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## **Chapter 18: Psychological therapies with people who have intellectual disabilities**

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### **Abstract**

Historically, many people with intellectual disabilities were considered unable to take part in psychological therapies. This view has changed considerably, and there has been an increasing focus on the development of psychological therapies for people with intellectual disabilities, including methods to help improve the accessibility of treatment. Within this chapter, cognitive-behavioural therapy, mindfulness, dialectical behaviour therapy, behavioural therapy, and psychodynamic therapy are reviewed. There is emerging evidence to indicate that a range of psychological therapies are effective with people who have intellectual disabilities, but a lack of large scale and well-designed clinical trials investigating a range of psychological interventions remains problematic.

### **Key words**

Psychotherapy, DBT, CBT, Outcome, Mindfulness

### **Introduction**

There is substantial evidence that children, adolescents and adults with intellectual disabilities are at increased risk of developing mental health problems, with some estimating the prevalence of mental health problems amongst this population to be as high as 50% (1-12). There are a variety of reasons why people with intellectual disabilities are more likely to develop enduring mental health problems that require treatment. These include an increased rate of disadvantageous social factors, including significant life events, family and developmental factors, as well as poor socioeconomic status, alongside an increased probability of having a predisposing genetic or biological vulnerability, often inherently associated with intellectual disabilities (5, 13-15). There is evidence to suggest a relationship between the severity of intellectual disabilities and some mental health problems (11, 16). Hove and Havik (16) demonstrated that severity of intellectual disability explained a proportion of the variance associated with mental health symptoms across a range of disorders, after controlling for age, gender, autism, genetic syndromes, neurological conditions, and psychosocial variables; some of these relationships were linear, while some were curvilinear.

Regardless of the relationship between intellectual disabilities and comorbid mental health problems, historically, many people were simply excluded from “talking” psychological therapies, which has been described as an enduring “therapeutic disdain” towards this population (17), not entirely dissimilar from the longstanding more generalised negative attitudes towards people with intellectual disabilities seen within wider society. This “therapeutic disdain”, while reflecting wider societal attitudes, was often portrayed as driven by an assumption that people with intellectual disabilities were unable to benefit from “talking” psychological therapies because of difficulties associated with their general intellectual functioning, which would likely have a negative impact upon their ability to take part and benefit from the process of “talking” therapy.

Many researchers have tried to tackle this assumption, and while there is no doubt that there is a remarkably high need for psychological therapies amongst this population, many have demonstrated that there is a relationship between verbal reasoning skills and ability to complete tasks thought to be integral to successfully completing some aspects of certain psychological therapies; for example, cognitive mediation skills are considered an important skillset for cognitive behavioural therapy, which may be difficult for some people with intellectual disabilities (18-23). Related, others have reported that people with intellectual disabilities may have difficulties discriminating between differing emotional states, and again, this is important as some ability to understand, report and discuss emotions are part of some psychological interventions (18, 21, 24, 25). However, there is also evidence that while there may be a relationship between improved psychotherapy outcomes and increasing verbal reasoning skills, there is also evidence that those with poorer verbal reasoning skills may actually make greater improvements following therapy (26).

### **Can People with Intellectual Disabilities take part in Psychological Therapies?**

Considering that the evidence to support the use of cognitive-behavioural therapy (CBT) across a range of disorders is clearly the most robust (27), it is not unsurprising that many researchers have tended to focus on whether people with intellectual disabilities have the necessary skillset to allow them to successfully take part in CBT. Some authors have suggested that many of the interventions for people with intellectual disabilities making use of cognitive therapy actually tend to focus more heavily on the use of behavioural therapy (28, 29), at the expense of cognitive interventions, bearing in mind that CBT for many disorders does focus heavily on behavioural interventions (e.g. exposure and response prevention). Nevertheless, the underlying issue is whether people with intellectual disabilities are able to take part in the

“cognitive” interventions which are thought to require increasing verbal reasoning skills, an understanding of emotional states, and cognitive mediation skills.

Similar issues have been considered in relation to people without intellectual disabilities regarding whether they have the required skills needed to take part in CBT. Fennell and Teasdale (30) reported that people who tended to respond positively to some aspects of CBT (e.g. written homework tasks) tended to have more positive outcomes, and clearly written homework tasks are likely to be problematic for many people with intellectual disabilities. Over 40 years ago, Sifneos (31) argued that intelligence, having a history of meaningful relationships, an ability to relate to the therapist, an ability to describe the symptoms, and having motivation were all likely to predict good outcome from psychotherapy. Others have talked about “psychological mindedness” as being both important for people with and without intellectual disabilities when taking part in therapy (25, 32).

Safran *et al.* (33) outlined a series of selection criteria which formed the Suitability for Short-Term Cognitive Therapy Scale (SSCT) administered as an interview in order to assess whether CBT was an appropriate intervention to use with an individual. These criteria were whether a person is able to: (a) access negative automatic thoughts about the difficulties they are experiencing, (b) distinguish between differing emotions, and identify those relevant to their difficulties, (c) identify that they are active, as opposed to passive, within the process of change, (d) consider and understand the tasks within CBT as relevant to them, such as cognitive mediation, and identify a goal, and (e) form an appropriate therapeutic alliance with the therapist. The criteria also included, (f) some consideration of how long-term and enduring the difficulties have been, (g) the nature and degree of strategies which are used to avoid dealing with difficult problems, which were referred to as “security operations”, which may inhibit appropriate exploration, and finally, (h) the ability of an individual to maintain a focus on their difficulties within therapy. There is evidence that scores on the SSCT predict treatment outcome (33-36), with more recent factor analytic work using the SSCT suggesting that capacity to take part in CBT is related to treatment outcome (36).

There are clear implications for people with intellectual disabilities, who may have difficulties with many of the aforementioned variables considered important for successfully taking part in, and benefiting from CBT. Others have highlighted that many people with intellectual disabilities encounter difficulties ensuring their mental health problems are successfully recognised, as they may be mistakenly considered inherent to having intellectual disabilities (37), or incorrectly seen as “challenging behaviour” (38). Clinicians may not communicate collaboratively with people who have intellectual disabilities about the reason why they are

being considered for psychological therapy (25), and there may be associated difficulties with establishing a therapeutic relationship, with a tendency for some to have difficulties avoiding overly dependent relationships (39). The most frequently considered issue is whether people with intellectual disabilities have the necessary cognitive skills to undertake some of the complex tasks within cognitive therapy, many of which draw on cognitive perspective-taking or mentalisation, emotional recognition, verbal communication, and self-monitoring, along with the use of homework tasks, which may involve reading and writing skills. Focusing on more complex skills, such as cognitive mediation, there is actually evidence that people with intellectual disabilities can indeed complete tasks related to some these abilities. For example, in one study, approximately two-thirds were able to link basic emotions to a scenario, although such abilities are related to verbal reasoning skills (40). Others have reported similar findings, and while not all people with intellectual disabilities are able to complete aspects of these tasks, it is the case that many can (18-23).

There have been some successful experiments investigating whether people with intellectual disabilities can be taught some of the skills that are thought to be necessary to successfully take part in CBT. Within the first study to consider this, adults with mild intellectual disabilities were randomised to either an attention control arm, where they received relaxation training, or an intervention arm, where they were taught using a series of pictorial aids to identify thoughts, feeling and behaviours, and practice linking thoughts to feelings, or in other words, cognitive mediation. The intervention attempted to replicate aspects of what might happen in therapy for people with intellectual disabilities as a therapist may have to spend extra time teaching concepts. The intervention led to a significant improvement in cognitive mediation skills, while ability to discriminate between thoughts, feelings and behaviours did not improve, suggesting that some of the skills needed in order to take part in CBT could be taught to some people with mild intellectual disabilities within a one hour session (41).

Two further recent experiments have made use of technology in an attempt to teach people with intellectual disabilities some of the skills needed to take part in CBT. The first involved randomising adults with intellectual disabilities to an intervention arm where a training task in cognitive mediation, using comic strips with accompanying audio was presented on a computer, based upon those used in an earlier study (40). Participants randomised to an attention-control condition viewed the comic strips and listened to the audio, but the learning prompts and questions were not administered. Participants who received the training had a significantly improved ability to select an appropriate emotion within the context of a situation linked to a belief. Ability to select an appropriate mediating belief, within the context of a

situation linked to an emotion, did not improve significantly following training, after controlling for intelligence and pre-test scores (42). In a second study, again using a training intervention delivered using a computer, participants with moderate to mild intellectual disabilities were randomised to a training intervention which aimed to teach cognitive mediation and ability to discriminate between thoughts, feelings and behaviours (43). The intervention led to a significant improvement in the ability of participants to discriminate between thoughts, feelings and behaviours, while there were no significant improvements in skills related to cognitive mediation. The average Full Scale IQ of participants included in this study was 50, which is substantially lower than that found in related studies.

While the majority of studies examining whether people with intellectual disabilities can successfully take part in psychological therapies have tended to focus on CBT, and related psychotherapies, there is evidence that while this is related to verbal reasoning skills, many can successfully complete some of the tasks thought important and related to successful outcome. Further, there have been several experimental studies demonstrating that many people with intellectual disabilities can be taught some of the skills thought necessary to be able to successfully take part in CBT. While such interventions can be easily integrated into psychological therapies, there still is a lack of evidence to indicate that they are associated with improved outcomes for this population within the context of well-designed psychotherapy trials.

Several authors have suggested a variety of augmentations that can be made to psychological therapies in order to help improve accessibility. Over 50 years ago, Sternlicht (44) wrote about how Rogers's (45) view was that insight, verbal communication and intelligence were needed in order to take part in psychotherapy, and as a consequence, people with intellectual disabilities were excluded. Sternlicht (44) challenged this view, and argued that having intellectual disabilities does not mean that a person does not have "intelligent behaviour", as many people with intellectual disabilities have strengths, and while some people with intellectual disabilities will have difficulties with verbal communication, non-verbal communication provides a wealth of information which is helpful to the psychotherapeutic process. He went on to discuss how aids, such as drawings, painting, music, and dance can be helpful with encouraging communication, while building relationships was vitally important. Interestingly, he also suggested that more directive psychotherapies may have benefits for people with intellectual disabilities, contrasting them at the time to non-directive counselling and psychodynamic approaches, while he also suggested that play therapy, dramatherapy, and group therapy could be helpful in overcoming some of the perceived difficulties.

Hurley *et al.* (46) outlined a variety of techniques and modifications that can be made to psychological therapies when used with people who have intellectual disabilities, drawn from the literature at the time. These included: (a) simplification by breaking down interventions and making sessions shorter, (b) reducing the use of complex language, (c) including drawings and homework assignments which have been augmented to help understanding, (d) including developmental level within therapy by ensuring that sessions, content and materials are appropriate, (e) increasing directedness by clearly outlining treatment goals, progress, and using visual guides, (f) ensuring flexibility and using change techniques related to cognitive level, (g) involving support staff and carers, (h) making use of strong boundaries to guard against increased risk of transference and countertransference, as there is a risk of attachments with a parental theme, and (i) discussing issues related to disability within therapy in order to work on the development of positive self-image.

More recent summaries of the techniques and modifications to psychological therapies for people with intellectual disabilities have been summarised for both CBT and psychodynamic approaches (47). In a similar vein to Hurley (46), simplification of techniques and language, using shorter sessions, incorporating drawings, pictures, videos and audiotapes, including adaptations and materials relating to developmental level, increasing use of directive methods, increasing flexibility, the inclusion of carers, paying further attention to transference and countertransference, and including issues relating to having intellectual disabilities within therapy were all included across the studies reviewed. However, as discussed by the authors, there has been little research into the effectiveness of many of the included components of therapy with people with intellectual disabilities, including many of the adaptations that have been used or developed. One of the difficulties that the authors found within the literature was that many had not sufficiently detailed the augmentations they made to therapies for people with intellectual disabilities, which of course made it difficult to describe the therapeutic content and process. Some of these issues were discussed by Vereenooghe and Langdon (48) who further recommended that the effectiveness of these augmentations need to be considered within the context of therapy for people with intellectual disabilities, while pointing out that people with intellectual disabilities are a heterogeneous population, and modern directive psychotherapies are formulation driven, and as such, interventions should be tailored, based upon the formulation, as should any adaptations to the techniques and therapeutic process.

### **Are Psychological Therapies Effective?**

Several groups have examined the effectiveness of psychological therapies for people with intellectual disabilities within meta-analyses. The majority of these have focused on structured and directive psychotherapies, such as CBT, while there is preponderance of case studies, and small single group designs investigating other psychological therapies, including psychodynamic approaches. Across all the therapeutic modalities, there are a lack of well-designed clinical trials, and of the studies that do exist, many have not employed adequate allocation concealment, appropriate randomisation, or comparison groups. Further still, many have made use of insufficient sample sizes, while often sampling bias has not been thoroughly addressed, as people with intellectual disabilities may not be afforded opportunities to take part in psychological therapy research, as participation is often reliant upon having supportive carers.

***Cognitive Behavioural Therapy.*** Bearing the difficulties mentioned above in mind, Vereenooghe and Langdon (48) completed a meta-analysis, which while not limited to studies involving CBT, included a majority of studies that examined the effectiveness of CBT with people who have intellectual disabilities. The majority of the studies included attempted to address anger problems, while other studies treated depression, or attempted to improve interpersonal functioning. They reported that studies where participants were randomised were associated with a moderate effective size,  $g = .56$ , while studies that did not employ randomisation were associated with a higher and large effect size,  $g = .85$ , and combining both groups of studies was associated with a moderate effect size,  $g = .68$ . They also contrasted studies that delivered therapy within a group vs. an individual format, and reported that the effect size of group based interventions, while moderate,  $g = .56$ , was lower than that associated with individual therapy,  $g = .78$ . Further still, examining treatment effectiveness according to the disorder or presenting problem being treated revealed that treatment effectiveness for anger was associated with a large effect size,  $g = .83$ , while for depression, treatment was associated with a moderate to large effect size,  $g = .74$ . Treatment for interpersonal problems was associated with a negative treatment effect,  $g = -.34$ . The authors went on to consider their findings in relation to some of the previously completed reviews (49-51), where some had attempted to include treatments focused solely on teaching relaxation or social skills, or excluded interventions that were delivered by staff members working directly with people who have intellectual disabilities. They commented that their calculation of the effect size associated with interventions for the treatment of anger problems was similar across studies (50, 51). They considered that there were no trials of psychological interventions for children and adolescents, nor were there any trials of psychodynamic interventions, which met the

inclusion criteria for their review. The authors made a series of recommendations for future clinical trials within this area which were that researchers need to: (a) measure and report the level of general intellectual functioning of participants, (b) describe methods and interventions clearly, (c) describe the adaptations that are made to therapy, and (e) conduct robust and well-designed clinical trials involving adults, as well as children and adolescents with intellectual disabilities.

More recently, Koslowski et al. (52) completed a meta-analysis where they excluded studies that failed to report the level of intellectual disabilities across participants, eventually including only 10 studies in their analysis. They noted an unclear risk of bias associated with masking of research staff, allocation concealment, and selective reporting. Symptoms or disorders treated within studies included behavioural problems, depression, anxiety, quality of life, and functioning. Only six of the 10 included studies made use of CBT as the intervention, while the remaining studies used medication or system-level interventions. They reported that CBT for the treatment of depression was associated with a nonsignificant moderate effect size,  $d = .49$ , while this was nonsignificant and small,  $d = .15$ , for the treatment of anxiety.

Unwin *et al.* (53) undertook a systematic review of CBT when used as a treatment for anxiety and depression with people with intellectual disabilities, including both the qualitative and quantitative literature. While they did not complete a meta-analysis, owing to the methodological difficulties with the literature, they did conclude that CBT appears to be feasible and well-tolerated by people with intellectual disabilities. Many of the qualitative studies tended to reflect positive attitudes toward treatment amongst patients and carers. The authors discussed whether it would be helpful to train carers in some of the techniques associated with CBT in order to help improve the generalisability of treatment effects, commenting further that this may lead to improved knowledge and attitudes, and an increased ability amongst carers to respond to distress.

**Mindfulness.** Often used in conjunction with CBT (54), mindfulness is a technique that probably originated from Buddhism and Yoga. It is a mental state of focusing on the present moment in a non-judgemental way (55), and has been reported to have a moderate effect size (56) in the general population. There is some emerging evidence to suggest that mindfulness may be helpful for people with intellectual disabilities who have anger problems (57), and Hwang and Kearney (58) reviewed twelve studies which involved teaching mindfulness to people with intellectual and developmental disabilities, some of whom were adolescents, concluding that there was emerging evidence to suggest that the intervention is efficacious. The majority of the studies made use of single case designs, and mindfulness had been used

most frequently with aggressive behaviour, but there were studies using the technique as an intervention for deviant sexual arousal (59), anxiety and obsessive compulsive disorder (60), smoking (61), and for weight loss with someone who Prader-Willi syndrome (62). A variety of modifications to the techniques were described when used with people with intellectual disabilities, including longer self-practice periods of up to one year, often for those with increasing complexity, and a greater degree of intellectual disability. Role play, verbal instructions, pictorial aids, and the use of audio recordings to help with instruction was also employed. Mindfulness had also been used as a technique for supporting carers and staff working with people who have intellectual disabilities (63), parents caring for a child with intellectual disabilities (64), while a recent randomised controlled trial using “mindfulness-based positive behavioural support” with staff members within an institution for people with severe and profound intellectual disabilities had been completed. The intervention involved training staff in positive behavioural support, while also training them to practice mindfulness. The intervention led to an improved ability of staff members to manage their stress, and reductions in the use of physical restraint and “as required” medication for service users (65). The authors also reported a reduction in aggression displayed by service users, and staff turnover.

***Dialectical Behavioural Therapy.*** Linehan’s (66) dialectical behavioural therapy (DBT) was developed in an attempt to help individuals who were feeling suicidal, who have difficulties with emotional dysregulation, frequently seen in personality disorder. The therapy includes helping individuals to shift towards increasing control over their behaviour, while encouraging the development of new skills, increasing motivation, and with a focus on the generalisation of skills within the context of everyday life. The therapy includes the use of group and individual therapy, coaching, which in many settings is delivered by telephone, and team consultation. Meta-analytic work has suggested that DBT is associated with a moderate effect size, but whether DBT is more efficacious than other interventions for similar difficulties remains unclear (67).

A recent systematic review examined the use of DBT with people who have intellectual disabilities, reviewing seven studies (68). DBT had been used within community and inpatient settings for people with intellectual disabilities, and many had made adaptations to the programme, including the use of visual aids, simplified language, more feedback and rehearsal of skills, and the inclusion of carers within the therapy to help with coaching. While many made use of telephone coaching, some did not because the therapy was delivered within an inpatient setting, and coaching was provided by staff members. While the included studies

reported improvements in functioning for many of the participants, the designs used did not allow for conclusions regarding causality. It was unclear whether some of the interventions were complete DBT programmes, and instead, were informed by DBT.

***Behavioural Therapy.*** While often considered in relation to the treatment of challenging behaviour, behaviour therapy (BT) is often an integral and important part of many modern directive psychotherapies, including CBT. This includes interventions like behavioural activation (69), and exposure and response prevention (70), as well as other techniques, collaboratively informed by learning theory. There is evidence that applied behavioural analysis is associated with moderate to large effect sizes when used with children who have autism (71), and meta-analytic work analysing single-subject designs has demonstrated that behavioural interventions are effective in treating challenging behaviour, drawing on techniques such as differential reinforcement, extinction, and antecedent control procedures; effect sizes were larger for those studies where a functional assessment had been conducted before implementing the intervention, outlining the important role that high quality assessment and formulation has in informing clinical interventions (72), something which has been reinforced by others (73).

Positive behavioural support (PBS; 74, 75) is directly informed by applied behavioural analysis, and many have argued that the focus within PBS, in comparison to applied behavioural analysis, is more upon the social values and the rights of people with intellectual disabilities (76), which includes a focus on meaningful outcomes, normalisation, and self-determination (77). It would be rather unethical, and exceptionally concerning, if any psychotherapy did not embrace such values when being used with any person, including people with intellectual disabilities. PBS is an organisational multicomponent framework for intervention, driven by a functional assessment; the goal is to implement evidence-based intervention to bring about an improvement in quality of life by reducing the probability of challenging behaviour. Techniques include the use of antecedent control strategies, which includes the manipulation of environmental conditions, along with reinforcement-based intervention strategies. These are organised into: (a) ecological strategies, (b) teaching functionally equivalent skills, (c) interventions drawn on our understanding of learning theory (e.g. differential reinforcement), and (d) and reactive strategies. Meta-analytic studies of the effectiveness of PBS, while drawn primarily on single case designs, have indicated that it is associated with a large effect size, but this is when PBS incorporates both antecedent control strategies and interventions using reinforcement, based upon a functional assessment (78). It is relatively clear that PBS is most effective when based upon a good functional assessment.

***Psychodynamic Psychotherapy.*** This particular type of therapy focuses on the use of the relationship between the patient and therapist as the mechanism for change. Significant attention is paid to developing a trusting relationship, which makes use of attentive listening, noting body language. Some may incorporate education and advice, which may not be included as part of therapy for people without intellectual disabilities. Ensuring that the therapist has a warm affect, coupled with friendliness, and making use of modelling around labelling emotions is useful. There are additional challenges for therapists, who may experience guilt because they may not have a disability, associated with fears of not understanding individuals, coupled with powerful projections and countertransference which may become magnified because of communication difficulties. However, Jackson and Beail (79), while considering many of the aforementioned modifications, commented that the majority of the literature in this area is reliant on descriptive case reports, and outlined how the therapeutic process draws on information gathering, formulation and understanding, along with communication of meaning, within a circular process, nested within the therapeutic frame. They also stated that within the literature there was a general absence of clear information about formulation with people who have intellectual disabilities (79).

Changes can be slow, subtle, and tend to occur after therapy has ended (80), or they can be sudden, which may be associated with the first stage of therapy. Some aspects of therapy, while beneficial for people with intellectual disabilities, may be judged by others as negative, as individuals increasingly develop a sense of self-efficacy. For example, in an early paper, Symington (81) reported how a person with intellectual disabilities announced that they were “retired” and no longer wished to attend a day centre, resulting in a perception that symptoms were “worsening”. However, Symington (81) further discussed how this individual presented as more “disabled”, retreating into his disability as a psychic defence; over time he began to use the bus independently to travel to sessions, and tended to use his disability as a mechanism for integrating more into his peer group. This illustrated how a “secondary handicap”, which is often an unconscious process, reduced early within therapy. This does involve acknowledging the pain of having a disability within a society inherently geared towards people who do not have disabilities.

The second stage of therapy is a “depressive” stage, and some have considered that it can take up to 12 months (82), while it may be shorter for others. During this stage, there can be a dip in affect and presentation, and working effectively with carers to support an individual is important, often to guard against dropout from therapy. Some may present as acutely distressed, and additional support may have to be offered, which may include hospitalisation

for those who have experienced severe trauma. This is not commonly encountered within community settings, but it is important to be aware of this process during therapy. Once this stage has been reached, it is important for people to continue with therapy for two to three months in order to reach resolution. There is evidence that people with intellectual disabilities use the same defence mechanisms, although some have considered there may be more of a reliance on “primitive” defence mechanisms, such as “acting out” (83). However, people with intellectual disabilities have been shown to make use of psychodynamic psychotherapy in such a way as to effect change (84).

People with intellectual disabilities tend to face higher rates of loss and trauma (85-87), and many have considered that having an intellectual disability can be inherently traumatising (88). Emotional attachments may be fragile, and it may take longer for individuals to develop a sense of self, while dependency upon others can lead to greater psychological dependency and reduced autonomy. Some individuals may take much longer to address difficult issues, and many may have developed strategies to avoid upsetting or distressing others, in an attempt to suppress negative emotions (89).

There are no clinical trials of psychodynamic psychotherapy involving people with intellectual disabilities. Recently, Shepherd and Beail (90) completed a systematic review of 13 studies in this area, concluding that this type of psychotherapy may be effective, but there were no controlled trials, and there were concerns about methodological quality.

## **Conclusions**

The evidence base for the use of psychological interventions for people with mental health problems who do not have intellectual disabilities is well established, while a comparable evidence base for people with intellectual disabilities remains lacking. The most thorough evidence exists for the use of interventions drawn on cognitive-behavioural therapy, and while there has been a focus on modifications and adaptations to help with accessibility, the evidence is not markedly robust. There is emerging evidence to support the use of mindfulness. The evidence for behavioural therapy is drawn predominantly upon single case designs, while the evidence for DBT and psychodynamic therapy, although promising, remains sparse. This should not be used as a reason to not offer psychological therapies to people with intellectual disabilities.

## **Multiple Choice Questions**

1. All of the following are true about modifications to CBT and psychodynamic psychological therapies for people with intellectual disabilities except
  - a. simplification of techniques and language
  - b. using longer sessions
  - c. incorporating drawings, pictures, videos and audiotapes
  - d. including adaptations and materials relating to developmental level
  - e. increasing use of directive methods

Answer: b

2. All of the following are true about studies on the effectiveness of therapy using mindfulness in people with intellectual disability except
  - a. the majority of the studies made use of single case designs
  - b. it has been used most frequently with aggressive behaviour
  - c. modifications to the techniques include longer self-practice periods
  - d. it may not be helpful for people with intellectual disabilities who have anger problems.
  - e. when used to support carers, there can be an improved ability to manage their stress.

Answer: d

3. All of the following are true about studies on the effectiveness of behaviour therapy in people with intellectual disability except
  - a. it is associated with moderate to large effect sizes when used with children who have autism
  - b. effect sizes were smaller for those studies where a functional assessment had been conducted before implementing the intervention
  - c. meta-analytic work analysing single-subject designs has demonstrated that it is effective in treating challenging behaviour
  - d. Positive behavioural support (PBS) is informed by applied behavioural analysis and includes a focus on meaningful outcomes, normalisation, and self-determination
  - e. A good functional assessment makes PBS effective

Answer: b

4. All of the following are true about studies on psychodynamic therapy in people with intellectual disability except
- changes can be slow and tend to occur after therapy has ended
  - changes may be associated with the first stage of therapy
  - it may take longer for individuals to develop a sense of self
  - there can be a depressive stage where there is a dip in affect and presentation
  - for those who reach a depressive stage, therapy should be stopped immediately

Answer: e

5. The following is true about Dialectical Behaviour Therapy for people with intellectual disabilities
- is effective only in in-patient settings
  - has been shown to be effective through a meta-analysis of randomised controlled trials
  - adaptations like the use of visual aids are not recommended
  - the inclusion of carers within the therapy to help with coaching is recommended
  - telephone coaching is not recommended

Answer: d

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