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The use of cognitive behavioural therapy to treat depression in people with intellectual disabilities: a systematic review – commentary

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### Abstract

**Purpose** To provide a commentary on “The use of cognitive behaviour therapy to treat depression in people with learning disabilities: a systematic review”.

**Design/Methodology/Approach** Drawing on the literature, as well as both clinical and research experience, some reasons are outlined for the lack of attention given to psychological therapies to treat depression amongst people with intellectual disabilities.

**Findings** More research is needed, but existing evidence is promising regarding the effectiveness of adapted cognitive behaviour therapy for depression amongst people with intellectual disabilities.

**Originality/Value** The commentary draws attention to the scope for developing a range of effective cognitive, behavioural and cognitive-behavioural treatments.

**Key words:** Learning disability, intellectual disability, cognitive behaviour therapy, depression, behavioural activation, meta-analysis

In 2013, we undertook a meta-analysis of psychological therapies, concluding that cognitive behavioural therapy appeared to be efficacious when used with people who have intellectual disabilities (IDs), reporting an overall effect size,  $g = .682$  (Vereenooghe & Langdon, 2013). The majority of studies included within our meta-analysis aimed to provide cognitive behavioural therapy for anger and aggression, while only three studies (Hassiotis et al., 2013; McCabe, McGillivray, & Newton, 2006; McGillivray, Lau, Cummins, & Davey, 2009) aimed to treat depression, with an associated effect size calculation of,  $g = .742$ .

Historically, “talking therapies” have often been seen as inappropriate for people with IDs, with many making reference to Bender (1993), who wrote about people with IDs being viewed with “therapeutic disdain”. Such a stigmatising view is exceptionally inappropriate, and while there has been a slow increase in the number of studies examining whether cognitive behavioural therapy is

beneficial for people with IDs, we still do have some way to go before we have a robust evidence base.

There are a variety of reasons why psychological therapy research with people who have IDs has lagged behind similar research with people who do not have IDs. Many may still think that “talking” psychological therapies are unlikely to benefit some people with IDs because they may have difficulty understanding the concepts taught. In order to improve accessibility, adaptations are often made, including the simplification of therapeutic methods, including the use of pictures, symbols, easier to read homework tasks, along with the use of both directive and flexible methods (Hamelin, Travis, & Sturmey, 2013; Hurley, Tomasulo, & Pfadt, 1998; Prout & Nowak-Drabik, 2003; Stenfert-Kroese, Dagnan, & Loumidis, 1997; Whitehouse, Tudway, Look, & Kroese, 2006). However, we still know little about whether many of these adaptations lead to improved outcomes for people with IDs, and as pointed out by Vereenoghe and Langdon (2013), many of these adaptations are idiographic, but nevertheless, formulation driven.

Additionally, there has been a lack of investment in funding for psychological therapy trials involving people with IDs, although this has been improving. Related to this, people with IDs are often explicitly excluded from clinical trials of psychological therapies because assumptions are made that the interventions are inappropriate, ignoring whether it may be possible to make some reasonable adjustments to improve accessibly, and ignoring opportunities to investigate these adaptations and how they relate to treatment outcome. Other issues need to be considered when recruiting people with IDs into clinical trials, including the role of “gatekeepers”. Carers often make the initial decision whether someone with IDs can be approached and invited to take part in research, and occasionally, this may mean that some people may not be afforded the opportunity to take part in clinical research. Issues about whether people with IDs understand the consent and randomisation process are highly relevant, often leading to the exclusion of people who lack capacity from psychological therapy trials. The Mental Capacity Act (2005), which would apply to psychological therapies trials, rather than a clinical trial of an investigational medicinal product, states that research involving those who do not have capacity to consent must be connected with an impairing condition affecting research participants who are unable to consent, or with the treatment of the condition, and researchers must consider whether the study could be carried out effectively with only those who are able to give consent. It is important to ask whether researchers in England and Wales are explicitly excluding people who do not have capacity to consent from research in order to avoid the regulations set out in the Mental Capacity Act (2005) because of the perceived burden? Inadvertently, are these regulations leading to the exclusion of people with IDs from clinical trials of psychological therapies?

While there are a variety of reasons why psychological therapy research with people who have IDs has lagged behind, more recently, there has been a shift to consider whether psychological therapies that rely less on cognitive strategies are likely to be beneficial for the treatment of depression amongst people with IDs. There is robust evidence that behavioural activation is effective in the treatment of depression, with effect sizes ranging from .70 to .87 (Cuijpers, van Straten, & Warmerdam, 2007; Ekers, Richards, & Gilbody, 2008; Ekers et al., 2014; Mazzucchelli, Kane, & Rees, 2009), and this is not dissimilar from effect sizes for cognitive-behavioural therapy. Behavioural activation is a psychological treatment for depression that involves identifying a client’s values and goals and increasing meaningful activity related to these values and goals, which may encompass goals about education, employment, relationships, hobbies and leisure. The theoretical basis of behavioural activation is that a lack of activity and withdrawal, or in other words, behavioural avoidance, are used to avoid environments that may be aversive. However, this reduces opportunities for positive reinforcement and maintains depression. Within treatment, the therapist

and patient work together to increase activities that are associated with positive reinforcement, leading to improvements in mood and symptoms of depression.

Behavioural activation is recommended by the National Institute for Health and Care Excellence (National Institute for Health and Care Excellence, 2009), and has been shown to be superior to general brief or supportive psychotherapy for people with depression (Cuijpers et al., 2007; Ekers et al., 2008). It is a core treatment delivered within the Improving Access to Psychological Therapies (IAPT) programme in England, and there is recent evidence from a small trial that behavioural activation can be successfully delivered by experienced generic mental health workers (Ekers, Richards, McMillian, Bland, & Gilbody, 2011). There is currently a funded multicentre single blind randomised control trial of behavioural activation compared to a guided self-help interventions for depression amongst people with IDs underway (BEAT-IT Trial - HTA Reference 10/104/34), led by Professor Andrew Jahoda at the University of Glasgow, which will add substantially to the evidence base relating to the use of psychological interventions for the treatment of depression amongst people with IDs. Recently, McGillivray and Kershaw (2015), attempted to compare cognitive, behavioural, and cognitive-behavioural interventions for depression amongst people with IDs, reporting no significant differences between the interventions in terms of treatment outcomes, although those who had received the cognitive-behavioural intervention reported fewer negative automatic thoughts.

Moving forward into the future, Vereenoghe and Langdon (2013) made several recommendations for clinical trials involving people with IDs. They stated that researchers should report the Full Scale IQ of participants, and fully described their methods and interventions, in order to help address heterogeneity, especially when conducted meta-analytic work. Researchers also need to describe fully any adaptations that have been made to improve accessibility, and we do need more experimental studies examining whether changes to therapy actually lead to improved outcomes. Finally, we continue to need more clinical trials of psychological therapies involving people with IDs, including both children and adolescents, as well as people with severe to profound IDs, a population that is very much overlooked.

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