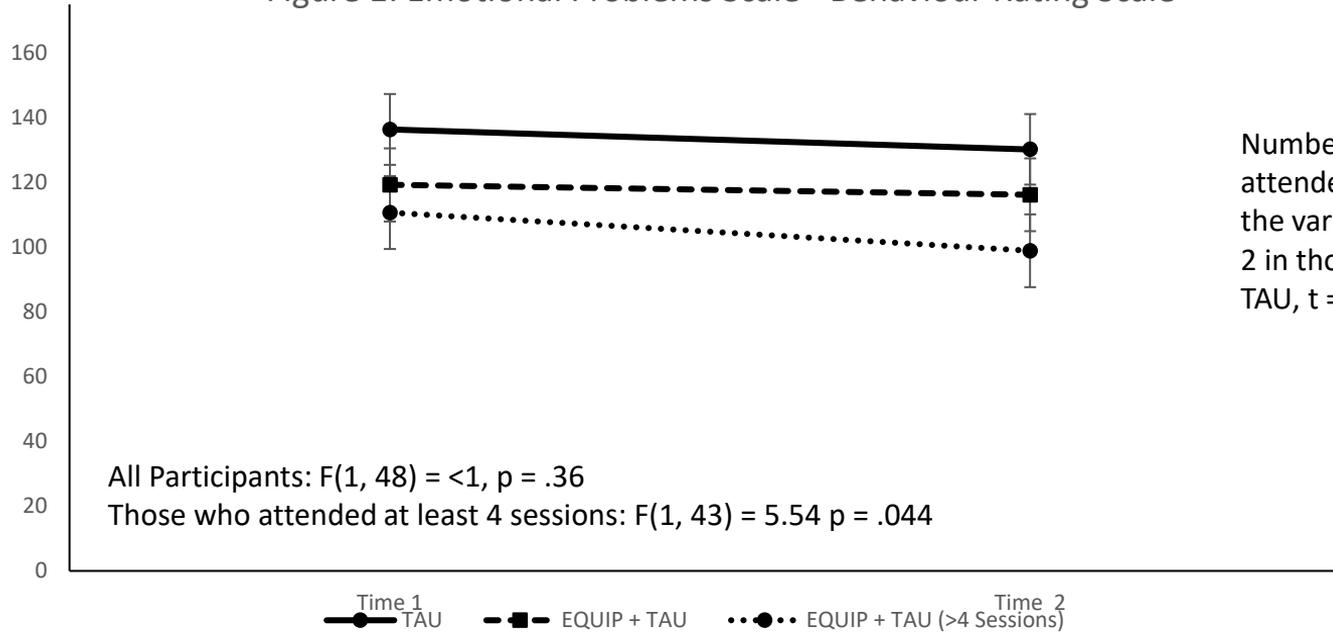
Peter E. Langdon\*<sup>†</sup>, Glynis H. Murphy<sup>†</sup>, Isabel C.H. Clare<sup>§</sup>%,\*\*\*, Emma J. Palmer<sup>††</sup> and Joanna Rees<sup>††</sup>

\*Department of Psychological Sciences, Norwich Medical School, University of East Anglia, East Anglia, UK; <sup>†</sup>Broadland Clinic, Hertfordshire Partnership NHS Foundation Trust, Norfolk, UK; <sup>‡</sup>Tizard Centre, University of Kent, Kent, UK; <sup>§</sup>Department of Psychiatry, University of Cambridge, Cambridge, UK; <sup>¶</sup>Cambridgeshire & Peterborough NHS Foundation Trust, Cambridge, UK; <sup>\*\*</sup>NIHR Collaborations for Applied Health Research and Care, Cambridge, UK; <sup>††</sup>School of Psychology, University of Leicester, Leicester, UK; <sup>‡‡</sup>Norfolk and Suffolk NHS Foundation Trust, Norwich, UK





Figure 1: Emotional Problems Scale - Behaviour Rating Scale



Number of EQUIP Sessions attended accounted for 13.1% of the variance in the EPS-BRS at Time 2 in those allocated to EQUIP + TAU,  $t = 2.19, p = .036$ .

