‘Identifying Our Emotions’ – A group intervention for adults with a mild learning disability and/or autism, to improve mood using cognitive-behavioural and compassion-informed approaches.

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Literature Review

- Transforming Care—helped people to manage behaviour, person-centred.
- NICE guidance (2018)—maximum waiting times for initial assessment.
- NHS England (2017) - community based care, provide education, community team interventions.
- Mood disorders are highly prevalent in adults with LD (Lindsay et al., 2015) and ASD (Reid, Smiley & Cooper, 2011), as are negative life experiences (Idusohan-Moizer et al., 2015).
- They have a similar if not higher prevalence of anxiety disorders (Raghavan, 1997) and low mood (Cooper et al., 2007).
- They are more likely to present with behavioural symptoms (Matson et al., 1997) such as self injurious behaviour or aggression (Challenging Behaviour Foundation, 2016).
- These symptoms place them ‘at risk’ in terms of safety, community access and inpatient admissions (Emerson, 1995) and negatively impact their quality of life (Hayes, Strosahl & Hofmann, 2011).
- ‘Happiness’ in adults with an LD is related to choice and independence, activities, social roles, staff, family and boundaries (Haigh et al., 2013).
- Over 50% of those with an LD display aggression (Benson & Brooks, 2008). Consequences include exclusion from services, placement breakdowns, and involvement with the CJS (Allen et al., 2007).
- It is recommended that effective services are developed for individuals with LD and/or ASD to mitigate potential long-term negative effects (Melville et al.,2008).
- Group interventions reduce waiting times and are an effective method of intervention when using CBT (Willner, 2005), CFT (Lucre & Corten, 2013)and mindfulness (Thornton, Williamson & Cooke, 2017).
- Practice based evidence and evidence based practice (BPS, 2019).

The current study

We designed and evaluated an evidence-based group intervention using elements of CBT, CFT and mindfulness. We offered this group to six adults with LD and/or ASD on our waiting list. We used a trans-diagnostic approach to support understanding.

PowerPoint, handouts, videos and structured discussions were used within the group, and primary carers were invited to the end of every session.

Research questions

1a. What factors contributed to non-attendance?
1b. Was the group relevant, interesting and helpful?
1c. Did the participants understand what was presented?
1d. Did it help them to talk about their feelings?
1e. Were staff perceived as sensitive?
2a. Was there a significant reduction in anxiety?
2b. Was there a significant reduction in low mood?
2c. Was there a significant improvement in happiness?
2d. Was there a significant reduction in anger?

Method

Design: Quasi-experimental pre-test post-test single group design (for questionnaires); Independent samples design (feedback form).

Participants: 6 participants (age range = 19-51, *M* = 28.83). Each had a diagnosis of a mild LD and/or ASD. Data were collected pre- and post- intervention.

Procedure: Telephone calls, invitations, pre-interview with an assistant psychologist, capacity, group programme.

Evaluation methods:

- Glasgow Anxiety Scale for people with an intellectual disability (GAS; Mindham & Espie, 2003)
- Glasgow Depression scale for people with a learning disability (GDS; Cuthill, Aspie & Cooper, 2003)
- Happiness Scale – adapted (based upon Lyubomirsky and Lepper, 1999).
- Novaco Provocation Inventory – 25-item; adapted (NPI-25; Novaco, 2003).
- Group feedback form (post-intervention only).

Results

Attendance: 5 participants completed all sessions (83.33%). Carer attendance was sporadic.

Feedback Form: 100% felt the sessions were relevant, interesting and helpful. 80% felt their needs were met with sensitivity. 80% said that the group had helped them to talk about their feelings. 60% fully understood the content and felt comfortable in a group situation.

Related *t*-tests were used for the 4 questionnaires.

Low mood: Low mood scores decreased (Pre: *M* = 15.20; *SD* = 8.61; Post: *M* = 12.20; *SD* = 7.79); however this was not statistically significant [*t* = 1.03(4)] at the *p*<0.05 level.

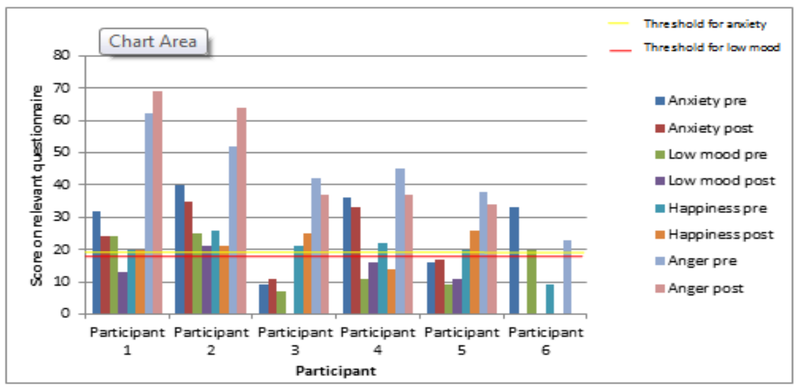
Anxiety: Anxiety scores decreased (Pre: *M* = 26.60; *SD* = 13.41; Post: *M* = 24.00; *SD* = 10.25); however this was not statistically significant [*t* = -1.40(4)] at the *p*<0.05 level.

Anger: Anger scores increased slightly (Pre: *M* = 47.80; *SD* = 9.44; Post: *M* = 48.20; *SD* = 16.84). 3 participants’ scores decreased; however this was not statistically significant [*t* = 0.10 (4)] at the *p*<0.05 level.

Happiness: Happiness scores decreased slightly overall (Pre: *M* = 20.60; *SD* = 4.45; Post: *M* = 20.00; *SD* = 2.74). Scores increased in 2, decreased in 2 and stayed the same for 1. This was not statistically significant [*t* = -.18(4)] at the *p*<0.05 level.

Resilience

- “The ability to bounce back from adversity or change” (Lock, Rees & Heritage , 2019).
- Emotional intelligence is “the ability to recognize the meanings of emotions and their relationships, and to reason and problem solve on the basis of them…to perceive emotions, assimilate emotion-related feelings, understand the information of those emotions, and manage them” (Mayer, Salovey & Caruso, 2004).
- Resilience and emotional intelligence are positively associated (Schneider, Lyons & Khazon, 2013).
- Therefore, by improving our participants’ ability to identify and cope with a range of emotions also helps them to improve in terms of resilience.



Graph 1: Bar chart demonstrating scores for anxiety, low mood, happiness and anger pre- and post- intervention (please refer to Appendix J for separate graphical depictions for separate outcome measures)

Limitations & Recommendations for Future Research

Limitations	Future Research
We did not measure ‘emotional understanding’	Use an ‘emotional understanding’ ROM
Small sample size	Larger sample to increase reliability
Communication adaptations	Assessments of cognition, commu-
We did not explore other therapeutic input	Consider concurrent input in terms of confounding variables
No random assignation	-
Sporadic carer attendance	Expectation to attend & feedback
No long-term follow-up	Conduct follow-up ROMs