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FIELD PLACEMENT PRACTICUM ESSAY
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**ADDRESSING THE NEEDS OF INDIVIDUALS WITH LEARNING CHALLENGES IN
GROUP CBT**

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ABSTRACT

This practicum essay is based on a 450 hour placement that was done within the *Mood and Anxiety Program* via Health Sciences North in Sudbury, Ontario. Here, I gained some clinical experience and a better understanding of the applications of group *Cognitive-Behavioral Therapy* approaches (CBT) for adults (16 years and older) who suffer from mood disorders. My objectives consisted of first, acquiring clinical skills and proficiency in the delivery of group *Cognitive Behavioral Therapy*. Second: to develop an understanding of approaches to social work assessment and individual therapy within MAP. Third, to adapt group CBT material to address the needs for people with learning challenges, this final objective represents my main challenge and represents the bulk of this essay. This project outlines some of the specific learning challenges found in populations with cognitive impairments focusing on those with Asperger's, mild intellectual disabilities and learning disabilities. Basic adaptations and teaching strategies are discussed in hopes of increasing accessibility and creativity with the CBT approach. The need for individual services is also recognized. I am proud to say that this experience has allowed me to grow as a competent professional in the social work field.

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Table of Contents

ABSTRACT	2
ACKNOWLEDGEMENTS	3
CHAPTER 1	6
1.1 THE ORGANIZATION AND ITS SERVICES	6
1.1.1 The Mood and Anxiety Program	6
1.1.2 Treatment Groups at MAP	7
1.1.3 Individual Services	8
1.2.1 Aim of the Specialized Field Placement	9
1.2.2 My Initial Questions.....	9
1.2.3 The Development of my Initial Questions	10
1.3 FIELD PLACEMENT GOALS	11
1.3.1 Acquiring Clinical Skills and Proficiency in the Delivery OF Group CBT.....	11
1.3.2. To Develop an Understanding of Approaches to Social Work Assessment and Individual Therapy within MAP	17
1.3.3 My Learning Progression within these Objectives	21
1.3.4 Adapt Group CBT Material to Address the Needs for People with Learning Challenges	21
CHAPTER 2	25
2.1 LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK	25
2.1.1 Introduction	25
2.1.2 Cognitive Behavioral Therapy	25
2.1.3. Major Therapies Associated with CBT	27
9. Dialectical Behavior Therapy	31
2.1.4 Depression and Generalized Anxiety	32
2.1.5. Cognitive Disabilities	34
2.1.6. Beck's Cognitive Model.....	37
2.2.1 Cognitive Processing	38
2.2.2 Emotions	41
2.2.3 Language	42
CHAPTER 3	44
3.1 METHODOLOGY	44

3.1.1 Literature Review	44
3.1.2 Participation in the Mood/GAD Group.....	44
3.1.3 Client Interviews.....	46
3.1.4 Developmental Clinical Services (DCS).....	51
3.1.5 Webinar: Adapted CBT for youth	52
CHAPTER 4	54
4.1 ADAPTATIONS	54
4.1.1 Introduction	54
4.1.2 Solutions: Cognitive Processing	54
4.1.3 Solutions: Emotions	58
4.1.4 Solutions: Language	59
4.1.5 Individual Support	59
4.1.6 The PowerPoint Presentation	61
CHAPTER 5	65
5.1 QUESTIONS REVISITED	65
CHAPTER 6	69
6.1 CONCLUSION	69
6.1.1 Reflection	69
6.1.2 Challenges	70
6.1.3 Final Remarks	71
APPENDIX 1	78
APPENDIX 2	79
APPENDIX 3	80
APPENDIX 4	81

CHAPTER 1

1.1 THE ORGANIZATION AND ITS SERVICES

1.1.1 The Mood and Anxiety Program

My 450 hour specialized placement was done within the *Mood and Anxiety Program* via *Health Sciences North* in Sudbury. This is a program that is funded by the *Ministry of Long Term Care* and supported by the *North East Local Health Integration Network*. The agency provides group based therapy services to individuals who are diagnosed with: depression, bi-polar disorder, social anxiety, generalized anxiety disorder, borderline personality disorder and post-traumatic stress disorder. Its clientele consists of men and women aged sixteen years and older who reside within the City of Greater Sudbury. Its services include individual assessment, group treatment and support, referral to community resources, belief in the client's abilities, hope and understanding.

The agency team consists of professional and experienced clinicians from social work, psychology, nursing and psychiatry disciplines. Their program is client-centered and treatment is based on recovery goals. They use evidenced-based structured approaches to psychotherapy including *Cognitive Behavioral Therapy (CBT)*; *Mindfulness based Cognitive Therapy (MBCT)* and *Dialectical Behavioral Therapy (DBT)*.

Health Sciences North and the *Mood and Anxiety program* share the mission of improving the health of Northerners. They value excellence, respect, accountability and engagement.

1.1.2 Treatment Groups at MAP

The *Mood and Anxiety Program* (MAP) offers a variety of treatment groups that utilize CBT, DBT and mindfulness based approaches. Group therapy is mostly used to compensate for the high demand of psychotherapy, because of long waiting lists, its efficiency, and financial gains (Bieling, McCabe and Antony, 2006). Group CBT is used to help treat depression, generalized anxiety, panic, social anxiety and obsessive-compulsive disorder. Group and individual DBT is utilized to assist clients in regulating their emotions, tolerating distress and managing multi-impulsive behaviors. Other treatment groups include: the interpersonal group, mindfulness-based group used for relapse prevention, seeking safety group and the bipolar education group.

In general, groups usually consist of approximately 8-12 participants and range from 12 to 20 weeks. Sessions are two hours in duration with a break half way through. They are led by two clinicians. It is an adult learning environment. Group sharing is focused on skills and management of symptoms. Individuals require stability, readiness and commitment to treatment. The benefits of group therapy include social support, self-improvement through peer support, and a sense of empowerment. The disadvantages of treatment groups can include difficult clients, challenges in group process and leadership (Bieling et al., 2006).

Individual personalities can also affect the atmosphere of the group. Bieling et al., (2006) identify six distinct personalities that influence any group: the quiet group member, the overbearing group member, the helper, the drifter, the disbeliever, and the member who is not

appropriate for group therapy. Each of these members can affect participation, treatment efficacy, group structure, goals, productive learning, attitudes, group morale and cohesion.

Challenges for the group process include the method of teaching, the structure, outside exposures and external observers. The manner in which the material is delivered must not inhibit sharing and openness of group members. It must also allow for group interaction. A rigid structure also session impedes on time for reflection and communication. Exposures outside of group can influence group cohesion because clients are usually divided into subgroups and outside observers can create an insecure environment.

The final challenge of CBT groups listed by these authors lies in leadership. This is a common challenge because there are usually two or more therapists facilitating the groups. Therapists working together may not share the same teaching style, or have conflicting ideas about the best intervention. There can also be disagreement on the management of the groups. Disaccord can often lead to disturbances in the group.

Another limit that I was able to identify through my experience and observations at MAP is that group therapy can overlook individual learning needs. If a group member suffers from a cognitive impairment or learning challenge and does not fully understand the material presented they may also face the stigma of their disabilities. Since they already suffer from mental illness, this may further inhibit them from asking questions or reaching out for help.

1.1.3 Individual Services

Individual therapy is primarily offered to clients with post-traumatic stress disorder. However, individual support is also offered in conjunction to some group services to populations

with multi-impulsive behaviors or trauma. The objective of these individual services is to establish clinical rapport and additional assessment including safety/behavior contracting. The treatment groups that are adjunctive to individual support include the Changing Behaviors group and the Seeking Safety group. Individual services can also be provided to facilitate readiness for group therapy.

1.2 PLACEMENT OBJECTIVES

1.2.1 Aim of the Specialized Field Placement

The aim of this specialized placement was to acquire clinical experience with the cognitive therapy approach and to demonstrate my findings on adapting the CBT material to suit individuals with learning challenges. The purpose of this project is to make CBT more inclusive to individuals with learning challenges.

1.2.2 My Initial Questions

The following questions were developed prior to the commencement of my field placement. They served as a guide to help me structure my learning objectives within this project.

- What are the theories that underpin CBT?
- What approaches are used with CBT?
- What is the process of group CBT?
- What population is suitable for group CBT?
- Why is group CBT considered to be an effective treatment?

- What are the limits of group CBT?
- What is the process of CBT with people with intellectual disabilities?
- What are some of the educational strategies that could be used with this population?

1.2.3 The Development of my Initial Questions

The majority of my initial questions were answered through research. The process of group CBT was evident when I was able to participate in the treatment groups. I attended a full 18-week treatment group and thus was able to grasp the entirety of the process. I was also able to observe and participate in group CBT for people with developmental disabilities as offered through the developmental service sector.

It is important to note that my original placement objectives were to acquire additional skills to intervene with a population suffering from a mood disorder and mild intellectual disabilities. This had to be modified because MAP does not cater specifically to individuals with disabilities; rather some individuals may have learning challenges yet are still appropriate for group therapy.

Therefore, in regards to adapting the CBT material to suit individuals with learning challenges my questions further developed to:

- i-What constitutes as a learning challenge?
- ii- What are some of the common learning challenges in relation to CBT?
- iii- What are the barriers faced in group?
- iv-How is the material being presented?

v- How can CBT material be adapted in a group setting?

vi- What are some individual CBT approaches that can be used?

1.3 FIELD PLACEMENT GOALS

The clinical opportunities available within the *Mood and Anxiety Program* allowed me to develop my objectives into three units.

My first objective is to acquire the clinical skills and proficiency in the delivery of group *Cognitive Behavioral Therapy*. My second objective is to develop an understanding of approaches to social work assessment and individual therapy within MAP. My final objective is to adapt the group CBT material to address the needs for people with learning challenges. An overview of these objectives can be viewed in Appendix 1.

1.3.1 Acquiring Clinical Skills and Proficiency in the Delivery OF Group CBT

The groups I participated in at MAP were the *Anxiety group*, the *Mood and Generalized Anxiety group* and the *Changing Behaviors group*.

1. The Anxiety Group

The Anxiety group is a 20-week CBT based program designed for clients who are negatively impacted by social anxiety and/or panic disorder in their everyday experiences. The purpose of this group is to help clients better understand the nature of social phobia, anxiety and panic. The group focuses on teaching healthy coping skills, challenging automatic negative thoughts, helping to normalize feelings and sensations of anxiety while supporting clients with

their goals and fear hierarchies through exposure treatment and helping participants to increase self-efficacy while confronting the obstacles that anxiety creates in their lives.

Group and individual treatment for anxiety and panic are very similar and are both effective. For instance, “CBT for panic disorder has been extensively evaluated in both individual and group format with similar results, suggesting that group treatment is clinically equivalent to individual treatment” (Bieling et al., 2006, p.130).

Although a large obstacle to group therapy is a high dropout rate and an overwhelming fear of a group setting, the group itself serves as a ready-made exposure. “The simple fact of group exposure can lead to changes in social anxiety”. (Bieling et al., 2006, p.214). Another advantage to any group therapy is the realization that the client is not alone in their illness.

2. Learning Activities and Outcomes

In this group, I was responsible for preparing and leading mindfulness activities, doing brief check-ins with clients, and participating in group-based activities and discussions. I also completed progress notes for every member of the group in the hospital’s electronic filing system.

The mindfulness exercises I created involved different senses (sight, smell, touch, taste and sound). I also used some grounding techniques and meditation. By doing these activities I have developed a gentle pace and a soothing tone. Through my mindfulness activities, clients were able to develop an awareness of their thoughts and the ability to be present in the moment.

I have learned a variety of principles that are associated with CBT and the treatment of anxiety disorders. First, the thought record is a cognitive restructuring tool that is prominently used in the CBT approach. Clients begin by completing what is called a basic thought record. The aim of the basic thought record is to explore the relationship between situations, emotions and thoughts and to identify thought distortions. The next step is the extended thought record, which challenges the thought distortions and allows the individual to identify possible solutions that may help them with the present or future situations. Third are interoceptive exposures, which are unique to the anxiety group. These are exercises that mimic the sensations of a panic attack. The aim of these exposures is to help the clients familiarize themselves with the feelings of a panic attack so that they are desensitized to the actual feelings of panic. Subjective units of distress (SUDs) are also used to estimate the degree of anxiety that an activity may cause. The SUDs scale ranges from 0 -100, 0 being total relief and 100 being unbearable. The therapeutic range is between 40-80. This scale is also used with graded exposures. Here, the clients determine a goal that causes them a minimum of 40 in the SUDs scale. They break down this goal into small steps and repeat each step until their SUDs are manageable. Both in vivo and interoceptive exposures are crucial to help reduce anxiety. “One of the most effective strategies for overcoming any fear is repeated exposure to the situation” (Bieling et al., 2006, p. 78).

3. The Mood/GAD Group

The *Mood and Generalized Anxiety* group is an 18-week CBT-based program designed to assist individuals with depression and generalized anxiety disorder. The clients are provided psychoeducation to help them better understand their illness. Behavioral activation, cognitive

restructuring, core belief work and mindfulness strategies are used to help reduce the symptoms of depression.

Group CBT for Mood/GAD carries many opportunities that individual therapy does not offer. As group cohesion develops the mutual support and empathy towards one another increases. The simple reassurance that group members provide for one another highlights the effectiveness of this treatment model. Group dialogue can also aid with some of the cognitive strategies that are associated with CBT. For instance, “as group members question one another, they are also learning how to question their own thoughts” (Bieling et al., 2006, p.231). Another benefit of having many people considering the same problem is the advantage of different perspectives. It also opens different avenues of exploration to questions that the therapists would otherwise not have considered.

The group begins with some education regarding the physiological symptoms of depression. The clients are then introduced to behavioral activation. When an individual suffers from depression, they withdraw themselves from many activities. Clients are encouraged to engage in pleasurable activities to initiate some motivation and to help them regain momentum in their lives. A central piece of work in the Mood/GAD group is the thought records (explained above). Clients repeatedly practice this exercise so that they can identify distorted thought patterns. The therapist uses guided discovery to help uncover the underlining assumptions associated with these thoughts. This technique allows clients to develop different ways of thinking, feeling and acting. These underlining assumptions lead to core beliefs. “Core beliefs are the fundamental views that people have of themselves, the world, and/or the future. In most

instances, these core beliefs drive the automatic thoughts that are elicited in particular situations” (Wenzel, Brown, and Beck, 2009, p.119). Core beliefs can be identified through the use of the downward arrow technique (Burns, 1980). The client chooses a common automatic thought and is cued by the therapist to discover the associated deep-rooted beliefs. Aaron Beck (1976) believed that core beliefs tend to fall in one or both of two categories: helpless core beliefs and unlovable core beliefs. A cost benefit analysis is used to modify the client’s beliefs to assess the need for change. A new core belief is then developed and the participant is encouraged to develop actions to enhance or maintain specific characteristic that help support this new belief. After this point in the treatment group, an improvement is clearly observed in the clients. The final step is relapse prevention. Tools and strategies that were taught in group are re-visited to help clients prepare for times of stress or low affect. After the completion of group therapy, each client meets with a clinician individually to determine the next steps in recovery.

4. Learning Activities and Outcomes

In this group I took on more of the role as a co-facilitator. I was still in charge of creating and leading mindfulness activities but I also presented sections of group material. For instance, I was responsible for presenting the material on emotions and emotional needs. This was also linked to the thought record, as the emotional needs can be useful in thinking of actions or behaviors that can help with the situation.

In taking on the role of a co-facilitator I have learned the importance of rewarding the client’s successes. Even if the client did not fully complete their homework it is important to acknowledge any attempts as a success. This can aid in increasing the client’s self-esteem and

motivation to continue their hard work. It is vital to understand the effort it takes for someone suffering from depression to complete any given task. I have also learned to use Socratic questioning and guided discovery as a cognitive group strategy. “Socratic dialogue leads to more logical, objective conclusions about one’s inner experiences” (Bieling et al., 2006, p.46). Socratic questioning encourages new perspectives and information that was not previously considered.

5. The Changing Behaviors Group

The *Changing Behaviors* group is a 12-week DBT skills group designed for multi-impulsive clients. Mindfulness, adaptive learning and skill building are used to help regulate emotion, change dysfunctional behaviors, and improve the participants’ overall quality of life. An individual therapist is also assigned to every client whom they must meet with at least once every two weeks. Individuals who participate in this group will learn how to manage their emotions and impulsive behaviors so that they are able to function better in their daily lives.

6. Learning Activities and Outcomes

Here, I participated in the delivery of *Dialectical Behavior Therapy* group. I presented DBT skills and led a two-hour session on interpersonal effectiveness. In this group I've learned numerous emotion regulation skills such as behavior chain analysis which helps identify the chain of actions, thoughts and feelings that lead to the problematic behavior. By independently leading a full session I have learned to use common examples that clients can relate to with everyday life situations and an interactive approach.

1.3.2. To Develop an Understanding of Approaches to Social Work Assessment and Individual Therapy within MAP

In terms of individual therapy, I led intake assessments under the co-therapy model of supervision with different MAP clinicians. I provided specialized support to a client with complex needs who also attended the changing behaviors group. Lastly, I co-led perinatal assessments under supervision. This is not part of the MAP program however; it was an opportunity that offered a unique learning experience.

1. Intake Assessments

A client care path is determined by completion of an intake assessment. After observing a number of intakes I led my own under the supervision of a MAP clinician. I used the bio-psycho-social approach to determine a suitable treatment plan within MAP. Through these intake assessments I have learned how to quickly develop a rapport with clients so that they feel comfortable and open to sharing. I have utilized the hospital's Bcare and Meditech systems to access the client's history so that I have an overview of their situation in order to avoid repetition. In addition, suicide risk assessments must be done with every client to ensure their safety. Clients who are at high risk of suicide are immediately accompanied to the hospital's emergency department or to Crisis Intervention. Crisis and other support services such as the Warm Line are also provided to every client for additional support. I have also learned how to do a mental status exam. This involves assessing an individual's appearance, behavior, cooperation, speech, thought, affect, mood, perception, level of consciousness, insight, cognitive functioning, knowledge, suicide ideations and reliability. I was responsible for documenting this information

in the hospital's electronic filing system. I was able to determine adequate care plans for clients based on the information I received during the assessment.

2. Specialized Support

I provided individual therapy to a client who attended the Changing Behaviors group with supervision. The client presented with qualitative social impairment and has a diagnosis of borderline personality disorder. I supported the client with DBT tools and conducted treatment planning using a client-centered approach to both engage and support the client with the acquisition of skills. I also used the seven core tasks of psychotherapy by Meichenbaum (2008) as a guide while working with this client. For instance, a therapeutic alliance was formed through the acknowledgment and understanding of the clients struggles and by providing an open and comfortable environment throughout the intervention process. Education surrounding the client's disorder and medications were used to facilitate their understanding of their feelings and behaviors. The client was encouraged to re-conceptualize their thoughts, feelings and behaviors by using specific incidents for critical reflection. For example, the client practiced behavioral chains to gain new perspectives on their problem behaviors. We focused on core mindfulness skills, interpersonal effectiveness skills, emotion modulation and distress tolerance skills as means of alternative coping strategies. Homework and personal experiments were given to the client to help them practice these skills. The client was encouraged to bring the homework into every session to review their barriers, insights and successes. The client's achievements were consistently acknowledged and they were assured responsibility for positive change. Safety planning, grounding skills and self-soothing skills were also encouraged for relapse prevention. I also used a solution-focused approach with this client as a means of enhancing behavioral

activation. Throughout the dialogue, I asked the client if they could go anywhere in the world where would it be, to which the client responded that they would prefer to be institutionalized as they benefited from 24 hour care and structure in their day. This allowed me to create a client care plan that focused on creating a daily routine that they could manage independently.

I appreciated the flexibility with integrative approaches. I was able to adapt the skills taught in group to suit the individuals learning style. For example, this client preferred hands on activities therefore; we did some exercises in session to help with the client's impulsivity in relation to self-harming behaviors. We practiced grounding techniques such as the 5-4-3-2-1 exercise (also known as Betty Erickson's Induction) and created a distress tolerance box where we made stress balls out of balloons and sand and other items such as cards with positive quotes and pictures.

3. Perinatal Assessments

The Perinatal program offers individual and family assessment and support to women 16 years and older. I was able to co-lead individual assessments with the program's nurse and with my supervisor who was the perinatal social worker. The perinatal assessment is very detailed. I used the early intervention mental health summary which includes the presentation, past history, medical and surgical history, family history of mental illness, obstetrical history, developmental history, educational and occupational history, financial history, legal history, supports and mental health status.

In a particular situation, I became aware of my own preconceptions and judgments involving a young mother. I took this opportunity to practice critical reflection using the resource

handbook by Fook and Gardner (2007) as a guide. I choose to focus on three specific questions to help me explore my biases. First, what are my beliefs about child rearing that lead me to my judgments and preconceptions? In short, I found myself having presumptions regarding her young age; I automatically felt that she was too immature and irresponsible to raise a child even before meeting her. She came to the appointment with her baby by bus, it was also during the winter months and it was particularly cold that day. I felt that she should not have taken a bus on such a cold day although she did not have any other means of transportation. I had judgments regarding her relationship with her partner because he did not want to participate in the program and was not contributing financially. I also found myself judging certain attitudes or behaviors regarding child rearing.

Second, what beliefs or preconceptions might allow me to be more open to other ways of seeing the situation? Increasing my knowledge surrounding depression and mental health has helped me understand the barriers that she faced. Listening to her past and present struggles lead me to acknowledge her resilience. I was also able to increase my understanding by appreciating her participation in the program; she is ameliorating her skills as a parent and increasing her well-being for her family.

Third, how has who I am affected what I noticed or felt was important? Coming from a single-family home, stability is very important to me, this may have influenced my concerns around the involvement of the partner and finances. I was also raised Catholic which may have influenced my preconceptions towards her young age.

In sum, this reflection allowed me to gain self-awareness, to be more empathetic and be able to overcome my personal blocks.

1.3.3 My Learning Progression within these Objectives

I experienced placement using my own learning styles. I began by learning through observation and then taking a more hands on approach by adopting more of a converging learning style. My learning progression was measured through the acknowledgement of my own professional development as well as through the feedback of my supervisor and other clinicians. As my placement advanced, I found myself wanting to be more involved with the clients and doing more clinical work. I noticed an increased level of confidence in my professional abilities and an eagerness to challenge myself and grow. I was able to demonstrate my involvement by formulating case conceptualizations, making decisions and taking on tasks independently. My progression was also noticed through my ability to develop working relationships with the MAP team, giving insight and asking for feedback. My learning was also assessed through biweekly supervision meetings. I was able to discuss my progress and ask for feedback on the challenges that I encountered. For example, how to engage a client who's only desire was to be institutionalized. These two objectives lead me to complete my placement with increased self-awareness, confidence and redefined skills.

1.3.4 Adapt Group CBT Material to Address the Needs for People with Learning Challenges

1. The Problem

The MAP team is consistently working to improve the quality and efficacy of their services to ensure that the clients fully benefit from therapy. They have observed that within their

population, there are some individuals that have difficulty understanding the material used in treatment groups. Thus, the question was how to be more inclusive to these members?

Some of the members that struggled in groups identified with having learning challenges. There is a wide range of cognitive impairments that may influence a person's acquisition of CBT. In fact, individuals with major depression and psychosis may also share some of these learning challenges. "Cognitive impairment is present in the majority of patients with schizophrenia, and, in some, it is already evident in the premorbid stages of the disorder" (Reichenberg, 2005, p.31). Rossiter and Holmes (2013) explain a variety of factors that influence a person's accessibility to CBT.

Factors that may impair or reduce cognitive functioning and, therefore, affect accessibility to CBT are numerous and include learning disabilities; pervasive developmental disorders (such as autistic spectrum disorders or Asperger's syndrome) and/or severe trauma and neglect; neurological disorders [such as epilepsy, stroke, head injury, attention deficit hyperactivity disorder (ADHD), dementia]; and there are impairments associated with ageing. Sensory impairments; literacy and/or language difficulties can all impair cognitive functioning. Mental health problems, such as anxiety and depression, can be associated with concentration difficulties; psychosis with reasoning biases, attention, and working memory problems. Medication for both mental and physical health is also known to interfere with cognitive abilities (p.3).

Thus, adaptations within the material and teaching strategies could be beneficial.

2. Importance of this Objective

The prevalence for mood disorders amongst individuals with learning challenges is evident. Therefore, there is a definite need to be more inclusive to this population in psychotherapy. Rossiter and Holmes (2013) explain that "in adult mental health services, behaviours associated with cognitive impairments (such as memory difficulties) frequently get

wrongly misattributed to ‘personality’ or ‘motivation’ and suitable adaptations to interventions are not considered” (p.3).

In addition, “individuals with Asperger syndrome are at increased risk for mental health problems compared to the general population, especially with regard to mood and anxiety disorders” (Weiss and Lunskey, 2010, p.438). McCabe, McGillivray and Newton (2006) did an extensive literature review regarding the prevalence of depression amongst individuals with intellectual disabilities. They found that as many as 1 in every 10 people with intellectual disabilities may experience clinical depression at some point in their lives. Hartley and MacLean (2009) also found that “depression is one of the most frequent psychiatric disorders in adults with intellectual disability” (p.147). These authors found that the experience of stressful social interactions, negative causal attributions and maladaptive coping strategies had a great impact on these findings.

CBT can also be effective for these populations. CBT is especially appropriate for use with individuals with Asperger's syndrome (Weiss and Yona, 2010; Lindgren and Doobay, 2011) as well as mild/moderate ID (McCabe, McGillivray, and Newton, 2006). It also increases in efficacy when material is slightly adapted and simplified. “Although the procedures need to be adapted and simplified, people with intellectual disabilities and a variety of mental health problems can benefit from interventions that retain all the key elements of cognitive therapy” (Taylor, Lindsay and Willner, 2008, p. 726).

3. Purpose of this Objective

The purpose of this objective is to make CBT more inclusive to individuals with learning challenges and to provide the MAP team with strategies to address the needs of this population for the Mood/GAD group. This objective will aid in suitability, accessibility and cultivating creativity within CBT. This is useful for the *Mood and Anxiety Program* because their treatment groups are heavily reliant on standardized CBT approaches.

The remainder of this practicum essay will be focused on this final objective.

CHAPTER 2

2.1 LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.1.1 Introduction

The purpose of this literature review and conceptual framework is to gain a better understanding of the CBT approach and the learning challenges that can be associated with it, this literature review and conceptual framework will include a brief history of CBT, a description of depression and generalized anxiety, a general description of cognitive disabilities and some of the common learning challenges in relation to CBT.

2.1.2 Cognitive Behavioral Therapy

1. CBT Definition

Cognitive Behavioral Therapy, also known as CBT, is a short-term, goal oriented psychotherapy that focuses on examining the relationships between thoughts, feelings and behaviors. By exploring negative and unhealthy thinking patterns that may lead to self-destructive actions, clients can transform their distorted thoughts and live more functional lives. The CBT approach differs from traditional psychodynamic psychotherapy in that the therapist and the client have an active and close working relationship (Duckworth and Freedman, 2012). According to Somers (2007), CBT focuses on current problems and follows a structured style of intervention. The development and administration of CBT is based on evidence-based research.

2. Historical Background

Cognitive Behavioral Therapy is derived from two historical strands: *behavioral therapies and psychodynamic models of therapy* (Dobson and Dozois, 2010). *Behavior therapy* is based on philosophies of learning: the classical and operant conditioning principles of behaviorism. The interventions were mainly focused on behavioral change. This form of therapy was popular for quite some time; however, by the end of the 1960's it became clear that this individual approach was not enough to account for all human behavior. Behavioral therapists focused on behavioral symptoms without fully understanding the cause of the problem or its relational factors. This lack of insight forced behaviorists to incorporate cognitive phenomena.

In the 1960's, Aaron Beck introduced a form of psychotherapy that was known as "*cognitive therapy*" (CT). He originally developed a short-term psychotherapy for depression that aimed to solve current issues and to change distorted thinking and behavior. CT is now used synonymously with *cognitive behavior therapy* by much of the social work field. This therapy is now modified to serve individuals who suffer from various disorders and problems. In all forms of CBT derived from Beck's CT model, treatment is based on a cognitive formulation (Alford and Beck, 1977). Aaron Beck is thus one of the major contributors to the development of CBT therapies. Another pioneer was Albert Ellis. The psychotherapist developed a *rational-emotive therapy* in which the client restates disruptive thoughts that are based upon childhood experience. This therapy is one of CBT's major approaches. In the 1970's the field of psychology was also going through a general transformation; what is now known as the cognitive revolution. It has

been argued that this change came about as a development within behavioral therapy (Marks, 2012, p.6).

Moreover, Marks (2012) explains that CBT was introduced in the mid 1970's, and gained popularity within the 1980's and 1990's. At this time, there was a concurrent movement for the integration of therapies. This period was characterized by an increasing acceptance of diverse approaches and a positive regard towards pluralism. Thus, interdisciplinary became common across the social sciences.

2.1.3. Major Therapies Associated with CBT

Numerous treatment approaches exist within the realm of CBT. There are far too many to be named here, however, I will present the major therapies that are associated with CBT.

Although there are some differences, they all share the same theory, which is that thinking or cognition influences behavior (Dobson and Dozois, 2010). These authors list the eight principle approaches that are associated with CBT.

1. Rational Emotive Behavioral Therapy (REBT)

Clinical psychologist Albert Ellis founded REBT. It was developed in response to the limitations of the analytic method. Ellis formulated a theory of emotional disturbance and treatment techniques that highlighted a more practical approach to dealing with life issues. The integration of the role of cognition in behavior therapies led to the acceptance of REBT as an alternative method to traditional models of psychotherapy. The underlying theory of REBT is that thoughts and emotions are significantly interrelated. It is also assumed that individuals have an innate tendency to think and behave irrationally; therefore durable change requires forceful

methods of treatment. The primary objective is to recognize and challenge distorted thoughts at the root of emotional disturbances. By replacing illogical demands with realistic desires, changes in emotions and behaviors can take place. REBT uses a multidimensional approach that combines cognitive, emotive and behavioral methods. According to Ellis (1979) the main therapeutic strategies remain scientific questioning, challenges, and debates used to help clients disclose their irrational beliefs. It is supposed that individuals who embrace a rational perspective will experience very few emotional disturbances.

2. Cognitive Therapy (CT)

Aaron Beck developed CT. It was originally established to address the cognitive factors that are associated with depression. Nonetheless, it has expanded to help with other disorders and difficulties. Again, CT assumes that unrealistic thinking can negatively influence feelings and behaviors. More specifically, the CT model suggests that affect and cognition mutually influence each other, which can lead to an increase of emotional and cognitive impairment. The goal of CT is to replace the individuals' irrational assessments of events with more realistic appraisals. Therapists use a collaborative, psycho-educational approach that includes explicit learning experiences.

3. Self-Instructional Training (SIT)

Donald Meichenbaum (1969) proposed SIT. The clinician designed a SIT program to help treat medication related deficiencies of impulsive children. Meichenbaum and his associates found that SIT significantly improved the task performance of impulsive children. Later on, SIT was used with individuals suffering from various psychological disorders. In general, clients

practice six global skills related to self- instruction: problem definition, problem approach, attention focusing, coping statements, error- correcting options, and self-reinforcement. SIT is often used in conjunction with another approach. In recent years, therapists refer to SIT when treating mentally handicapped youth and when specific skill training is needed.

4. Self-Control Treatments

Various self-regulation interventions have been introduced within the general scope of CBT. One example is Goldfried's coping skills orientation. Goldfried (1971) interpreted "systematic desensitization" as a means of teaching clients a general self- relaxation skill. This ultimately led to the development of "Systematic Rational Restructuring" (SRR). Goldfried hypothesized that clients can adopt more effective coping strategies by changing automatic thought patterns that occur during anxiety provoking situations. The goal of SRR is to teach individuals to interpret situational cues more accurately and to provide clients with resources that may help them cope with future stressors. Another self-control treatment is Suinn and Richardson's (1971) Anxiety Management Training (AMT). This approach was developed for anxiety control. The goal of AMT is to teach clients relaxation and competency skills that help them manage their anxious feelings. This approach focuses on eliminating anxiety without paying specific attention to the situation causing the anxiety.

5. Stress Inoculation

Meichenbaum (1973) emphasized the importance of learning to manage small amounts of stress as a way to facilitate treatment. It is assumed that individuals who learn how to deal

with mild levels of stress develop the ability to control higher levels of stress. This approach is commonly used to teach generalized coping skills.

6. Problem-Solving Therapy

According to D’Zurilla and Goldfried (1971) “problem solving refers to an overt or cognitive process that makes available a variety of effective response alternatives for coping with a problem situation and increases the likelihood of selecting the most effective response available” (as cited in Dodbson and Dozois, 2010, p.21). Therapists teach clients basic problem-solving skills and practice applying them in actual situations.

7. Structural and Constructivist Psychotherapy

Structural psychotherapy is based on the idea that problem behaviors are a result of an individual’s cognitive organization. In this perspective, the goal of psychotherapy is to modify cognitive structures. Moreover, constructivist therapy involves identifying specific characteristics in behavior and understanding how meaning is linked to experience. In this type of therapy, there is less emphasis on the thoughts themselves but rather on the process of thinking.

8. “Third-Wave” Cognitive- Behavioral Therapy

Third-Wave CBT is often associated with acceptance and commitment therapy (ACT). These models place emphasis on the usefulness of different ways to think and behave. Again, individuals are not to focus on the content of the thoughts but on the process of thinking. A

distinction of third-wave CBT's to other CBT's is that there is a focus on metacognitive processes along with mindfulness.

9. Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) is a form of cognitive and behavior therapy primarily used in the treatment of borderline personality disorder, including suicidal behaviors. DBT's overriding characteristic is an emphasis on dialectics. Lineman (1993) describes dialectics as "the reconciliation of opposites in a continual process of synthesis" (p.19). The most fundamental dialectic is the necessity of accepting clients just as they are within a context of trying to teach them to identify problematic behaviors and thoughts that are causing significant emotional distress. In DBT, emotion regulation, interpersonal effectiveness, distress tolerance, core mindfulness and self-management skills are actively taught. DBT is very similar to standard cognitive and behavior approaches. However, there are four characteristics that make this approach unique: the focus on acceptance and validation of behavior as it is in the moment, the emphasis on treating therapy-interfering behaviors, the emphasis on the therapeutic relationship as an essential part of treatment, and the focus on dialectical processes.

10. Mindfulness

Jon Kabat-Zinn (1990) describes "mindfulness" as a particular way of focusing attention in the present moment without judgment. Mindfulness means living in the moment and awakening to experience. It is a good strategy help improve unhelpful thinking habits that are causing distress. The core features of mindfulness involve observing, participating, being non-

judgmental and focusing at one thing at a time (Vivyan, 2009). Mindfulness is a skill that requires ongoing practice.

2.1.4 Depression and Generalized Anxiety

My main focus for this project was the Mood and Generalized Anxiety group offered through MAP. Therefore, a thorough definition of depression and generalized anxiety is relevant.

1. Depression

The Mental Health Commissions of Canada (2011) defines depression as “a depressed mood or the loss of interest or enjoyment in nearly all activities, as well as additional symptoms, for a period of at least two weeks” (p.1). There are several forms of depressive disorders; major depression, persistent depressive disorder, psychotic depression, postpartum depression, seasonal affective disorder and bipolar disorder. The MHCC explains that major depression is the most common of all mood disorders, affecting 13 percent of Canadian adults in their lifetimes.

They also state that depression is a principal cause of disability and is a dominant contributor to disease for persons aged 15 to 44. Most people with a depressive illness will not seek treatment; however, they will seek help for depressive related symptoms. The general physical signs of depression are; a look of forlorn, slow speech, poor hygiene, lethargic or agitated and decreased energy. In an attitudinal sense, individuals with depression have a very negative perspective with thoughts of helplessness and hopelessness and experience a sense of worthlessness or guilt. The majority of persons suffering from this illness can get better with treatment. The Centre of Mental Health Research at the Australian National University reviewed the efficacy of a number

of treatments for depression. The most effective medical treatments were antidepressants and electroconvulsive therapy. CBT was rated as the top psychological treatment.

2. Generalized Anxiety

Anxiety is a natural response that can occur in many situations. It can be helpful to stimulate motivation and increase performance. Anxiety is also a physiological response of self-preservation, resulting in a reaction of fight or flight when an imminent danger is perceived. Anxiety disorders are characterized by excessive worry that interferes with daily living. According to the MHCC (2011) anxiety differs from normal anxiety through intensity and durability.

It also occurs in inappropriate situations of non-danger. If untreated, this illness can become chronic and lead to other comorbidities. The MHCC (2011) stated that 2.5 million Canadians over the age of 20 suffer from an anxiety disorder. It is also more prevalent in women than in men. This illness can commence at any age often with shy children and adolescents. There are many types including: generalized anxiety disorders, panic disorder, phobic disorder, obsessive-compulsive disorder and post-traumatic stress disorder. The one specified here is *Generalized Anxiety Disorder (GAD)*.

The MHCC (2011) explains that the main symptom of GAD is an overwhelming anxiety and worry for more days than not. These symptoms last for a minimum of six-months. The psychological symptoms are excessive worry, irritability, restlessness, agitation, trouble concentrating, etc. The physical symptoms are rapid heartbeat, headaches, stomach pains, tremors, muscle tension, dizziness, sweating, dry mouth and fatigue. The MHCC (2011) suggests

that effective treatments for anxiety include a combination of medications such as antidepressants or anti-anxiety drugs and CBT.

2.1.5. Cognitive Disabilities

The factors that may impair or reduce cognitive functioning are immense (Rossiter and Holmes, 2013). They can also be ambiguous and difficult to define. Many of the terms are used interchangeably in research and are often confused. This is a large reason why a specific population is not defined within this project. Nonetheless, most of my research is based on individuals with Asperger's, persons with mild intellectual disabilities and learning disabilities as they share many commonalities. "The disorders with the greatest overlap with intellectual disabilities are those in the autism spectrum" (Matson et al., 1996; Wilkins and Matson, 2009; as cited in Matson and Shoemaker, 2009 p.1108). Many of the characteristics of mild intellectual disability correspond to those of learning disabilities (Watson, 2014). Therefore, they have similar barriers in relation to CBT. They also form the basis of my research because studies have proven their suitability for CBT approaches (Willner, 2005; McCabe, McGillivray, and Newton, 2006; Weiss and Yona, 2010; Lindgren and Doobay, 2011).

1. Asperger's

According to Hall (2009) Hans Asperger first coined Asperger's in 1944 when he observed delays and unusual social characteristics in a group of children. Although this disorder was identified in 1944, it was not officially recognized in the DSM until the fourth edition. The DSM-IV described Asperger's as "repetitive and restricted patterns of behavior, and social

interaction difficulties. For a diagnosis to be made, there must be no significant delays in cognitive or language development” (as cited in Hall, 2009, p.9).

Asperger’s disorder is part of the autistic spectrum. This term was first introduced by Wing and Gould (1978) who observed similar features amongst three conditions; Autistic Disorder, Asperger’s Disorder, and Pervasive Developmental Disorder. Autism spectrum disorders is officially defined as “ a group of neurodevelopment disabilities defined by significant impairments in social interaction, deficits in communication, and the presence of rigid behaviors and restricted interests” (Lindgren and Doobay, 2011, p. 4) The characteristics of these three diagnoses vary in severity.

Asperger’s Disorder is the least severe diagnosis on the spectrum and can be easily confused with the term high-functioning autism. Though they are very similar, the primary difference is in language development. With high functioning autism, language is delayed in the early year’s development. Children with Asperger’s develop language at a normal progression (Hall, 2009).

2. Intellectual Disabilities

Intellectual disabilities are characterized by significant limitations in both intellectual functioning and in adaptive behavior. Intellectual functioning refers to the general mental capacity. It is measured using an IQ test; a score of 70-75 signifies a limitation in this area. However, intellectual disabilities can range from mild to profound (Gluck, 2014). Adaptive behavior consists of conception, social and practical skills such as: language, literacy, interpersonal skills, and activities of daily living. This disability usually begins during the

developmental period and is diagnosed depending on the severity of the deficits in adaptive functioning. According to the American Psychiatric Association (2013), the disorder is considered chronic and often co-occurs with other mental conditions like depression, attention-deficit/hyperactivity disorder, and autism spectrum disorder. According to Watson (2014), many of the characteristics of a mild intellectual disability correspond to those of learning disabilities. Gluck (2014) also explains that approximately 85 percent of people with intellectual disabilities have a mild level of impairment. This population can still achieve academic success.

3. Learning Disabilities

According to the Learning Disabilities Association of Ontario (2001), learning disabilities can be easily confused with intellectual disabilities. The key difference between the two is that learning disabilities are specific rather than global impairments. They can be linked to a variety of disorders that impact one or more psychological processes that are related to learning, such as the ability to gain, retain, understand, and organize verbal and non-verbal information. They can also impact social perception and social interaction. Other than these specific impairments, the individual can have average abilities. The LDAO (2001) explains that learning disabilities are due to genetic and neurobiological factors. They can also coincide with attentional, behavioral and emotional disorders as well as sensory impairments and other conditions. They may become apparent during the pre-school years or much later in development. They can be evident through low academic scores or achievement that requires considerable effort and support.

2.1.6. Beck's Cognitive Model

Many authors including Hassiotis, Serfaty, Azam, Martin, Strydom, and King (2012) and Gaus (2007) use Beck's Cognitive Model as the core theoretical foundation for the treatment protocol when working with people who have cognitive deficits. Crowley, Rose, Smith, Hobster, and Ansell (2008) have found this model to be effective; "the application of the cognitive behavioral model has been successfully used in an adapted form with people with intellectual disability and a number of different mental health problems" (Crowley et al., 2008, p.27).

To summarize, Beck's model of cognitive-behavioral therapy proposes that individuals process information according to schemas that are based on core beliefs (Gaus, 2007). This influences the way an event is perceived and the behavioral response. When the core belief is irrational, it leads to a number of thinking style errors. According to Hassiotis et al., (2012) these negative thoughts occur in one of three domains: the self, the world, and the future. This is known as the cognitive triad. When an individual has a negative view of themselves they associate adverse experiences to personal inadequacies. The world in this sense presents as a challenge and its demands are too difficult to overcome. Because of this, even pleasurable experiences can be considered threatening. A negative view of the future encourages the belief that current difficulties will never subside. Such distortions can cause an individual to strictly consider information that reinforces their negative beliefs. Thus, these core beliefs must be challenged.

According to Hassiotis et al., (2012) people with a concurrent diagnosis of depression and learning disabilities hold more negative views of the self than those with a learning disability that do not suffer from depression. They also carry a negative view of the world or the future regardless of psychiatric diagnosis. In addition, Gaus (2007) explains that individuals with Asperger's are vulnerable to maladaptive thinking patterns. Members of this population have social and cognitive deficits which make it difficult for them to consider information within a social context. Their cognitive rigidity also leads to strongly held schemas. Daily struggles with social skills and self-management can reinforce negative beliefs within the cognitive triad. Cognitive deficits such as these can increase ones vulnerability to negative schemas (Gaus, 2007).

This leads us to explore some of the specific learning challenges that individuals with these cognitive disabilities may experience within the context of *Cognitive Behavioral Therapy*.

2.2 LEARNING CHALLENGES

The most repeated learning challenges within the literature in relation to CBT can be categorized in three units: cognitive processing, emotions and language. There are specific difficulties within each category that are further defined.

2.2.1 Cognitive Processing

In this category, cognitive processes such as the interpretation of abstract concepts, executive functioning and cognitive rigidity are described.

1. Abstract concepts

Many individuals who have learning challenges or cognitive deficits tend to be concrete literal thinkers. Therefore, they may experience some difficulty interpreting concepts that are too abstract. For example, Willner (2005) explains that individuals with learning disabilities may misunderstand concepts such as the irreversibility of death. Gaus (2007) also mentions that people with Asperger's have this same issue. When doing CBT, the idea of monitoring and recording thoughts may pose as a challenge. Most understand the concept of a thought but may struggle with accessing them in relation to a situation or exploring their thoughts from an observer's point of view. A similar example is when a therapist is referring to self-talk. The individual may confuse this concept with hearing voices and psychosis. Even persons with mild learning disabilities will generally have a limited vocabulary and understand fewer complex words (Winn and Baron, 2009 as cited in Hassiotis et al., 2012).

2. Executive Functioning

Aron (2008) explains executive functioning as a higher order cognitive process that sanctions the ability to formulate plans and goals. Individuals who have difficulties with executive functioning primarily struggle with planning and organization (Gaus, 2007). It can also influence motivation, prioritization, flexibility in problem solving as well as time perception and management (Anderson and Morris, 2006). In a therapeutic setting, the client may have difficulty reporting situations in an organized manner, retrieving information from memory, creating new ideas, remembering information; multitasking and can easily become overwhelmed. (Gaus, 2007). In relation to CBT, the client can experience difficulty recalling the situation that caused them distress and even more difficulty with trying to retrieve the thoughts or emotions

experienced during that time frame. This may also pose problems when attempting to challenge their thoughts, developing new perspectives, or developing new healthy coping skills. The idea of homework can actually provide structure for these individuals; therefore, they can be very compliant with this. However, if they are already overwhelmed by the tasks of daily living, (as this is also common for individuals experiencing depression) the idea of homework can become alarming (Gaus, 2007).

3. Cognitive Rigidity

Individuals who struggle with cognitive rigidity have a “reduced cognitive flexibility, which could reflect difficulty shifting from a previously learned response pattern or a failure to maintain a new response set” (Miller, Ragozzino, Cook, Sweeney and Mosconi, 2014, p.805).

This is particularly the case for those with Asperger's. They are often very rigid in their thinking. Gaus (2007) found that every client with Asperger's exhibited all or nothing thinking patterns. The author explains that because of neuropsychological dysfunctions, individuals with this diagnosis struggle with thinking about things on a continuum; there are no shades of grey. This also ties into central coherence, which is defined as “the construct used to describe the natural drive to integrate information into context, gestalt, and meaning” (Berger, Aerts, Spaendonck, Cools and Teunisse, 2003p.503). A weak central coherence leads to difficulty seeing the essence of information.

The CBT approach helps people modify and challenge their thoughts therefore clients who are prone to these difficulties will respond at a slower pace than a typical client. They will

also have a greater difficulty linking situations, thoughts and emotions, and modifying the core beliefs that make up schemas (Gaus, 2007).

2.2.2 Emotions

When talking about difficulties regarding emotions, it is important to mention theory of mind and alexithymia as these are primary deficits in some people who experience learning challenges.

1. Theory of Mind

Drubach (2007) explains that theory of mind “refers to a cognitive process which allows an individual to “place him/herself” in the other person’s “mind,” so as to comprehend the latter’s cognitive and emotional status, so as to predict his/her behavior and emotional response to a particular situation” (p. 354). This cognitive process plays a key role in everyday interactions and can be particularly important in therapeutic relationships. In other words, deficits in this area can influence one’s ability to empathize and identify emotions in others. In group CBT, this can affect the person’s ability to appropriately respond to other group members or to the clinicians.

2. Alexithymia

Alexithymia is a “lack of access to words describing emotions and mental states” (Gaus, 2007, p.206). Clients have difficulty reporting important emotional experiences. For example, Hassiotis et al., (2012) explain that individuals with learning disabilities have difficulty expressing their feelings using words and rely on non-verbal gestures.

In sum, people with learning challenges may have difficulty recognizing or identifying emotions in others and difficulty perceiving, regulating and reporting their own emotional experiences. The premise of CBT involves establishing the relationship between thoughts, feelings and behaviors. Thus, this may present as a struggle for those who have difficulty reporting their emotions.

2.2.3 Language

Within the language category, auditory processing, alexithymia and pragmatics are worth mentioning.

1. Auditory Processing

Auditory processing refers to receptive communication (Gaus, 2007). It is important to note that individuals with cognitive deficits may indeed be very articulate and use complex sentences however; they may not understand this same level of language when someone is speaking to them. The complication here is that the facilitator or other group member may misinterpret the level of understanding. The client may seem that they are following the material when they may in fact be struggling.

2. Alexithymia

Alexithymia (described above) may interfere with the expressive communication domain in relation to expressing emotions which is imperative for CBT.

3. Pragmatics

Lastly, pragmatics is part of the interactive communication domain. It is defined as the “social use of language” (Gaus, 2007, p.40). Here, clients may have difficulty with reciprocity in their interactions. They often appear to be having a one-sided conversation and miss other

people's interjections, questions or attempts to change the topic. They can be unresponsive to any nonverbal cues that one may use to communicate. They may also have difficulties with interpersonal boundaries. This learning challenge can influence the rapport between the therapist and the client. It can also complicate the group agenda, time, and the relationships with other group members.

CHAPTER 3

3.1 METHODOLOGY

3.1.1 Literature Review

My first step was a literature review that was completed prior to the commencement of placement. It entailed research on group CBT and how this approach was adapted to suit individuals with mild intellectual disabilities. This allowed me to gain a general understanding of group structure and the basis of this approach. The research on CBT with people who have intellectual disabilities also gave me some strategies on how some of the material could be modified and some specific teaching techniques.

3.1.2 Participation in the Mood/GAD Group

The second step was to participate in treatment groups and to identify, through observation, the possible barriers and difficulties that the clients had with the CBT material. As previously mentioned, the treatment group that I focused on was the Mood and Generalized Anxiety group because this is the group that is most frequented. Nonetheless, the strategies that I provided to the MAP team can also be applied to other treatment groups and also to individual services. I decided to extend my placement to complete the entirety of the Mood/GAD group (18 weeks) to get a thorough understanding of the process and to grasp where the difficulties may lie.

Through my observations and my experience at MAP, I came to realize that a specific label of a disability could not be defined. Participants who attended this treatment group did not necessarily have a diagnosis. Nonetheless, some did identify with being in the autistic spectrum, having a learning disability, or problems with emotions or memory retention. This led me to

refocus my research on individuals with Asperger's, mild intellectual disabilities, and learning disabilities. As discussed in chapter 2, it was found that the challenges experienced in relation to CBT are very similar. A redefined literature review aided in clarifying the difficulties observed in group and provided valid evidence. This research also allowed me to explore the diverse strategies (outlined in chapter 4) that can be used to address these difficulties.

In group, I noticed that clients had the most difficulties with the basic and extended thought records. One challenge was distinguishing situations, thoughts and emotions. For instance, when asking the client about a situation they would identify schemas instead of events. Automatic thoughts were also often mixed with emotions. For example, when asking a client "what thoughts went through your mind in that situation?" they identified their first thought as "I was scared". Another difficulty here was the concepts themselves such as automatic thoughts. This term was often too abstract. Some also had difficulty understanding certain thinking style types as a number of them are hard to differentiate. For example, mental filter is described as only paying attention to certain types of evidence, and disqualifying the positive is being dismissive to good or positive experiences; the two are very similar. In addition, some clients had difficulties linking the situation, thoughts and emotions. This is partly because they were unsure what emotion was felt in that situation or had trouble explaining what was felt. A final challenge was the reappraisals which involves adapting a softer perspective. This is the most challenging part of the thought record for anyone suffering from depression, however it poses as an insurmountable task when the basic thought record; linking the situations, thoughts and feelings are not thoroughly understood or if an individual is very rigid in their thinking and already experiences problems with shifting mindsets.

These difficulties connect with the challenges that were identified through research. There are clear struggles with abstract concepts and linking thoughts to emotions and situations. This can lead to issues with central coherence. Issues with reappraisals can also tie into rigid thinking.

Outside of the thought record, another observable difficulty was staying on topic. When the facilitators would ask about a situation that caused them distress, it was not uncommon for a client to begin with the situation but then connect it to other schemas that were irrelevant to this process. Lastly, homework completion was a considerable problem. Only a few group members would complete their homework. When they were asked “what got in the way ?” they would often respond that they forgot or left it somewhere or that they were feeling too tired or overwhelmed to do it. Two clients in particular reported that it was because they didn't understand the task.

Again, these are similar to what was found within the literature. Challenges with staying on topic can be associated with pragmatics. Difficulties with homework completion and feeling overwhelmed resemble the obstacles with executive functioning.

3.1.3 Client Interviews

Next, I interviewed two individuals who attended the Mood/GAD group whom identified with learning challenges in relation to the CBT material. The purpose of these interviews were to gain insight on their perspectives and experiences with the group and to identify their barriers in relation to the CBT material. For confidentiality purposes I will refer to these clients as client A and client B.

1. Client A

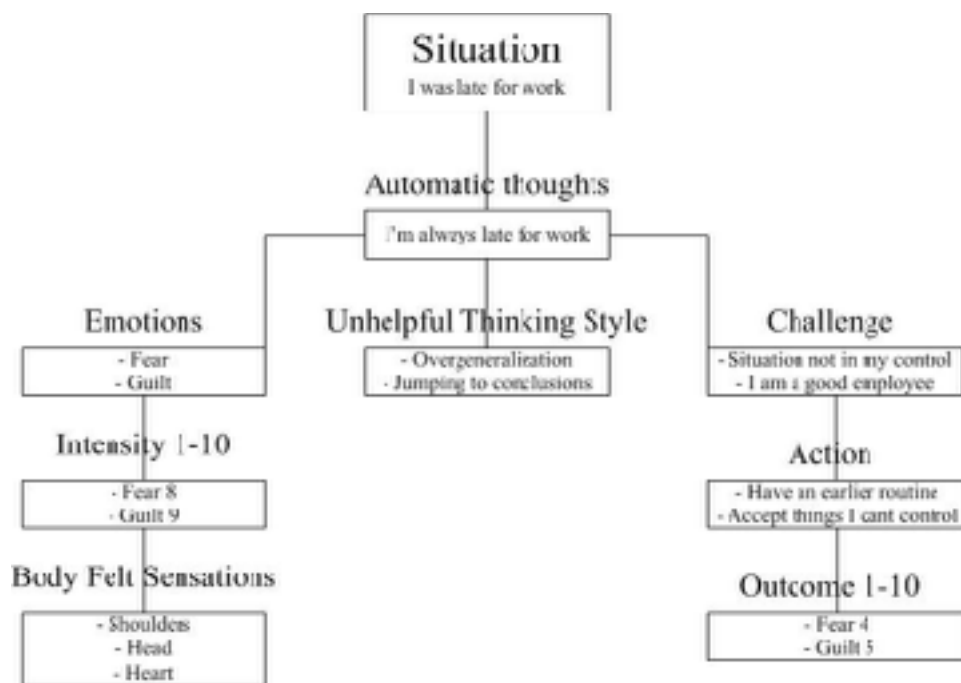
This client was diagnosed within the autistic spectrum. Their struggles were apparent as they went through the process of the extended thought record during the group session. This client felt very overwhelmed and needed lots of time and guidance to get through the process. They felt that its structure was too complicated to follow so they made their own version of a thought record and showed it to the group. The group appreciated this structure and a few group members even felt that it was easier to interpret. The client's version of the thought record is outlined below. I approached this client after group and asked if they would be willing to meet with me to show me how they came up with this structure and to talk about their difficulties encountered in group. This client was very eager and willing to meet. This meeting took place after the entirety of the Mood/Gad group was completed. We met for approximately 90 minutes.

During the interview, the first question I asked was “what posed the most difficult for you in group?” The client stated that they had the most difficulty with the extended thought record. The challenges lied in the structure, which the client described as being very intimidating. My next question was “what about the structure that was most intimidating?” They responded that it was very difficult for them to list their thoughts at once, trying to interpret how their thoughts connected with the emotions and then linking them to the reappraisals. They also reported difficulty with emotions. They had trouble with feeling the emotions in their bodies and explaining/identifying their emotions.

In connection with the literature, these struggles connect with executive functioning central coherence and alexithymia.

Next, I asked the client to walk me through their version of the thought record. Their suggestion was to write down one automatic thought to challenge at a time. They found it easier to identify the automatic thought first and then connect that thought to the emotion. Thus, it was easier for them to make one thought record per automatic thought.

My final question was if there was anything outside of the thought record that the client would change in group. The client's final recommendations were: more group interaction, breathing exercises for mindfulness and more examples of unhelpful thinking styles. The client gave good feedback for the rest of the group process. They also explained that they thrived in the core belief work because one section was done at a time, making it easier to interpret.



Client A's perspective of the extended thought record

2. Client B

Client B did not complete any of the homework and participated minimally in group. However, they did attend every group session. They refused to do a thought record on the white board with a facilitator. At times, they would ask questions to help clarify the group material or the homework but admittedly stated that they felt embarrassed and incompetent. Nearing the end of the group sessions, the client expressed feeling overwhelmed with the material and felt like they were on a different level compared to the rest of the group. With permission from my field supervisor and the facilitators, I privately approached the client and asked if they would like to meet individually to help with the difficulties encountered with the group work. This client was very eager to meet privately as they often felt very uncomfortable and scared to ask questions in group. Thus, meeting with this individual served two purposes; to increase the clients understanding and to identify their struggles. For this case, I met with the client on two separate occasions. The client would have liked to continue the meetings but time did not allow for this to happen. Each meeting was approximately two hours.

Our first meeting was dedicated to answering the questions they had in relation to the homework or group material. They were confused with the mindfulness activities and with the thought record. A mindfulness activity was done at the beginning of every group session. They were still unsure about the significance of this term or why this activity was done. I explained the term and its benefits. I also showed them some guided meditation practices on YouTube for easy access. They were also familiar with YouTube so it seemed like an easy alternative for mindfulness, seeing as they had difficulties coming up with exercises on their own. We then set a specific time for them to do these activities. They responded well to an organized schedule. Next,

we concentrated on the thought records as this is the heart of CBT. We went through a basic thought record together. Through this process I discovered that they had trouble understanding the terms of the thought record. They had trouble expressing and describing their thoughts in relation to a particular situation. Therefore, they would often confuse thoughts with situations or thoughts and emotions. We then did some exercises taken from the manual “Mind over Mood” by Greenburger and Padeski (1995) to help distinguish these terms. An example of this is outlined in Appendix 2. This helped them understand the differences between the terms. I gave them a basic thought record to complete on their own for homework. In the next session, they brought in their completed homework. We reviewed it together. It was still apparent that they had some difficulty accessing their thoughts and emotions and translating them into words however, they were able to independently complete this thought record. We then moved onto the extended thought record. Here, they showed great difficulty challenging their automatic thoughts and changing perspectives. They were observed to be very rigid in their thinking. In my opinion, they would benefit from more individual sessions to help develop some strategies to overcome this cognitive rigidity. During these meetings the client repeatedly stated that individual work benefitted them more than group work. They felt more comfortable to ask questions and very much appreciated this time.

The group facilitators and I did a final interview with this client at the end of the group sessions to determine the next step in terms of treatment. They agreed to repeat the group as the final sessions was missed to meet with me and they had somewhat of a better understanding of the work. They requested individual sessions but the facilitators could not accommodate this at

the time. However, it was agreed that the client would call one of the facilitators and work through any hang ups encountered throughout the process.

In terms of research, the challenges identified with client B can be linked to cognitive functioning; cognitive rigidity, executive functioning (difficulty with planning to complete their homework) and abstract concepts. There was also some struggles that can be associated with emotions and language; alexithymia, as they had difficulty explaining their thoughts and emotions.

3.1.4 Developmental Clinical Services (DCS)

I connected with the DCS program and participated in one of their treatment groups to gain insight on different approaches used for low functioning individuals. DCS is a counselling and treatment service for adults 18 years and older who have developmental disabilities. They are located at 127 Cedar Street (Sudbury) and operated by *Health Sciences North*. They work in conjunction with other service providers and families and offer a variety of community-based clinical services that help increase their quality of life. Their interdisciplinary team includes psychiatrists, psychologists, social workers, behavioral therapists and occupational therapists. They offer psychological assessments, behavioral analysis, drug review, family, group and individual counselling, support and education workshops. They use both DBT and CBT approaches. The treatment group that I participated in was titled anger management.

In this group, I acted as a co-facilitator; independently leading segments of group sessions. I presented different scenarios involving anger using visual aids such as videos and role

playing with the use of puppets. These scenarios allowed the clients to identify feelings of anger in themselves and in others, as well as appropriate ways of dealing with anger. I also presented the rules of anger using pictures and symbols. Situations involving triggers and consequences of anger were also role played with the participation of clients and then discussed.

During my time spent at DCS, I have learned specific teaching strategies that are useful for this population. For instance, I have learned to use a didactic approach; addressing my questions to one individual instead of the group, to use visual aids such as videos, role plays and tactile materials. Furthermore, repetition, short sentences, key concepts and to ensure that nonverbal body language mimics verbal language are all helpful to consider when presenting materials. I incorporated some of the strategies used here to address a few of the barriers that some individuals may have in relation to the Mood/GAD group at MAP.

3.1.5 Webinar: Adapted CBT for youth

To increase my knowledge about the various ways CBT can be modified, I attended a webinar presented by Brian Tallant from *Aurora Mental Health* who talked about adapted CBT group therapy for youth who have dual diagnosis. In their CBT approach they focus specifically on challenging distorted thoughts, cognitive restructuring and repetitive skill building. Brian also talked about a technique called event mapping. Here, the individual tells a story about decision making that leads to a positive or negative consequence. They draw pictures representing the scenarios, identify and label feelings thoughts and behaviors, and use self-talk to map alternative choices. They use a DBT approach and focus on distress tolerance, emotion regulation and mindfulness. When delivering their material they use concrete language,

repetition for retention, visual cues and they attempt to adopt a common language. They also use visual material such as body maps to label emotions and bodily felt sensations. These strategies are also considered for the Mood/GAD group and for individual therapy.

CHAPTER 4

4.1 ADAPTATIONS

4.1.1 Introduction

Simple modifications can be used to ameliorate the client's receptiveness to the CBT approach. "There is a growing literature on adaptations to improve accessibility of CBT for people with cognitive impairments, learning difficulties/disabilities and/or neurodevelopmental disorders" (Rossiter and Holmes, 2013, p.3). These authors explain that CBT typically utilizes written materials with the rooted assumption of cognitive ability and psychological flexibility. Adaptations can serve to meet the client's individual needs. In this section, specific strategies and solutions that correspond to the learning challenges outlined in chapter 2 are discussed. An overview of these strategies can also be viewed in the PowerPoint presentation (Appendix 2).

4.1.2 Solutions: Cognitive Processing

First, a brief exercise that helps distinguish key concepts can aid in the clients understanding of the thought record. As mentioned, client B often confused situations thoughts and emotions. This confusion was often observed in other group members as well. It was common for the clients to form situations into questions rather than statements. This exercise was very constructive for this particular case. This method is used in the manual developed by Greenburger and Padesky (1995). They use simple short sentences and ask the client to indicate whether they correspond to a situation, thought or emotion. An example of this is demonstrated in Appendix 2.

A second strategy is to use plain language. This is neither slang nor a simplified version of the English language but a very clear and concise way of communicating. Plain language was

developed by the Plain English Campaign. They were formed in in 1979, to lobby against jargon and misleading public information. They believe that everyone should have access to clear information. They have also helped many government departments and official organizations with various official publications. With permission from this campaign, I was able to present two of their training guides to the MAP team. The first guide is titled “How to write in plain English”. In short, it provides useful pointers on how to write in a way that is suitable for the reader. This can be used in their program materials (see Appendix 3). The second guide is titled “The A to Z of alternative words”. This provides the professional team with a simpler alternative to complex words (see Appendix 4).

Furthermore, pictures and symbols help make abstract concepts more concrete. Diagrams and drawings can be beneficial when introducing the thought record and cognitive model to some clients. Anderson and Morris (2006) reported that “visually based systems for monitoring thoughts and feelings have been developed and evaluated for CBT with learning disabled adults and may be equally useful for those with AS” (p.296).

Gaus (2007) made use of cartoon symbols as depicted here to help define thoughts.



Figure 7.4 p.169

A final strategy to help with abstract concepts is to use metaphors. For example, Gaus (2007) found that asking one of her clients to imagine a tape recording running in their mind was useful in helping them record their automatic thoughts. Another client independently came up with a “board of directors” metaphor that were dialoging on events that were happening thus, making it easier for the client to log their thoughts around stressful events.

A basic review of the key information presented in the previous sessions and repetition of key words can help with memory retention and deficits in executive functioning. A practical strategy for those who have difficulty remembering to complete homework is to use visual cues (Gaus, 2007). This also helps the client feel organized. In one of her case studies, Gaus (2007) used a bright red folder for homework assignments. She reported increased homework compliance because the folder stood out and served as a signal for homework.

Since the thought records can often be perceived as overwhelming, an alternative method is through the use of the downward arrow technique. Gaus, (2007) used this technique with clients that were highly distressed and emotionally aroused by an event. The client takes one

automatic thought and traces the origins of it leading to a deep rooted core belief. This method increases the client's awareness of each distorted thought, facilitates logical thinking and reveals the core beliefs. This is primarily used in individual therapy but may also be presented to a group as a second option to the traditional thought records.

Another strategy to help with the thought records is the "hot thought", labeled by Greenberger and Padesky (1995). Hot thoughts are automatic thoughts that hold the most emotional intensity. Once the hot thought is identified the client can circle or highlight it, making it easier for them to challenge. If the hot thought is not apparent just by looking at the list of thoughts another method of doing it would be to look at each thought and rate the corresponding mood individually and the thought with the highest rating would be the hot thought. From here, the client can work on challenging this one thought as it is the most pertinent. This could be helpful for individuals who are easily overwhelmed, such as client A.

Clients who are very rigid in their thinking can benefit from stimulating methods to challenge their cognitions. One example is by doing role plays. Lindsay *et al.* (1997) role played positive ways of thinking when doing CBT with individuals who have intellectual disabilities. They reported evidence in improvement with positive thinking. As mentioned, role plays were often used in developmental clinical services. Clients enjoyed participating in these activities and were able to take away concrete information.

Next, for those who experience difficulty linking situations, thoughts and feelings, pictorial images and videos are favorable. For example, Cresswell (2001) used television soap

operas with learning disabled clients to demonstrate this link and to explore alternative responses to situations. In addition, Rossiter and Holmes (2013) presented O’Neils (1999) think, feel, do sequence to demonstrate the correlation.

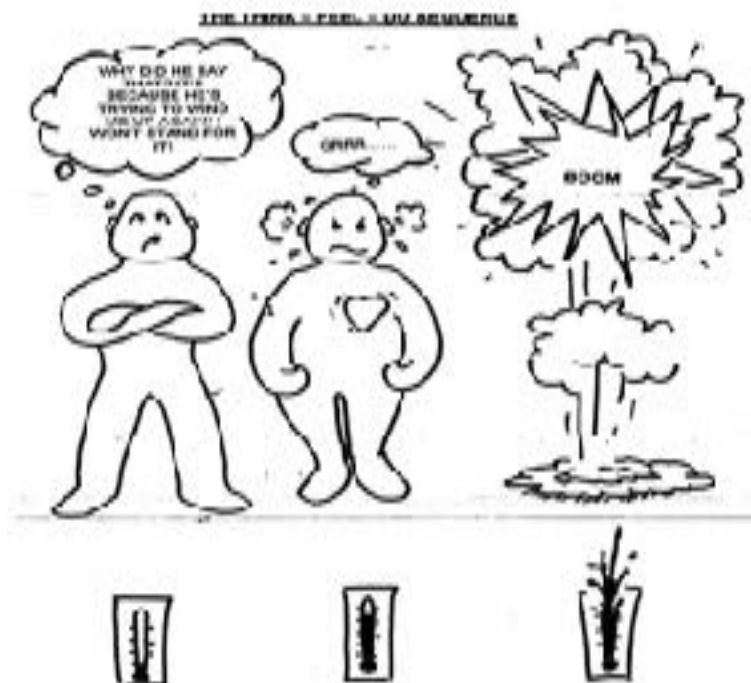


Figure. 2. O’Neill 1999, (as cited in Rossiter and Holmes, 2013)

4.1.3 Solutions: Emotions

Again, visual aids can be quite useful for interpreting and expressing emotions. Anderson and Morris (2006) cited many authors including McAfee, 2001; Moyes, 2001; Silver and Oakes, 2001; Baron-Cohen, 2002 who used materials such as books, games, videos and CD-ROMs to teach individuals with Asperger’s about emotions. The developmental service sector used videos to demonstrate the differences amongst emotions for example, what anger looks like compared to sadness. Gray (1998) used comic strip conversations to help individuals with Asperger’s and

high functioning autism learn about emotions. The author also used colours to help label different emotions. Attwood, Sofronoff and Hinton (2005) used thermometers to rate emotional intensity in their CBT intervention with children diagnosed with Asperger's. Lastly, body maps are largely used in CBT interventions for different types of populations. Hassiotis et al., (2012) used this strategy to help individuals with intellectual disabilities identify the physiological signs of anxiety and depression in the body. This could also help identify bodily felt sensations. The use of body maps allows the clients to express themselves in a manner that is most comfortable for them: written words, symbols, colors or drawings.

4.1.4 Solutions: Language

To help with language discrepancies, miscommunication can be avoided by checking in with client and asking them to reiterate or summarize important information. Adopting a common language is also beneficial. This is commonly done with the youth population. For instance (Tallant, 2014) used the term "stinking thinking" when referring to automatic negative thoughts. The Clinicians can also use plain language. Furthermore, individuals may need more time to respond or to finish making their point. However, if the client is clearly going off topic, the facilitator may need to interrupt and redirect the individual.

4.1.5 Individual Support

An Individualized approach may be necessary if the client still does not respond to adapted approaches. Roster and Holmes (2013) state that personalized techniques give greater emphasis to specific difficulties. If the individual is clearly struggling with homework or participating minimally in group, a conversation about what would be best suitable is necessary.

A prime candidate in need of individual support is client B because of their grave discrepancies with cognitive processing. For instance, a technique that could have been useful for this client is the partial thought record (Gaus, 2007). The partial thought record considers the situation and the automatic thoughts. The other categories (emotions, bodily felt sensations and reappraisals) are gradually introduced over time. This would allow Client B to fully master each section. A second option is the simple thought record that focuses on the three main categories in CBT: situations, thoughts and emotions. Another individual strategy is event mapping (Tallant, 2014). This is a storytelling technique that helps identify automatic negative thoughts, feelings, bodily felt sensations and actions. The therapist prompts the client with specific questions leading to the development of positive self-talk and different perspectives of a stressful situation. This strategy is beneficial for clients who experience difficulty expressing themselves on paper.

Moreover, a great tool used to help individuals communicate their emotions are talk blocks. These are developed by innovative interactions (2005) and used by Gaus (2007) in her CBT work with adult Asperger's clients who have difficulty with alexithymia. The talk blocks are a multi modal tool of communication. They allow the individual to realize that every feeling has a need and a simple change in the environment can help reduce stress. The blocks have verbal presentation of the words, pictures, color coding and tactile involvement. Thus, it optimizes various learning styles. There are two sets of blocks: a set of red blocks that described feelings and a set of blue blocks that describe needs. First, the client chooses a feeling block that best describes their current state. Then, the client is handed the blue blocks and they must choose what it is they need to help them with this feeling. Finally, the client connects the two choices. For example; I feel anxious, therefore I need more information.

Lastly, Anderson and Morris (2006) explain that some cognitive deficits may require shorter or longer sessions. It can be too draining for the client to finish an hour long CBT session, or the individual may need more time to process information, or to allow for rambling speech patterns. Individual sessions would make this possible.

4.1.6 The PowerPoint Presentation

At the end of my placement, I presented to the MAP team the learning challenges and the strategies to overcome them both in group and in individual work (Appendix 2). In my presentation, I used interactive activities to help demonstrate alternative ways of teaching and learning. For instance, I used an exercise from Greenberger and Padesky's (1995) "Mind over Mood" manual for distinguishing situations thoughts and emotions. I ask the team to fill in the blanks to some simple short sentences which was the same exercise I used with client B. I played a video clip from the well-known sitcom "The Fresh Prince of Bel Air" to encourage a conversation about emotional needs and the differences between certain emotions. I also presented a representation of the talk blocks by innovative interactions (2005). I asked a team member how they were feeling, they reported feelings of excitement, I then asked what need is connected to this feeling, the member rotated the blocks and chose the need to have fun. They were then able to formulate a sentence that identified their feelings and emotional needs: "I feel excited, therefore I need to have fun" (as demonstrated in the image below). I also presented the partial thought record and the simple thought record as alternatives to the extended thought records (see images below). As mentioned, I also provided the team with the Plain English Campaign's general guide as well as their A-Z alternative words guide (see Appendix 3 and 4). I

received some positive feedback from my presentation. They empathized with the struggle of simplifying the materials to such a diverse group. The alternative ways of presenting materials were appreciated.



Representation of the talk blocks, Adapted from Innovative Interactions (2005)

Extended Thought Record

SITUATION (trigger) <i>(What was happening?)</i>	EMOTIONS <i>(Write the emotion)</i>	INTENSITY <i>(Rate the intensity of the emotion) (1-10)</i>	BODILY FELT SENSATION <i>(Where in your body did you feel the emotion?)</i>
I got to work late. My boss called me.	Fear Guilt	8 10	Palms and forehead sweating Tightness in my chest and chest Butterflies in my stomach
AUTOMATIC THOUGHTS <i>(What went through your mind?)</i>	THINKING STYLES <i>(see thinking style types)</i>	Is this thought: - true - partly true but distorted - not true at all Unhelpful Thinking Style: #1 - All or nothing #2 - Mental filter #3 - Jumping to conclusions #4 - Emotional reasoning #5 - Labeling #6 - Overgeneralizing #7 - Disqualifying the positive #8 - Catastrophizing #9 - Shoulds & musts #10 - Personalization	
I was late for work three weeks ago. I'm always late for work. I'm a bad employee. I will be fired. I'll never find another job.	First Overgeneralizing All or nothing, Labeling All or nothing, overgeneralizing, Jumping to conclusions Magnification		
CHALLENGE (reappraisal) <i>(What is the evidence?) What is an alternative explanation? <i>(to what...?)</i></i>	ACTION TO TAKE <i>(How can you test the truth? Improve the situation now or next time?)</i>	OUTCOME <i>(How do you feel now?) List and re-rate the emotions) (1-10)</i>	
I have no evidence that I will be fired. All my performance reviews have been good. I've really only been late three times but each time I had a good excuse. Being late happens from time to time for most people. I'm a dedicated employee. I have experience and could find another job if need be.	I will let the boss know why I'm late. I'll get better organized so how to minimize the possibility of being late. I will remind myself of the great work I do.	Fear 3 Guilt 4	





Dw 12/14/98

The Extended Thought Record, *Mood and Anxiety Program* (2015)

Date	Situation	Thoughts
11/29	Arriving late for work	I am a bad employee
12/1	Making a mistake at work	I will be fired
12/3	Calling in sick for work	They will think I am faking it.

The Partial Thought Record adapted from Gaus (2007)

Simple Thought Record

Situation Who, what, when, where?	Feelings What did you feel? <small>Rate your emotion 0-100%</small>	Thoughts What was going through your mind as you started to feel this way? (Thoughts or images)
		
		
		
		

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The Simple Thought Record, Psychology Tools (2008) <http://psychology.tools/cbt.html>

CHAPTER 5

5.1 QUESTIONS REVISITED

1. What constitutes as a learning challenge?

In this practicum essay, I refer to learning challenges as obstacles that can get in the way of an individual's understanding of the CBT approach. Rossiter and Holmes (2013) identified an array of factors that contribute to a person's accessibility to CBT. They explain that various diagnosis such as learning disabilities, pervasive developmental disorder's, neurological disorders, attention deficit disorder and dementia all carry cognitive functioning impairments that may affect a person's understanding and accessibility to this approach. They further explain that people with sensory impairments, literacy and language difficulties along with other variables such as medications, difficulties with working memory, reasoning and concentration can also hinder cognitive capabilities. In this essay, I focused on the learning challenges present in individuals with Asperger's syndrome, persons with mild intellectual disabilities and learning disabilities as they share many of the struggles that can be associated CBT. These members' frequent MAP's services and they are also suitable for this approach. It is important to mention that individuals do not need to have a diagnosis to experience the learning challenges that are listed in this paper.

2. What are some of the common learning challenges in relation to CBT?

The most repeated learning challenges within the literature involved difficulties with cognitive processing, emotions and language. In cognitive processing, the hindrance was with

abstract concepts, executive functioning abilities and cognitive rigidity which also include difficulties with central coherence. Challenges with emotions involved the inability to identify emotions in others and reporting one's own emotional experiences. Listed in the language category were the difficulties expressing thoughts and feelings, understanding the level of language used, and obstacles with reciprocity.

3. What are the barriers faced in group therapy?

Bieling et al., (2006) explain that client personalities, challenges in group process and clashing leadership styles can all led to barriers in group therapy. In addition, the barriers witnessed through my observations of the Mood/GAD group were: the lack of consideration for individual learning needs, the high drop-out rate and the absences of facilitators. It is evident that some group members may need further adaptations which may not necessarily be beneficial for the entirety of the group. The lack of understanding as well as the general difficulties with mental illness can also make it too overbearing for the client to ask for clarifications. This was the case for client B. This particular client shared that they were too embarrassed to ask questions in group. They would participate minimally and did not complete homework; however, their presence to every group session still demonstrated a willingness to learn. This was a clear indication that the client was having difficulty understanding the material. This presents an issue in group therapy because the focus of facilitators is directed to those who complete their homework and engage in group. Individual struggles are important to identify in order to maintain a good group structure and to ensure that the clients are receiving the best possible services. The groups I attended at MAP also had high drop- out rates. The mood/GAD group

started with approximately 15 participants and ended with 5. This affects the group member's motivation, the belief of treatment efficacy and group cohesion. A final barrier is the absence of group facilitators. When a foreign facilitator fills in, the therapeutic rapport becomes impaired. Clients can feel abandoned and develop mistrust. It is obvious that the clients are less open to share and participate when a new facilitator is present.

4. How is the material being presented?

The MAP team uses a standardized CBT approach. They follow the basic structure and implementation of CBT groups for generalized anxiety and depression. Two facilitators run a closed group for a period of 18 weeks, sessions are two hours in length. The sessions always begin with a mindfulness exercise. These range from different types of breathing to visual and tactile exercises. Next, the facilitators complete a status check to assess the member's successes, barriers and insights encountered with the assigned homework. The agenda for the session is then presented. Information for skill development is generally introduced through the use of a white board, handouts and PowerPoint presentations. The sessions end with homework and a closing go-around. The facilitators make it clear that homework completion is essential for progress especially with thought records. Each group member is encouraged to complete a thought record on the white board in front of the group. The facilitator works one on one with the client while the rest of the group members observe. This same process is done with the core belief work. The group ends with the facilitator meeting with each member individually to discuss their next steps in terms of treatment.

5. How can CBT material be adapted in a group setting?

Materials can be adapted in a group setting by using plain language and more pictorial representations. However, the emphasis should be on alternative and creative ways of teaching and presenting the materials. Thus, videos, soap operas, comic strips, role plays, body maps can be used whether or not a cognitive impairment is present. The hot thought can also a more effective way of getting to the more pressing issues. Furthermore, taking the time to distinguish concepts, doing a brief review at the beginning of group, repeating key concepts, adopting a common language, redirecting, allowing time for responses and doing check-ins can also be helpful for all group members.

6. What are some individual CBT approaches that can be used?

Some of the individual approaches listed in this paper were to breakdown the homework into smaller units, (Gaus, 2007), the talk blocks (Innovative Interactions, 2005), the partial and simple thought records (Gaus, 2007) and event mapping (Tallent, 2014).

CHAPTER 6

6.1 CONCLUSION

6.1.1 Reflection

This experience has led me to reflect on the stigma of mental illness and cognitive disabilities and its influence on micro, meso and macro systems. The prevalence of mental illness is finally being recognized. Awareness, education and training are helping to eliminate the fear and clarify the misconceptions surrounding mental illness. Individuals are also being informed of the importance of mental health, especially within the workplace. Issues pertaining to health equity for diverse populations are also being brought to light. However, some discrepancies within western society still remain for individuals with cognitive disabilities. Presently, these persons are being viewed as being outside of normalcy, with the idea that the way they are is not the way they should be. Thus, they are sympathized or treated differently. In my opinion, the attention should be directed towards changing the way disabilities are perceived. Disabilities can bring about strengths that we tend to forget as soon as we hear the word. For instance, individuals with Asperger's tend to be creative and very detailed oriented. In addition, Client A, who was diagnosed within the autistic spectrum, was very skilled in creating diagrams and they helped the other group members understand the extended thought record. We need to step away from the compulsion to fit people into norms. In relation to this paper, the need diversity and health equity can be linked to the importance of recognizing alternative means to learning in both individual and in group settings.

6.1.2 Challenges

One of the biggest challenges within this project was defining the population. The individuals that make up the groups at MAP come from various backgrounds and those who struggle with the CBT material do not necessarily have a diagnosis of a disability. In addition, the mental health and addictions program offers a developmental disability sector (DCS) that tailors to people who have an IQ under 70. The target population then became the individuals who struggle with learning challenges but do not qualify for DCS services.

Another hurdle was adapting the material to a group setting. Group materials can only be adapted to an extent. In a group setting where intellectual abilities vary, it is important not to over simplify the material at risk of insulting the clients. For this reason, specific challenges were presented amongst alternative ways of learning instead of strictly focusing on the adaptations of materials. I did offer some individual strategies to the MAP team supposing their considerations for individual support if the need is clear. The therapist would be able to work more closely with the client to adapt the material to meet their specific needs. As Roster and Holmes (2013) explain; “it is crucial that professionals are competent and confident in individualized approaches to assessment, formulation and intervention not only ‘manualized’ therapy” (p.12).

A final challenge was time. Throughout my placement, I was involved in many clinical activities as I wanted to fully benefit from this learning experience. I also focused on identifying the common learning challenges in groups which involved participating in the entirety of the 18

weeks for the mood/Gad group. Although I did extend my placement, I still did not have enough time to try and present some of the teaching strategies to a group.

6.1.3 Final Remarks

One of the biggest surprises at MAP was the demand and need of their services. The team is regularly doing orientation sessions to large groups of people. There is a steady flow of intakes and groups fill up rather quickly. This opened my eyes to the prevalence of mood and anxiety disorders. Luckily for me, this helped facilitate my learning. The multiple clinical opportunities and complex cases made the experience highly beneficial. The clinicians were always very open and willing to accommodate my learning needs. The accessibility to other programs offered throughout the building at 127 Cedar was also very helpful. My placement supervisor led me to numerous opportunities where I was able to connect theory to practice.

Although I look back on this experience in a positive light, I would have done a few things differently. I would have pushed myself in taking more of a role in the deliverance of the mood group material. I also wish that I had structured my time in a way that would allow me to utilize some of the group strategies presented to the MAP team in order to evaluate its effectiveness. I did do some individual work in my interviews with client B who was struggling with the material but I would have preferred to use more tools such as the partial thought record or the talk blocks to see if this would be helpful in increasing the clients understanding.

In closing, the development of my goals and objectives prior to the commencement of placement was challenging because the actuality of the program is unclear until you can physically experience the gist of what is offered at MAP. Nevertheless, through these clinical

experiences I was able to develop and redefine my placement. This was an immense learning experience and I gained profound knowledge in the deliverance CBT approaches. I also gained confidence in my professional abilities: integrating theory to practice. In relation to my project, the importance of offering more diverse and creative ways of presenting CBT needs to be recognized. Individual therapy also needs to be considered for those who have specific learning needs. I hope the MAP team can benefit from the tools and strategies presented to them.

Cognitive impairment or not, one size does not fit all.

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APPENDIX 1
LEARNING CONTRACT

APPENDIX 2

POWERPOINT PRESENTATION

APPENDIX 3

PLAIN ENGLISH CAMPAIGN: GENERAL GUIDE

APPENDIX 4

PLAIN ENGLISH CAMPAIGN: A TO Z ALTERNATIVE WORDS GUIDE